

CHIPPEWA COUNTY
HEALTH & HUMAN SERVICES BOARD
REGULAR MEETING
JUNE 16, 2022
CHIPPEWA COUNTY COURTHOUSE, RM 302
7:45 AM

1. CALL TO ORDER

The meeting was called to order by Chair Ives at 7:45 a.m.

2. ROLL CALL

Attendee Name	Organization	Title	Status	Arrived
Kari Ives	Chippewa County	District 21 (Chair)	Present	
Harold Steele	Chippewa County	District 2 (Vice-Chair)	Present	
James Ericksen	Chippewa County	District 8	Present	
Caden Berg	Chippewa County	District 13	Present	
Dean Mueller	Chippewa County	District 20	Present	
John Halbleib	Chippewa County	Citizen Rep	Present	
Nichole Wallsch	Chippewa County	Citizen Rep	Absent	
Stacey Sperlingas	Chippewa County	Citizen Rep	Absent	
Marcia Kyes	Chippewa County	Citizen Rep	Present	

Others Present: Angie Weideman County Health Officer/Public Health Director; Tim Easker, Human Services Director; Pauline Spiegel, Human Services Administrative Assistant; Sarah McQuillan, Public Health Fiscal Manager; Audra Knowlton, Public Health Administrative Assistant; Randy Scholz, County Administrator; Paul Brenner, Senior Fiscal Manager; Leslie Fijalkiewicz, ADRC Manager

3. MEMBERS OF THE PUBLIC WISHING TO BE HEARD

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

4. CONSENT AGENDA

- Initially Berg made a motion to approve the consent agenda; seconded by Ericksen.
- Steele then made a motion to remove the Aging & Disability Resource Center (ADRC) Board and Public Health Professional Advisory Committee minutes from the consent agenda; seconded by Mueller. Motion withdrawn as these minutes are not part of the consent agenda; they are under reports so questions/concerns will be addressed during reports.
- Berg made a motion to approve consent agenda as presented; seconded by Halbleib. Approved unanimously.

RESULT:	APPROVED [UNANIMOUS]
MOVER:	Caden Berg, District 13
SECONDER:	John Halbleib, Citizen Rep
AYES:	Ives, Steele, Ericksen, Berg, Mueller, Halbleib, Kyes
ABSENT:	Wallsch, Sperlingas

1. Approve the Agenda
2. Approve the Minutes

Health & Human Services Board

Minutes
Regular Meeting

Chippewa County Courthouse, Rm 302

June 16, 2022
7:45 AM

Health & Human Services Board - Regular Meeting - May 19, 2022 7:45 AM

3. Schedule Next Meeting Date - July 21, 2022

5. REPORTS

1. Advisory Boards/Committee Meeting Minutes

Steele requested information regarding Public Health's Professional Advisory Committee (PAC) minutes - having virtual meetings and this last one with only 50 percent attendance. Weideman explained history of this committee being a special committee with members that are not appointed through the County Board process, but approved by the Health and Human Services Board (HHSB) through a Public Health policy. The PAC is advisory only for ethical issue reviews. The Public Health policy for PAC also states the County Corporation Counsel and Department of Administration will be involved when there is an ethical issue to address. Public Health is recruiting for new committee members. The PAC meets quarterly and future meetings will be in person.

Item 7.2 - 2022 Aging & Disability Resource Center (ADRC) Program Rankings from the ADRC Board meeting minutes were also discussed. It was clarified the purpose of the HHSB reviewing the minutes is for information and awareness only. HHSB members do not approve these minutes. Members can access and view all the documents included in the ADRC packet (including the program rankings) through the meeting portal on the Chippewa County website by opening either the agenda or minutes packet for that date.

RESULT:	DISCUSSED
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2. Public Health Director's Program and Financial Report

Director Angie Weideman presented the Public Health Program and Financial Report. In recognition of their work during the COVID pandemic, Public Health received a plaque and letter from Governor Evers.

COVID STATS

- Worldwide: 537,209,701 cases; 6,314,191 deaths
- United States: 85,935,634 cases; 1,012,577 deaths
- Wisconsin: 1.7 million cases, 14,711 deaths
- Chippewa County: 19,550 cases, 191 deaths

OTHER COVID INFO:

- There has been a slow decline of COVID cases over the last few weeks. Chippewa County's risk level is currently low.

Weideman highlighted several items from the written report including feedback from the recent accreditation site visit, numerous environmental health inspections due to the many events occurring this summer and many human health hazards reports, Monkeypox, Avian bird flu, tickborne Lyme disease, communicable diseases, and fiscal information. Public Health will be requesting a new position of an additional environmental health worker through the Department of Natural Resources (DNR) grant and Food Safety and Recreational Licensing (FSRL).

RESULT:	DISCUSSED
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Health & Human Services Board

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Regular Meeting

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3. Human Services Director's Program and Financial Report

Director Tim Easker presented the Human Services Program and Financial Report. Easker highlighted several items from his written report including fiscal information, out-of-home placements, case data, staff updates, new Children, Youth & Families Division positions through the 2023 budget process, and hosting a Day in the Life event later this year.

RESULT:	DISCUSSED
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4. Health & Human Services Board Orientation

Easker provided a general overview of Human Services Department programs through a Power Point presentation.

Weideman reviewed the sections in the Health and Human Services Board Orientation Manual regarding general Board and Public Health Department information.

RESULT:	DISCUSSED
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6. BUSINESS ITEMS

7. AGENDA ITEMS FOR FUTURE CONSIDERATION

8. ADJOURN

Meeting adjourned at 9:35 a.m.

RESULT:	APPROVED [UNANIMOUS]
MOVER:	Caden Berg, District 13
SECONDER:	Dean Mueller, District 20
AYES:	Ives, Steele, Ericksen, Berg, Mueller, Halbleib, Kyes
ABSENT:	Wallsch, Sperlingas

CHIPPEWA COUNTY
HEALTH & HUMAN SERVICES BOARD
REGULAR MEETING
MAY 19, 2022
CHIPPEWA COUNTY COURTHOUSE, RM 302
7:45 AM

1. CALL TO ORDER

2. ROLL CALL

Attendee Name	Organization	Title	Status	Arrived
James Ericksen	Chippewa County	District 8	Present	
Harold Steele	Chippewa County	District 2	Present	
Caden Berg	Chippewa County	District 13	Present	
Dean Mueller	Chippewa County	District 20	Present	
Kari Ives	Chippewa County	District 21	Present	
John Halbleib	Chippewa County	Citizen Rep	Present	
Nichole Wallsch	Chippewa County	Citizen Rep	Present	
Stacey Sperlingas	Chippewa County	Citizen Rep	Present	
Marcia Kyes	Chippewa County	Citizen Rep	Present	

Others Present: Angie Weideman County Health Officer/Public Health Director; Tim Easker, Human Services Director; Pauline Spiegel, Human Services Administrative Assistant; Sarah McQuillan, Public Health Fiscal Manager; Audra Knowlton, Public Health Administrative Assistant; Randy Scholz, County Administrator; Paul Brenner, Senior Fiscal Manager; Lori Wedemeyer, Human Services Fiscal Manager; Kyra Secraw, Children, Youth & Families Manager; Sam Flatland, Public Health Environmental Health Coordinator; Leslie Fijalkiewicz, ADRC Manager; Members of the Public: Lisa Mancl

3. ELECTION OF CHAIR

James Ericksen nominated Harold "Buck" Steele; Caden Berg nominated Kari Ives.
Kari Ives approved as Health & Human Services Board Chair by a majority vote.

RESULT:	APPROVED [5 TO 3]
AYES:	Berg, Ives, Halbleib, Wallsch, Sperlingas
NAYS:	Ericksen, Steele, Mueller
ABSTAIN:	Kyes

4. ELECTION OF VICE-CHAIR

John "Jack" Halbleib nominated Harold "Buck" Steele for vice-chair. Steele approved as Health & Human Services Board Vice-chair by unanimous vote.

Minutes Acceptance: Minutes of May 19, 2022 7:45 AM (Consent Agenda)

Health & Human Services Board

Minutes
Regular Meeting

Chippewa County Courthouse, Rm 302

May 19, 2022
7:45 AM

RESULT:	APPROVED [UNANIMOUS]
MOVER:	John Halbleib, Citizen Rep
SECONDER:	Dean Mueller, District 20
AYES:	Ericksen, Steele, Berg, Mueller, Ives, Halbleib, Wallsch, Sperlingas, Kyes

5. MEMBERS OF THE PUBLIC WISHING TO BE HEARD

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

6. CONSENT AGENDA

Harold "Buck" Steele made a motion to remove approval of the agenda from the consent agenda. Motion seconded by James Ericksen. Motion failed.

The stated reasons by Steele were that orientation for the Health & Human Services Board had not yet occurred and there are too many agenda items.

Steele made a motion to eliminate the business items from the agenda. Motion seconded by Ericksen. Motion failed.

Per discussion, it was clarified board orientation will occur in June and several items on this agenda have timeline importance, which is why they are on the May agenda.

John "Jack" Halbleib made a motion to approve consent agenda as presented. Motion seconded by Caden Berg. Approved 8-1 by majority vote.

RESULT:	APPROVED [8 TO 1]
MOVER:	John Halbleib, Citizen Rep
SECONDER:	Caden Berg, District 13
AYES:	Ericksen, Berg, Mueller, Ives, Halbleib, Wallsch, Sperlingas, Kyes
NAYS:	Steele

1. Approve the Agenda
2. Approve the Minutes

Health & Human Services Board - Regular Meeting - Mar 17, 2022 7:45 AM

7. REPORTS

1. Minutes of Advisory Committees/Boards
The minutes of the March 10, 2022 Aging & Disability Resource Center Board Meeting were presented for review.
2. Human Services Director's Program and Financial Report
Director Tim Easker presented the Human Services Program and Financial Report. Easker highlighted several items from his report: treatment programs for children/youth and financial, caseload, and out-of-home placement data. He also noted it is foster care and mental health awareness month. There was some confusion with the chart for out-of-home placement costs and recommendation made to show data as monthly and annually for greater clarification. Easker explained projected cost is included for transparency and budget/financial awareness. Since many acronyms are used, it was suggested to provide a list of them and/or spell them out more in the reports.

Minutes Acceptance: Minutes of May 19, 2022 7:45 AM (Consent Agenda)

Health & Human Services Board

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Regular Meeting

Chippewa County Courthouse, Rm 302

May 19, 2022
7:45 AM

RESULT: **DISCUSSED**

3. Public Health Director's Program and Financial Report

Director Angie Weideman presented the Public Health Program and Financial Report.

COVID STATS

- Worldwide: 525,493,361 cases; 6,283,923 deaths
- United States: 82,951,434 cases; 1,001,269 deaths
- Wisconsin: 1.65 million cases; 14,514 deaths
- Chippewa County: 19,173 cases; 187 deaths

OTHER COVID INFO:

Chippewa County moved from low level to medium level per CDC guidelines for community risk level. Of the six surrounding counties, two are at low, two at medium, and two at high. Weideman also noted the COVID numbers are based on PCR confirmed tests.

OTHER PUBLIC HEALTH INFO:

Public Health is paying close attention/taking preventive measures regarding Avian (bird) Influenza. Weideman also highlighted items from her report: Women, Infant and Children (WIC) Program (shortage of baby formula), NACCHO COVID-19 Hotwash (similar to a debriefing) report, strategic plan update, and the State Statute 140 review August 2022.

RESULT: **DISCUSSED**

8. BUSINESS ITEMS

1. Set Regular Meeting Date and Time

The Health & Human Services Board will continue to meet the third Thursday each month at 7:45 a.m.

RESULT: **APPROVED [UNANIMOUS]**
MOVER: Harold Steele, District 2
SECONDER: James Ericksen, District 8
AYES: Ericksen, Steele, Berg, Mueller, Ives, Halbleib, Wallsch, Sperlingas, Kyes

2. Public Health 2022 Program Priority Ranking

Public Health Director Angie Weideman reviewed and explained the Public Health program ranking process. The Public Health 2022 program rankings approved as presented.

RESULT: **APPROVED [UNANIMOUS]**
MOVER: Harold Steele, District 2
SECONDER: Caden Berg, District 13
AYES: Ericksen, Steele, Berg, Mueller, Ives, Halbleib, Wallsch, Sperlingas, Kyes

3. Public Health 2023 Financial User Fees

Minutes Acceptance: Minutes of May 19, 2022 7:45 AM (Consent Agenda)

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7:45 AM

Public Health Director Angie Weideman presented information on 2023 consumer fees for Public Health. She will be requesting an environmental health specialist position through the budget process that is grant funded. The Public Health consumer fees for 2023 approved as presented.

RESULT:	APPROVED [UNANIMOUS]
MOVER:	John Halbleib, Citizen Rep
SECONDER:	Caden Berg, District 13
AYES:	Ericksen, Steele, Berg, Mueller, Ives, Halbleib, Wallsch, Sperlingas, Kyes

4. Public Health 2021 Annual Report

Public Health Director Angie Weideman presented the Public Health 2021 Annual Report and highlighted several areas: accreditation, staff recognition and changes, Friend of Public Health, COVID-19 2020 and 2021 COVID-19 data comparison and other COVID related information, other communicable diseases, overdose fatality grant, Stanley tornado, Environmental Health, Nutrition/WIC, Western Regional Center, and community partnerships. The Public Health 2021 Annual Report approved as presented.

RESULT:	APPROVED [UNANIMOUS]
MOVER:	John Halbleib, Citizen Rep
SECONDER:	Marcia Kyes, Citizen Rep
AYES:	Ericksen, Steele, Berg, Mueller, Ives, Halbleib, Wallsch, Sperlingas, Kyes

5. Human Services 2023 Financial User Fees

Human Services Director Tim Easker and Human Services Fiscal Manager Lori Wedemeyer presented information on 2023 consumer fees for Human Services. The Human Services consumer fees for 2023 approved as presented.

RESULT:	APPROVED [UNANIMOUS]
MOVER:	Caden Berg, District 13
SECONDER:	James Ericksen, District 8
AYES:	Ericksen, Steele, Berg, Mueller, Ives, Halbleib, Wallsch, Sperlingas, Kyes

6. Human Services 2021 Annual Report

Director Tim Easker presented the Human Services 2021 Annual Report and acknowledged the teamwork and community partnerships that are important in effectively providing services. The Human Services 2021 Annual Report approved as presented.

RESULT:	APPROVED [UNANIMOUS]
MOVER:	Dean Mueller, District 20
SECONDER:	Caden Berg, District 13
AYES:	Ericksen, Steele, Berg, Mueller, Ives, Halbleib, Wallsch, Sperlingas, Kyes

7. Review Draft Resolution to Create 2 Full time Social Worker Positions in DHS for CLTS Services

Human Services Director Tim Easker and Children with Differing Abilities Manager Kyra Secraw presented and explained the need to create two full-time new social work positions in the Children with Differing Abilities Unit of the Children, Youth & Families Division.

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Resolution approved for submission to the Executive Board.

RESULT:	APPROVED [UNANIMOUS]
MOVER:	Nichole Wallsch, Citizen Rep
SECONDER:	Caden Berg, District 13
AYES:	Ericksen, Steele, Berg, Mueller, Ives, Halbleib, Wallsch, Sperlingas, Kyes

8. Review Draft Resolution to Create a Full Time Mental Health Crisis Worker in DHS
Tim Easker presented and explained the need for one full-time mental health crisis worker in the Recovery and Wellness Consortium Division of Human Services.
Resolution approved for submission to the Executive Board.

RESULT:	APPROVED [UNANIMOUS]
MOVER:	John Halbleib, Citizen Rep
SECONDER:	Caden Berg, District 13
AYES:	Ericksen, Steele, Berg, Mueller, Ives, Halbleib, Wallsch, Sperlingas, Kyes

9. Human Services Policy 18 Revision - Dress Code
Director Tim Easker presented and explained the minor change to the Human Services Dress Code policy.
The revised dress code policy approved as presented.

RESULT:	APPROVED [UNANIMOUS]
MOVER:	Caden Berg, District 13
SECONDER:	Dean Mueller, District 20
AYES:	Ericksen, Steele, Berg, Mueller, Ives, Halbleib, Wallsch, Sperlingas, Kyes

10. Human Services Policy 12 Revision - HIPAA Security and Privacy
Tim Easker presented and explained the changes to the Human Services HIPAA Security and Privacy Policy, primarily eliminating duplication (because of the Chippewa County HIPAA Policy) and adding current HIPAA privacy and confidentiality standards.
The revised HIPAA Security and Privacy Policy approved with "break room" verbiage eliminated in the Physical Security section of the policy.

RESULT:	APPROVED [UNANIMOUS]
MOVER:	James Ericksen, District 8
SECONDER:	Caden Berg, District 13
AYES:	Ericksen, Steele, Berg, Mueller, Ives, Halbleib, Wallsch, Sperlingas, Kyes

9. AGENDA ITEMS FOR FUTURE CONSIDERATION

Health & Human Services Board orientation at June meeting.

10. ADJOURN

Meeting adjourned at 10:22 a.m.

Minutes Acceptance: Minutes of May 19, 2022 7:45 AM (Consent Agenda)

Health & Human Services Board

Minutes
Regular Meeting

Chippewa County Courthouse, Rm 302

May 19, 2022
7:45 AM

RESULT:	APPROVED [UNANIMOUS]
MOVER:	James Ericksen, District 8
SECONDER:	Dean Mueller, District 20
AYES:	Ericksen, Steele, Berg, Mueller, Ives, Halbleib, Wallsch, Sperlingas, Kyes

Minutes Acceptance: Minutes of May 19, 2022 7:45 AM (Consent Agenda)



**STATEMENT OF EXPLANATION
ADVISORY BOARDS/COMMITTEE MEETING MINUTES**

5.1

Review of Advisory Boards/Committee Meeting Minutes:

- May 12, 2022 - Aging & Disability Resource Center (ADRC) Board
- June 3, 2022 - Public Health Professional Advisory Committee

CHIPPEWA COUNTY**ADRC (AGING & DISABILITY RESOURCE CENTER) BOARD****REGULAR MEETING****MAY 12, 2022****CHIPPEWA COUNTY COURTHOUSE, RM 302****4:45 PM****1. CALL TO ORDER**

The meeting was called to order by Chair Kari Ives at 4:45 PM.

2. ROLL CALL

Attendee Name	Organization	Title	Status	Arrived
Kari Ives	Chippewa County	District 21 (Chair)	Present	
Larry Marquardt	Chippewa County	Citizen Rep, Vice-Chair	Present	
Patricia German	Chippewa County	Citizen Rep	Present	
Don Hauser	Chippewa County	Citizen Rep	Present	
Mary Frasier	Chippewa County	Citizen Rep	Present	
Janet Mayer	Chippewa County	Citizen Rep	Present	
Glen Howell	Chippewa County	Citizen Rep	Absent	

Others Present: Leslie Fijalkiewicz, ADRC Manager; Tim Easker, Human Services Director; Renee Price, Administrative Assistant

3. MEMBERS OF THE PUBLIC WISHING TO BE HEARD

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

4. ELECTION OF VICE-CHAIR

Patricia German was elected as vice-chair.

RESULT: APPROVED [UNANIMOUS]
MOVER: Mary Frasier, Citizen Rep
SECONDER: Larry Marquardt, Citizen Rep, Vice-Chair
AYES: Ives, Marquardt, German, Hauser, Frasier, Mayer
ABSENT: Howell

5. CONSENT AGENDA

RESULT: APPROVED [UNANIMOUS]
MOVER: Janet Mayer, Citizen Rep
SECONDER: Mary Frasier, Citizen Rep
AYES: Ives, Marquardt, German, Hauser, Frasier, Mayer
ABSENT: Howell

1. Approve the agenda
2. Approve the Minutes

ADRC (Aging & Disability Resource Center) Board

Minutes
Regular Meeting

Chippewa County Courthouse, Rm 302

May 12, 2022
4:45 PM

ADRC (Aging & Disability Resource Center) Board - Regular Meeting - Mar 10, 2022 4:45 PM

6. REPORTS

1. ADRC 2021 Social Media Report - Breanna Schemenauer

ADRC Manager Leslie Fijalkiewicz presented social media information and data from June 2021 Facebook implementation to present time. Discussion on intent of having a Facebook page and also exploring doing more outreach through the ADRC website.

RESULT: **DISCUSSED**

2. ADRC Manager Report

ADRC Manager Leslie Fijalkiewicz presented the ADRC Manager Report. She highlighted several items from her report: staff changes, dementia program updates, need for nutrition staff and Meals on Wheels volunteer drivers, the fiscal report and funding updates (appropriation of funds).

RESULT: **DISCUSSED**

3. ADRC Advocacy Report

ADRC Manager Leslie Fijalkiewicz shared current advocacy information.

RESULT: **DISCUSSED**

4. ADRC Modernization (State Initiative)

Leslie provided information on the State of Wisconsin's new initiative to modernize ADRCs in order to create efficiencies and get information distributed sooner. New technology with a virtual resource platform and client tracking system will be developed.

RESULT: **DISCUSSED**

7. BUSINESS ITEMS

1. Set Regular Meeting Date and Time

The ADRC Board meetings will continue to be 4:45 p.m. the second Thursday of odd months. However, the next meeting (normally scheduled for July 14) will be July 7.

RESULT: **APPROVED [UNANIMOUS]**
MOVER: Patricia German, Citizen Rep
SECONDER: Mary Frasier, Citizen Rep
AYES: Ives, Marquardt, German, Hauser, Frasier, Mayer
ABSENT: Howell

2. 2022 ADRC Program Prioritization

The 2022 ADRC program priority rankings as determined by the ADRC Board members were reviewed and approved.

Attachment: 5.1 ADRC Board Minutes 05-12-22 (7092 : Advisory Boards/Committee Meeting Minutes)

ADRC (Aging & Disability Resource Center) Board

Minutes

May 12, 2022

Regular Meeting

Chippewa County Courthouse, Rm 302

4:45 PM

RESULT:	APPROVED [UNANIMOUS]
MOVER:	Mary Frasier, Citizen Rep
SECONDER:	Patricia German, Citizen Rep
AYES:	Ives, Marquardt, German, Hauser, Frasier, Mayer
ABSENT:	Howell

8. AGENDA ITEMS FOR FUTURE CONSIDERATION

Board members are asked to contact Leslie or Kari with suggestions for future agenda items.

9. ADJOURN

Meeting adjourned at 5:53 p.m.

RESULT:	APPROVED [UNANIMOUS]
MOVER:	Larry Marquardt, Citizen Rep, Vice-Chair
SECONDER:	Don Hauser, Citizen Rep
AYES:	Ives, Marquardt, German, Hauser, Frasier, Mayer
ABSENT:	Howell

Attachment: 5.1 ADRC Board Minutes 05-12-22 (7092 : Advisory Boards/Committee Meeting Minutes)



Professional Advisory Committee Meeting

Friday, June 3, 2022
1:00 p.m. to 1:55 p.m.
Virtual GoToMeeting

Please join my meeting from your computer, tablet or smartphone.

<https://www.gotomeet.me/ChippewaCounty/pac>

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United States: [+1 \(646\) 749-3122](tel:+16467493122)

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Team Members Invited	
Team Member Name:	Attendance: Present/Absent
James Fenno	Absent
Linda Lorentz	Present
Mary Proue	Absent
Stacey Sperlingas	Absent
Stephanie Abbe	Present
Sam Flatland	Absent
Kristen Kelm	Present
Sarah McQuillan	Present
Dawn Stark	Absent
Angie Weideman	Present
Others Present:	
Audra Knowlton, recorder	

DRAFT MINUTES

Prepared by: Audra Knowlton

Topic	Domain #	Description	Action Items/Notes
Welcome/Introductions			Introductions took place.
Review minutes	#3 Inform & Educate	Review and Approve Minutes (Attached) o February 25, 2022	(Lorentz/Kelm) motion to approve the minutes as presented. Motion carried.
2021 Annual Report	#3 Inform & Educate	Review the 2021 Annual Report-Angie (Attached Electronically)	Lorentz was very impressed with the services and programs that the Public Health Department has accomplished. She commented on being an Accredited Health Department, what a marvelous job the Public Health Department, along with community members, have accomplished during the Pandemic, in addition to all their

Attachment: 6-3-22 PAC Minutes (7092 : Advisory Boards/Committee Meeting Minutes)

			regular work. Lorentz asked for clarification of the graphs on Page 24. The percentage rates were based on greater than 50 vaccinated residents per 100 residents. Lorentz commented on the quarantine options graph and shared a few quarantine stories. The report reflects how the staff have listened to the recommendations from the state and CDC to make our COVID-19 response a success, even with all the negativity. Lorentz stated there is a special way that Chippewa County Department of Public Health connects with people and they follow high standards for the community.
Highly Pathogenic Avian Influenza	#3 Inform & Educate	Update on Avian Influenza and Monkeypox – Kristen	Kelm gave a brief overview of the Avian Flu. A team was created with multiple departments and community members to put together a plan in the event we would need to respond to an outbreak in Chippewa County. They have called all the farms who have poultry, gathered their poultry numbers, and provided information about the Avian Flu. Postcards were sent to the farms with information. If there were an outbreak, Public Health would work closely with the workers to monitor their health. Avian Flu can have an impact with fowl (geese) and animals that live in the wild. In addition, be cautious of standing water and wild bird feces. Kelm shared information on Monkeypox. There have been 21 cases reported in the United States. Most of the cases have been connected to international travel from Africa. Monkeypox goes through multiple stages and the incubation period is 21 days. There is a vaccine for treatment.
COVID-19 Update	#3 Inform & Educate	Update on COVID-19 – Angie	Weideman stated we are at a low risk level and previously at a medium risk level. If we would reach a high-risk level, masks would be recommended for anyone over the age of two. Weideman shared how the department has worked so well together during the pandemic. The COVID-19 Incident Command System (ICS) structure officially closed May 25. Weideman talked about expanding like an accordion and encouraging taking time off as needed. We are able to manage within

			our department and with current LTEs now. We have backup plans in place if it does start to flare. We plan to work with accelerated lab for testing if things get worse and we need to expand that accordion again. We would expand within the Public Health Department, but not with community partners. We had about 300 people that were a part of our community calls. This was Chief Kelm's idea to invite community members to join the calls. There was great involvement even from the legislative offices, which at times was challenging but other times refreshing. Discussion was held on COVID-19 home tests available by the government and to purchase. There was concern about case numbers being skewed if people do not report testing positive. Weideman noted that individuals who use a home test and inform Public Health they are positive are following quarantine options.
Other Issues or Items Follow-up to Questions	All Domains		Weideman stated Marcia Kyes was appointed to the Health & Human Services Board (HHSB) as our nurse representative. Weideman asked Kyes if she would be interested in being a member on the PAC. Kyes has verbally accepted. We need to take the appointment to the HHSB meeting for approval. Weideman is going to ask for another full time Environmental Health Specialist (EHS) during the budget process. This person would work with the Transient Non-Community Well Water Testing program. Zoning previously contracted with the DNR with this program. We are in the beginning stages of applying with the DNR to take on this program. The new EHS would also help with licensing event facilities, and human health hazards. The governor invited Public Health Directors to his residence to thank them for all they have done over the last 2 1/2 years with the pandemic. Weideman noted it was a nice event and she had an opportunity to network with other Public Health Directors. The department celebrated being an Accredited Health Department and the Pandemic slowing in May. It was a nice event.

			Lorentz mentioned there is a group of individuals who would like to raise more awareness for environmentally friendly options for the community. Weideman wi share this idea out and connect our Community Health Planning and Promotion Specialist with Lorentz.
Adjourn			(Lorentz/McQuillan) motion to adjourn th meeting. Carried.



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

5.2

Health Officer/Public Health Director Angie Weideman provides a department program and financial report for review and discussion.



Chippewa County Health and Human Services Board

Department of Public Health Angie Weideman's Director's Report

June 2022

COVID-19 Updates

The Public Health Director will give an update of disease numbers reported from the world level down to the Chippewa County level at the meeting. Attached is the Chippewa County COVID-19 case updates for June 8.

Administration Division

As summer is approaching, the Admin Team has geared up and started doing Beach Water testing. This year, like last year, we are going to be testing the water weekly at 11 beaches. In May, we sent out the Food Safety and Recreational Licensing (FSRL) renewals to all facilities, and we have already seen a lot of payments coming in.

We are continuing to see a lot of activity with our loan closet. A lot of wheelchairs are going out and being returned. We continue to send reminder and overdue equipment letters to individuals with overdue equipment rentals.

The Public Health Department has resumed regular immunization clinics. Our Administrative Assistants provide support at these clinics. We also continue to offer assistance in scheduling vaccination appointments, providing support at the COVID vaccination clinics, car seat questions, Breastfeeding Peer Counseling, Fit Testing as requested, and general Public Health questions.

Community Health Division

Accreditation Annual Report



Public Health became an accredited health department in March 2020. As outlined by the Public Health Accreditation Board (PHAB), the department continues with specific accreditation efforts. Accredited health departments are required to submit an Annual Report to PHAB. The report is due at the end of the quarter in which the health department was accredited. The Annual Report is comprised of two sections. Section I contains three categories for the agency to address. Category 1 provides an opportunity for the health department to report on circumstances that could potentially jeopardize continued conformity to PHAB's standards. Category 2 reports on specific measures the

Accreditation Committee requested the department address. Category 3 requests the department report on adverse findings or communications related to oversight or control from federal or state funding that would put the health department at risk of losing programs. In Section II of the Annual Report, the health department provides information related to improvement activities, continuing processes, and emerging public health issues and innovations.

Our second Annual Report was due in March and April of 2022. Some highlighted themes in our annual report focused on our communication and evolving workforce that adapted to meet the need of the

pandemic. In 2021, we did a quality improvement process on the information technology programs that are used within our department. We looked to see if the programs were meeting our needs, to see if we had duplication of programs (virtual meeting platforms), and if there were any other programs that we needed. The project is ongoing as the needs of the department continue to expand. Another topic highlighted in our report is the health equity work that went into our COVID-19 vaccine response; primarily looking at doing clinics in outlying communities and at the senior center.

Attached you will find the Annual Report Review Form from PHAB including the reviewer's comments and recommendations for best practices.

Monkeypox

Monkeypox is a rare disease that is caused by infection with the Monkeypox virus. Monkeypox is in the same viral family as smallpox. First discovered in 1958 when two outbreaks of a pox-like disease occurred in colonies of monkeys kept for research, thus the name of the virus. The first human case was recorded in 1970 in the Democratic Republic of the Congo. In the United States, cases are very rare and do not naturally occur, however, cases are associated with international travel or importing of animals.

At the time of this report, there are 10 cases in the United States in 8 different states. There are cases in several countries around the world at this time. The signs and symptoms for Monkeypox start with fever, headache, muscle aches, backache, swollen lymph nodes, chills, and exhaustion. After one to three of the previous symptoms, a rash appears (often on the face first) then spreads to other parts of the body. The incubation period from time of exposure to symptoms is usually 7 to 14 days but can range from 5 to 21 days. Illness usually lasts 2-4 weeks. Anyone with a history of international travel showing the above symptoms should seek medical care. In Africa, Monkeypox has been shown to cause death in as many as 1 in 10 persons who contract the disease.

Highly Pathogenic Avian Influenza

Our local team of county departments continue to meet to discuss the new cases in Wisconsin and prepare for the potential cases in Chippewa County. Mapping of the farms with poultry is under way. Phone calls have been made to poultry owners to collect information on the number of poultry on their farms and to see if they have any questions. Education was provided to these owners. Postcards will be sent out shortly to farm owners and provided to businesses to help spread awareness of the risk of Avian Influenza.

Avian Influenza is spread between birds, animals that prey on birds, and can be spread from infected animals to humans. The risk to domestic birds happens when they interact with wild birds such as wild water fowl. Animals of prey, such as fox, will consume wild birds that are infected thus getting infected themselves. Humans that work with domestic poultry that have been infected with Avian Influenza can become ill by not wearing proper protective equipment in handling the birds.

Tickborne Illness

With warmer temps comes increased risk for tickborne illnesses. There is a long list of tickborne illnesses reportable in the state of Wisconsin. These include: Lyme Disease, Anaplasmosis, Ehrlichiosis, Babesiosis, Spotted Fever Group Rickettsiosis, Powassan Virus, Borrelia Miyamotoi, and Tularemia. Through interviews with the cases and review of medical information, the classification is made. A patient with Lyme Disease is a confirmed case in Wisconsin if they have erythema migrans (EM) rash which appears like a bullseye. If the patient does not have an EM rash they would need lab testing done. Testing needs to be completed twice which usually doesn't happen. This is why you will see cases listed as



probable not confirmed. This goes for most of the tickborne illnesses as each have the different criteria for classification as a confirmed case, probable case, suspect case, and not a case.

We currently have tweezers, bug spray and wipes available to anyone that needs tick prevention or removal supplies. They are available in the Public Health waiting room.

Hepatitis

Since October of 2021, there have been 246 children under investigation for hepatitis (inflammation of the liver) in 38 different states. The children that are under investigation are not considered a confirmed case of hepatitis, but their medical records are being reviewed, as they are potential cases. This all stems back to late fall when a noticeable increase in hepatitis cases started occurring in children with no known cause of the hepatitis. The children presented to the hospital with hepatitis symptoms but tested negative for types A, B, and C the most common types of hepatitis. They did test positive for adenovirus, which typically causes cold and/or flu-like illness. So far, there have been nine hepatitis cases confirmed.

Parents should monitor their children for signs of liver inflammation, which include fever, fatigue, loss of appetite, nausea, vomiting, abdominal pain, dark urine, light colored stools, joint pain, and jaundice. Keep children up to date on vaccines including Hepatitis A and B.

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 May, we received 1,499 new reports: 449 confirmed (445 Coronavirus and 1 Chlamydia); 61 probable (53 Coronavirus, 5 Lyme Laboratory Report and 1 E-Coli); and 966 that did not meet the definition of a case (940 Coronavirus, 9 Influenza-Associated Hospitalization, and 6 Lyme Laboratory Report). See the attached report for further breakdown by disease type.

Environmental Health Division

May is the start of the busy season for Environmental Health. This is the time of year that we start sending out renewal notices to all our licensed facilities. With over 600 licensed establishments getting all these renewals in the mail is no small task. Once these get sent out, the steady flow of renewal payments starts coming in. This is also the time of year that our campgrounds and pools start opening up and inspectors start spending more time outdoors.

Sixty-two inspections were documented in May. This included 10 retail facilities (5 routine & 5 pre-inspections), 24 restaurants (17 routine, 1 complaint, 5 pre-inspections, & 1 re-inspection), 8 school food safety program inspections, 20 lodging (13 routine, 6 pre-inspections, & 1 re-inspection), and 1 campground inspection. This was an above average month for pre-inspections with many new tourist rooming houses being licensed, a new food truck and base facility being licensed, temporary licenses being issued for the upcoming events in Chippewa County, and multiple facilities changing hands.

Nutrition

Women, Infant and Children (WIC) Program

WIC Program income guidelines increase annually on July 1 and are posted for the public at <https://www.dhs.wisconsin.gov/wic/income-guidelines.htm>. Most pregnant and breastfeeding women, infants, and children who receive Medicaid/BadgerCare Plus health insurance are considered adjunctively income eligible for WIC Program participation. The value of a child's food package is around \$60/month

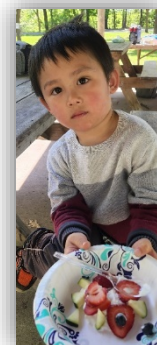
and up to \$100/month for breastfeeding women. Participating in WIC can save on a family's food budget especially during the summer months when school is out. New or returning families are welcome to apply this summer by calling 715-726-7903 or completing a quick pre-application online at www.co.chippewa.wi.us/wic. Referrals from our community partners are encouraged.

Due to the infant formula shortage, infant formula substitutions were extended through August 31 allowing families the opportunity to find a comparable formula. WIC Dietitians continue to field numerous calls from concerned parents to help them provide safe and adequate nutrition for their infants. Two Facebook posts were created to educate the public on the Do's and Don'ts during the formula shortage. You can view those posts here: <https://bit.ly/3m6M2N8> and <https://bit.ly/3tzbM9p>.

On May 20, J.M. Smucker Co. voluntarily recalled select Jif peanut butter products due to potential Salmonella contamination. Peanut butter is one of the foods WIC participants receive, is a great source of protein, and contains iron and folate among other nutrients that are important during rapid periods of growth that benefit pregnant women and young children. WIC staff helped participants who had questions about the recall.

Fit Families

Our Fit Families Program has partnered with Place Space in Chippewa Falls who graciously donated day passes for our Fit Families participants. This partnership encourages families to Move More, Watch Less, which is one of the pillars of the Fit Families Program. On May 24, Amy Ralph, MS, RD, one of our Fit Families coaches, participated in one of Riversource Family Center's Play & Learn playgroups at Irvine Park. She promoted the Fit Families pillar, "Make Every Bite Count: More Fruits and Vegetables" by making flowers with fruit, vegetables, and yogurt with the kids.



Wellness

Chippewa County is again partnering with the Red Cross to host a blood drive on July 27 from 10 am - 4 pm in Room 003 of the Courthouse. To make an appointment to donate, visit www.redcrossblood.org with sponsor code Chippewa County or call Stephanie Abbe at 715-726-7870. Did you know? Each blood donation can help save up to three lives. Every 2 seconds someone in America needs blood.

Western Regional Center (WRC)

The Western Regional Center now has its own Facebook page! We were able to launch the site just a few weeks ago, and are already getting many followers throughout the region. We continue to update our website as well. We are involved in a major marketing project in which we are contacting 18 Public Health Departments, 18 county Children's Long-Term Support units, and many other entities to request that the Western Regional Center be listed as a resource for families, and to also request listing our Facebook page. On a similar topic, we have completed our 2022 Community Engagement assessment with families and providers. Our weakest area has been in the area of our on-line presence, so the Facebook page should help us reach more people in a timelier manner.

We attended the annual Circles of Life Conference in Stevens Point in May and presented two parent trainings, both of which were well received. We were able to finance three families to attend the conference this year. We were able to successfully recruit a parent from our region and her 18-year old son who has complex medical needs to present a special transition session for other parents of children of transition age with complex needs at this same conference. We hope to continue with this trend of facilitating a parent leadership model in every aspect of our work.

Savannah participated in a 12-hour training event titled "Midwest Genetics Parent Leadership Training", in order to gain more skills in facilitating parent leadership opportunities and self-advocacy.

The Children's Long-Term Support Waiver and Comprehensive Community Services referrals continue on an upward trajectory. On May 31, 2021, the average monthly intakes were 10.8, and this year we are at an average of 11.4 per month. The great news is that more and more families are aware of these programs, and more and more children are receiving these services than ever before in our county.

One major topic on the horizon is a proposal from the State Department of Health and Human Services to provide funding to invest in a huge advertising campaign throughout the State to attempt to reach families of children with special needs, who may not know about Regional Centers or programs and services that are available to them. When the Aging & Disability Resource Centers (ADRC's) opened a number of years ago, a similar campaign occurred and was highly successful. Today, most people know what an ADRC is, and how to get help, in large part due to the funding that was invested in that marketing campaign. Regional Centers for Children and Youth with Special Health Care Needs (CYSHCN) are basically ADRC's for families with children with disabilities and special needs, but somehow similar advertising and marketing never occurred. Even after 30 years, many people have never heard of the regional centers. If this marketing project does occur, there will likely be a very large increase in information and referral calls throughout the State.

Jeanne Gustafson's last day with us was May 2. We will miss her terribly, but we are very happy for her in her retirement and will keep in touch with her!

Years of Service

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

- ❖ Dawn Stark, Western Regional Center Manager – 10 years
- ❖ Rachel Potaczek, Community Health Registered Nurse – 8 years
- ❖ Fernanda Garcia, Community Health Planning and Promotion Specialist LTE – 1 year



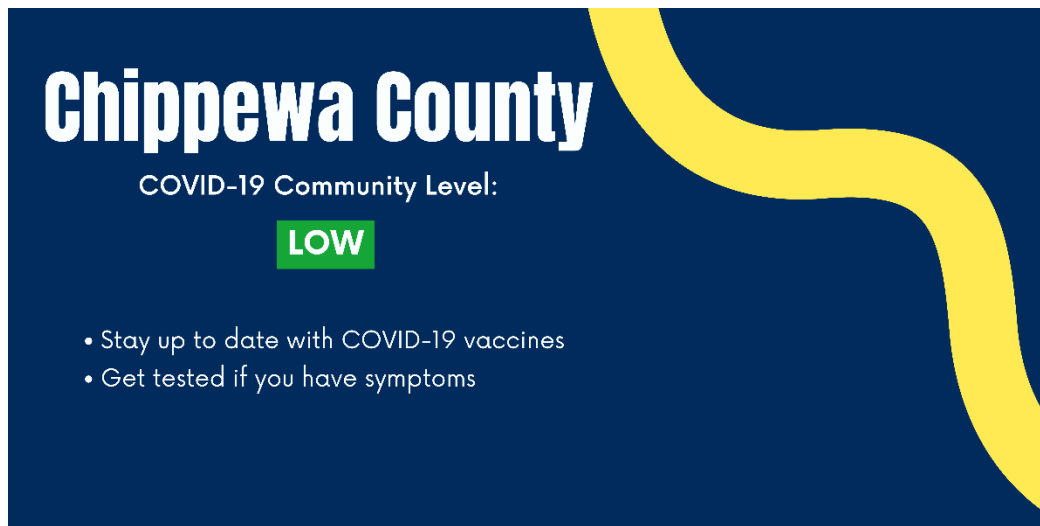
Chippewa County COVID-19 Update

COVID-19 Community Level

The CDC COVID-19 Community Levels metrics are designed to help minimize the impact COVID-19 has on our health care systems, while also protecting those who are most at risk of severe illness.

Chippewa County's community level is currently low. The COVID-19 Community Level and associated metrics presented are updated weekly on Thursday.

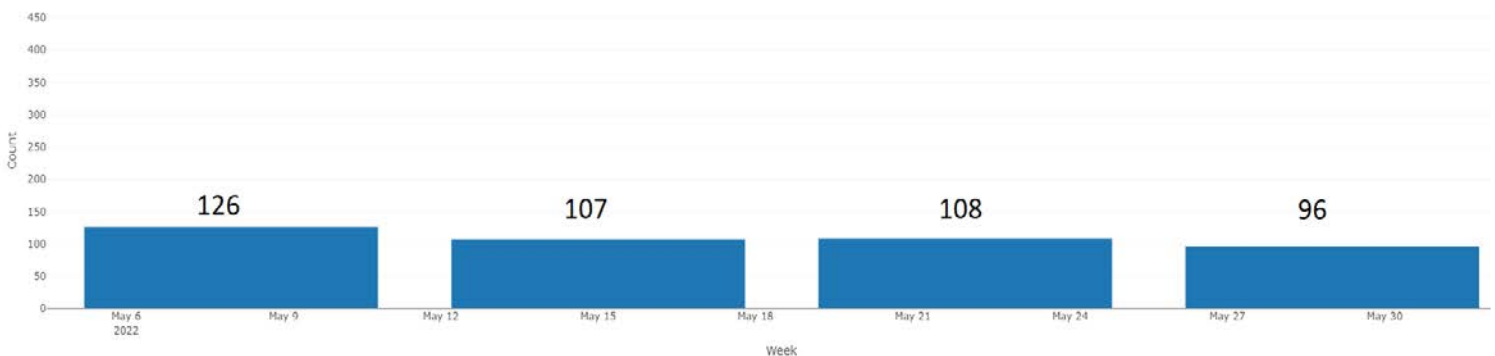
- COVID-19 hospital admissions per 100,000 population: 6.8
- The average percent of staffed inpatient beds occupied by COVID-19 patients: 3.8%
- COVID-19 cases per 100,000 population: 143.83



COVID-19 Case Update

COVID-19 case counts have remained steady in Chippewa County over the past 4 weeks, as shown in the graph. There was a total of 326 cases over the past 4 weeks.

- Week of May 8: 126
- Week of May 15: 107
- Week of May 22: 108
- Week of May 29: 96





**Review Form for
PHAB Annual Report Section II
Form Released: January 2019**

Each year accredited health departments must submit an annual report to PHAB attesting to their continued conformity and describing their performance management and quality improvement efforts. The review of Section II of the annual reports is overseen by the Evaluation and Quality Improvement (EQI). This review is aimed at supporting the maintenance and advancement of a performance management and quality improvement culture in the accredited health department.

The form below includes the reviewer's comments and recommendations for best practices, based on the information provided in the health department's annual report.

Health Department Name
Chippewa County Department of Public Health
Month Review Form Submitted
April 2022
Overall Impressions
Chippewa County Department of Public Health is to be commended on its work to adapt and learn from the COVID-19 pandemic, shift staff responsibilities, and provide valuable public health services to its jurisdiction. CCDPH has prioritized the well-being of their greatest asset, the staff, which is extremely important and admirable. CCDPH's use of technology has enhanced their COVID-19 response, and also elevated work in other internal and external ways. Thank you for submitting your Annual Report. PHAB staff and the Evaluation and Quality Improvement Committee have reviewed your Annual Report. The Evaluation and Quality Improvement Committee has the following feedback specific to your performance management and quality improvement efforts.
Performance Management, Quality Improvement Plan, and Culture
Performance Management - As CCDPH re-engages with PM, it may be helpful to reflect on how the team was functioning pre-pandemic. The department could evaluate elements such as if PM/QI team expectations were clear, if there was dedicated time for this work, what could be beneficial to the team or new team members, how does the transfer of knowledge work when team members rotate, how might all staff be involved in PM/QI ownership, etc. - As CCDPH moves forward, consider creating a routine, formal process that is documented that specifically outlines how the department should update, add, and remove performance measures over time. This type of process keeps PM dynamic and up to date as the context changes over time. It can also help all staff clearly see how their work is aligned with the PM process as a whole. - Regarding the consideration that there are many new staff, remember that performance management can be intimidating to staff, especially if they feel anxious that their work is being judged. However, improvements related to PM and QI are focused on processes, not people. Leaders can encourage employees to identify and talk about challenges and opportunities for improvement. Quality Improvement:

- Engaging all department staff in QI planning can be an important way to elevate QI as a departmental priority and build a culture of quality.
- Coming off of the COVID-19 response where staff were daily engaged in QI processes (whether they realized it or not) to meet the ever-changing demands of COVID-19, staff are more acutely aware of process issues now that impede successful performance and the health department could do some deep dives with staff to mine that experience for the betterment of the department's operations.
- Consider reviewing PHAB's requirements for the QI Plan included in Version 2022.
- CCDPH has plans to update the training plan that supports workforce development. It will be important to assess what training needs are the highest priority as work begins and staff get acquainted/reacquainted with this work.

Quality Improvement Culture:

- Feedback and evaluation are essential hallmarks in building a culture of improvement. Consider collecting feedback from stakeholders (staff, community, and governing entity) about how frequently they would like to receive information, the best methods (email, visuals/dashboards), and what key information they would like to see related to performance management and quality improvement. CCDPH could examine how its communication of results works from the perspective of both those who are responsible for reporting results and the intended audience. This can be helpful to see if the if the communication was effective and what priorities may exist for implementing VMSG or story mapping.
- The health department experienced several staff transitions in the past year. If it has not done so already, the department may consider examining and documenting the experiences, processes used during the transitions, and the related transfer of responsibilities to make any future transitions as smooth as possible.

Response to Questions from Health Department

Question from CCDPH, "Please describe Prioritizing time for QI during the pandemic":

- Encourage and create opportunities for staff to share their own PM and QI updates and key learnings with colleagues. As staff hear more about informal and formal QI projects and activities, staff will naturally start incorporating improvements in their day-to-day work.
- Consider:
 - Including expectations about QI involvement in job descriptions or acknowledging QI participation in team meetings
 - Fostering a community of practice for collaborative learning or connecting PM/QI mentors with PM/QI learners. Providing ongoing support and learning opportunities will help new staff become more confident working with PM/QI. This could be accomplished internally with the health department or also neighboring health departments.
 - Creating a communications calendar to routinely share QI information
 - Hosting a yearly event to celebrate QI champions, projects, successful completion of QI Planning objectives, etc.
- It may be helpful to review PHAB's COVID-19 and quality improvement course on Bridge, PHAB's learning platform. This course provides ideas for how QI can be woven into ongoing work and a few examples from health departments that have been willing to share helpful tools.
- Regarding data, it may be helpful to use the PM system to track and monitor COVID-19 data, or subsets of COVID-related data/outcomes. If trends emerge, try to use QI principles or tools for problem solving.
- It is important to hear from staff what might be helpful in prioritizing QI versus attempting to determine what needs they might have. Staff may have ideas on how the outcomes of a QI project could create efficiencies in their work.
- If you are not already a member of the Public Health Performance Improvement Network, PHAB encourages you to become a member. The Public Health Performance Improvement Network

([phPIN](#)) is a learning community and peer exchange network for those of you providing leadership in performance improvement in public health. [phPIN](#) offers a forum for innovative performance improvement practitioners in public health to network, access just-in-time resources and share emerging practices on:

- Performance management
- Quality improvement
- Accreditation
- Community health assessment and improvement planning
- Workforce development plans and training

Other Comments

During an unprecedented time for public health, CCDPH appears to have taken the many challenges associated with the COVID-19 pandemic and found ways to innovate, strengthen existing partnerships, establish new partnerships, and build trust within their community.

Kudos for making a very intentional effort to support staff well-being, personal self-care, and engagement! Consider how CCDPH could share this body of work (beyond Wisconsin) because it is clear staff shared great insights and leadership were open to making adjustments through action items to support staff.

Throughout the report, it was evident CCDPH has utilized many technology and informatics platforms to benefit their internal work as well as data sharing and communications efforts to stakeholders and the public. Excellent work!

As noted in last year's Annual Report, CCDPH continues to help other health departments by sharing experiences and assisting other HD staff. Thank you for your willingness to share your expertise with others!

PHAB partnered with accredited health departments to develop a new education series, *Emerging Stronger*, to share how health departments have strengthened their work throughout the pandemic. The three short on-demand modules discuss health equity, supportive work environments, and strategies for the community health assessments and improvement plans. Modules are available in Bridge.

Version 2022 of the Standards and Measures has recently been released. All information, frequently asked questions, and a recorded webinar is available on PHAB's website: [Version 2022 - Public Health Accreditation Board \(phaboard.org\)](#)



**Wisconsin Department of Health Services
Division of Public Health
PHAVER - WEDSS**

County Board of Health Report

Jurisdiction: Chippewa County

Received Date: 5/1/2022 to 5/31/2022

Disease	Confirmed	Probable	Suspect	Not A Case	Total
CORONAVIRUS, NOVEL 2019 (COVID-19)	445	53	0	940	1438
LYME LABORATORY REPORT	0	5	0	6	11
INFLUENZA-ASSOCIATED HOSPITALIZATION	0	0	0	9	9
HEPATITIS C, CHRONIC	0	0	3	4	7
CHLAMYDIA TRACHOMATIS INFECTION	1	0	4	0	5
E-COLI, ENTEROPATHOGENIC (EPEC)	0	1	3	0	4
HEPATITIS B, CHRONIC	0	2	2	0	4
CAMPYLOBACTERIOSIS	1	0	2	0	3
STREPTOCOCCAL DISEASE, INVASIVE, GROUP B	0	0	2	1	3
VARICELLA (CHICKENPOX)	0	0	3	0	3
HAEMOPHILUS INFLUENZAE, INVASIVE DISEASE	0	0	0	2	2
INFLUENZA	0	0	0	2	2
ANAPLASMOSIS, A. phagocytophilum	0	0	0	1	1
ARBOVIRAL ILLNESS, JAMESTOWN CANYON, Unspecified	0	0	1	0	1
BORRELIOSIS, BORRELIA MIYAMOTOI	1	0	0	0	1
GONORRHEA	0	0	1	0	1
MYCOBACTERIAL DISEASE (NON-TUBERCULOUS)	1	0	0	0	1
PERTUSSIS (WHOOPING COUGH)	0	0	0	1	1
SYPHILIS REACTOR	0	0	1	0	1

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Page 1 of 2

Attachment: May CD Report (7093 : Public Health Director's Program and Financial Report)

Disease	Confirmed	Probable	Suspect	Not A Case	Total
YERSINIOSIS	0	0	1	0	1
Total	449	61	23	966	1499

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Public Health (Pre-Audited) Financial Results: May 2022



CHIPPEWA COUNTY
Public Health
Prevent. Promote. Protect.

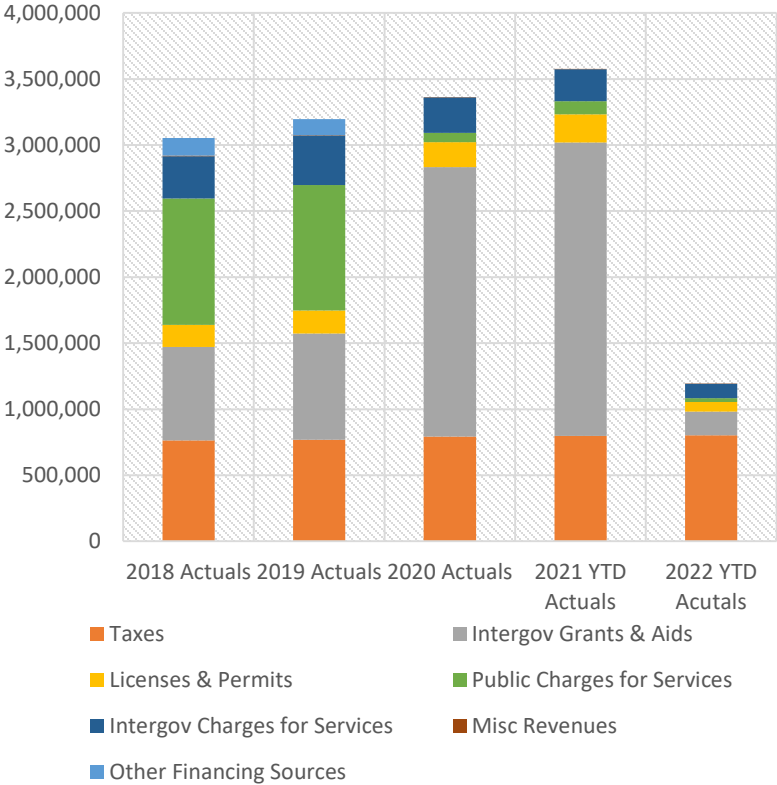
Fund	Description	Revenue			Expense		
		Budget	Actual	% Collected	Budget	Actual	% Spent
54100	Community Health	\$ (706,490.00)	\$ (682,862.54)	96.7%	\$ 706,490.00	\$ 148,428.01	21.0%
54121	Nurse Family Partnership	(119,269.00)	(43,370.92)	36.4%	119,269.00	41,235.03	34.6%
54123	Farmers Market	(3,871.00)	(196.20)	5.1%	3,871.00	196.20	5.1%
54125	Prenatal Care Coordination	(63,686.00)	(2,904.06)	4.6%	63,686.00	4,899.22	7.7%
54128	Public Health Preparedness	(49,188.00)	6,778.65	-13.8%	49,188.00	21,367.52	43.4%
54132	Drug Free Community Grant	(132,814.00)	(31,312.94)	0.0%	132,814.00	47,386.61	0.0%
54135	Bright Start River Source	(10,594.00)	(7,677.22)	72.5%	10,594.00	4,473.31	42.2%
54140	WIC	(409,779.00)	(137,945.10)	33.7%	409,779.00	120,535.89	29.4%
54142	Maternal & Child Health Program	(27,664.00)	(1,055.45)	3.8%	27,664.00	5,677.80	20.5%
54144	Wisconsin Wins	(4,614.00)	(185.25)	4.0%	4,614.00	1,289.47	27.9%
54148	COVID Workforce	-	-	0.0%	-	91.73	0.0%
54149	Pre-Venture	(20,037.00)	(449.65)	2.2%	20,037.00	916.31	4.6%
54150	Prevention	(8,951.00)	(466.15)	5.2%	8,951.00	6,285.87	70.2%
54151	Equipment Loan Closet	(6,943.00)	(542.35)	0.0%	6,943.00	1,300.80	0.0%
54152	Western Regional Center	(189,752.00)	(7,401.10)	3.9%	189,752.00	73,922.55	39.0%
54154	Title X Reproductive Health	(14,766.00)	(2,186.30)	0.0%	14,766.00	29,388.83	0.0%
54156	FIT WIC	(37,178.00)	(3,848.15)	10.4%	37,178.00	13,916.33	37.4%
54157	Reproductive Health	(54,091.00)	(6,385.17)	11.8%	54,091.00	15,194.25	28.1%
54158	WIC BF Peer Counseling	(14,720.00)	(572.80)	3.9%	14,720.00	5,251.65	35.7%
54159	Diabetes Grant	(15,863.00)	(1,498.15)	0.0%	15,863.00	6,785.34	0.0%
54161	Health Clinics	(34,334.00)	(2,467.54)	7.2%	34,334.00	1,988.77	5.8%
54162	COVID Vaccine	(11,346.00)	(4,744.35)	41.8%	11,346.00	10,552.23	93.0%
54163	Overdose Fatality Review	(36,958.00)	(2,321.55)	0.0%	36,958.00	14,213.46	0.0%
54164	COVID Contact Tracing	(99,790.00)	(105,551.35)	0.0%	99,790.00	231,555.33	0.0%
54165	GYT - Get Yourself Tested	(2,083.00)	(48.70)	2.3%	2,083.00	48.70	2.3%
54171	Food Safety Recreation License	(257,236.00)	(117,918.60)	45.8%	257,236.00	86,500.30	33.6%
54172	Infant Immunization Grant	(16,088.00)	(1,282.80)	8.0%	16,088.00	5,208.34	32.4%
54173	Early Hearing Detection & Prev	(112,735.00)	(4,875.45)	4.3%	112,735.00	44,049.87	39.1%
54174	Forward Health Outreach	(21,318.00)	(1,431.25)	6.7%	21,318.00	6,742.78	31.6%
54176	Environmental Health	(24,525.00)	(21,512.62)	0.0%	24,525.00	5,380.02	0.0%
54180	DHS Agreement	(109,061.00)	(5,885.70)	5.4%	109,061.00	37,042.44	34.0%
54182	HCET (Health Care, Ed & Tr)	(7,796.00)	(173.20)	2.2%	7,796.00	173.20	2.2%
54184	Childhood Lead Poisoning Prev.	(9,930.00)	(642.50)	6.5%	9,930.00	2,836.13	28.6%
54186	Charity Outreach Program	(500.00)	-	0.0%	500.00	-	0.0%
54190	Public Health Donation Expendi	(1,000.00)	(30.00)	3.0%	1,000.00	-	0.0%
		\$ 2,634,970.00	\$ 1,192,966.46	45.3%	\$ 2,634,970.00	\$ 994,092.30	37.7%

Public Health Revenues vs Expenses

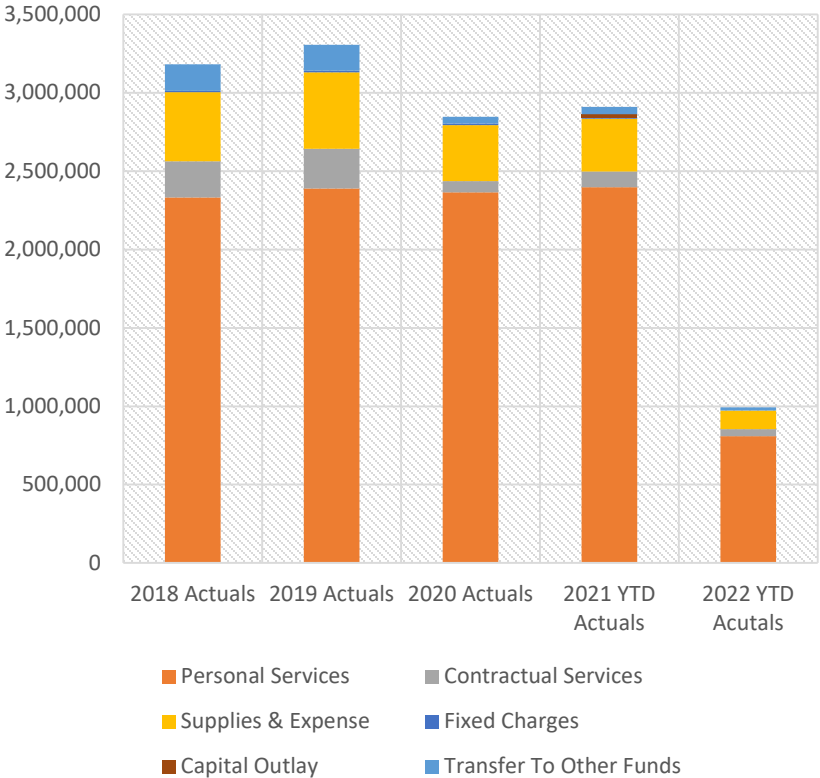
Variance YTD through May 2022



Total Revenues for All Years



Total Expenses for All Years





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

5.3

Human Services Director Tim Easker provides a department program and financial report for review and discussion.

Director's Report to the Health & Human Services Board

Tim Easker

Board Meeting Date: June 16, 2022

1. WCHSA Updates

Division of Children's and Families (DCF)

Fingerprint Checks for Congregate Care Employees – DSP released Licensing Memo 2022-10 in April providing questions and answers about the fingerprint requirement for employees of congregate care facilities. The memo updates the previous licensing memo 2020-04.

<https://dcf.wisconsin.gov/files/cwportal/policy/pdf/memos/2022-10-lic.pdf>

DCF April Town Hall meetings- Three town hall meetings were held in April with Child Welfare Staff, Legal Professionals, and Directors. They covered a variety of subjects related to Putting Families First. For those that were not able to attend the most recent Fall Town Halls, you can view the recordings on the [Family First website](#).

Phase 1 of Safety Planning Revision Workgroup - The first phase of changes to danger threat language will roll out this summer with the June eWiSACWIS release (June 11, 2022). The focus of these changes has been to look at the present and impending danger threats through a race, equity, and inclusion lens. The June 2022 update will include language changes to 12 danger threats across both Present and Impending Danger. The language revisions in the June 2022 update **do not change** the original intent or function of the danger threat. DCF does not anticipate a substantive impact on current case practice or documentation.

2021 Wis. Act 252 – The legislation signed by the Governor in April authorizes the Department of Corrections to borrow up to \$41.8 million to construct a new type 1 juvenile correctional facility in Milwaukee County to replace Lincoln Hills and Copper Lakes. The Department of Administration may approve the construction plan only if the site has support from the municipality where the site is located. <https://docs.legis.wisconsin.gov/2021/related/acts/252>

Raising Wisconsin – DECE in partnership with the Wisconsin Early Care Coalition (WECA) announced in April the official launch of [Raising Wisconsin](#), a statewide initiative dedicated to advocating for transformational change in Wisconsin's early care and education system and optimal child health and well-being. The coalition led by WECA brings together expertise and experiences from across the state to build upon the efforts of the Wisconsin Infant Toddler Policy Project and the Preschool Development Grant managed by DECE. [Visit the Raising Wisconsin website to learn more.](#)

Division of Health Services (DHS)

- **Funding Awarded to Cover Room and Board Costs for Residential Opioid Use Disorder Treatment for Medicaid Members April 21, 2022**
- **DHS Hosts Event to Share Findings of Innovative Local Pilot Programs Addressing the Social and Emotional Needs of Children April 12, 2022**
- **Diagnosed Conditions and Atypical Development Guidance for Wisconsin's Birth to 3 Program**- Neonatal abstinence syndrome has been added to Chart 2 of the [Diagnosed conditions and Atypical Development Guidance for Wisconsin's Birth to 3 Program, P-00893](#).
- **Community Mental Health Allocation CY 2022 DCTS Action Memo 2022-07** This memo references Profile #516 of the State and County Contract for Social and Community. This memo is distributed at this time to foreshadow reporting requirements for CY 2022 mental health services. Counties must comply with the reporting requirements in the PPS.

- **Community Mental Health Services Block Grant – Community Aids Formula Allocation and Reporting Requirements** [DCTS Action Memo 2022-06](#) This memo outlines the reporting requirements for calendar year 2021 MHBG funds and expenditure requirements for the use of CY 2023 MHBG funds. The CY 2021 expenditures report/CY 2023 expenditures plan must be submitted through an online reporting form, the Mental Health Block Grant Community Aids Report, F- 00251. This report must be completed no later than May 13, 2022.
- **Survey of Crisis Programs Regarding Local Law Enforcement** We are surveying county crisis programs about their relationships with their local law enforcement agencies. *Please complete this survey by May 20, 2022.*

2. Department and Division Updates

Department Updates:

- I am working with division and unit managers and supervisors to develop metrics that we will track in order to make data informed decisions. For those who are new, this is a part of our leadership team's strategic plan. We are being careful to "not measure for the sake of measuring." We need to have quality data that will be useful in guiding future programmatic decisions.
- I am pleased to report we received the Collaborative Crisis Intervention Services to Youth grant. This was a collaborative effort along with Lutheran Social Services (LSS) who actually wrote the grant. It was also in conjunction with the core counties of Buffalo and Pepin who we partner with in the provision of some mental health services. The grant will allow LSS to more fully deploy Dialectical Behavioral Therapy (DBT) in the schools. We will also be training certain school staff along with social workers in DBT related skills. Jefferson County DHS utilized this approach with a very positive impact on their emergency detentions of children and subsequent placements. The majority of the grant will be devoted to LSS staff who will implement the DBT skills portion.
- We would like to recognize the following dedicated staff for their years of service: Kristin Wojtalewicz (Child Protective Service, CPS) 2 years, Beth Holm (Child Protective Service, CPS) and Hanna Kleist (Children with Differing Abilities CWDA) 3 years, Kari Kerber (Child Protective Service, CPS), Cheryl Kivi-Lemanski, Economic Support ES) and Danielle Jones (Economic Support ES) 5 years, and Melinda Steele (Economic Support ES) 7 years. THANK YOU!

Division Updates:

Aging & Disability Resource Center (ADRC)

- These reports usually talk about programmatic things but this time, it will be all about staff!
- Exciting news to report! We have accepted offers for the two Administrative Assistant positions and while I don't want to "jinx" it, we are hoping to offer the Nutrition Program Assistant position to someone very soon!
- Michelle Fellom has already started assisting customers in her new role as the Elder Benefits Specialist. Considering the fact that it typically takes several months in this position for people to be able to actually start assisting customers, this is very exciting for us, though not surprising.
- Equally important is the fact that Renee Price has been demonstrating her incredible organizational skills as the sole Administrative Assistant handling phones, walk-ins, and so much more. Sometimes, we don't get to see the depth of someone's skills until they are challenged beyond their usual. While I know she can't keep up this pace forever, it has been incredible to just stay out of her way and watch her do her thing!
- I'm not surprised to tell you about Breanna Schemenauer and what she has been doing. Breanna has once again been asked to take on more responsibility as it relates to the Disability Benefits Specialist position. She has been working closely with customers, Social Security Administration, and providing guidance to folks who are struggling with their disability applications and appeals. I might add that she has been doing this while we are also in the midst of trying to get the Senior

Farmers Market Voucher distributed. There are so many intricacies to all of these programs and Breanna is cool as a cucumber when it comes to juggling all of these things plus keeping our website updated.

- Last, but certainly not least I have to give a huge shout out to Jeff Hahn. He has been our only Nutrition Program Assistant for two months now. The position is supposed to be shared and we have only recently received applications with a prospect of hiring. Jeff is very good natured about all of the extra hours he didn't sign up for, which we are grateful for. Especially grateful knowing he was just blessed with another grandchild that he is itching to visit more!
- While I only featured a few of the exemplary staff of the ADRC, I think you will agree that Chippewa County is blessed to have this very fine team!

Children, Youth & Families Division

- Children, Youth, and Families Manager Kari Kerber will be relocating. Her last day at Chippewa County is Friday, August 5, 2022. Foster Care Coordinator Abby Smasal recently returned from leave and will be working diligently to license a number of relative homes to achieve permanency for children. In addition, there are three general homes eager to become licensed. There have been a number of cases that are transferring to Ongoing Services due to child safety. However, Ongoing Workers have been working diligently at achieving permanency for children resulting in their overall case numbers remaining status quo.
- Birth to Three applied for the Child and Family Focused Pandemic Recovery Support Grant to support children and families in the Birth to Three Program affected by the pandemic. They have an orientation call on June 10 to discuss grant implementation and reporting requirements.
- Birth to Three is still down a full-time speech therapist through their contracted provider, Prevea, due to a retirement in March. They hired a speech therapist, however, she ended up having another opportunity. They have since hired another speech therapist who plans to start at the end of August 2022.
- Birth to Three continues to have a record number of referrals.
- Youth Justice:
 - Staff are covering case load for FMLA in ongoing Youth Justice.
 - We were awarded \$23,640 in 2022-2023 for the YJ Community Intervention Program (CIP) grant!
 - We will be expanding ART and partnering more closely with Restorative Justice out of Eau Claire.
 - Thanks to Manda for doing the bulk of the work on this application!
- Children With Differing Abilities (CWDA):
 - Karla Halverson has been hired for Rachel's CWDA Supervisor position. Karla will be starting on July 25.
 - We are doing a phenomenal job on our CCS waitlist; almost to zero!

Economic Support Division

No update – business as usual.

Fiscal & Contracts

- We have been busy providing information to CliftonLarsonAllen (CLA), the external auditor firm performing the annual 2021 county audit.
- The summer months are also busy with the budget process as well as the reconciliation cost reporting process known as the Wisconsin Medicaid Cost Reporting (WIMCR).
- We also have a new Account Assistant that is starting on June 13 - Tiffany Fedie.

Recovery & Wellness Consortium (RWC) Division

June is Elder Abuse Awareness Month. World Elder Abuse Awareness Day is June 15. Elder abuse is largely hidden and growing problem in the U.S.

Elder abuse is an intentional act or failure to act that causes or creates a risk of harm to the older adult. Older adult is identified as someone 60 years of age. There are seven different types of abuse (emotional, physical, sexual, financial exploitation, neglect, abandonment and self-neglect).

Signs of Mistreatment

- *Neglect*
 - Lack of clean clothing or clothing inappropriate for the weather
 - Lack of basic hygiene
 - The home is cluttered, dirty, in need of repairs or the home has fire and other safety hazards
 - The home does not have needed utilities such as electricity, working plumbing, heating/cooling
- *Financial Abuse/Exploitation*
 - Unusual patterns of spending or withdrawals from an older adult's account
 - Frequent purchases of inappropriate items
 - Bills going unpaid or utilities being turned off
 - The presence of a new "best friend" who is accepting generous "gifts" from the older adult
- *Physical Abuse*
 - Bruises, especially on the head or torso, and those shaped like a hand, finger, or thumb
 - Unexplained burns, cuts, sores, or other injuries
 - Denying an older person enough food/water, needed medications, or assistive devices such as canes, walkers, hearing aids, and glasses
 - Giving older adults unnecessary tranquilizers or sleeping pills, or confining or tying an older person to a bed or a wheelchair
- *Emotional/Psychological Abuse*
 - Intimidation or yelling
 - Making threats
 - Humiliating or ridiculing someone
 - Isolating an older adult from friends and keeping them from activities they enjoy for no good reason
- *Sexual Abuse*

If there is an unexplained genital infection, we should look to have a conversation with the older adult's healthcare provider. If the name of the healthcare provider is not known, try to get more information about the infection from the older adult and contact the authorities.

 - Unexplained anal or vaginal bleeding
 - Torn or bloodied underwear
 - Bruises around breast or genitals.

3. 2022 Monthly Fiscal Information

Through Month of: May 2022

Prorated 2022 Budget (total is \$24,807,743):	\$10,336,560	5 months
Expenses paid through May:	8,892,095	
Variance to Budget:	\$1,444,465	

Note: The May Over/(Under) amounts are an estimated annualized amount for each placement category as of May 31. Prior months estimated amounts are shown to indicate if expense variances are trending up, down, or remaining the same.

2022 Kinship Placement with a Relative

Month	Kinship	Projected Cost	2022 Budget*	Over/(Under)
January	106	\$369,402	\$394,020	(\$24,618)
February	105	375,414	394,020	(18,606)
March	107	379,940	394,020	(14,080)
April	107	380,097	394,020	(13,923)
May	109	381,240	394,020	(12,780)

2022 Children and Youth in Out-of-Home Placements

Month	Out of Home*	Out of Home**	Projected Cost*	2022 Budget	Over/(Under)
January	86	15	\$2,729,304	\$1,577,818	\$1,151,486
February	85	14	2,745,456	1,577,818	1,167,638
March	81	14	2,819,543	1,577,818	1,241,725
April	89	10	2,803,043	1,577,818	1,225,225
May	78	9	2,780,072	1,577,818	1,202,254

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

**Additional children placed with relatives (unpaid)

2022 Adult Mental Health and AODA Out-of-Home Placements:

Month	Out of Home	Projected Cost	2022 Budget	Over/(Under)
January	13	\$368,280	\$713,987	(\$345,707)
February	11	371,700	713,987	(342,287)
March	13	407,640	713,987	(306,347)
April	13	440,254	713,987	(273,733)
May	13	428,388	713,987	(285,599)

2022 Institute for Mental Disease (IMD) Placements

Month	Inpatient Days	Projected Cost*	2022 Budget	Over/(Under)
January	114	\$662,556	\$401,392	\$261,164
February	117	737,190	401,392	335,798
March	170	879,884	401,392	478,392
April	166	1,024,512	401,392	623,120

* IMD invoices are received two months in arrears

Department of Human Services – Consumer/Caseload Data

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

Year	Screened in CPS Reports 01-01-22 to 05-31-22	Number of IA Workers	Projected End of Year based on 01-01-21 to 05-31-22	Actual End of Year
2022	102	4	245	N/A
2021	110	4	264	199
2020	128	4	307	261
2019	129	4	310	272
2018	120	4	288	250
2017	79	3	190	186

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 (06-08-22)

Caseload Type	1 FTE	1 FTE	1 FTE	1 FTE	1 FTE	1 FTE	1 FTE	1 FTE	1 FTE	1 FTE
Initial Assessment	12	8	13	7						
Ongoing					17	14	16	16	14	15

Total Families/Cases Open: Initial Assessment = 30; Ongoing = 92; equals 120 Total

Out-of-Home Placement Yearly Comparison

Total Children/Youth Served January 1 to current Date of Each Year (includes Kinship)

2022	2021	2020	2019	2018	2017	2016	2015
149	158	140	164	178	148	83	51

Children/Youth Opened in CCS and/or CLTS (06-08-22)

Children/Youth Opened	15
Children Waiting to be Screened to Determine Eligibility	21
Waitlist - CCS	0
Waitlist – CCS/CLTS (Dually Eligible)	1
Waitlist - CLTS	41

Current IMD Expenditures

Children/Youth – IMD	\$ 99,091
Adults – IMD	\$ 242,413
Total	\$ 341,504

Yearly Comparison Crisis: January – March

	Adults	Children
2022	219	67
2021	168	60
2020	217	76
2019	220	55
2018	189	45

Yearly Comparison Youth Justice Referrals

Year	Jan-March	End of Year
2022	77	308(Projected)
2021	59	236
2020	98	243
2019	90	362
2018	123	351

In the Spotlight



Jessilyn Balsiger
Children, Youth & Families
CWDA

***Before working at Chippewa County, what was the most unusual or interesting job you've ever had?** My first job was working at an antique/resale shop called The Big Chicken when I was 15. It had a giant chicken on the roof, and I sometimes got to put hats on it. The store wasn't super busy, so I would mostly just eat ice cream and people-watch the people at the park across the lake.

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

I would totally love to be a park ranger that tours with Smokey the Bear talking to kids about how to prevent forest fires. I also wouldn't be opposed to touring as Smokey the Bear. Either would be good.

Rachel Kilde
Multi-County
Clinician for
The RWC



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

I like to say that stand-up comedy is my fall back career. In reality I would probably open a dog boarding business as I really enjoy helping people and dogs. Having a few dogs of my own, I understand how enjoyable a vacation or time away can be when your dogs are being watched by someone you trust. I think I have the vision and skills to make this happen....who knows, maybe I'll give it a go when I retire?

Which way does your toilet paper hang on the wall-over or under? Over
What is the best career lesson you have learned so far?

The power of self-determination. I'm a fixer by nature and when I learned that I need to allow others to make choices for themselves and not take their choices personally, it became a game changer in working with others.

If you could only eat one meal, every day for the rest of your life, what would it be? Lunch

Leslie Fijalkiewicz, ADRC Manager

- * **What is the best career lesson you have learned so far?** Own your mistakes and remind your employees that you don't expect perfection but you expect them to own their mistakes too.
- * **What's your proudest moment working here?** By making many difficult and sometimes unpopular changes in the nutrition program we were able to save money. The money saved allowed us to expand our Meals on Wheels delivery to areas we have never been able to serve!
- * **What's a fun fact about you many people may not know?** I held the school record at Eau Claire North for shotput for a short time. (very short time...record was broken the following school year).
- * **Three words to best describe you:** Quirky, talkative, and optimistic
- * **One TV show/movie you are ashamed to admit you love:** too ashamed to actually tell you this.
- **If you could learn to do anything, what would it be?** I would love to learn sign language and a foreign language.



In the Spotlight

December

Ann Teuteberg Children, Youth & Families Birth to 3 Program



- * **What's a fun fact about you many people may not know?**
I share a birthday with my daughter, Cienna. This year it is on Thanksgiving!
- * **What celebrity do people think you look like?**
Leann Rimes.
- * **If you could learn to do anything what would it be?**
I would love to learn sign language.



Michelle Snyder Fiscal & Contracts



What is the best career lesson you have learned so far?

I have two and they also apply to life: Attitude matters. If you think you can't, you won't but if you think you can, you will. Also, don't assume anything! Communication is the bond that keeps people together.

What's your proudest moment working here?

We came together for strategic planning sessions. It's beautiful to watch the process of my team work together so openly.

What is something you learned in the last day, week, month or year?

I have learned that it's important to see people as they are, not as they should be. In order to do this, we have to accept ourselves as we really are.

Ericka Zillmer Economic Support

- * **What would you do for a career if you weren't doing this?**
I would be a nurse.
- * **Where's your favorite place in the world?** Lambeau Field. There's just something about walking in and feeling the energy. I absolutely love it there.
- * **What chore do you absolutely like/dislike?** I don't mind doing the dishes or doing laundry....but I dislike putting laundry away....and dusting. I loathe dusting!
- * **Which way does your toilet paper hang on the wall-over or under?** Over, always over. If I go to someone's house and it's not hanging over, I'm that person that will change it.



In the Spotlight

5.3.d



A BIG and WARM welcome to three new employees in the CYF Division:

- ◆ Kerri Nowicki (to the left)
- ◆ Sherry Deyoe (below)
- ◆ Kalin Hiess (bottom of page)

Kerri Nowicki
Children, Youth & Families -
Children with Differing Abilities



Career if I was not doing this: I would love to run an animal sanctuary, from dogs and cats to farm animals that have been abused/neglected, old/sick, or just strays. Animals need love and attention and it is great therapy and connection for all of us!

Fun fact: I used to be fluent in American Sign Language! I may not be as fluent now, but can still carry on conversations and I love to learn new signs when I can!

What I would like to learn: I would love to learn to play an instrument, so I can play in Phil Vassar's band (country musician) and follow him around the country and explore new things!

Additional info provided by Sherry:

I am a Chippewa County native. I have been married to Darin for over 33 years. We have two sons who are making their way in the adult world and making me feel older as they age. We have had many fur children grace us over the years. Pictured is our Chloe who is now 12-1/2 years old. We have a puppy and kitten, as well.

I retired in 2020 with the Department of Corrections Division of Community Corrections as a probation /parole/ extended supervision agent. I worked a year as an LTE for DOC in Clark County until recently. A great experience and I met wonderful people there.

I am excited to be on this new course in life. Thank you all for being so friendly and encouraging. The atmosphere is welcoming here at DHS.

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

I worked as a Probation Parole Agent for nearly 30 years (Milwaukee, Waukesha, Eau Claire, and Clark Counties), including my year as an LTE after retirement. What made this position interesting was no two people or situations were alike. I was always on the go and enjoyed this aspect especially if the person was moving toward a positive change. I appreciated the opportunities within the Department to work outside the traditional role as a probation agent; such as, working with the treatment courts, NGI's and 980's and so much more. I appreciated my co-workers the most!

What do you like to do when you aren't working? I like hanging out with family, spending time with my fur babies, reading, camping and just being in the moment. I really like just watching the river flow with the breeze drowning out the sound of vehicles sitting on my camping chair pretending to read. Preferably with my husband (and my boys if available) nearby and a sleeping puppy too.

What is your favorite thing to do in the Chippewa area? Camping/visiting at Brunet Island State Park just down the road from my parents. A great backyard to grow up in!!



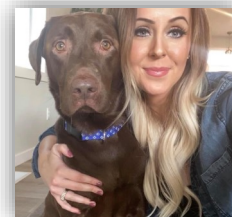
Kalin Hiess
Children, Youth & Families -
Child Protective Services

What do you like to do when you aren't working?

When I'm not at work, I enjoy spending time with my husband and our two dogs, whether that be going on long walks, hanging out at our camper up north, or binge watching a new favorite TV show. I also love spending time with family and friends, cheering on the Packers, and crafting!

What is your favorite thing to do in the Chippewa area?

I like going to the Farmers Market and *Music in the Park* during the summertime, shopping at the local boutiques, and getting coffee at Bridge Street Brew!



In the Spotlight

5.3.d



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

Several years ago, I worked for Schneider National in Green Bay. I taught ergonomics and safe lifting techniques to drivers. I also taught them healthy eating habits and stretches to do at truck stops. I have a lot of respect for truck drivers, it's a tough job. One year on my birthday, they let me drive a semi on the skid pad! That was so fun!

What is your favorite place in the world? It's a tie, my hometown of Westby, WI and Salzburg, Austria.

What is your favorite thing to do in the Chippewa area? Another tie, walking through Irvine Park and window shopping and coffee in downtown Eau Claire.

**Carla Berscheit -
ADRC
Dementia Care
Specialist**



**Brandi Engel
Economic
Support/
A-Team**



- ♦ If you could only eat one meal, every day for the rest of your life, what would it be? If I could eat only one meal for the rest of my life, it would be Chicken Teriyaki from Kobe's.
- ♦ If you could have any superpower what would it be? If I could have any superpower, it would be to teleport – then I could travel wherever I want, whenever I want!
- ♦ What chore do you absolutely like/dislike? Laundry. It is rare that I successfully complete a load of clothes from wash to fold.

**Brittney Gee
Economic Support**

- ♦ What do you like to do when you are not working? I enjoy reading, running, and traveling. As of today, I am on book #40 and mile #435 for the year. 2021 has been a busy year of travel for me including trips to Virginia Beach, VA, Salem, MA, Nashville, TN, Atlanta, GA, Gatlinburg, TN, Asheville, NC, Charleston, SC, and Savannah, GA.
- ♦ What's a fun fact about you many people may not know? I have an identical twin.
- ♦ Where's your favorite place in the world? Either Tybee Island, GA or Coronado, CA. I have a feeling this will change when I make it to the Maldives one day! ☺



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

My dream job would be an investigative journalist who investigates cold cases. While others listen to music on their way to work, I listen to true crime podcasts.

Where's your favorite place in the world?

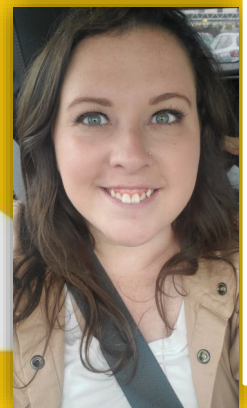
All my worries seem to melt away near the water. Cities next to oceans and the great lakes always feel so magical to me. I am getting married in June in one of those places that feel magical to me: Duluth.

One TV show/movie you are ashamed to admit you love:

7th Heaven. The acting is subpar, the storylines are not great, but I've seen every episode multiple times. As a kid, I wanted to be Reverend Camden and help people struggling in the community - go figure, I became a social worker!



**Caitlin
Mitchell -
Recovery &
Wellness
Consortium**



Attachment: 5.3d January 2022 Spotlights (7108 : Human Services Director's Program and Financial Report)



STATEMENT OF EXPLANATION HEALTH & HUMAN SERVICES BOARD ORIENTATION

5.4

Directors Tim Easker and Angie Weideman will provide board and department orientation to the Health & Human Services Board members. An electronic copy is attached but a hard copy binder will also be provided to board members.



CHIPPEWA COUNTY HEALTH & HUMAN SERVICES BOARD ORIENTATION MANUAL



Chippewa County Health & Human Services Board Orientation Manual Table of Contents

Health & Human Services Board Information

1. Health & Human Services Board Contact Information
2. People First Language
3. Board Performance Evaluation
4. Member Associations

Human Services Department Information

1. Mission, Goals, and Priorities
2. Human Services Acronym List
3. Statutory Authority and Budget
4. Organizational Chart – Employees
5. Organizational Chart – Programs
6. Program/Services Descriptions and Ranking 2022
7. Strategic Plan 2022 – 2024
8. Human Services Division Info PowerPoint

Public Health Department Information

A. *Chippewa County Department of Public Health*

1. Mission/Vision/Values, Accreditation Domains
2. Public Health Acronym List
3. Organizational Chart-Employees
4. Organizational Chart-Services
5. 2022 Program Ranking
6. 2022 Public Health Budget
7. Strategic Plan 2020 – 2023

B. *General Public Health Information*

1. Who Works in Public Health
2. Public Health's 10 Essential Services
3. Public Health Accreditation Board Standards (PHAB)
4. Statutory Authority
5. State Statute Chapter 251 – Local Health Officials
6. State Statute Chapter 252 – Communicable Diseases
7. DHS 140 WR WAHL DAB Overview
8. Level III Health Department Designation
9. State Statute Chapter DHS 140 – Required Services of Local Health Departments

Chippewa County Health & Human Services Board

Name	Address	Phone	E-mail	Term Expiration	Representation
Caden Berg	14312 47th Avenue Chippewa Falls, WI 54729	715-220-5438 (cell)	cberg@co.chippewa.wi.us	April 2024	County Board Supervisor
James Ericksen	519 Kennedy Avenue Stanley, WI 54768	715-703-0437 (cell)	jfericksen@co.chippewa.wi.us	April 2024	County Board Supervisor
John (Jack) Halbleib	4705 145th Street Chippewa Falls, WI 54729	715-723-0516 (home) 715-577-6524 (cell)	jhalbleib@yahoo.com	April 2025	Citizen Member
Kari Ives	562 E. South Avenue Chippewa Falls, WI 54729	715-720-3446 (work) 715-379-7511 (cell)	kives@co.chippewa.wi.us	April 2025	County Board ADRC Board Crossover
Marcia Kyes	5476 171 st Street Chippewa Falls, WI 54729	715-456-9912 (cell)	Kyes.marcia@gmail.com	April 2025	Citizen Member (Nurse if possible) Supervisor
Dean Mueller	18261 57th Avenue Chippewa Falls, WI 54729	715-852-0223	dmueller@co.chippewa.wi.us	April 2024	County Board Supervisor
Stacey Sperlingas	8368 163rd Street Chippewa Falls, WI 54729	715-563-6406 (cell) 715-726-4133 (work)	sperlingas@yahoo.com	April 2023	Citizen Member
Harold (Buck) Steele	27260 269th Avenue Holcombe, WI 54745	715-312-0361 (cell)	hsteele@co.chippewa.wi.us	April 2024	County Board Supervisor
Nichole (Nycki) Wallsch	705 Newman Street Bloomer, WI 54724	715-450-1604 (cell)	nycki@exposwisconsin.org	April 2023	Citizen Member

HHSB Terms are three years

To ensure INCLUSION, FREEDOM, AND RESPECT for all, it's time to embrace PEOPLE FIRST LANGUAGE

by Kathie Snow, www.disabilityisnatural.com

Did you know that people with disabilities constitute our nation's largest minority group (one in five Americans has a disability)? It is also the most inclusive and most diverse group: all ages, genders, religions, ethnicities, sexual orientations, and socioeconomic levels are represented.

Contrary to conventional wisdom, individuals with disabilities are not:

- People who *suffer* from the *tragedy* of birth defects.
- *Paraplegic heroes* who *struggle* to become *normal* again.
- *Victims* who *fight* to *overcome* their *challenges*.

Nor are they the *retarded*, *autistic*, *blind*, *deaf*, *learning disabled*, etc.—*ad nauseam*!

They are *people*: moms and dads; sons and daughters; employees and employers; friends and neighbors; students and teachers; scientists, reporters, doctors, actors, presidents, and more. People with disabilities are people, *first*.

They do not constitute the stereotypical perception: a homogenous sub-species called “the handicapped” or “the disabled.” They are unique individuals.

The only thing they may have in common with one another is being on the receiving end of societal misunderstanding, prejudice, and discrimination. Furthermore, this largest minority group is the only one which *any person can join at any time*: at birth or later—through an accident, illness, or the aging process. When it happens to *you*, will you have more in common with others who have disability diagnoses or with family, friends, and co-workers? How will you want to be described and how will you want to be treated?

WHAT IS A DISABILITY?

Is there a universally-accepted definition of disability? No! First and foremost, a disability descriptor is simply a *medical diagnosis*, which may become a *sociopolitical passport* to services or legal status. Beyond that, the definition is up for grabs, depending on which service system is accessed. The “disability criteria” for

early intervention is different from early childhood, which is different from vocational-rehabilitation, which is different from special education, which is different from worker's compensation, and so on. Thus, “disability” is a *social construct*, created to identify those who may be entitled to services or legal protections due to *characteristics* related to a medical condition.

—THE POWER OF LANGUAGE AND LABELS—

Words are powerful. Old, inaccurate descriptors and the inappropriate use of medical diagnoses perpetuate negative stereotypes and reinforce a significant and an incredibly powerful attitudinal barrier. And this invisible, but potent, force—not the diagnosis itself—is the *greatest obstacle* facing individuals who have conditions we call disabilities.

When we see the diagnosis as the most important characteristic of a person, we devalue her as an individual. Do *you* want to be

known for your psoriasis, gynecological history, the warts on your behind, or any other condition?

Unfortunately, disability diagnoses are often used to define a person's value and potential, and low expectations and a dismal future may be the predicted norm. A person's diagnosis is often used to decide how/where the person will be educated, what type of job he will/won't have, where/how he'll live, and more, including what services he is thought to need.

With the best of intentions, we work on people's bodies and brains, while paying scant attention to their hearts and minds. And far too often, the “help” provided can actually cause harm—and *can ruin people's lives*. For “special” services frequently result in the social isolation and physical segregation of children and adults: in special ed classrooms, congregate living quarters, day programs, sheltered work environments, segregated recreational activities, and more. Are other people isolated, segregated, and devalued because of *their* medical conditions?

**The difference between the right word
and the almost right word is the
difference between lightning
and the lightning bug.**

Mark Twain

—INACCURATE DESCRIPTORS—

“Handicapped” is an archaic term (no longer used in federal legislation) that evokes negative images of pity, fear, and more. The origin of the word is from an Old English bartering game, in which the loser was left with his “hand in his cap” and was said to be at a disadvantage. Based on this meaning, it was applied to people with certain conditions. A *legendary* origin of the word refers to a person with a disability begging with his “cap in his hand.” This antiquated, derogatory term perpetuates the negative image that people with disabilities are a homogenous group of pitiful, needy people! Others who share a certain characteristic are not all alike, and individuals who happen to have disabilities are not alike. In fact, people with disabilities are more *like* people *without* disabilities than different!

“Handicapped” is often used to describe modified parking spaces, hotel rooms, restrooms, etc. But these usually provide *access* for people with physical or mobility needs—and they may provide *no benefit* for people with visual, hearing, or other conditions. This is one example of the misuse of the H-word as a *generic descriptor*.

(The accurate term for modified parking spaces, hotel rooms, etc. is “accessible.”)

“Disabled” is also not appropriate. Traffic reporters often say, “disabled vehicle.” They once said, “stalled car.” Sports reporters say an athlete is on “the disabled list.” They once said, “injured reserve.” Other uses of this word today mean “broken/non-functioning.” *People with disabilities are not broken!*

If a new toaster doesn’t work, we say it’s “defective” or “damaged” and return it. Shall we return babies with “birth defects” or adults with “brain damage”? The accurate and respectful descriptors are “congenital disability” or “brain injury.”

Many parents say, “My child has special needs.” This term generates *pity*, as demonstrated by the usual response: “Oh, I’m *so sorry*,” accompanied by a sad look or a sympathetic pat on the arm. (*Gag!*) A person’s needs aren’t “special” to him—they’re ordinary! Many adults have said they detested this descriptor as children. Let’s learn from them, and *stop using this pity-laden term!*

“Suffers from,” “afflicted with,” “victim of,” “low/high functioning,” and similar descriptors are inaccurate, inappropriate, and archaic. A person simply “has” a disability/medical condition.

—DISABILITY IS *NOT* THE “PROBLEM”—

We seem to spend more time talking about the “problems” of a person with a disability than anything else. People *without* disabilities, however, don’t constantly talk about *their* problems. This would result in an inaccurate perception, and would also be counter-productive to creating a positive image. A person who wears glasses, for example, doesn’t say, “I have a *problem* seeing.” She says, “I wear [or need] glasses.”

What is routinely called a “problem” actually reflects a *need*. Thus, Susan doesn’t “have a problem walking,” she “needs/uses a wheelchair.” Ryan doesn’t “have behavior problems,” he “needs behavior supports.” Do *you* want to be known by your “problems” or by the many positive characteristics which make you the unique individual you are? When will people *without* disabilities begin speaking about people *with* disabilities in the respectful way they speak about themselves?

Then there’s the use of “wrong” as in, “We knew there was *something wrong* when...” What must it feel like when a child hears his parents repeat this

over and over and over again? How would *you* feel if those who are supposed to love and support you constantly talked about what’s “wrong” with you? Isn’t it time to stop using the many words that cause harm?

THE REAL PROBLEMS ARE ATTITUDINAL AND ENVIRONMENTAL BARRIERS!

The real problem is *never* a person’s disability, but the attitudes of others! And a change in attitudes and beliefs can change everything.

If educators believed in the potential of *all* children, and if they recognized boys and girls with disabilities need a quality education so they can become successful in the adult world of work, millions of children would no longer be *segregated and undereducated* in special ed classrooms. If employers believed adults with disabilities have (or could learn) valuable job skills, we wouldn’t have an estimated (*and shameful*) 75 percent unemployment rate of people with disabilities. If merchants saw people with disabilities as customers with money to spend, we wouldn’t have so many inaccessible stores, theaters, restrooms, and more. If the service system identified people with disabilities as “customers,” instead of “clients/consumers/recipients,” perhaps it would begin to meet a person’s *real* needs

***If thought corrupts language,
language can also corrupt thought.***

George Orwell

(like inclusion, friendships, etc.) instead of trying to remediate his “problems.”

If individuals with disabilities and family members saw *themselves* as first-class citizens who can and should be fully included in all areas of society, we might focus on what’s really important: living a *Real Life in the Real World*, enjoying ordinary opportunities and experiences and dreaming big dreams (like people without disabilities), instead of living a *Special Life in Disability World*, where low expectations, segregation, poverty, and hopelessness are the norm.

—A NEW PARADIGM—

“DISABILITY IS A NATURAL PART
OF THE HUMAN EXPERIENCE...”

U.S. Developmental Disabilities Bill of Rights Act

Like gender, ethnicity, and other traits, a disability is simply one of many natural characteristics of being human. Are *you* defined by your gender, ethnicity, religion, age, sexual orientation, or other trait? No! So how can we define others by a characteristic which is called a “disability”?

Yes, *disability is natural*, and it can be *redefined* as “a body part that works differently.” A person with spina bifida has legs that work differently, a person with Down syndrome learns differently, and so forth. And the body parts of people *without* disabilities are also different—it’s the *way* these differences affect a person which creates the eligibility for services, entitlements, or legal protections.

In addition, a disability is often a *consequence of the environment*. For example, most children with ADD and similar conditions are not diagnosed until they enter public school. Why is this? Could it be that as young children, their learning styles were supported by parents, preschool teachers, etc.? But once in public school, if the child’s learning style doesn’t mesh with an educator’s teaching style, the child is said to have a “disability.” Why do we blame the child, label him, and segregate him in a special ed classroom? Shouldn’t we modify the regular curriculum (per special ed law) and/or provide supports to meet his needs so he can learn in ways that are best for him?

When a person is in a welcoming, accessible environment, with the appropriate supports,

accommodations, and tools, does he still have a disability? No! *Disability is not a constant state*. The *diagnosis* may be constant, but whether it’s a disability is more a *consequence of the environment* than what a person’s body or mind can/cannot do. We don’t need to change people with disabilities through therapies or interventions. We need to change the *environment*, by providing assistive technology devices, supports, and accommodations to ensure a person’s success!

USING PEOPLE FIRST LANGUAGE IS CRUCIAL!

People First Language puts the person before the disability, and describes what a person *has*, not who a person *is*.

Are you “myopic” or do you wear glasses?
Are you “cancerous” or do you have cancer?
Is a person “handicapped/disabled”
or does she have a disability?

If people with disabilities are to be included in all aspects of society, and if they’re to be respected and valued as our fellow citizens, we must stop using language that devalues and sets them apart.

The use of disability descriptors is appropriate *only* in the service system (at those ubiquitous “I” team meetings) and in medical or legal settings. Medical diagnoses have no place—and they should be irrelevant—within families, among friends, and in the community.

Many erroneously share a diagnosis in order to convey information, as when a parent says, “My child has Down syndrome,” hoping others will realize her child needs certain accommodations or supports. But the outcome of this action can be less than desirable! A diagnosis can scare people, generate pity, and/or set up exclusion (“We can’t handle people *like that*...”). In these circumstances, *and when it’s appropriate*, we can simply describe the person’s *needs* in a respectful, dignified manner, and *omit the diagnosis*.

Besides, *the diagnosis is nobody’s business*! Have individuals with disabilities given us permission to share their personal information with others? If not, how dare we violate their trust! Do *you* routinely tell every Tom, Dick, and Harry about the boil on your spouse’s behind? (I hope not!) And we often talk about people with disabilities *in front of them, as if they’re not there*. We must stop this demeaning practice!

**The greatest discovery of my
generation is that human beings
can alter their lives by altering
their attitudes of mind.**

William James

My son, Benjamin, is 22 years old. His interests, strengths, and dreams are more important than his diagnosis! He loves politics, classic rock, and movies, and has earned two karate belts, performed in plays, and won a national award for his *Thumbs Down to Pity* film. Benj is attending college, where he's a member of Phi Theta Kappa national honor society, and he wants to become a writer. He has blonde hair, blue eyes, and cerebral palsy. His diagnosis is just one of many characteristics of his whole persona. *He is not his disability, and his potential cannot be predicted by his diagnosis.*

When I meet new people, I don't whine that I'll never be a prima ballerina. I focus on my strengths, not on limitations. Don't you do the same? So when speaking about my son, I don't say, "Benj can't write with a pencil." I say, "Benj writes on a computer." I don't say, "He can't walk." I say, "He uses a power chair." It's a simple, *but vitally important*, matter of perspective. If I want others to know what a great young man he is—more importantly, *if I want him to know what a great young man he is*—I must use positive and accurate descriptors that portray him as a valuable, respected, and wonderful person.

The words used to describe a person have a powerful impact on the person's self-image. For generations, the hearts and minds of people with disabilities have been crushed by negative, stereotypical words which created harmful, mythical perceptions and caused other detrimental consequences. We must stop believing and perpetuating the myths—the *lies*—of labels. Children and adults who have conditions called "disabilities" are unique individuals with unlimited potential, like everyone else!

The Civil Rights and Women's Movements prompted changes in language and attitudes. The Disability Rights Movement is following in those important footsteps. People First Language was created by individuals who said, "We are *not* our disabilities." It's not "political correctness," but good manners and respect.

We can create a new paradigm of disability. In the process, we'll change ourselves and our world—as well as the lives of millions of children and adults. It's time to care about the *feelings* of the *people we're talking about* and to carefully consider what *perceptions* we create about people with disabilities with our words.

***Isn't it time to make this change? If not now, when? If not you, who?
Using People First Language is the right thing to do, so let's do it!***

EXAMPLES OF PEOPLE FIRST LANGUAGE

SAY:	INSTEAD OF:
People with disabilities.	The handicapped or disabled.
Paul has a cognitive disability (diagnosis).	He's mentally retarded.
Kate has autism (or a diagnosis of...)	She's autistic.
Ryan has Down syndrome (or a diagnosis of...)	He's Down's; a Down's person; mongoloid.
Sara has a learning disability (diagnosis).	She's learning disabled.
Bob has a physical disability (diagnosis).	He's a quadriplegic/is crippled.
Mary is of short stature/Mary's a little person.	She's a dwarf/midget.
Tom has a mental health condition	He's emotionally disturbed/mentally ill.
Nora uses a wheelchair/mobility chair	She's confined to/is wheelchair bound.
Steve receives special ed services	He's in special ed; is a sped student/inclusion student.
Tonya has a developmental delay	She's developmentally delayed.
Children without disabilities	Normal/healthy/typical kids.
Communicates with her eyes/device/etc.	Is non-verbal.
Customer.	Client, consumer, recipient, etc.
Congenital disability	Birth defect.
Brain injury	Brain damaged.
Accessible parking, hotel room, etc.	Handicapped parking, hotel room, etc.
She needs . . . or she uses	She has a problem with. . . /She has special needs.

Keep thinking—there are many other descriptors we need to change!

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Health & Human Services Board Evaluation 2021

The Health & Human Services (HHS) Board evaluation provides feedback to the HHS Board, HHS Board Chair, Public Health Director, and Human Services Director on what is working well and areas that may require further development. Please rate your answers on a 1 to 5 satisfaction scale with 1 indicating low satisfaction, 5 indicating high satisfaction, and 3 being neutral. Written comments are also appreciated. Thank you so much.

HHS Board Meetings

	1	2	3	4	5
1. Board meetings begin on time.	☐	☐	☐	☐	☐
2. Board meetings are completed in a reasonable amount of time.	☐	☐	☐	☐	☐
3. Board meetings are focused and stick to the agenda.	☐	☐	☐	☐	☐
4. Board meetings have a positive tone.	☐	☐	☐	☐	☐
5. Board meetings encourage participation by all members.	☐	☐	☐	☐	☐
6. Board meetings focus on policy and outcomes rather than management issues.	☐	☐	☐	☐	☐
7. Board meeting discussion/participation indicate members come prepared to take action on policies and programs.	☐	☐	☐	☐	☐
8. Board meetings are held in adequate facilities.	☐	☐	☐	☐	☐

9. Board meetings are cordial and personal attacks avoided. ☐ ☐ ☐ ☐ ☐

HHS Board Meeting Comments

10. Suggestions on how to further develop meetings that will assist you the most:

11. Additional Comments:

HHS Board Members (Pertaining to Human Services Department)

	1	2	3	4	5
12. Board members understand and support Human Services' mission and strategic plan.	☐	☐	☐	☐	☐
13. Board members understand Human Services' statutory responsibilities.	☐	☐	☐	☐	☐
14. Board members understand that communication with staff goes through the Human Services Director.	☐	☐	☐	☐	☐
15. Board members work with the Human Services Director to secure and maintain sufficient staff.	☐	☐	☐	☐	☐
16. Board members take advantage of Human Services related	☐	☐	☐	☐	☐

learning opportunities such as conferences, summits, and other activities.

- | | | | | | |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 17. Board members communicate community needs to the Human Services Director. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 18. Board members support improving efficiency and effectiveness of Human Services through staff training and quality improvement initiatives. | ☐ | ☐ | ☐ | ☐ | ☐ |

HHS Board Member Section Comments (Human Services)

19. Additional Comments:

^
v

HHS Board Members (Pertaining to Public Health Department)

- | | 1 | 2 | 3 | 4 | 5 |
|---|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 20. Board members understand and support Public Health's mission and strategic plan. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 21. Board members understand Public Health's statutory responsibilities. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 22. Board members understand that communication with staff goes through the Public Health Director. | ☐ | ☐ | ☐ | ☐ | ☐ |

- | | | | | | |
|---|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 23. Board members work with the Public Health Director to secure and maintain sufficient staff. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 24. Board members take advantage of Public Health related learning opportunities such as conferences, summits, and other activities. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 25. Board members communicate community needs to the Public Health Director. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 26. Board members support improving efficiencies and effectiveness of Public Health through staff training and quality improvement initiatives. | ☐ | ☐ | ☐ | ☐ | ☐ |

HHS Board Member Section Comments (Public Health)

27. Additional Comments:

^
v

The HHS Board

- | | 1 | 2 | 3 | 4 | 5 |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 28. The Board reviews important documents (e.g. policies, programs, strategic plan, etc.). | ☐ | ☐ | ☐ | ☐ | ☐ |
| 29. The Board reviews the annual budget. | ☐ | ☐ | ☐ | ☐ | ☐ |
| | ☐ | ☐ | ☐ | ☐ | ☐ |

30. The Board is provided adequate information and data to make informed policy decisions.

The HHS Board Section Comments

31. Additional Comments:

HHS Board Member Orientation

32. The Board member orientation session provided an adequate overview of my role and responsibilities.

- ☐ 1
☐ 2
☐ 3
☐ 4
☐ 5

33. Suggestions that you think would be helpful to include in board member orientation:

Submit Your Responses

Member Associations

Wisconsin Counties Association (WCA) – WCA is the foremost voice of county officials representing all 72 counties in Wisconsin. We are a financially well-positioned, highly visible civic force with a well-informed and motivated membership governed by a diverse Board. We are a highly interactive service provider to county officials and other government entities offering lobbying, insurance programs, education, research, grant development and consulting services resulting in our ability to affect public policy to the benefit of county government.

www.wicounties.org

Human Services

Wisconsin County Human Service Association (WCHSA) – The purpose of WCHSA is to provide a statewide association to promote positive and professional relations in the field of human services among association members, public officials, constituents, and recipients of services, as a means of meeting the needs of local agencies for educational programs, coordinating activities, and administrative exchange.

www.wchsa.org

Wisconsin Counties Association – Health and Human Services Steering Committee - Responsible for issues affecting aging, public health, mental health, alcohol and drug abuse, developmental disabilities, social services, human services, nursing homes and mental health facilities.

<https://www.wicounties.org/about-us.iml#steering-committee>

Public Health

Wisconsin Association of Local Health Departments and Boards (WALHDAB) – Local health departments and their boards of health are eligible for membership. The equivalent of a local health department and board of health established by a tribal governing body is also eligible for membership. Each health department has two voting members, one vote from the agency health officer and one vote from a board of health member. The Wisconsin state health officer, administrator of the Division of Public Health, and the Regional Office Directors will be ex-officio members of the organization with no voting rights.

www.walhdab.org

National Association of County and City Health Officials (NACCHO) – The National Association of County Health Officials (NACHO) was founded in 1965. In early 1984, the organization experienced remarkable growth in membership and the organization opened its own office. In 1994, it was renamed to National Association of County and City Health Officials (NACCHO).

Since its inception, NACCHO has sought to improve the public's health while adhering to a set of core values: equity, excellence, participation, respect, integrity, leadership, science & innovation. Today, NACCHO comprises nearly 3,000 local health departments across the United States. Together, we form an organization focused on being a leader, partner, catalyst, and voice for change for local health departments around the nation.

www.naccho.org

Wisconsin Public Health Association (WPHA) – The priorities related to advancing WPHA’s mission are to: Support a strong, skilled and sustainable public health workforce, support collective advocacy for policy change that makes Wisconsin the healthiest state, and recognize, celebrate and promote professional development.

www.wpha.org

Wisconsin WIC Association (WWA) – The purpose of the WWA is to foster good health and nutrition among lower income women, infants and children in Wisconsin. To bring together all parties interested in the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) in order to stimulate effective relationships and helpful cooperation and to provide peer support, orientation, training and/or assistance. To educate the public and policy makers on the success of the WIC program to positively impact the nutrition and health status of families. To promote legislation that enhances the nutritional health and well-being of lower income women, infants and children in Wisconsin. To act as a resource for governmental bodies and individual legislators regarding issues particular to the health and nutrition of women, infants and children and the WIC program.

www.wiwica.org

American Nurses Association (ANA) – The ANA is here to improve patient care through supporting both individuals and organizations to advance the nursing profession. From advocating in the halls of Congress, to setting the bar for credentialing worldwide, the ANA Enterprise exists to give every nurse the best chance of success. ANA members have access to unparalleled professional development opportunities, the very latest in nursing news, and support from nurses across the nation.

www.nursingworld.org

National Association of Local Boards of Health (NALBOH)* - The National Association of Local Boards of Health (NALBOH) informs, guides, and is the national voice for boards of health. In today’s public health system, the leadership role of boards of health makes them an essential link between public health services and a healthy community. Uniquely positioned to deliver technical expertise in governance and leadership, board development, health priorities, and public health policy, NALBOH strives to strengthen good governance where public health begins—at the local level.

NALBOH has been engaged in establishing a significant voice for local boards of health on matters of national public health policy. If you are involved with a local board of health, NALBOH is here to support you!

www.nalboh.org

*This association is available for local Board of Health members.



CHIPPEWA COUNTY

Human Services

**Chippewa County
Health & Human Services Board
Orientation Manual**

Department Information

Department of Human Services

Mission Statement



“Strengthening our community through partnerships and services to promote dignity, increase resilience, and provide hope.”



“The mission of the Aging and Disability Resource Center of Chippewa County is to advocate for and empower individuals with disabilities and adults 60+ to secure needed services or benefits in order to promote their dignity and independence.”

Goals

- Build a culture of community engagement.
- Utilize data driven decision making.
- Demonstrate fiscal responsibility.
- Build a culture of service.
- Continue to build and maintain a healthy workplace.

Priorities

- Continue to implement trauma informed care practices throughout Human Services.
- Implement employee engagement strategies as laid out in our employee engagement action plans and 2022-24 strategic plans to improve engagement and reduce turnover.
- Provide the right service at the right time in the right amount.
- Continue to work with collaborative partners/stakeholders to reduce out of home care costs for children and adults.
- Measure those things which are important and use that data to drive decisions.
- Renew and improve relationships with community partners and stake holders through education and collaboration.

Department of Human Services

Statutory Authority

46.23 (1) County Department of Human Services. Enable and encourage counties to develop and make available to all citizens of this state a comprehensive range of human services in an integrated and efficient manner; utilize and expand existing governmental, voluntary and private community resources for the provision of services to prevent or ameliorate social, mental and physical disabilities.

46.23(3) County Department of Human Services. Upon approval by the secretary of health services, by the secretary of corrections, and by the secretary of children and families of a feasibility study and a program implementation plan, the county board of supervisors of any county with a population less than 500,000, or the county boards of supervisors of 2 or more contiguous counties, each of which has a population of less than 500,000, may establish by resolution a county department of human services on a single county or multi-county basis to provide the services required.

46.23(4) County Human Services Board. In any single-county or multicounty department of human services, the county human services board shall be composed of not less than 7 or more than 15 persons of recognized ability and demonstrated interest in human services. Not less than one-third nor more than two-thirds of the county human services board members may be members of the county board of supervisors. At least one member appointed to a county human services board shall be an individual who receives or has received human services or shall be a family member of such an individual. The remainder of the county human services board members shall be consumers of services or citizens-at-large. No public or private provider of services may be appointed to the county human services board.

46.283 Aging & Disability Resource Centers. A county board of supervisors, and in a county with a county executive or county administrator, may decide whether to authorize one or more county departments to apply to the state department of health services for a contract to operate a resource center and if so, which to authorize and what client group to serve.

Budget (Tax Levy)

Expense	Amount
Personnel (Salaries, Fringe Benefits, Health Ins.)	\$1,269,030
Contracted Services	\$1,253,135
Other (Supplies, Cell Phone, Postage, Mileage, etc.)	\$ 53,518
Net Taxpayer Levy	\$2,575,683

Non-Lapsing Fund	Amount
Fund Balance as of 12/31/21 Human Services	\$ 44,181
Fund Balance as of 12/31/21 ADRC	\$550,000
Fund Balance Applied to 2022 Budget	\$ 34,000

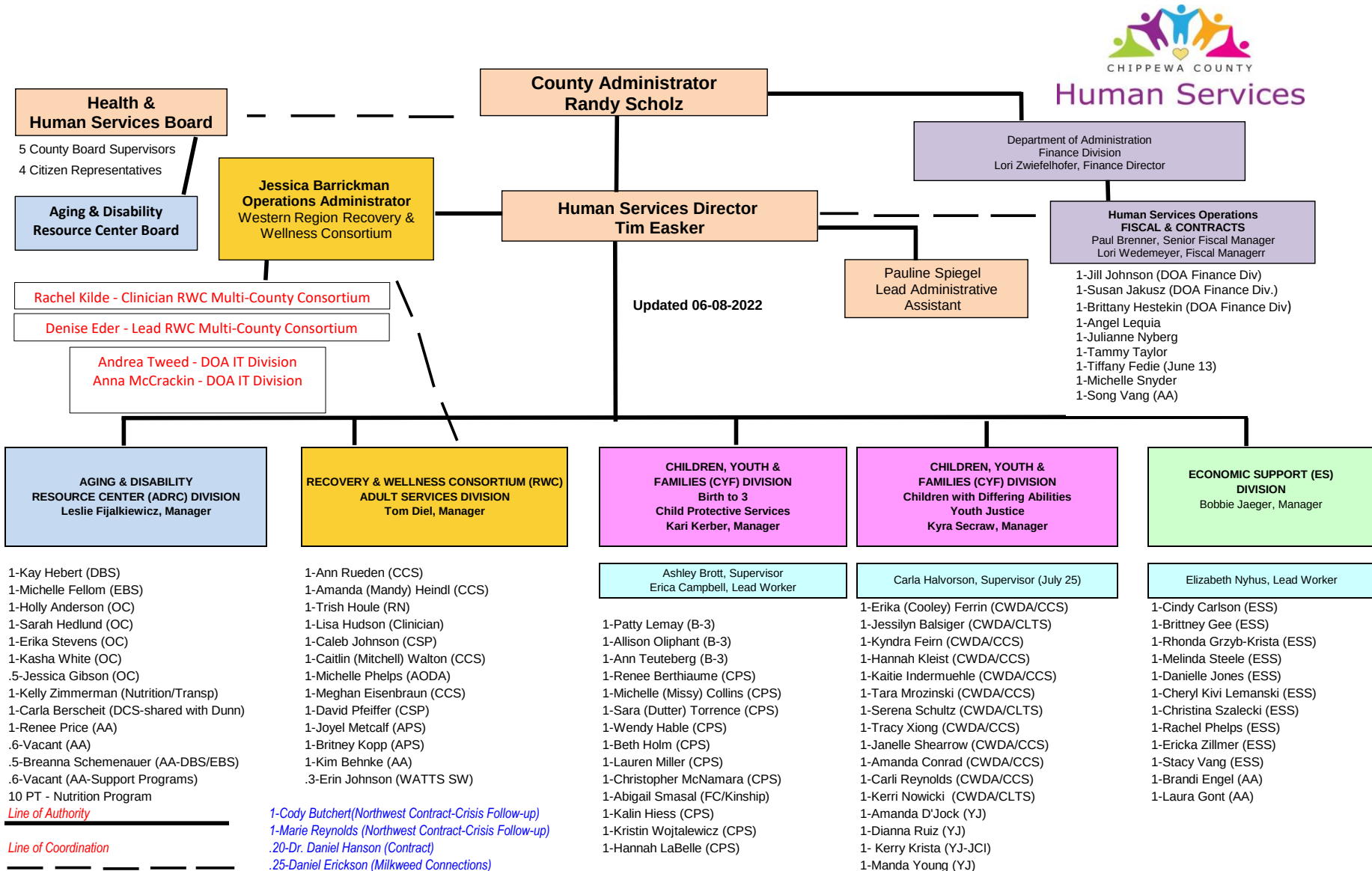


Acronym List

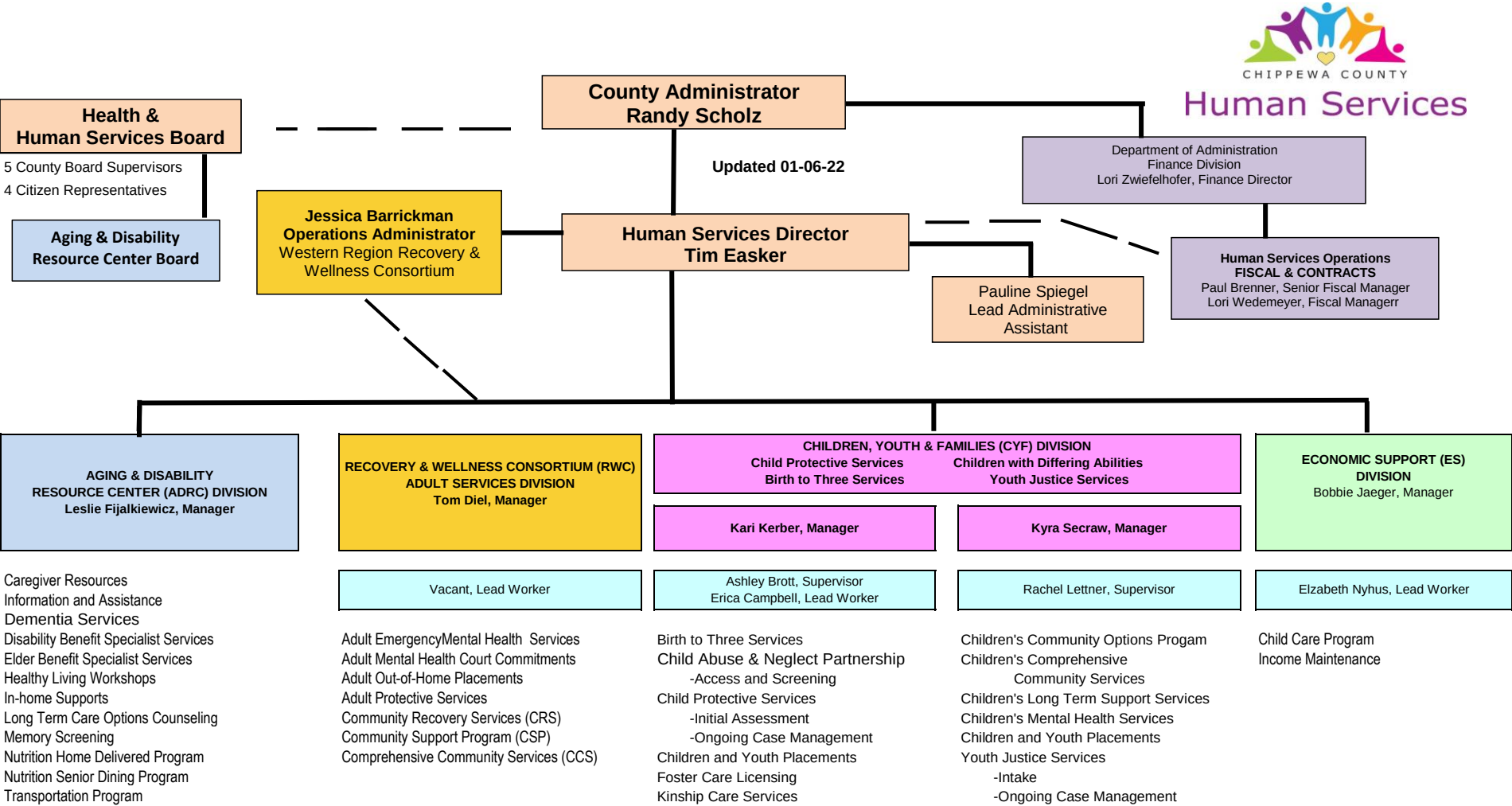
Acronym	What it Stands For
ACL	Administration on Community Living (federal)
ADRC	Aging Disability Resource Center
AODA	Alcohol and Other Drug Abuse
APS	Adult Protective Services
B-3	Birth to Three
CCOP	Children's Community Options Program
CCS	Comprehensive Community Services
CHIPS	Children in need of Protection and/or Services
CLTS	Children's Long-Term Support
CPS	Child Protective Services
CRS	Community Recovery Services
CSP	Community Support Program
CST	Coordinated Services Team
CWDA	Children with Differing Abilities
CYF	Children, Youth & Families
DCF	Department of Children and Families (State of Wisconsin)
DHS	Department of Health Services (State of Wisconsin)
EBD	Elderly, Blind and Disabled
ED	Emergency Detention
EMHS	Emergency Mental Health Services (Crisis)
ES	Economic Support
GRC	Great Rivers Consortium
IMD	Institute for Mental Disease
JIPS	Juvenile in need of Protection and/or Services
LSS	Lutheran Social Services
LTC	Long Term Care
MA	Medical Assistance
MCO	Managed Care Organization
OAA	Older Americans Act
RCC	Residential Care Center
RWC	Recovery and Wellness Consortium
TFC	Treatment Foster Care
TPR	Termination of Parental Rights
WCHSA	Wisconsin Human Services Association
YJ	Youth Justice

Chippewa County Department of Human Services Organizational Chart - Employees

5.4.a



Chippewa County Department of Human Services
Organizational Chart - Services



2022 Chippewa County Human Services Program Descriptions – HHS Board Ranking

MANDATORY

Division	Name	Description	2021 HHSB Rank 1-12	2022 Ldrshp Rank 1-12	2022 HHSB Rank 1-12
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*	2	1*
Children, Youth & Families	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.	1*	1	1*
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	3	3
Children, Youth & Families - Children with Differing Abilities	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	5	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	4	5
Children, Youth & Families - Youth Support & Services	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.	6	6	6
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.	9*	10	10
Economic Support	Income Maintenance	Medial Insurance for single adults, parents, and children.	11	11	11
Economic Support	Wisconsin Shares Child Care	Provides child care 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, Sacred Heart Hospital, and Mayo Clinic Health System.	7	7	8

Division	Name	Description	2021 HHSB Rank 1-12	2022 Ldrshp Rank 1-12	2022 HHSB 1-12
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	8	7
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*	9	9

*Tied for that Ranking

ESSENTIAL

Division	Name	Description	2021 HHSB Rank 1-8	2022 Ldrshp Rank 1-8	2022 HHSB 1-8
Children, Youth & Families	Kinship	Provides financial support for a child residing with a relative to decrease family stress or temporary familial problems, rather than being placed in out-of-home care or placed for adoption.	5	5	5
Children, Youth & Families - Children with Differing Abilities	Children's Community Options Program (the Family Support Program and Community Options Program merged)	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	6
Children, Youth & Families - Youth Support & Services	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	7
Children, Youth & Families - Youth Support & Services	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

Division	Name	Description	2021 HHSB Rank 1-8	2022 Ldrshp Rank 1-8	2022 HHSB 1-8
Recovery & Wellness Consortium	Mental Health Emergency Services (Crisis Services)	Provides immediate assistance to an 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.	4	4	4

OPTIONAL

Division	Name	Description	2021 HHS Rank 1-2	2022 Ldrshp Rank 1-2	2022 HHSB 1-2
Children, Youth & Families - Youth Support & Services	Coordinated Service Teams	This program forms an integrated team to address the child or youth behavior within the family and community. Care is coordinated by a social worker that includes school, clinicians. Faith-based, and others chosen by the family.	1	1	1
Recovery & Wellness Consortium	Community Recovery Services	Provides three specific services to adults with a mental health diagnosis; Community Living Skills, Supported Employment, and Peer Supports. It is a community-based program that promotes recovery, stability, and allow the adult to live in a community-based setting. These services may prevent the need for out-of-home placement and can be used to offset the cost of the placement if needed.	2	2	2



Strategic Plan 2022 – 2024

Department/Division Goals:

1. Build a culture of community engagement.
2. Utilize data driven decision making.
3. Demonstrate fiscal responsibility.
4. Build a culture of service.
5. Continue to build and maintain a healthy workplace.

- **Mission:** Strengthening our community through partnerships and services to promote dignity, increase resilience, and provide hope.
- **Vision:** Everyone reaching their full potential to live their best life.
- **Values:** Advocacy, Compassion, Empowerment, Partnership, Respect

Leadership Team		
Objectives	Strategies	Tactics/Responsible Party
❖ Improve interconnectedness within Leadership Team by December 31, 2024.	▪ In person presentations at leadership meetings.	▪ Create schedule for presentations at leadership meetings – Leadership Team. ▪ Determine topics of interest (e.g. specific program and or topic for each division/unit to present on) - Leadership Team. ▪ Presentation at Leadership meeting by a division/unit leader regarding specific program/topic - individual leaders.
	▪ Leaders will shadow leaders or staff of other divisions/units.	▪ Leaders shall determine areas in which they would like additional education and the method (e.g. shadow, attend unit/division meeting etc.) - Leadership Team. ▪ Create a schedule of events, who, what, when - Leadership Team. ▪ Leaders shadow other leaders or staff - Leadership Team. ▪ Leaders debrief with one another after event and bring to a Leadership meeting - Leadership Team.
	▪ Create opportunities for relationship building to occur within Leadership.	▪ Schedule group lunches, potlucks, and other activities for Leadership Team – Leadership Team.
❖ Educate County stakeholders and decision-makers on DHS programs by December 31, 2022.	▪ Increase awareness of DHS programs and staff roles.	▪ Explore feasibility of Day in the Life presentation – Leadership Team. ▪ Re-implementation of Policy, Practice, and People at HHS and ADRC Board meetings – Leadership Team. ▪ Explore feasibility of Meet and Greets with County Committees – Leadership Team.

Leadership Team		
Objectives	Strategies	Tactics/Responsible Party
❖ Continue to increase employee engagement by December 31, 2023.	▪ Create opportunities for relationship building to occur with staff.	▪ Having a conversation-inducing video or activity at All Staff meetings – Director/Leadership Team. ○ Continue conversation at division meetings – division manager/supervisor. ▪ Explore having ice breakers at All Staff meetings – Director/Leadership Team. ▪ Host a unity event – Leadership Team. ▪ Host interdivision meetings – division manager/supervisor.
❖ Improve outcomes through data driven decisions by December 31, 2022.	▪ Develop process for measuring and analyzing data.	▪ Units/divisions will meet and determine which data to track - manager/supervisor/department head. ▪ Determine frequency of data collection - manager/supervisor. ▪ Meet semiannually and annually to review data - manager/supervisor/department head. ▪ Determine what processes if any need altering to improve outcomes - manager/supervisor. ▪ Share information semiannually and annually with the HHSB - department head.

Aging & Disability Resource Center (ADRC) Division		
<i>Build a Culture of Community Engagement</i>		
Objectives	Strategies	Tactics
❖ Improve staff knowledge of community resources and ensure partners have accurate information about the ADRC by hosting three meeting each year with various partners.	▪ Host three meetings each year with various partner agencies and/or stakeholders.	▪ Create a team in the ADRC each year that will facilitate these meetings ▪ Identify Team leader – division manager. ▪ Determine and schedule meeting dates/times and whether it is in person, virtual or hybrid – team. ▪ Review/evaluate each meeting for usefulness – team/team leader. ▪ Evaluate frequency for bringing each group together again – team. ▪ Identify possible partners each year: those to consider include discharge planners, case managers, police departments, assisted living – team. ▪ Develop agenda for the meetings to include but not limited to: gaps noticed, education about each agency, processes for referrals, ways to help each other – team/team leader.

Aging & Disability Resource Center (ADRC) Division

Utilize Data Driven Decision-Making

Objectives	Strategies	Tactics
❖ Improve online community access to information about resources and ADRC programs, services and events.	Review Facebook and Website and newsletter analytics/trends quarterly and make recommendations for improvements.	- Create an ADRC workgroup each year that will facilitate the evaluation of online presence – manager. - Identify workgroup leader – workgroup. - Determine meeting frequency and schedule meetings – workgroup/leader. - Obtain and review 2020 analytics for website and 2021 analytics for Facebook to use as baselines – leader/workgroup. - Develop website survey to identify opportunities for enhancements – workgroup. - Develop question to include in all evaluations of program/educational sessions – workgroup. - Develop voicemail template that includes mention of website and FB – workgroup/manager. - Identify other methods for sharing information about Facebook, website, and newsletter – workgroup/manager.

Aging & Disability Resource Center (ADRC) Division

Demonstrate Fiscal Responsibility

Objectives	Strategies	Tactics
❖ Improve operational efficiencies within ADRC programs and/or services.	Streamline at least one program/service each year by working with other ADRC's or partner agencies to collaborate or improve efficiency.	- Create an ADRC workgroup each year to that will work on this issue – manager. - Identify Workgroup Leader – workgroup. - Determine meeting frequency and schedule meetings – workgroup/leader - Survey ADRC staff to identify where they feel inefficiencies exist – workgroup/manager. - Identify program(s) or service(s) that are in most need of developing efficiencies – workgroup/manager. - Utilize BADR, GWAAR, etc. to identify agencies that have found efficiencies in targeted program/service – manager. - Identify ways in which “paperless” processes can be implemented – workgroup. - Implement changes – workgroup/manager. - Evaluate changes for usefulness – workgroup/manager.

Aging & Disability Resource Center (ADRC) Division

Build a Culture of Service

Objectives	Strategies	Tactics
❖ Chippewa County residents will receive up-to-date information about ADRC programs and services available in each community.	Chippewa County residents will have access to at least one additional ADRC service/program that was not previously offered in the county or in a region of the county.	- Create an ADRC workgroup each year that will work on this issue – manager. - Identify workgroup leader – workgroup. - Determine meeting frequency and schedule meetings – workgroup/leader. - Review with staff importance of unmet needs documentation in WellSky – manager. - Workgroup to evaluate unmet needs report and waiting lists for services - workgroup - ADRC staff training in cultural competence to improve customer service and outreach to marginalized populations – manager. - Team will identify opportunities to collaborate with other ADRCs and community partners to expand services -workgroup/manager. - Staff training on internal programs/services provided at one meeting monthly - workgroup/manager.
❖ The ADRC of Chippewa County will promote consumer empowerment and advocacy.	Advocacy training sessions will be offered annually each year for consumer and staff participation.	- Identify and promote opportunities for empowerment of consumers – manager/ADRC team. - Advocacy and empowerment sessions will be shared with consumers and staff - manager/ADRC team. - Team will identify educational staff needs as it relates to specific diversity, ethnicity and cultural issues and provide to ADRC manager - manager/ADRC team.

Aging & Disability Resource Center (ADRC) Division

Continue to Build and Maintain a Healthy Workplace

Objectives	Strategies	Tactics
❖ The ADRC Team will continually improve a healthy work environment through enrichment and engagement opportunities.	ADRC courthouse staff will plan and facilitate one organizational work day per year that includes team building and individual well-being components.	- Create an ADRC workgroup each year that will work on this issue – manager. - Identify workgroup leader – workgroup. - Determine meeting frequency and schedule meetings ADRC planning team will be created each year – workgroup/leader. - Workgroup will send out date saver (mandatory attendance) - leader. - ADRC manager will provide workgroup with a budget for the training day – manager. - Workgroup will identify speakers, location, and food (with confirmation from manager) -workgroup/manager. - Agenda will be developed – workgroup. - AAs will arrange for phone coverage – reception AAs.
	ADRC nutrition program staff will meet every other week via conference call or in person.	- Agenda will typically include day-to-day operations and administrative updates, customer service changes, status of supplies, blizzard packs, registrations, etc. will be reviewed – nutrition program coordinator/manager. - Meeting schedule will be sent out to all nutrition staff - manager - Nutrition Staff provided opportunity to add to agenda and share personal or work-related updates - nutrition program coordinator/manager.

Economic Support (ES) Division		
Objectives	Strategies	Tactics
❖ Create a marketing plan regarding Economic Support by 12/31/2022.	Form committee of ES staff to determine key components such as Access app, Chippewa Co. document drop box, Great Rivers Call Center	- Identify staff interested in participating in the committee. - Committee determines means to communicate the information to the public (website, newsletters, etc.).
	Explore potential outreach opportunities.	- Committee identifies partners to present marketing information to (e.g. Chippewa County Jail, Open Door Clinic, Aging and Disability Resource Center, etc.). - Marketing materials will be distributed according to the recommendations of the committee.
❖ Implement an in-person training program for Economic Support Staff annually through 2024.	Survey staff to determine training needs outside of technical job functions (e.g. soft skills, stress reduction, time management, etc.).	- Manager will identify available trainings. - A minimum of one training annually will be held in person. - Manager will follow up with surveys will be used to determine effectiveness of training and assist in identifying future trainings. - Manager will conduct a debriefing to be held within 30 days of training to determine strategies staff will implement.
❖ Support telework through balancing the needs of the consumer, team, and individual staff by 12/31/2022.	Determine unique needs of consumers, ES team, and individual staff arising from telework.	- Create a workgroup of ES staff to identify the number of face-to-face appointment requests made by consumers and determine the best method for ensuring coverage and fair distribution of appointments to ES staff. - Gather input from other division staff through survey to identify unmet needs of consumers arising from telework. - Manager to create survey of ES staff to determine unmet needs arising from telework. - Manager to create an action plan to address unmet needs of staff identified in the survey. - Manager to meet with teams: Family, EBD/LTC and Child care to identify unmet needs and create an action plan based on team suggestions. - Manager to meet with HR, DHS Director, IT, etc. as needed to address unmet needs identified by consumers, teams, and individual staff.

Children, Youth & Families (CYF) Division – Child Protective Services (CPS)/Birth to Three (B-3)		
Objectives	Strategies	Tactics
❖ Educate community members about Child Protective Services and Birth to Three programs by December 2023.	Determine the need and the best way to provide education to community partners/stakeholders.	- Kari to identify staff to reach out to Community Partners (Law Enforcement throughout the county, Schools throughout the county, medical professionals, Judges, Health and Human Services Board, County Board) to see if they are interested in learning more about what CPS and Birth to Three do on a daily basis. - Identified staff will put together a brief presentation/talking points to have available for when they reach out to community partners to identify interest.
	Determine feasibility of restarting meetings with the Chippewa Falls School District.	- Kari to reach out to Chippewa Falls School district to determine if monthly meetings are held. - If monthly meetings are still held, ask to be invited to meetings to collaborate with Chippewa Falls School District.
	Increase awareness of Child Protective Services and Birth to Three in community partners, Health and Human Services Board, and County Board.	- Kari to form a team of CPS and Birth to Three members to identify the most important topics for education. - The team will put together a presentation regarding roles/responsibilities for community Partners and create training videos/handouts. - The team will present to community partners throughout 2023/2024.
❖ Improve permanency outcomes for children in out of home care by 2024.	Explore ways to increase the budget through grants.	- Kari and Ashley to establish a grant search/writer group in order to share the workload. - The group will reach out to the Universities in the area to see if they have the ability/are willing to help the group search for/write grants. - The group will present at the DEC/MDT Meetings to see if there are any community partners that are inclined to assist with writing/implementing projects if grants are received. - The group will utilize the Child Protective Service Clearing House to identify potential grant opportunities. - When grant opportunities are received from the State of Wisconsin, DCF, Kari will pass these opportunities on to the grant group.
	Explore ways to support Child Protective Services and Birth to Three staff by providing ongoing education.	- Ashley/Erica will reach out to EAP to see what education they are able to provide about secondary trauma/burnout including costs associated with that. - Ashley/Erica to survey the group to identify specific trainings that staff feel would be helpful in moving children towards permanency and improving their knowledge base. - Ashley/Erica will reach out to specific trainers to identify costs/feasibility of training (virtual/in person). - Kari to add training ideas/suggestions to the Unit meeting agenda.

Children, Youth & Families (CYF) Division – Youth Justice (YJ)		
Objectives	Strategies	Tactics
❖ Explore potential researched based groups that can be facilitated by YJ staff by October 1, 2022.	Explore potential research-based groups that can be facilitated by YJ staff.	- Identify current needs of cases in Youth Justice - YJ unit. - Identify time commitments and costs - Dianna/Manda. - Collaborate with other counties that utilize groups - YJ unit. - Identify necessary training for implementation - Dianna/Manda.
	Research grants.	Identify funding sources – Kyra.
	Re-implement Support Service & Advisory Team meetings (SSATs).	- Research staffing formats utilized by Eau Claire and Barron Counties - Kyra. - Update format of SSAT and present ideas to the leadership team and YJ unit for feedback – Kyra. - Prepare draft format – Kyra. - Review and update SSAT policy; send to director for approval – Kyra. - Obtain HHSB approval - department head. - Implement/train staff on new SSAT format – Kyra.
❖ Differentiate actual YJ Out-of-Home Placement (OHP) costs from actual CPS OHP costs within the DHS budget by January 1, 2023.	Explore the ability to differentiate actual YJ out of home placement (OHP) costs from actual CPS OHP costs within the DHS budget	- Research systems used in other Western Region Counties – Kyra. - Form workgroup - YJ unit. - Develop proposal - workgroup.
	Obtain support of DHS and Fiscal leadership.	- Develop PowerPoint to present to Leadership - Kyra and workgroup - Present PowerPoint proposal to DHS and Fiscal Leadership - Kyra and workgroup.
	Maintain existing YJ OHP spreadsheet.	- Expand data tracking to include Mental Health and Disrupted Guardianships/Adoptions on youth we serve in Youth Justice – Kyra and Geri. - Route all OHP bills through YJ manager before sending to fiscal; YJ manager will route to fiscal - YJ unit and Kyra. - Review YJ OHP spreadsheet in unit meetings for accuracy on a monthly basis – Kyra. - Establish & maintain O-Drive location for YJ OHP Spreadsheet with limited editing permissions – Kyra.

Children, Youth & Families (CYF) Division – Children with Differing Abilities (CWDA)

Objectives	Strategies	Tactics
❖ Develop strategies to improve customer service by December 31, 2024	Operate waitlist free in compliance with State mandates.	- Continue updating data sheet regarding projections on consumer referrals and staff capacity - Kyra and Rachel. - Research other counties' strategies on hiring for projected needs - Kyra and Rachel. - Advocate with DHS director to move for board approval for hiring based on projected needs vs playing catch up - Kyra and Rachel.
	Educate referral sources.	Meet with new CYF division staff to educate on referral process and programs – Rachel.
	Evaluate infrastructure needs.	- Collaborate with RWC Manager & CCS Clinical Coordinator about clinician's current capacity and projected position needs - Kyra and Rachel. - Present proposed clinical staffing needs to DHS director - Tom, Kyra, and Rachel.
❖ Increase CWDA employee satisfaction and engagement by December 31, 2024.	Improve work, life balance to reduce burn out.	- Evaluate productivity hours requirement - Kyra and Rachel. - Meet with DHS Fiscal Manager to review billing requirements for CCS and CLTS programs – Rachel. - Present data findings regarding productivity hours to DHS director - Kyra and Rachel. - Develop new productivity hour procedure if applicable - Kyra and Rachel. - Encourage more staff team bonding outside of work hours - CWDA staff.
	Improve support for dual-program staff.	- Create a workgroup to strategize ways on streamlining the CCS and CLTS dual program cases – Rachel. - Workgroup will present ideas to manager. - Manager and supervisor will decide on strategies to implement. - Meet with RWC support staff on improving Avatar functionality for CCS and CLTS Programs – Rachel. - Develop an internal audit checklist for CCS and CLTS Programs - workgroup. - Create a process for peer to peer file audits - Rachel and Kyra. - Continue attending Avatar Super User meetings and consortium-wide CLTS/CCS workgroups – Rachel. - Continue to explore ways to ensure CLTS QA oversight in dual-program cases - Rachel and Kyra.

Recovery & Wellness Consortium (RWC) Division		
Objectives	Strategies	Tactics
❖ Increase utilization rate of the Recovery House to 50 percent by December 31, 2022.	Form a committee of RWC staff, consumers, and county staff to evaluate program structure, admission criteria and program rules and expectations.	- Identify RWC staff who will take the lead to form initial workgroup and determine who should be a part of the committee. - RWC staff develops strategy for consumer engagement. - Committee will identify “champions” to promote utilization of the Recovery House.
	Establish Recovery House mission and vision statements.	- Committee will identify a member who will actively participate in the Western Region Recovery Residence Network meetings to strengthen the Recovery House mission. - Committee will establish a mission and vision statements. - Committee identifies champions.
	Implement a new admission procedure, program structure (rules and expectations).	- Committee will review current Recovery House practices and make recommendations on new program structure. - Committee develop an after-hours protocol for law enforcement. - Committee explore use of post satisfaction survey completed by consumers. - Committee explores training opportunities utilized by Recovery Residence Network. - Committee will evaluate utilization rate for 2022, provide recommendations to full RWC team, and then determine next steps for further improvement in utilization of Recovery House. - Evaluate appropriateness to accept referral from Core Counties (Buffalo and Pepin) .
❖ Implement an “onboarding” process for all RWC programs to increase staff knowledge of all RWC programs by December 31, 2022.	Identify RWC programs affected.	- Manager will identify clinician and lead staff from each of the following programs; Community Support Program (CSP), Crisis, Community Recovery Services and Comprehensive Community Services (CCS) and Adult Protective Services (APS). - Manager will facilitate discussion of onboarding objectives and requirements with staff. - Super user (Caleb Johnson) will conduct periodic AVATAR and SharePoint training.
	Develop a flow chart on how programs can overlap with each other.	- Manager in collaboration with student intern will create Intake and Services flow chart for CCS, CSP, CRS, APS and Crisis. - Manager will pull in staff from each program as needed for consultation on flow charts.

Recovery & Wellness Consortium (RWC) Division		
Objectives	Strategies	Tactics
❖ Improved seamless collaboration with Aging & Disability Resource Center (ADRC) by December 31, 2023 as evidence by pre and post survey scores.	Establish biannual informational sharing sessions between RWC and ADRC.	- RWC Manager will reach out to ADRC manager to discuss opportunity to share information of respective program criteria and referral process. - Managers from RWC and ADRC will co-facilitate biannual informational sessions for staff from each division.
	Develop pre/post survey communication tool.	RWC manager in collaboration with ADRC manager will identify staff from each division to take the lead in creating a communication survey tool.
	Encourage “job shadowing” between divisions when appropriate	- Manager will facilitate discussion with RWC team to develop a “shadowing” plan for all RWC employees. - RWC staff will observe RWC consumer long-term functional screen intake conducted by ADRC staff.
❖ Increase efficiency between Adult Protective Services (APS) and mental health services by December 31, 2023 as evidence by pre and post survey scores.	Increase staff knowledge of all internal programs within the RWC.	- Manager will identify presenter and coordinate training opportunities on case presentation. - APS staff will develop quick Guardianship reference guide. - Manager will facilitate discussion with RWC team to develop a “shadowing” plan for all RWC employees. - Manager will facilitate monthly reviews of shared cases for quality improvement.
	Conduct periodic team building activities.	Manager will create schedule for each RWC staff member to sign up and facilitate a team building activity.
	Develop pre/post survey communication tool.	Manager in collaboration with identified staff from crisis and APS will create a communication survey tool.
	RWC manager will explore at the regional and state level on how counties may integrate APS and Crisis services to ensure seamless continuum of services to residents.	- Manager will have dialogue with outside county APS programs that currently have APS workers embedded in their crisis programs. - If warranted APS staff will complete crisis training per statute requirements.

Fiscal Division		
Objectives	Strategies	Tactics
❖ Increase Employee Engagement by 12/31/2022.	Assess task assignments based on strengths.	- Individual staff will create a task list and rank each task based on strengths. - Managers will meet and review results to determine next steps. - Go through results as a group to discuss feasibility. - Managers will reassign tasks (if possible) to utilize strengths and interests.
❖ Increase division efficiencies by 12/31/2024.	Review current processes for efficiencies.	- Staff and managers will perform walk through to determine what processes will be targeted. - Staff and managers will develop and/or utilize existing reports to obtain data (e.g. crystal reports rather than Geneva). - Staff and managers will create instructions for all team members to have as a reference. - Staff and managers will train on software and reports.
❖ Increase training and professional opportunities by 12/31/2022.	Determine who should attend what meetings.	- Managers will share meeting opportunities with the team to allow them opportunities to attend those that relevant to their positions. - Have staff on “stand-by” for meetings to join if needed.
	When possible, structure fiscal topics in one section of the meeting.	Managers will contact meeting organizer to determine if this is feasible.
	Determine trainings which staff may benefit from.	- Managers will seek staff input. - Managers will Investigate free or low-cost opportunities available that are relevant to the staff.
❖ Ensure all processes have trained and qualified backup staff by 6/30/2023.	Determine which processes do not have a viable backup.	- Staff and managers will update the master task list. - Staff and managers will determine appropriate backup. - Staff and managers will update procedures and update them on the master list. - Staff and managers will schedule time for cross training.
❖ Provide up to date information regarding productivity and staffing levels by 12/31/2023.	Create comprehensive document to house and track the data to maintain appropriate fiscal staffing level.	- Managers will monitor consortium staffing levels. - Managers will monitor consumer levels. - Managers will create reports to track invoice data entry (lines and invoices). - Managers will create reports to monitor MSO data entry.

Chippewa County Department of Human Services

Health & Human Services Board Orientation - 2022

MISSION

Strengthening our community through partnerships and services to promote dignity, increase resilience, and provide hope.

VISION

Everyone reaching their full potential to live their best life.

VALUES

Advocacy, Compassion, Empowerment, Partnership, and Respect



Recovery & Wellness Consortium (RWC)

- **Comprehensive Community Services (CCS)**
 - Fully funded Medicaid program
 - County performs service coordination, rely on the private sector for the provision of services
 - Voluntary
 - Must have a diagnosis of mental illness and or substance use disorder
 - State prohibits counties from having a waiting list
 - Guided by Department of Health Services Chapter 36

Recovery & Wellness Consortium (RWC)

- **Community Support Program (CSP)**
 - Combination of Medicaid and state funds
 - County provides service facilitation and nursing services
 - Serves adults diagnosed with a severe and persistent mental illness
 - Supports consumers so they can continue to live in the community
 - Voluntary
 - Guided by Department of Health Services Chapter 63



Recovery & Wellness Consortium (RWC)

- **Emergency Mental Health Services (Crisis)**
 - Combination of Medicaid, state and local funding
 - Serves children and adults
 - Contract with Northwest Connections for 24/7 phone, mobile crisis response as well as linkage and follow-up
 - Provides an immediate response to those who are experiencing a mental health crisis
 - Coordinates with law enforcement, local and state hospitals, care providers, and others
 - Guided by Department of Health Services Chapters 34 and 51



Recovery & Wellness Consortium (RWC)

- **Adult Protective Services (APS)**
 - State and locally funded
 - Provides services to any adult or elder at risk from physical, emotional, sexual abuse, or financial exploitation
 - Also includes self-neglect where an individual is no longer able to care for themselves



Children with Differing Abilities (CWDA)

- **Children's Long Term Support (CLTS) aka Waiver**
 - Medicaid funded
 - County performs service coordination, rely on the private sector for the provision of services
 - State prohibits counties from having a waiting list
 - Serves children with a developmental disability, physical disability, and severe emotional disturbance
 - Allows children who are assessed at an institutional level of care to remain in the home
 - Children and families are supported through a vast array of services
 - Voluntary



Children with Differing Abilities (CWDA)

- **Comprehensive Community Services (CCS)**
 - See previous slide in RWC for program description
- **Children’s Community Options Program (CCOP)**
 - Provides flexible funding for families who need assistance caring for their child with long-term support needs
- **Coordinated Services Teams (CST)**
 - State funded
 - Contract with Lutheran Social Services for service facilitation
 - “Wraparound” model of care supports child and family with community-based supports
 - For children with complex behavioral needs
 - Voluntary



Youth Justice (YJ)

- Combination of state and local funding
- Youth justice workers are Chippewa County employees
- 938.01 Juvenile Justice code
 1. Protect the community from juvenile crime
 2. Impose accountability for violations of law
 3. Equip juvenile offenders with competencies to live responsibly and productively
- 938.13 Juveniles in need of protection and or services (JIPs)
 1. Uncontrollable
 2. Truancy
 3. Delinquent act before age of 10
 4. Not responsible or competent
 5. Runaway
- Typically, is an involuntary program



Child Protective Services (CPS)

- Combination of state and local funding
- Initial assessment and ongoing workers are Chippewa County employees
- 48.01 Children’s code
 1. Protect children and unborn children
 2. Preserve the unity of the family and strengthening families through assisting parents and expecting mothers
 3. Assisting parents in changing circumstances in the home which might harm the child.
- Children taken into custody become “children in need of protection” (CHIPS)
- CPS becomes involved after a report of possible physical, sexual, emotional abuse, or neglect of a child.
- Involuntary program



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Aging & Disability Resource Center (ADRC)

- Funding: federal and state with required local match
- Serve older people and adults with physical and intellectual disabilities
- Promote empowerment of people to make informed choices
- Help people access the services and supports that promote quality of life
- Many experts under one roof...Benefits Counseling, Dementia Support, Options Counseling, and more



Economic Support (ES)

- Federal and state funding with local funding (Maintenance of Effort - level set in 2009)
- Member of a 10-county Income Maintenance Consortia - Great Rivers
- Great Rivers operates a call center for members to report changes, apply for services, answer eligibility and program questions, and process documents related to eligibility
- Determine eligibility for entitlement programs
 - BadgerCare and Wisconsin Medicaid (including waivers and long-term care programs)
 - Wisconsin Share Child Care Subsidy
 - FoodShare (SNAP-Supplemental Nutrition Assistance Program)
 - Caretaker Supplement



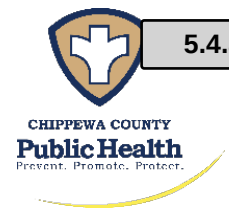
CHIPPEWA COUNTY
Public Health
Prevent. Promote. Protect.

**Chippewa County
Health & Human Services Board
Orientation Manual**

Department Information

Chippewa County

Department of Public Health



Vision

- *The Healthiest County to Live, Learn, Work, and Play*

Mission

- *Prevent, Promote, Protect*

Values *(P.R.I.D.E.)*

- *Partnership, Respect, Innovation, Dedication, Equity*

Accreditation Domains

-  Domain 1 - Assess
-  Domain 2 - Investigate
-  Domain 3 - Inform & Educate
-  Domain 4 - Community Engagement
-  Domain 5 - Policies & Plans
-  Domain 6 - Public Health Laws
-  Domain 7 - Access to Care
-  Domain 8 - Workforce
-  Domain 9 - Quality Improvement
-  Domain 10 - Evidence-Based Practices
-  Domain 11 - Administration & Management
-  Domain 12 - Governance

Acronyms List

AAR	After Action Report
AC	Accreditation Coordinators
ACEs	Adverse Childhood Experiences
ADRC	Aging and Disability Resource Center
AODA	Alcohol and Other Drug Abuse
APEX-EH	Assessment Protocol for Excellence in Environmental Health
APEXPH	Assessment Protocol for Excellence in Public Health
APHA	American Public Health Association
AS	Accreditation Specialist
ASI	Accreditation Support Initiative
ASTHO	Association of State and Territorial Health Officials
BID	Background Information Disclosure
CADCA	Community Anti-Drug Coalitions of America
CBRF	Community-Based Residential Facility
CCS	Comprehensive Community Services
CDC	Center for Disease Control and Prevention
CHA	Community Health Assessment
CHIP (big)	Community Health Improvement Partnership (coalition)
CHIP (little)	Community Health Improvement Plan
CYSHCN	Children and Youth with Special Health Care Needs
DATCP	Wisconsin Department of Agriculture, Trade, and Consumer Protection
DCF	Department of Children and Families
DFC	Drug Free Communities (grant)
DHS	Department of Health Services
DPH	DHS Division of Public Health
EAP	Employee Assistance Program
EBP	Evidence-Based Practice
EHR	Electronic Health Record
EOP	Emergency Operations Plan
ERP	Emergency Response Plan
FAS/FASD	Fetal Alcohol Spectrum Disorder
FDA	US Food and Drug Administration
FHC	Family Health Center
FPOS	Family Planning Only Services
FSET	FoodShare Employment and Training
FY	Fiscal Year
HHA	Home Health Agency
HIPAA	Health Insurance Portability and Accountability Act

HMO	Health Maintenance Organization
HSHS	HSHS Sacred Heart Hospital
ICS	Incident Command System
IRB	Institutional Review Board
IT	Information Technology
JIC	Joint Information Center
LEP	Limited English Proficiency
LHD	Local Health Department
MA	Medical Assistance/Medicaid
MAPP	Mobilizing for Action through Planning and Partnerships
MCH	Maternal Child Health
MH	Mental Health
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
MTM	Medical Transportation Management
NIH	National Institutes of Health
NACCHO	National Association of County and City of Health Officials
OPPA	Office of Practice and Policy Alignment
OSHA	Occupational Safety and Health Administration
PAC	Professional Advisory Committee
PH	Public Health
PHAB	Public Health Accreditation Board
PHEP	Public Health Emergency Preparedness Public Health Emergency Plan
PM	Performance Management
PPE	Personal Protective Equipment
QI	Quality Improvement
QPR	Question, Persuade, Refer
RWJF	Robert Wood Johnson Foundation
SAMSHA	Substance Abuse and Mental Health Services Administration
SP	Strategic Plan
TA	Technical Assistance
TTY	Teletypewriter
VMSG	Vision, Mission, Services, Goals
WALDAB	Wisconsin Association of Local Health Departments and Boards
WEDSS	Wisconsin Electronic Disease Surveillance System
WFD	Workforce Development
WIC	Women, Infants, and Children Program
WIR	Wisconsin Immunization Registry

Vision: The Healthiest County to Live, Learn, Work, and Play

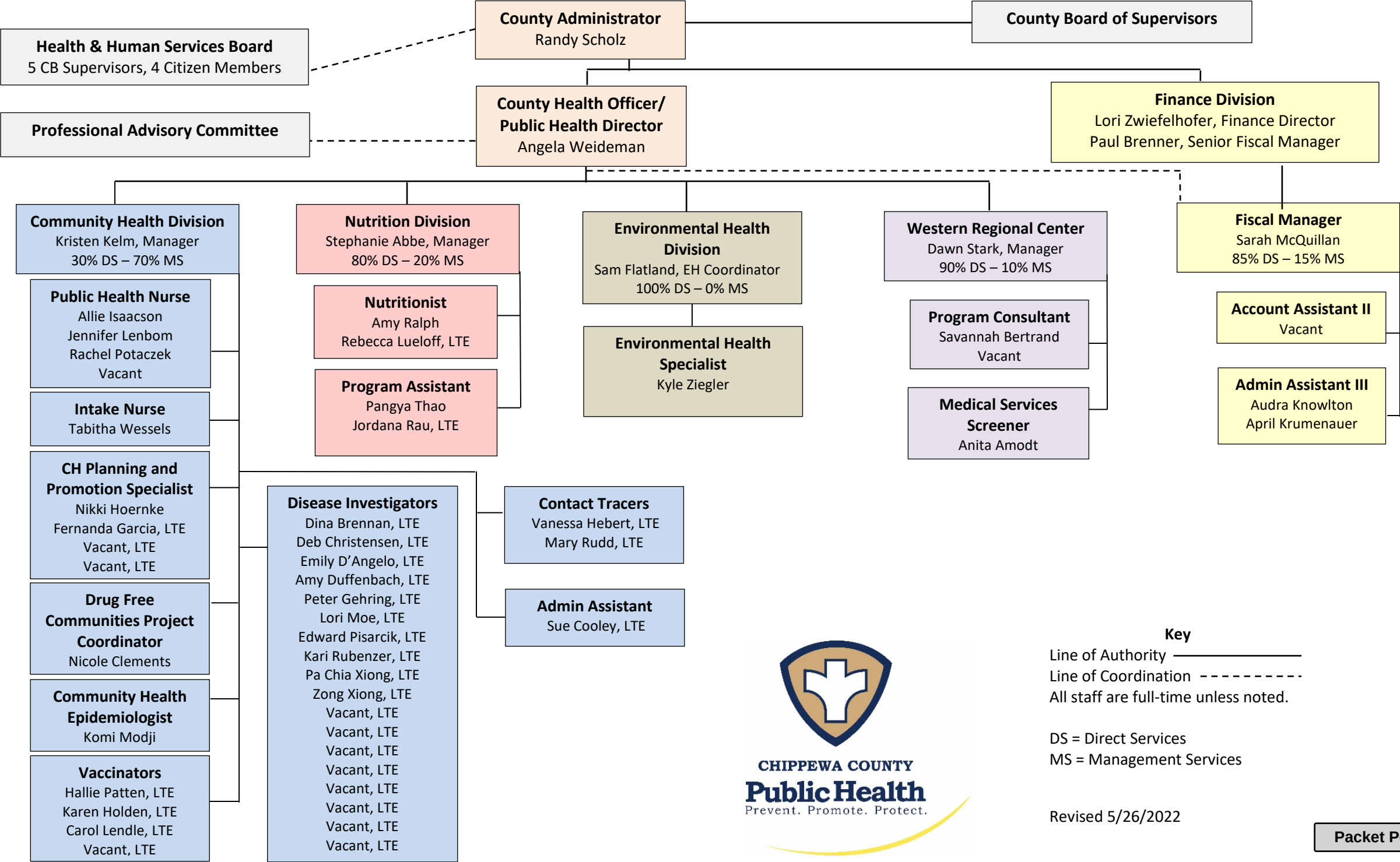
Mission: Prevent, Promote, Protect

Values: Partnership, Respect, Innovation, Dedication, Equity

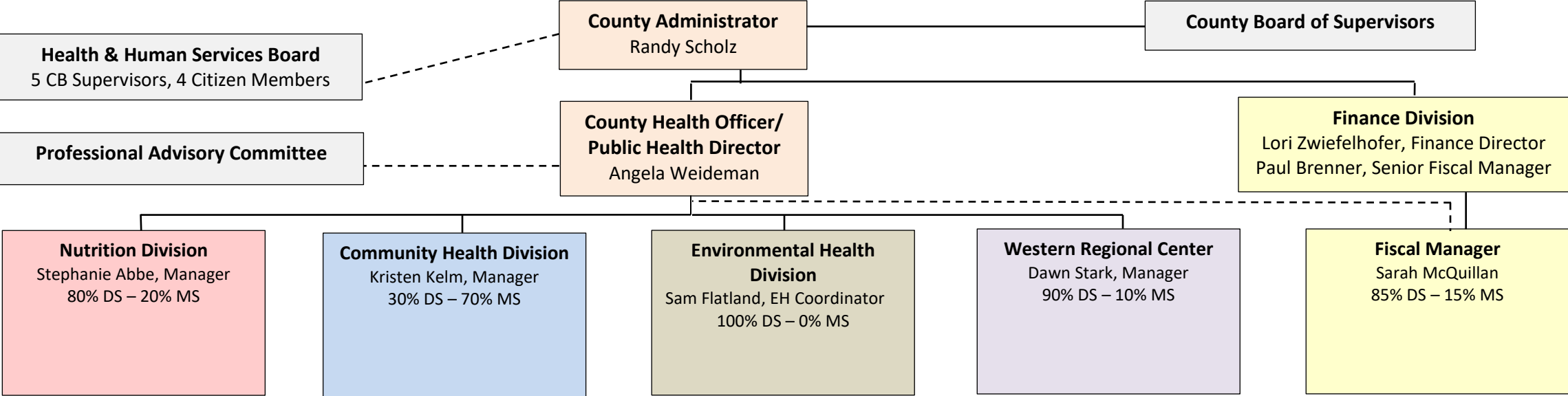
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Chippewa County Department of Public Health
Organizational Chart



Chippewa County Department of Public Health
Organizational Chart - Services



WIC - Women, Children, and
Infants
Fit Families
Farmer’s Market
Breastfeeding Peer
Counseling
Forward Health
Diabetes Prevention

Maternal Child Health
WI Wins
Childhood Lead Case Manager
Immunizations (Children and
Flu)
Health Care Education and
Training
Preparedness
Prenatal Care Coordination
Bright Start Riversource
Accreditation
Pre-Venture
Postvention
Nurse Family Partnership
Reproductive Health
Communicable Disease
Overdose Fatality Review
Narcan Distribution
Drug Free Communities
Charity Outreach
DOT Car Seats

Food Safety/Recreational
Licensing
Childhood Lead
Human Health Hazards
Beachwater Testing
Household Meth Testing
Radon Consultation

Children and Youth with
Special Health Care Needs
Early Hearing Detection and
Intervention (EHDI)
DHS Single Point of Entry
Children’s Long Term Care
Functional Screens

Donations

Key
Line of Authority _____
Line of Coordination - - - - -
All staff are full-time unless noted.

DS = Direct Services
MS = Management Services





RANK SERVICES 1-3 BELOW

MANDATED SERVICES

					Funding Sources		
Board Rank 2022	Leadership Team Rank 2022	Board Rank 2021	Program	Description	Tax Levy	Revenue, Grants or Contracts	2022 Budget Request
1	1	1	Public Health Nursing (i.e.-Communicable Disease Follow-up/Intake)	Prevention and control of communicable disease, foodborne outbreaks, tuberculosis, and rabies through surveillance, investigation and education.	\$657,379	\$9,950	\$667,329
2	2	2	Environmental Health (i.e.-Human Health Hazards)	Investigation and enforcement of Chippewa County Ordinance relating to human health hazards from vermin infestations, accumulations of trash or rubbish, pollution of surface water, unfit housing, and more.	\$18,010	\$2,900	\$20,910
3	3	3	Health Clinics	Includes costs associated with clinics (i.e.-TB skin testing).	\$0	\$33,000	\$33,000

RANK SERVICES 1-27 BELOW

ESSENTIAL PREVENTION SERVICES

					Funding Sources		
Board Rank 2022	Leadership Team Rank 2022	Board Rank 2021	Program	Description	Tax Levy	Revenue, Grants or Contracts	2022 Budget Request
1	1	1	Environmental Health-Facility Licensing	Department of Agriculture, Trade, and Consumer Protection agents to inspect facilities (i.e.-restaurants, lodging, retail) and enforce food code.	\$36,457	\$205,641	\$242,098
2	2	2	WIC (Women Infant Children)	Provides supplemental food, nutrition education, and nutrition counseling to high-risk populations.	\$69,726	\$304,743	\$374,469
3	3	3	Western Regional Center	Provides information and referral resources to families with children birth to 21 with a long-term health concern. Systems work to develop parent leaders, ensure smooth transition for teens	\$0	\$177,100	\$177,100
4	5	4	Public Health Emergency Preparedness (PH Emergency Plan)	Includes awareness and understanding of potential public health emergencies, collaboration with other agencies, and determination of personnel needs in emergencies.	\$0	\$46,644	\$46,644
5	7	7	Drug Free Communities (New in 2020)	Focuses on substance abuse prevention in our youth through education and programming. Systems changes through policy and ordinance changes.	\$0	\$125,000	\$125,000

ESSENTIAL PREVENTION SERVICES

Board Rank 2022	Leadership Team Rank 2022	Board Rank 2021	Program	Description	Funding Sources		
					Tax Levy	Revenue, Grants or Contracts	2022 Budget Request
6	4	5	Nurse Family Partnership	Evidence-based program pairing Public Health Nurse with first-time, low-income moms from prenatal through second birthday. NFP empowers first-time moms to transform their lives and create better futures for themselves and their babies. Through the structured home-visit schedule the nurse and mom build a trusting relationship that the mom can rely on for advice and guidance. NFP helps prevent Adverse Childhood Experiences (ACEs) and helps with parent-to-child attachment.	\$14,330	\$98,000	\$112,330
7	6	8	Reproductive Health/Dual Protection/BRIDGES	Administration of the Dual Protection/BRIDGES Clinic including outreach to local partners. Reproductive health program providing testing/treatment of sexually-transmitted diseases, birth control options, and prevention of communicable disease.	\$4,000	\$70,523	\$74,523
8	9	10	Prenatal Care Coordination (Medicaid Program)	Case management and education to pregnant women (prenatal to 60 days after birth), to assure healthy birth.	\$0	\$60,000	\$60,000
9	8	13	DHS Contract (in Regional Center)	Conducting intake for Birth to Three program and Children's Long Term Support Waivers. Meets with families who have children transitioning to adult services to help transition plan. Intake for children's Comprehensive Community Services (CCS) for Human Services.	\$0	\$99,000	\$99,000
10	10	6	Immunization - Consolidated Contract & Public Health	Prevention of disease through provision of immunizations and education.	\$0	\$15,290	\$15,290
11	12	9	Forward Health Outreach	Wisconsin ForwardHealth Program assists participants with applications/renewals including WI Medicaid, BadgerCare Plus, Family Planning Waiver and FoodShare.	\$0	\$20,000	\$20,000
12	16	20	Diabetes	Supports the design, testing and evaluation of novel approaches to address evidence-based strategies aimed at reducing risks, complications and barriers to prevention and control of diabetes and CVD in high-burden populations	\$0	\$15,000	\$15,000

ESSENTIAL PREVENTION SERVICES

Board Rank 2022	Leadership Team Rank 2022	Board Rank 2021	Program	Description	Funding Sources		
					Tax Levy	Revenue, Grants or Contracts	2022 Budget Request
13	15	14	Preventure	Evidence based program aimed at preventing the start of use of substances including alcohol, tobacco, and other drugs. Funded with Human Services AODA prevention money. Nurses and school staff will be trained to deliver the program.	\$0	\$19,268	\$19,268
14	11	12	WI Sound Beginnings/Early Hearing Detection (regional service)	Ensures all babies born in WI are screened early for hearing loss and diagnosed/referred for intervention.	\$0	\$104,401	\$104,401
15	20	17	Prevention	Enhances the health and well being of residents by collaborating with area agencies and community to improve health status and quality of life.	\$0	\$8,465	\$8,465
16	14	16	Breastfeeding Peer Counseling	Provides peer support to breastfeeding moms on the WIC program to increase breastfeeding initiation & duration.	\$0	\$13,741	\$13,741
17	13	11	Maternal & Child Health (MCH) - COVID	Focus on to improving the health of mothers, children, and families during the COVID-19 pandemic.	\$0	\$26,161	\$26,161
18	17	21	Overdose Fatality Review	Focuses on the complex and changing nature of the drug overdose epidemic and highlights the need for an interdisciplinary, comprehensive and cohesive public health approach	\$0	\$35,000	\$35,000
19	18	18	Fit Families	Behavior change program (healthy eating and physical activity) that provides health coaching for families with children.	\$0	\$35,347	\$35,347
20	19	19	Lead - Consolidated Contract & Childhood Lead	Provide case management and lead risk assessment of children who are/at risk of being lead poisoned.	\$0	\$9,363	\$9,363
21	21	22	Farmers Market	Provides WIC participants with farmers market vouchers to help increase fruit and vegetable consumption.	\$0	\$3,536	\$3,536
22	23	24	Environmental Health - Beach Water Testing	Collect water samples from public beaches to test for E.Coli to prevent disease and advise citizens.	\$2,285	\$0	\$2,285
23	22	23	Bright Starts (River Source)	Provides personal Parents as Teachers visits from a parent educator, parent group connections, screenings, and resources in collaboration with River Source Family Center.	\$0	\$10,000	\$10,000



ESSENTIAL PREVENTION SERVICES

Board Rank 2022	Leadership Team Rank 2022	Board Rank 2021	Program	Description	Funding Sources		
					Tax Levy	Revenue, Grants or Contracts	2022 Budget Request
24	24	25	Loan Closet	Providing wheelchairs on loan for up to six months at no cost.	\$0	\$6,500	\$6,500
25	25	26	WI WINS	Conducts compliance inspections of tobacco retailers and recognizes those not selling to youth.	\$0	\$4,350	\$4,350
26	26	27	Charity Outreach	Dispersal of funds from Rutledge Charities for primary health care needs of residents with children as a priority.	\$0	\$500	\$500
27	27	28	Donations	Individuals donating to Public health mainly for immunizations.	\$0	\$1,000	\$1,000

2022 Board Prioritization Ranking results are based on five responses.

2022 Public Health Budget

Program	Division	Funding				Total
		Grants	Other Rev	Tax Levy	Indirect Rev	
Public Health Nursing	54100	\$ 7,700	\$ 2,250	\$ 657,379	\$ 39,161	\$ 706,490
Health Clinics	54161		33,000		1,334	34,334
Nurse Family Partnership	54121		98,000	14,330	6,939	119,269
Farmer's Market (Nutrition)	54123	3,536			335	3,871
Prenatal Care Coordination	54125		60,000		3,686	63,686
Public Health Preparedness	54128	46,644			2,544	49,188
Drug Free Communities	54132	125,000			7,814	132,814
Bright Start RiverSource	54135	10,000			594	10,594
Women, Infants & Children (WIC)	54140	304,743		69,726	35,310	409,779
Maternal & Child Health (MCH)	54142	26,161			1,503	27,664
Wisconsin Wins	54144	4,350			264	4,614
Pre-Venture	54149	19,268			769	20,037
Prevention	54150	8,465			486	8,951
Equipment Loan Closet	54151		6,500		443	6,943
Western Regional Center	54152	177,100			12,652	189,752
Title X Reproductive Health	54154	14,000			766	14,766
FIT WIC (Nutrition)	54156	35,347			1,831	37,178
Reproductive Health	54157	41,923	5,100	4,000	3,068	54,091
Breastfeeding Peer Counseling	54158	13,741			979	14,720
Diabetes	54159	15,000			863	15,863
COVID Vaccine	54162	10,706			640	11,346
Overdose Fatality Review	54163	35,000			1,958	36,958
COVID Contact Tracing	54164	76,661			23,129	99,790
Get Yourself Tested GYT	54165	2,000			83	2,083
Food Safety Recreation Licensing	54171		205,641	36,457	15,138	257,236
Infant Immunization	54172	15,290			798	16,088
Early Hearing & Detection	54173	104,401			8,334	112,735
Forward Health Outreach	54174	20,000			1,318	21,318
Environmental Health	54176		2,900	20,295	1,330	24,525
DHS Agreement	54180		99,000		10,061	109,061
HCET (Health Care, Ed & Tr)	54182	7,500			296	7,796
Childhood Lead Poisoning Prevention	54184	9,363			567	9,930
Charity Outreach	54186		500			500
Donations	54190		1,000			1,000
Totals		\$1,133,899	\$513,891	\$802,187	\$184,993	\$2,634,970
Percentage of Funding		43.03%	19.50%	30.44%	7.02%	



CHIPPEWA COUNTY
Public Health
Prevent. Promote. Protect.

2020-2023 STRATEGIC PLAN

CHIPPEWA COUNTY DEPARTMENT OF PUBLIC HEALTH

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Message from the Director

Dear Friends and Colleagues,

I am excited to present the Chippewa County Department of Public Health (CCDPH) Strategic Plan 2020-2023. Amazing work was done by CCDPH staff from 2017-2020 to improve the department. A few highlights from the last three years include:

- Creating and utilizing a Department Facebook page.
- Offering performance management (PM) and quality improvement (QI) trainings for staff and creating a Vision, Mission, Services, and Goals (VMSG) Dashboard for tracking PM/QI.
- Creating an Agency Outreach Coordination Procedure and checklist.
- Having all staff complete a Public Health Core Competencies Assessment and training on the Public Health Core Competencies.
- Planning and celebrating the Department's 100 Year Anniversary.
- Creating a Health Equity Policy for the Department.
- Applying for National Public Health Accreditation.



Thank you to CCDPH staff, the Health and Human Services Board (HHSB), and community partners for your feedback and involvement in creating the 2020-2023 strategic plan.

Looking forward to the next three years, we will be focusing on four goals:

- Goal 1: Improve communication skills and information sharing in order to strengthen the workforce and build an understanding of public health internally and externally.
- Goal 2: Integrate PM/QI throughout the Department.
- Goal 3: CCDPH is a positive, supportive, and engaged workplace that is recognized locally, statewide, and nationally as leaders.
- Goal 4: A culture of Health Equity is embedded throughout the County of Chippewa.

This strategic plan represents our call to action to improve our organization and communities. We believe our staff are up to the challenge to carry out this ambitious strategic plan with the support of our Health and Human Services Board and community partners. Our department continues on the path to achieving National Public Health Accreditation.

We invite you, as community members, to join us in making Chippewa County the healthiest place to live, learn, work and play in for all. Your input, feedback and support are always welcome!

Your partner in health,

Angela Weideman

Angela Weideman, LMFT

Director/Health Officer

Chippewa County Department of Public Health

Vision, Mission, Values

Vision

The Healthiest County to Live, Learn, Work, and Play

Mission

Prevent, Promote, Protect

Values

Partnership

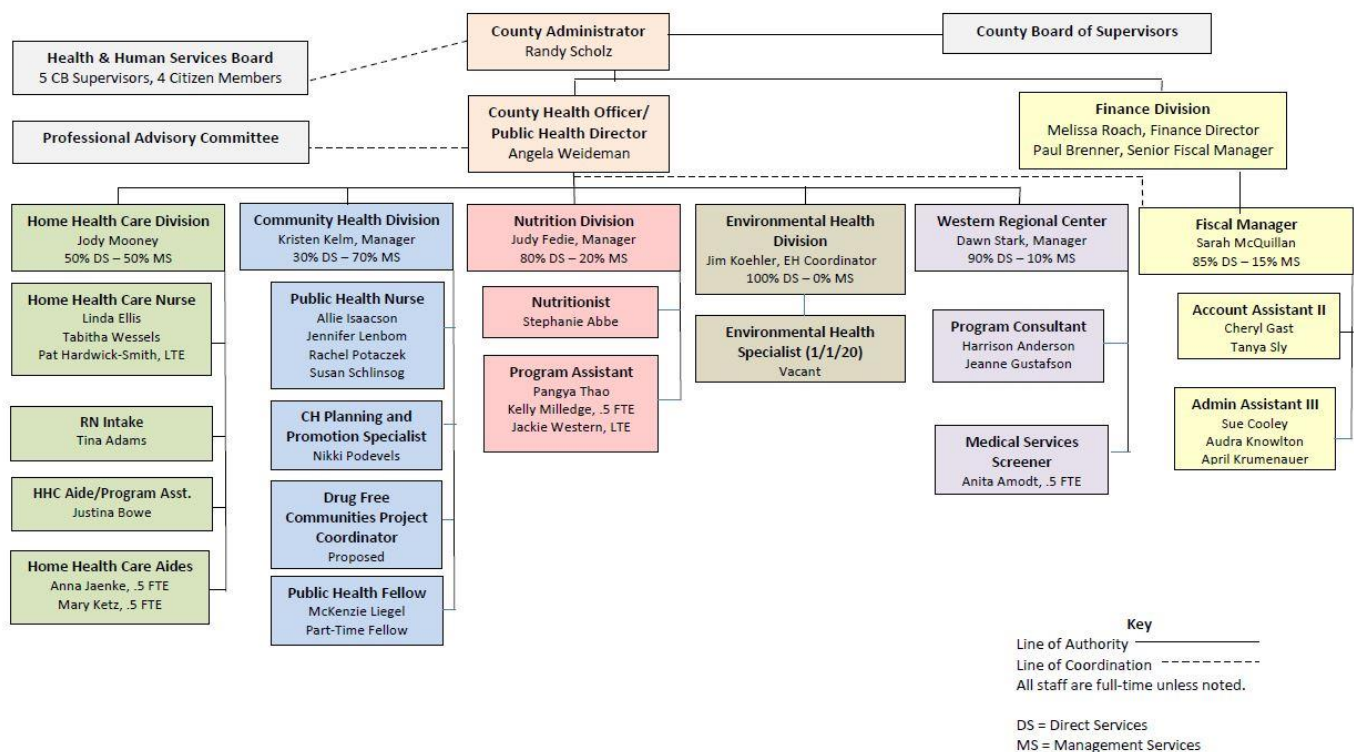
Respect

Innovation

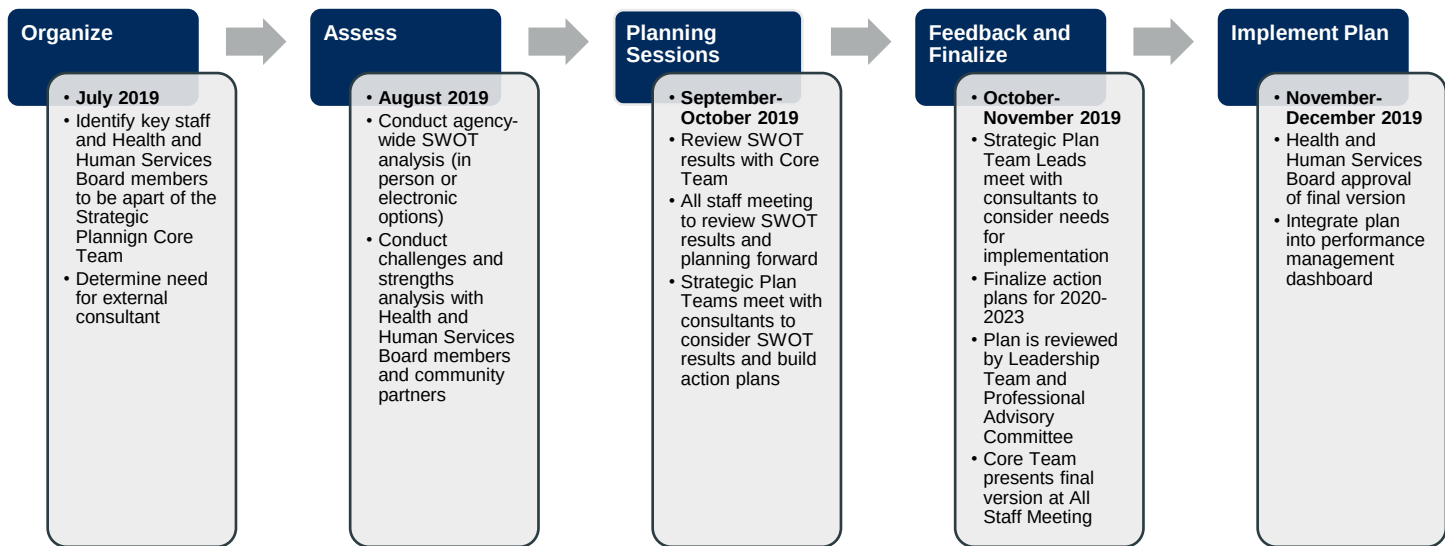
Dedication

Excellence

Organizational Chart



Strategic Plan Overview and Process



The 2020-2023 Chippewa County Department of Public Health (CCDPH) Strategic Plan lays out what the organization plans to achieve, how the organization will achieve it, and how achievements will be measured. The strategic plan provides a guide for making decisions on allocating resources and on taking action to pursue strategies and priorities. CCDPH utilized the National Association of City and County Health Officials (NACCHO) Strategic Planning Process for Local Health Departments as a guide during the strategic planning process and the development of the plan.

The process, outlined above and in Appendix A, included staff, community partner, and Health and Human Services Board member input. CCDPH consulted with Wisconsin Department of Health Services Division of Public Health- Office of Policy and Practice Alignment (OPPA) staff to collect and analyze data and support CCDPH in the development of work plans and the strategic plan.

In order to develop a clearer picture of strengths, gaps, and barriers for CCDPH, the consultants from OPPA led the staff through a Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis. A SWOT analysis looks at both the internal strengths and weaknesses, alongside external factors that might influence work in the future (opportunities and threats). Staff were given the opportunity to perform the SWOT analysis electronically or in person, in order to best meet needs. To draw themes from the SWOT analysis, the OPPA consultants compiled all CCDPH staff SWOT results into one document and community partner survey results into another. The compilations were scanned for recurring words and statements, and then cross-referenced using a word cloud tool. The themes from both documents were then reviewed by another OPPA consultant for consistency and highlighted within the documents. The final step was to cross examine the themes from both the staff and community partner analyses and highlight the themes that appeared in both. Themes from the staff SWOT analysis are in table 1 below. Appendix B has the full list of staff responses.

Table 1.
Themes from Staff SWOT Analysis
**Items in bold were mentioned multiple times*

Strengths	Weaknesses
• Innovative: Level 3 Health Department; Services that cover the life span; Health equity focus • Leaders in the community • Leadership within CCPHD: New managers; Leader with mental health background • Partnership: CHA/CHIP; Collaborations • Staff ○ Community Engagement: Involved; Charitable; willing to do outreach ○ Customer Service: Friendly; Professional; Prompt ○ Experience/Knowledge: Diversity of experience; Expertise; Educated staff ○ Passionate: Client-focused; Responsible ○ Resourceful/Adaptable: Evidence-based practice and research; Troubleshooting; Moving targets; Resourceful when seeking funding; Solutions focused; Open to new ideas ○ Flexible with their personal and work schedules ○ Teamwork: Supportive of each other both personally and professionally; Approachable; Employee recognition; Colors training	• Accountability and follow-through • Communication with department of Admin/State • External Communication • Inconsistent leadership/management policies: Flexibility for personal schedules; Flexibility not reciprocal; job responsibilities and assignments • Internal Communication: Staff availability; Who to contact/when; Continuity of operations; Top-down; Multiple calendars; Trust, gossip, and assumptions; Clear, concise, and timely communication • Leadership: Continuity; Presence of Director in office • Moving Targets • Orientation and Staff Education: Inconsistent; Time to meet staff and learn roles; On the job training; Learning styles; follow up on surveys and learning • Personnel; Matching strengths to programs; Change • Policies and Procedures: Details; Draft status; Rigid • Technical/Computer Skills • Time: Burn out; Too much documentation; Complicated time coding; Not enough staff; Rural outreach; Unable to take time off • Work Space
Opportunities	Threats
• Accreditation • Chronic disease prevention • Communication with dentists • Community: Invested in CCPHD; Awareness of CCPHD; Marketing • Employees: Skills; Internships; Fellowships • Expansion: Small community; Public transportation; Opportunities to expand programming • Funding: Grants and Medicaid expansion • Health Equity: Health in All Policies • Jail programming • New partnerships and opportunities: local businesses; Rural communities • Partnerships/Relationships: ADRC; CHA/CHIP; Regional/state staff availability • Restructuring of job tasks • Technology and Innovation: QI; VMSG; Training; Improving/expanding technology	• Changing health care systems: Buy-outs, and mergers • Community perceptions: Knowledge/support of PH; HHS Board understanding of CCPHD; Partner buy-in; Prevention is a tough sell; Gov't as authority or helpful; Willing to accept assistance; Communication barriers • Funding: Lack of funding; Timing of award; Competition for grants; Regionalization of services • Less home care communication • Local dynamics: Poverty; Transportation; Technology; Rural outreach; Schools are different • Politics: Changing administrations; Legislation that affects residents; Mixed messaging • Staff retention: Competition with larger HDs • Time • Unwillingness to share knowledge • Working leaders • Working with the State: State doesn't understand rural/local needs and structures; Timely notification and guidance; Reporting requirements; Health literacy/complex wording of state forms

The OPPA consultants also developed a community partner survey, which the Core Team distributed electronically to a list of over 300 community partners (approximate 10% response rate) and the Chippewa County Health and Human Services Board. Community partners were asked specifically about strengths and challenges of CCDPH. Themes from the community partner survey are found in table 2.

Table 2.

Themes from the Community Partners Survey

**Items in bold were also themes in the staff SWOT analysis*

Strengths	Challenges
• Collaboration and partnership: teamwork; willing to share knowledge and expertise; communication; work with schools • Community Involvement: visible; trusted • Desire to improve; creative; open to change • Employees: Committed; competent; caring; customer service; dedicated; enthusiastic; knowledgeable; prompt response; skilled • Leadership: at director level; supportive board • Stability of staffing; low turnover • Willing to address community needs: able to reach all age groups; able to identify needs; concerned about residents; effort to address needs; emphasis on prevention; flexibility; passion	• Access to services outside of Chippewa Falls: rural communities • Communication: visibility and knowledge of Public Health Services; reaching a broad audience • Funding: decreased resources with increased needs; CHIP does not include strong fiscal plan to achieve goals; reinvestment of services • Politics • Local dynamics: pressures on residents including economic, employment, food insecurity, family stability; large geographic area; mental health, substance use; unhealthy weight; vulnerable populations • Staffing: burn out; doing more with less staff; retention; retirements and resignations • Systems thinking; Working with other agencies • Time

Results of the SWOT analysis and community partner survey, along with the community health assessment and community health improvement plan, were used to inform the development of strategic plan priority areas and action plans. During internal staff strategic plan goal setting meetings, staff discussed and decided upon the priority areas below. These priorities were also approved by the CCDPH Leadership Team and the strategic plan core team. The priority areas are:

1. Communication
2. Performance Management/ Quality Improvement
3. Workforce and Engagement
4. Health Equity

Priority Areas, Goals, and Objectives

Priority Area: Communication

Goal 1: Improve communication skills and information sharing in order to strengthen the workforce and build an understanding of public health internally and externally.

- Objective 1.1: By December 31, 2022, increase the average staff core competency score for communication skills to at least 3.55 (baseline 3.58, 2019 assessment).
- Objective 1.2: By July 1, 2021, update the communication plan to include best practices around internal communication (i.e., preferred methods of communication, guidelines for emails, etc.).
- Objective 1.3: By December 31, 2020, implement and maintain an internal communication board to increase positive workplace communication and boost morale.
- Objective 1.4: Review the communication plan annually, and update as needed.
- Objective 1.5: By July 1, 2020, implement a more effective All Staff Meeting structure.
- Objective 1.6: Complete at least 20 outreach activities annually targeted at aging adults, parents/guardians of youth with special health care needs, or individuals living in rural communities.

Priority Area: Performance Management/Quality Improvement (PM/QI)

Goal 2: Integrate PM/QI throughout the department.

- Objective 2.1: Coordinate three trainings on PM/QI at all staff meetings annually.
- Objective 2.2: Review the PM/QI plan annually, and update as needed.
- Objective 2.3: Annually, hold each division accountable to completing at least one QI project.
- Objective 2.4: By February 15, 2020, develop and implement a Just Do It form to improve PM/QI tracking and documentation.
- Objective 2.5: By June 30, 2020, research activities to increase the visibility of QI.
- Objective 2.6: Review the results of the customer satisfaction survey (to identify and begin a QI project) quarterly to identify themes and develop an action plan based on results.
- Objective 2.7: Assess (and improve) the culture of QI annually.

Priority Area: Workforce and Engagement

Goal 3: Chippewa County Department of Public Health is a positive, supportive, and engaged workplace that is recognized locally, statewide, and nationally as leaders.

- Objective 3.1: Review the Workforce Development Plan annually, and update as needed.
- Objective 3.2: By September 30, 2022, increase overall staff satisfaction of Chippewa County Department of Public as a workplace to at least 4.00, as measured by the Chippewa County Employee Engagement Survey (baseline 3.91, 2019 survey).
- Objective 3.3: Increase staff understanding of public health and strengthen the workplace by coordinating at least 12 staff development opportunities annually.
- Objective 3.4: Increase capacity of the workplace by recruiting at least three interns and/or fellows annually.
- Objective 3.5: By December 31, 2021, revise Chippewa County Department of Public Health's succession plan.
- Objective 3.6: Increase the number of staff who report they have received recognition or praise for doing good work in the last seven days as measured by the Chippewa County Employee Engagement Survey annually (baseline 3.83, 2019 survey).
- Objective 3.7: Assemble and coordinate at least two event-planning committees annually.

Priority Area: Health Equity

Goal 4: A culture of Health Equity is embedded throughout the County of Chippewa.

- Objective 4.1: By December 31, 2020, complete a health equity assessment to determine areas that may need funding.
- Objective 4.2: By December 31, 2023, incorporate health equity in all department communication.
- Objective 4.3: By December 31, 2023, increase awareness in the community and in CCDPH about health equity.
- Objective 4.4: Annually, review and implement the CCDPH health equity policy.
- Objective 4.5: By December 31, 2022, evaluate hiring practices to include health equity.

**A full, detailed version of the 2020-2023 strategic plan activities can be found in Appendix C.*

Alignment with Local Plans

In the development of the strategic plan, CCDPH staff and the Core Team considered how the plan would fit within other health department and community-driven plans. There is direct alignment with the 2019-2021 community health improvement plan (CHIP), which has a goal of working towards health equity in Chippewa County. One activity in the strategic plan is to assist Chippewa Health Improvement Partnership Health Equity Action Team in carrying out the work plan for the CHIP.

Another place of alignment is with the CCDPH PM/QI plan. The PM/QI plan is reviewed and managed by the strategic plan team focusing on PM/QI; that relates to objective 2.2 in the strategic plan. The PM/QI plan focuses on the continuous improvement of all areas of the health department including the strategic plan teams. Tracking for the strategic plan is done in our performance management system VMSG for continuous monitoring of goals and areas of improvement.

Monitoring and Revisions

Monitoring

Staff and partners in four small teams (PM/QI, Workplace Development and Engagement, Communication, and Health Equity) will carry out the implementation of objectives under each goal. Staff were asked by the health officer which teams they were interested in working on. Based on responses, all staff (except LTE positions) were assigned to at least one team. During orientation, new staff will be asked which teams they are interesting in working on and assigned. Each team was assigned a lead, co-lead, and at least one member of leadership. Team leads are selected from non-leadership roles, in order to develop leadership skills in all levels of staff. Leads from each strategic plan team will share accomplishments and barriers with the core team during bi-monthly leads meeting. The full core team will meet quarterly and revise strategic plan as needed.

All goals and objectives were entered into VMSG, a cloud-based performance management system designed specifically to assist public health departments in the development, implementation, and performance management of the strategic and operational planning process from end to end. A lead will be assigned to each objective who will be responsible for entering data to track outcomes. The core team will review VMSG reports at quarterly meetings. An annual report is provided to community partners and the Board received reporting on strategic plan updates quarterly. See Appendix D for an example of what fields are included in VMSG.

Revisions

The core team will review the full plan annually and revise the strategic plan as needed. All changes must be approved by either the Health Officer or the Leadership Team. The table below will track revisions.

Revision Date	Revision Description	Revised by:	Authorized by:
2.12.2020	Description of how data was analyzed from SWOT analysis by OPPA on p. 6	McKenzie Liegel, Nikki Podevels and Kristen Kelm	Angela Weideman

Fiscal Considerations

CCDPH's budget is supported by a variety of funds including local tax levy, state and federal grants, and program generated revenues and fees. Included in each annual budget are funds designated for each strategic priority area team. CCDPH continuously researches and seeks additional funding opportunities (i.e., state and federal grants, community foundations, corporate foundations) to address needs identified in our strategic plan, community health improvement plan, and/or by community members and partners to fulfill all the functions and duties of the health department.

Acknowledgments

CCDPH would like to thank Christa Cupp and Joe Larson, Wisconsin Department of Public Health OPPA, for their facilitation and guidance during the strategic planning process. Their expertise and support were invaluable.

We would like to thank our community partners and stakeholders for their time in providing feedback on our work and department's strengths and weaknesses.

Finally, we would like to thank Chippewa County's Health and Human Services Board for their participation and ongoing feedback and support.

Strategic Plan Core Team Members:

Angie Weideman

Director/Health Officer
Chippewa County Department of Public Health

Kristen Kelm

Community Health Division Manager
Chippewa County Department of Public Health

Nikki Podevels

Community Health Planning and Promotion Specialist
Chippewa County Department of Public Health

McKenzie Liegel

Wisconsin Population Health Service Fellow
Chippewa County Department of Public Health

Jack Halbleib

Chair
Chippewa County Health and Human Services Board

Tom Thornton

Vice Chair
Chippewa County Health and Human Services Board

Appendix A: Strategic Planning Process Timeline

Date	Activity	Details
August 14, 2019	Strategic Plan Core Team Meeting	The core team met to discuss and finalize proposed timeline provided by consultants at the Wisconsin Department of Health Services, Division of Public Health, Office of Policy and Practice Alignment (OPPA).
August 15-30, 2019	Staff Strategic Planning Sessions (SWOT Analysis)	CCDPH leadership completed a SWOT analysis facilitated by WRO on August 27. All other CCDPH staff were invited to participate in an in-person or electronically via email on August 15. The in-person analysis was completed on August 27. Electronic versions were requested to be forwarded directly to OPPA consults by August 30.
August 16-30, 2019	Community Partners and Stakeholders Strategic Planning Survey	Community partners and stakeholders were invited via email to complete an electronic survey to provide feedback on strengths and challenges of CCDPH on August 16. The survey closed on August 30.
September 11, 2019	Strategic Plan Core Team Meeting	The OPPA consultants reviewed the results and common themes from staff SWOT analysis and survey of community partners and stakeholders to the core team.
September 18, 2019	CCDPH All Staff Meeting	WRO consultant reviewed the results and common themes from staff SWOT analysis and survey of community partners and stakeholders with all staff during meeting. Afterwards, the core team reviewed the progress of the strategic plan and presented identified priority areas. Staff were invited to provide feedback.
September 23-24, 2019	Staff Strategic Planning Sessions (Goals, Objectives, and Strategies Brainstorm)	WRO consultants facilitated discussions with each priority area team to begin drafting goals, objectives, and activities.
October 4-15, 2019	Strategic Plan Priority Teams Drafted Action Plans	The core team provided priority team leads with notes from brainstorm sessions facilitated by OPPA consultants. Priority area teams met to continue drafting initial action plans (goals, objectives, strategies).

Attachment: 5.4 HHSB Orientation Manual 2022 Final (7109 : Health & Human Services Board Orientation)

Date	Activity	Details
October 14, 2019	Strategic Plan Core Team Meeting	The core team reviewed progress and updated the timeline to reflect the following deadlines: • Priority area teams will submit finalized action plan to core team by November 8. • Nikki Podevels and McKenzie Liegel will complete a first draft of the strategic plan and present to full core team on November 15.
October 16, 2019	CCDPH All Staff Meeting	The core team provided updates on progress of strategic plan with all staff during meeting. Time was provided for staff to provide feedback on process and ask questions. The core team thanked staff for their continued support and hard work during the strategic planning process.
October 17, 2019	Strategic Plan Priority Area Teams Leads Meeting	The leads from each priority area team discussed action plans. OPPA consultants facilitated conversations regarding resources needed by groups to carry out plans.
November 18, 2019	Strategic Plan Core Team Meeting	McKenzie Liegel presented the first draft of the strategic plan to the core team. The core team provided feedback and edits.
November 19, 2019	CCDPH Leadership Team Meeting	Nikki Podevels presented the updated strategic plan to CCDPH leadership. Leadership provided feedback and edits.
November 20, 2019	CCDPH All Staff Meeting	McKenzie Liegel and Nikki Podevels presented the updated strategic plan to all CCDPH staff. Staff were provided the opportunity to ask questions and provide feedback.
November 25-December 5, 2019	Consultant Feedback	The strategic plan was emailed to OPPA consultants to provide feedback. The plan was revised based on feedback provided.
December 11, 2019	Presentation of Strategic Plan to Professional Advisory Committee (PAC)	Angela Weideman presented the 2020-2023 to the Professional Advisory Committee (PAC). The plan was approved.
December 19, 2019	Presentation of Strategic Plan to Health and Human Service Board	Angela Weideman presented the 2020-2023 to the Health and Human Services Board. The plan was approved.

Appendix B: CCDPH Staff SWOT Analysis

	<i>Helpful</i>		<i>Harmful</i>	
	Strengths		Weaknesses	
Internal	- Adaptable to moving targets - All levels of staff are involved in our work. It's not just managers or Angie telling us to do things; they are also involved. - Approachable; use each other as resources - Change in leadership team- new managers - Charitable - Chippewa health improvement partnership - Client-focused; passion for helping - Collaborations/community partners - Colors training - Community partners - Customer Service - Dedicated staff - Diversity of experience - Employee recognition - Engaged with the community; charitable - Expertise - External communication - Friendly reception and intake - Great partnership for the CHA and CHIP with community partners - Having a leadership team in place - Health equity work - Helpful Policies and Procedures - High achievers (staff) - High expectations - High rate of helping children with special health care needs - Innovative Programming - Leader with mental health background - Level 3 health department - Open to new ideas and changes to programs (for example all the health equity work) - Opportunities for professional development - Passion - Passionate staff - Personable and welcoming - Professionalism - Prompt response to referrals and phone calls - Provide services that cover the life span - Resourceful with funding - Responsible staff make sure clients do not fall through the cracks - Seek out funding - Serving more men - Solution focused - Staff educated and involved - Staff is flexible with work schedules		- Accountability - Assumptions - Basic life skills - Change in leadership - Clear, Concise, and timely internal communication - Communication - Communication across divisions - Communication from top down both internally and with Dept. of Administration - Complex procedures - Computer skills - Continuity - Continuity of operations during staff absences - Details in procedures and training - Divisions are very different - Documentation requirements take away from time to do job - Efficiency/time management - Extensive learning curve for new staff - Flexibility for personal schedules; inconsistent across divisions and with different managers; flexibility not reciprocal - Follow through - Follow through on surveys and team learning - Getting to know staff and roles during orientation - Gossiping - Hard to know what is happening with other divisions - Having a closed mind to ideas - Inefficiency due to lack of knowledge of what others are doing (communication) - Keeping calendars, email, and voicemail up to date - Lack of tech skills - Matching programs to strengths or passion; conversations with staff about assignments - Moving Targets - Multiple calendars - No enough staff to handle the work load resulting in long travel times, working over hours, having to take on other positions to meet needs of clients, actually having to turn down referrals because we don't have enough staff. - Not able to take time off because of low staff. Adds to stress and burnout - On the job training - Orientation process standardization, follow up, and consistency - P&Ps in draft status - Presence of Director in the office - Redundancy in documentation of where people are and what they do	

	<i>Helpful</i>	<i>Harmful</i>
Internal	Strengths (cont.)	Weaknesses (cont.)
	• Supportive of each other, both personally and professionally • Team building exercises • Teamwork • Teamwork and morale is good—people laughing and having fun regularly • Troubleshooting skills • Use of evidence-based practice and research • Willingness to volunteer and do outreach • Work well with partners • Working leaders • Years of experience	• Rigid processes; Gray areas not reflected in Policies and Procedures • Rural outreach • Seem to be at capacity for all of our divisions and programs—there is no time, energy, or funding available for people to take on other projects • Space – our loan closet is a very busy much needed service but lacks good working storage space for dirty, cleaned and reserved equipment. • Staff in or out • Step by step procedures • Taking on more without eliminating something; burn out • Teaching to different learning styles • Time for orientation and review • Time to code timesheets • Time to do job • Timesheets are complicated • Trust issues both internally and externally • Understanding job responsibilities and availability • Who to contact and when • Workflow – our WIC clinic is struggling to find a good way to serve clients timely using the main reception area instead of their own reception area. WIC doesn't have enough staff to have their own reception area open.

External	Opportunities	Threats
	• Accreditation • Availability of Regional/state staff • Awareness of Chippewa County Public Health • Businesses • Chronic disease prevention • Collaboration with partners; schools and healthcare systems • Community invested and involved in public health work • Create list for dentist about fluoride • Grant writing • Grants • Health equity • Health in All Policy • Improve tech skills • Jail programming • Marketing of HHC • Medicaid expansion possibility still • Men served • Mid-west/small community (expansion) • Need of public transportation • New employees • Partnership with ADRC • QI projects • Relationships and social network connections builds community trust • Restructure job tasks • Rural communities • Share knowledge • Technology improving • Think there is still a high need for our services in rural areas that we are missing • Train staff to work with a victim mentality • Using employee's skills • Utilization of interns and fellows • VMSG • Work with other departments to assure we are not duplicating services	• Being close to Eau Claire HD—they are larger and very well recognized, so they get more funding, have more opportunities, can pay staff better. • Changes in legislation that affects population served • Changing and competing healthcare systems • Clinic buy-outs and mergers • Communication barriers with the public • Community perception of government • Funding • Health and human services board and DOA not knowing what Public Health does or is about • Lack of finances/budget cuts • Lack of funding • Lack of funding for chronic disease prevention work • Lack of public support • Lack of staff • Language of external forms sounds intimidating; too complex or threatening • Less home care communication • Limited technology and access in rural areas • Mixed messaging • No transportation across the county • Notification/guidance from state • Other departments wanting to work with us • Partner buy-in • Pay for Performance going away • Perception of department as authority versus helpful • Physical location of health department; not centralized • Politics; changing administrations and rules • Poverty • Prevention is a hard sell • Prevention is hard to fund • Regionalization of services • Regulations • Reporting requirements • Rural outreach • Schools are very different • Split funding with Eau Claire • Staff retention • State supported software and data systems changes • The State doesn't understand rural populations, local needs, and local structures for reporting requirements • Time • Timing of funding awards • Unwillingness to share knowledge with others • Willingness of community to accept help or follow up • Working leaders

Appendix C: All Goals, Objectives, and Activities

Priority Area: Communication

Goal 1: Improve communication skills and information sharing in order to strengthen the workforce and build an understanding of public health internally and externally.

- Objective 1.1: By December 31, 2022, increase the average staff core competency score for communication skills to at least 3.55 (baseline 3.58, 2019 assessment).
 - Collaborate with Workforce and Engagement to coordinate at least two trainings annually targeted at increasing communication skills.
 - Develop and implement an after training action plan to operationalize content learned.
 - Evaluate trainings for effectiveness.
- Objective 1.2: By July 1, 2021, update the communication plan to include best practices around internal communication (i.e., preferred methods of communication, guidelines for emails, etc.).
 - Research best practices around internal communication.
 - Update communication plan to include best practices.
 - Educate staff on best practices.
 - Incorporate education on internal communication best practices into new staff orientation.
- Objective 1.3: By December 31, 2020, implement and maintain an internal communication board to increase positive workplace communication and boost morale.
 - Purchase a dry erase board.
 - Develop a calendar of messages/questions for the dry erase board.
 - Identify the most effective place to hang and install.
 - Present initiative at all staff meeting.
 - Implement initiative.
- Objective 1.4: Review the communication plan annually, and update as needed.
- Objective 1.5: By July 1, 2020, implement a more effective All Staff Meeting structure.
 - Contact similar size health departments to learn more about their meeting structure.
 - Assess staff on current agenda structure and preferences for future meetings.
 - Provide recommendations to leadership by May 1, 2020.
- Objective 1.6: Complete at least 20 outreach activities annually targeted at aging adults, parents/guardians of youth with special health care needs, or individuals living in rural communities.
 - Develop common definition of outreach.
 - Finalize outreach procedure.
 - Develop and implement an outreach strategy/calendar.
 - Track completed outreach activities in VMSG.
 - Partner with UW-Eau Claire's Communication and Journalism Department to create additional health promotion materials with the target audience being aging adults, parents/guardians of youth with special health care needs, and/or individuals living in rural communities.

Priority Area: Performance Management/Quality Improvement (PM/QI)

Goal 2: Integrate PM/QI throughout the department.

- Objective 2.1: Coordinate three trainings on PM/QI at all staff meetings annually.
 - Collaborate with Workforce and Engagement to explore types of training and ways to implement.
 - Review and follow up on PM/QI training and terminology (i.e., new employee training, acronyms).
- Objective 2.2: Review the PM/QI plan annually, and update as needed.
- Objective 2.3: Annually, hold each division accountable to completing at least one QI project.
 - Use VMSG to identify opportunities for QI.
 - Work with CCDPH Home Health Care Division to learn how they utilize VMSG/data to identify PM/QI projects.
- Objective 2.4: By February 15, 2020, develop and implement a Just Do It form to improve PM/QI tracking and documentation.
 - Research tools used by other local health departments to track and document PM/QI projects.
 - Develop a Just Do It form.
 - Present to all CCDPH staff and begin implementation.
 - Assess form 9 months after implementation and revise as needed.
- Objective 2.5: By June 30, 2020, research activities to increase the visibility of QI.
- Objective 2.6: Review the results of the customer satisfaction survey (to identify and begin a QI project) quarterly to identify themes and develop an action plan based on results.
- Objective 2.7: Assess (and improve) the culture of QI annually.

Priority Area: Workforce and Engagement

Goal 3: Chippewa County Department of Public Health is a positive, supportive, and engaged workplace that is recognized locally, statewide, and nationally as leaders.

- Objective 3.1: Review the Workforce Development Plan annually, and update as needed.
- Objective 3.2: By September 30, 2022, increase overall staff satisfaction of Chippewa County Department of Public as a workplace to at least 4.00, as measured by the Chippewa County Employee Engagement Survey (baseline 3.91, 2019 survey).
 - Research, development, and conduct an annual engagement initiatives survey.
 - Implement at least two engagement initiatives and dissolve at least one annually.
 - Develop a procedure to implement stay interviews (Find Your Why/Start with Why (Ted Talk)
 - Research and explore technology that allows flexibility in staff scheduling (such as VPN)
 - Research tool to evaluate work/life balance of staff
 - Research tool to evaluate staff workload.
- Objective 3.3: Increase staff understanding of public health and strengthen the workplace by coordinating at least 12 staff development opportunities annually.
 - Conduct Competency Assessment for Tier 1 Public Health Professionals and analyze results annually.
 - Partner with other strategic planning teams to implement staff development opportunities based on their focus areas.
 - Develop and implement an annual staff development opportunities calendar.
 - Track and evaluate completed staff development opportunities.
- Objective 3.4: Increase capacity of the workplace by recruiting at least three interns and/or fellows annually.
- Objective 3.5: By December 31, 2021, revise Chippewa County Department of Public Health's succession plan.
 - Research succession planning from other health departments or Public Health organizations.
 - Research the Chippewa County succession plan.
- Objective 3.6: Increase the number of staff who report they have received recognition or praise for doing good work in the last seven days as measured by the Chippewa County Employee Engagement Survey annually (baseline 3.83, 2019 survey).
 - Research ideas for staff recognition.
 - Maintain "AHA" awards.
- Objective 3.7: Assemble and coordinate at least two event-planning committees annually.

Priority Area: Health Equity

Goal 4: A culture of Health Equity is embedded throughout the County of Chippewa.

- Objective 4.1: By December 31, 2020, complete a health equity assessment to determine areas that may need funding.
 - Research, create, and implement assessment tool.
 - Secure funding to carry out work that advances health equity.
- Objective 4.2: By December 31, 2023, incorporate health equity in all department communication.
 - Develop a message map to deliberately include health equity in communication.
 - Develop common language and definitions for health equity communication.
 - Hearing loop for all presentations.
 - Ensure that meeting materials are accommodating for all.
 - Ensure that outreach is done to rural areas.
 - Create a quarterly menu for health equity learning.
 - Review the department communication plan and meeting guidelines through a health equity lens.
 - Create guidelines of best practices for hosting an equitable meeting.
- Objective 4.3: By December 31, 2023, increase awareness in the community and in CCDPH about health equity.
 - Create a health equity story-sharing template.
 - Discover and share stories that highlight health equity.
 - Post monthly about health equity via social media.
 - Research training opportunities and potential external partners.
 - Conduct implicit bias training.
 - Conduct the BARHII every two years.
- Objective 4.4: Annually, review and implement the CCDPH health equity policy.
- Objective 4.5: By December 31, 2022, evaluate hiring practices to include health equity.

Appendix D: VMSG Activity Page

Performance Management System x VMSG Dashboard by KCA x +

la.vmsgdashboard.com/fmi/webd/vmsg_app

Orgs Groups Vision, Mission & Values Services & Initiatives Goals Objectives Activities

ACTIVITY SELECTION & MANAGEMENT

Rollup ▲ Act# Activity Statement Activity Leader Type Start End %

Green Last Updated on: 11/13/2019 by: mliegel

Activity Number 1 Activity Type Project-based Activity PERFORMANCE METRIC/TARGET

Activity Leader & Team Members FTE 0

Start Date End Date % Done

Activity Partner Contact Name

Organization Chippewa CDPH Group Strategic Plan Service/Initiative 6 Goal 1 Objective 1 Activity

Type here to search

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Attachment: 5.4 HHSB Orientation Manual 2022 Final (7109 : Health & Human Services Board Orientation)



Chippewa County Department of Public Health
711 N Bridge Street
Chippewa Falls, WI 54729

<https://www.co.chippewa.wi.us/ccdph>





CHIPPEWA COUNTY
Public Health
Prevent. Promote. Protect.

**Chippewa County
Health & Human Services Board
Orientation Manual**

General Information

WHO WORKS IN PUBLIC HEALTH AND WHAT DO THEY DO?

What is a Health Officer?

A health officer is the administrator of the Local Health Department. The health officer is an individual with statutory authority and responsibility to enforce public health law within that agency's jurisdiction, to administer funds for public health programs, enforce local ordinances and support qualified public health staff. This individual must meet qualifications as specified in State and Administrative Rule.

What is the Board Of Health?

The Board of Health (BOH) is a governmental structure comprised of elected and appointed community members. Its major function is to assess the health needs, establish policy and program direction, and assure that the local health services are responsive to the health needs of the community.

What is a Public Health Nurse?

The public health nurse (PHN) is a registered professional nurse who has a special education to combine professional nurse practice with the basics of public health practice for the purpose of improving the health of the community through primary prevention and health promotion. She/he meets the qualifications specified in State Statutes and Administrative Rules.

A generalized public health nursing program includes components of professional nursing practice such as direct care, risk assessment, health education, and counseling. Also included are the distinguishing components of public health nursing practice: 1) community analysis; 2) case finding and concern for those who do not present themselves for care; 3) an emphasis on prevention at the most appropriate level; and 4) referral to other agencies to ensure comprehensive health services.

PHN services are not limited to a specific segment of the population designated by age, setting, or health problem. Health promotion, health maintenance, coordination, and continuity of care are utilized in a holistic approach to the family, group, and community according to established program priorities consistent with identified community needs and expectations.

What is a Public Health Sanitarian?

The public health sanitarian is an environmental specialist who, through education, training, and experience applies this knowledge and skill in the protection of both human and environmental health. This individual must meet the qualifications as specified in State Statutes and Administrative Rules.

A generalized environmental health program is directed toward the assessment, control and prevention of environmental factors that may adversely affect the health, comfort, safety or well-being of individuals.

What is a Public Health Nutritionist?

A public health nutritionist is a dietitian registered by the Commission on Dietetic Registration, the credentialing agency of the American Dietetic Association, and certified by the Department of Regulation and Licensing under s448.70 (1m), who:

- 1) creates partnerships in the community to assure adequate and appropriate food and nutrition resources for the whole population, all ages and life stages;
- 2) facilitates nutrition system and policy changes in the community;
- 3) assures nutrition expertise and leadership in programs, services, and those community initiatives focused on nutritional health improvement; and
- 4) assesses the whole community or targeted groups of the population to identify priority areas for population-based nutrition intervention.

Public health nutrition efforts are primarily focused on nutrition behaviors, the nutrition environment, and food and nutrition policy.

What is a Public Health Educator?

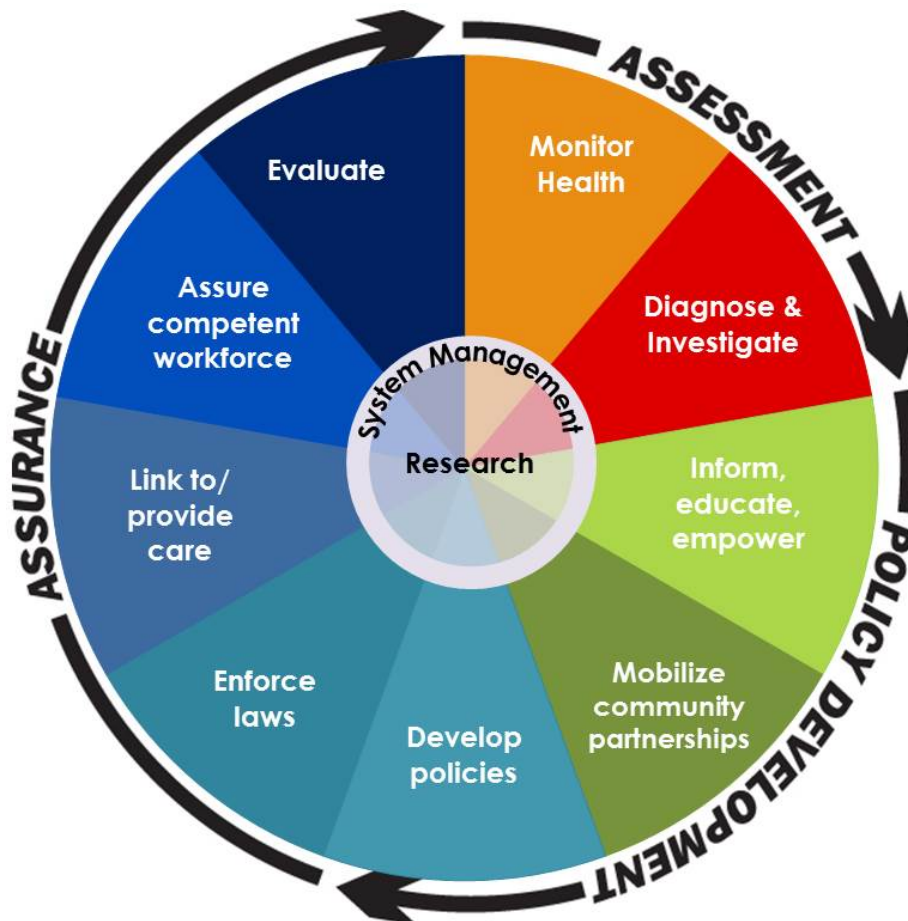
A public health educator is a professional that has education or experience in the science of health education.

Public health educators assess individual and community needs, plan and implement effective health education programs and evaluate the success of the program.

The 10 Essential Public Health Services

The 10 Essential Public Health Services describe the public health activities that all communities should undertake:

1. Monitor health status to identify and solve community health problems
2. Diagnose and investigate health problems and health hazards in the community
3. Inform, educate, and empower people about health issues
4. Mobilize community partnerships and action to identify and solve health problems
5. Develop policies and plans that support individual and community health efforts
6. Enforce laws and regulations that protect health and ensure safety
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable
8. Assure competent public and personal health care workforce
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services
10. Research for new insights and innovative solutions to health problems





*Advancing
public health
performance*

Public Health Accreditation Board

STANDARDS: AN OVERVIEW

VERSION 1.5
Adopted December 2013

STANDARDS: AN OVERVIEW

ASSESS

DOMAIN 1: Conduct and disseminate assessments focused on population health status and public health issues facing the community

- Standard 1.1:** Participate in or Lead a Collaborative Process Resulting in a Comprehensive Community Health Assessment
- Standard 1.2:** Collect and Maintain Reliable, Comparable, and Valid Data that Provide Information on Conditions of Public Health Importance and On the Health Status of the Population
- Standard 1.3:** Analyze Public Health Data to Identify Trends in Health Problems, Environmental Public Health Hazards, and Social and Economic Factors that Affect the Public's Health
- Standard 1.4:** Provide and Use the Results of Health Data Analysis to Develop Recommendations Regarding Public Health Policy, Processes, Programs, or Interventions

INVESTIGATE

DOMAIN 2: Investigate health problems and environmental public health hazards to protect the community

- Standard 2.1:** Conduct Timely Investigations of Health Problems and Environmental Public Health Hazards
- Standard 2.2:** Contain/Mitigate Health Problems and Environmental Public Health Hazards
- Standard 2.3:** Ensure Access to Laboratory and Epidemiologic/Environmental Public Health Expertise and Capacity to Investigate and Contain/Mitigate Public Health Problems and Environmental Public Health Hazards
- Standard 2.4:** Maintain a Plan with Policies and Procedures for Urgent and Non-Urgent Communications

INFORM & EDUCATE

DOMAIN 3: Inform and educate about public health issues and functions

- Standard 3.1:** Provide Health Education and Health Promotion Policies, Programs, Processes, and Interventions to Support Prevention and Wellness
- Standard 3.2:** Provide Information on Public Health Issues and Public Health Functions Through Multiple Methods to a Variety of Audiences

COMMUNITY ENGAGEMENT

DOMAIN 4: Engage with the community to identify and address health problems

- Standard 4.1:** Engage with the Public Health System and the Community in Identifying and Addressing Health Problems through Collaborative Processes
- Standard 4.2:** Promote the Community's Understanding of and Support for Policies and Strategies that will Improve the Public's Health

POLICIES & PLANS

DOMAIN 5: Develop public health policies and plans

- Standard 5.1:** Serve as a Primary and Expert Resource for Establishing and Maintaining Public Health Policies, Practices, and Capacity
- Standard 5.2:** Conduct a Comprehensive Planning Process Resulting in a Tribal/State/Community Health Improvement Plan
- Standard 5.3:** Develop and Implement a Health Department Organizational Strategic Plan
- Standard 5.4:** Maintain an All Hazards Emergency Operations Plan

PUBLIC HEALTH LAWS

DOMAIN 6: Enforce public health laws

- Standard 6.1:** Review Existing Laws and Work with Governing Entities and Elected/Appointed Officials to Update as Needed
- Standard 6.2:** Educate Individuals and Organizations on the Meaning, Purpose, and Benefit of Public Health Laws and How to Comply
- Standard 6.3:** Conduct and Monitor Public Health Enforcement Activities and Coordinate Notification of Violations among Appropriate Agencies

ACCESS TO CARE

DOMAIN 7: Promote strategies to improve access to health care

Standard 7.1: Assess Health Care Service Capacity and Access to Health Care Services

Standard 7.2: Identify and Implement Strategies to Improve Access to Health Care Services

WORKFORCE

DOMAIN 8: Maintain a competent public health workforce

Standard 8.1: Encourage the Development of a Sufficient Number of Qualified Public Health Workers

Standard 8.2: Ensure a Competent Workforce through Assessment of Staff Competencies, the Provision of Individual Training and Professional Development, and the Provision of a Supportive Work Environment

QUALITY IMPROVEMENT

DOMAIN 9: Evaluate and continuously improve processes, programs, and interventions

Standard 9.1: Use a Performance Management System to Monitor Achievement of Organizational Objectives

Standard 9.2: Develop and Implement Quality Improvement Processes Integrated Into Organizational Practice, Programs, Processes, and Interventions

EVIDENCE-BASED PRACTICES

DOMAIN 10: Contribute to and apply the evidence base of public health

Standard 10.1: Identify and Use the Best Available Evidence for Making Informed Public Health Practice Decisions

Standard 10.2: Promote Understanding and Use of the Current Body of Research Results, Evaluations, and Evidence-Based Practices with Appropriate Audiences

ADMINISTRATION & MANAGEMENT

DOMAIN 11: Maintain administrative and management capacity

Standard 11.1: Develop and Maintain an Operational Infrastructure to Support the Performance of Public Health Functions

Standard 11.2: Establish Effective Financial Management Systems

GOVERNANCE

DOMAIN 12: Maintain capacity to engage the public health governing entity

Standard 12.1: Maintain Current Operational Definitions and Statements of the Public Health Roles, Responsibilities, and Authorities

Standard 12.2: Provide Information to the Governing Entity Regarding Public Health and the Official Responsibilities of the Health Department and of the Governing Entity

Standard 12.3: Encourage the Governing Entity's Engagement In the Public Health Department's Overall Obligations and Responsibilities



The **PHAB STANDARDS** apply to all health departments—Tribal, state, local, and territorial. Standards are the required level of achievement that a health department is expected to meet. Domains are groups of standards that pertain to a broad group of public health services. The focus of the PHAB standards is “what” the health department provides in services and activities, irrespective of “how” they are provided or through what organizational structure. Please refer to the **PHAB Standards and Measures** Version 1.5 document, available at www.phaboard.org, for the full official standards, measures, required documentation, and guidance.



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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30329-4027

April 22, 2020

Angela Weideman, LMFT
Health Officer, Public Health Director
Chippewa County Department of Public Health
711 N. Bridge St Rm 121
Chippewa Falls, Wisconsin 54729

Dear Ms. Weideman:

On behalf of the Centers for Disease Control and Prevention (CDC), we are pleased to congratulate the Chippewa County Department of Public Health on its accreditation by the Public Health Accreditation Board (PHAB).

Your national accreditation status lets your partners and community know that your organization meets national standards and provides services that all residents should come to expect from their health departments. Moreover, because the national accreditation program seeks to improve the quality and performance of all health departments, your participation in this program indicates your commitment to the continuous improvement of your health department's services.

Your accreditation from PHAB is an impressive achievement. CDC recognizes the time and effort that leaders and staff members from all levels of your health department have dedicated to this effort. We commend the Chippewa County Department of Public Health for this extraordinary accomplishment.

Sincerely,

Robert R. Redfield, MD
Director, CDC, and
Administrator, ATSDR

José T. Montero, MD, MHCDS
Director, Center for State, Tribal,
Local, and Territorial Support



**Chippewa County
Department of Public Health**

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Statutory Authority

[Wisconsin State Statute Chapter 140 \(Required Services of Local Health Dept\)](#)
[Wisconsin State Statute Chapter 139 \(Qualifications of Public Health Professionals\)](#)
[Wisconsin State Statute Chapter 95 \(Animal Health\)](#)
[Wisconsin State Statute Chapter 146 \(Misc Health Provision\)](#)
[Wisconsin State Statute Chapter 250 \(Health, Admin and Supervision\)](#)
[Wisconsin State Statute 251 \(Local Health Officials\)](#)
[Wisconsin State Statute 252 \(Communicable Disease\)](#)
[Wisconsin State Statute 253 \(Maternal and Child Health\)](#)
[Wisconsin State Statute 254 \(Environmental Health\)](#)
[Wisconsin State Statute 255 \(Chronic Disease and Injuries\)](#)
[Wisconsin State Statute 441 \(Board of Nursing\)](#)



SUMMARY OF RESPONSIBILITIES AND AUTHORITY FOR LOCAL HEALTH DEPARTMENTS FROM WISCONSIN'S PUBLIC HEALTH STATUTES

LOCAL BOARD OF HEALTH SHALL:

- Govern each local health department. §251.04(1)
- Assure the enforcement of state public health statutes and public health rules of the department as prescribed for a Level I local health department. §251.04(1)
- Assure that its local health department is a Level I, Level II, or Level III local health department as specified in §251.04(1), 251.04(2)
- Report to the department as required by rule. §251.04(4)
- Meet at least quarterly. §251.04(5)
- Assess public health needs and advocate for the provision of reasonable and necessary public health services. §251.04(6)(a)

LOCAL BOARD OF HEALTH MAY:

- Contract or subcontract to provide public health services. §251.04(1)
- Adopt those regulations for its own guidance and for the governance of the local health department that it considers necessary to protect and improve the public health. §251.04(3)

LOCAL BOARD OF HEALTH SHALL:

- Develop policy and provide leadership that fosters local involvement and commitment, that emphasizes public health needs and that advocates for equitable distribution of public health resources and complementary private activities commensurate with public needs. §251.04(6)(b)
- Assure that measures are taken to provide an environment in which individuals can be healthy. §251.04(7)
- Employ qualified public health professionals, including a public health nurse, to conduct general public health nursing program under the direction of the local board of health and in cooperation with the department. §251.04(8)
- Coordinate the activities of any sanitarian employed by the county board. §251.04(8)

LOCAL BOARD OF HEALTH MAY:

- Employ one or more sanitarians to conduct environmental programs and other public health programs not specifically designated by statute as functions of the public health nurse. §251.04(8)
- County executive or administrator may assume the powers and duties of the local board of health. In those instances, the board of health shall only be a policy-making body determining the broad outlines and principles governing the administration of the county health department. §251.04(9)
- Adopt regulations and recommend enactment of ordinances for animal and vector-borne disease control. §251.51(5)

LOCAL HEALTH DEPARTMENT WITH OVERSIGHT FROM THE BOARD OF HEALTH SHALL:

- Meet the requirements specified, and employ a health officer with the qualifications specified at least for Level I. §251.05(1) and (1)(a)
- Provide at least surveillance, investigation, control and prevention of communicable disease, other disease prevention, health promotion, and human health hazard control. §251.05(2)(a)
- Regularly and systematically collect, assemble, analyze, and make available information on the health of the community, including statistics on health status, community health needs and epidemiologic and other studies of health problems. §251.03(3)(a)
- Develop public health policies and procedures for the community. §251.05(3)(b)
- Involve key policy makers and the general public in determining a set of high priority public health services and assure access to these services to every member of the community. §251.05(3)(c)
- Submit data as requested to the local public health data system established by the department. §251.05(3)(d)
- Enforce state rules for animal and vector-borne disease control. §251.51(4)

LOCAL HEALTH DEPARTMENT MAY:

- Meet the requirements specified for Level II or Level III. §251.05(1)
- Provide services jointly with other local health departments. §251.09
- Be designated to carry out the functions of the department for environmental health. §251.015
- Serve as agent of the department in inspecting and issuing permits for recreational, food, and lodging facilities. §254.69(1)
- Declare housing that is dilapidated, unsafe, or unsanitary to be a human health hazard. §254.593

LOCAL HEALTH OFFICER SHALL:

- Administer the local health department in accordance with state statutes and rules. §251.06(3)(a)
- Enforce state public health statutes and rules. §251.06(3)(b)
- Enforce any regulations that the local board of health adopts and any ordinances that the relevant governing body enacts if those regulations and ordinances are consistent with state public health statutes and regulations. §251.06(3)(c)
- Administer all funds received by the local health department for public health programs. §251.06(3)(d)
- Appoint all necessary subordinate personnel, assure that they meet appropriate qualifications, and have supervisory power over subordinate personnel. §251.06(3)(e)
- Investigate and supervise the sanitary conditions of all premises within the jurisdictional area of the local health department. §251.06(3)(f)
- Have access to vital records and vital statistics from the register of deeds as specified in Ch. 69. §251.06(3)(g)
- Have charge of the local health department and perform the duties prescribed by the local board of health. §251.06(3)(h)

LOCAL HEALTH OFFICER MAY:

LOCAL HEALTH OFFICER SHALL:

- Submit an annual report of the administration of the local health department to the board of health. §251.06(3)(h)
- Promote the spread of information as to the causes, nature of prevention of prevalent diseases, and the preservation and improvement of health. §251.06(3)(i)
- Investigate the appearance and circumstances of any communicable disease and make a full report to the appropriate governing body and the department. §252.03(1)
- Promptly take all measures necessary to prevent, suppress, and control communicable disease and report to the appropriate governing body the progress of the communicable diseases and the measures used against them. §252.03(1)
- Advise the department of measures taken to control communicable disease outbreaks or epidemics. §252.03(2)
- Receive reports of communicable diseases and report them to the department or direct persons reporting to him/her to report to the department. §252.05(1)

LOCAL HEALTH OFFICER MAY:

- Inspect schools or public buildings within the jurisdiction as needed to determine whether the buildings are kept in a sanitary condition. §252.03(1)
- Do what is reasonable and necessary for the prevention and suppression of (communicable) disease. §252.03(2)
- Forbid public gatherings when deemed necessary to control outbreaks or epidemics. §252.03(2)

LOCAL HEALTH OFFICER SHALL:

- Cause a permanent record of any report (of a communicable disease) to be made and upon demand transmit an original or a copy to the department together with other information the department requires. §252.05(6)
- Immediately report the occurrence of an outbreak or epidemic (of communicable disease) to the department, and at all times keep the department informed of the prevalence of the communicable diseases in the locality in the manner and with the facts the department requires. §252.05(7)
- Order laboratory testing in response to a communicable disease report if there is a dispute regarding disease determination, if the disease may have potential public health significance, or if more extensive laboratory tests will aid in the investigation. §252.05(9)
- Investigate and make or order such examinations to be made as are necessary if the health officer suspects or is informed of the existence of any communicable disease. §252.06(3)

LOCAL HEALTH OFFICER MAY:

- Require isolation of a patient, quarantine of contacts, concurrent or terminal disinfection, or modified forms of these procedures as may be necessary and which are determined by the department by rule. §252.06(1)

LOCAL HEALTH OFFICER SHALL:

- Consult a physician as speedily as possible where there is a reasonable doubt or disagreement in diagnosis (of a communicable disease) and where advice is needed. §252.06(3)
- Investigate evasion of the laws and rules concerning communicable diseases and act to protect the public. §252.06(3)
- Employ as many persons as are necessary to execute his/her orders and properly guard any place if quarantine or other restrictions on communicable disease are violated or intent to violate is manifested. §252.06(5)
- When the health officer deems it necessary that a person be quarantined or otherwise restricted in a separate place, remove the person, if it can be done without danger to the person's health, to this place. §252.06(6)
- Upon report of any person with a positive laboratory test for TB, at once investigate and make and enforce the necessary orders. §252.07(05)
- Investigate or cause to be investigated, as necessary, any reported or reasonable suspected case or contact to a sexually transmitted disease. §252.11(2)

LOCAL HEALTH OFFICER MAY:

- Require the examination of food handlers. §252.18

LOCAL HEALTH OFFICER SHALL:

- Order the abatement or removal of a human health hazard on private premises within a reasonable time period. §254.59(1)
- If a human health hazard is found on private property, notify the owner and the occupant of the property by registered mail with return receipt requested of the presence of the human health hazard and order its abatement or removal within 30 days. §254.59(2)
- If the local health officer deems it necessary to abate or remove a human health hazard found on private property, he/she shall serve notice on the owner or occupant to abate or remove within a reasonable time that is not less than 24 hours. §254.59(4)
- If the owner or occupant fails to comply, or if the human health hazard is on property whose owner is a nonresident, or cannot be found, the local health officer shall cause abatement or removal. §254.59(4)

LOCAL HEALTH OFFICER MAY:

- Request information and follow-up and coordinate care for children with adverse birth and developmental outcomes. §253.12(6)
- If the owner or occupant fails to comply, may enter upon the premises and abate or remove the human health hazard. §254.59(1)
- In cities under general charter, may enter into and examine any place at any time to ascertain health conditions. §254.59(4)

CHAPTER 251

LOCAL HEALTH OFFICIALS

251.001	Legislative findings.	251.115	Multiple municipal local health department and city–county local health department; how financed.
251.01	Definitions.	251.12	City health department, how financed.
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251.10	County health department, how financed.		
251.11	City–county health department and multiple county health department, how financed.		

Cross-reference: See definitions in s. 250.01.

251.001 Legislative findings. The legislature finds that the provision of public health services in this state is a matter of statewide concern.

History: 1993 a. 27.

251.01 Definitions. In this chapter:

(1g) “City–county board of health” means a board of health for a city–county health department.

(1r) “County board of health” means a board of health for a single county health department or for a multiple county health department.

(3) “County health officer” means the position of a local health officer in a single county health department or in a multiple county health department.

(7m) “Represented employee” means an employee in a collective bargaining unit for which a representative is recognized or certified under subch. IV of ch. 111.

(8) “Sanitarian” means a sanitarian, as defined in s. 440.98 (1) (b), who is registered under s. 440.98 (5).

History: 1993 a. 27 ss. 196, 197, 460; 2001 a. 16; 2007 a. 130.

251.02 Local health department; establishment. (1) In counties with a population of less than 750,000, unless a county board establishes a city–county health department under sub. (1m) jointly with the governing body of a city or establishes a multiple county health department under sub. (3) in conjunction with another county, the county board shall establish a single county health department, which shall meet the requirements of this chapter. The county health department shall serve all areas of the county that are not served by a city health department that was established prior to January 1, 1994, by a town or village health department established under sub. (3m), or by a multiple municipal local health department established under sub. (3r) or by a city–county health department established under sub. (3t). No governing body of a city may establish a city health department after January 1, 1994.

(1m) Subject to sub. (1r), in counties with a population of less than 750,000, the county board and the governing body of a city that has a city health department may jointly establish a city–county health department, which shall meet the requirements of this chapter. A city–county health department shall serve all areas of the county that are not served by a city health department that was established prior to January 1, 1994, by a town or village health department established under sub. (3m), or by a multiple municipal local health department established under sub. (3r). A city–county health department established under this subsection after September 1, 2001, is subject to the control of the city and county acting jointly under an agreement entered into under s.

66.0301 that specifies, in conformity with this chapter, all of the following:

(a) The powers and duties of the city–county health department.

(b) The powers and duties of the city–county board of health for the city–county health department.

(c) The relative powers and duties of the city and county with respect to governance of the city–county health department and the city–county board of health.

(1r) If a city that assigns represented employees to its city health department and if a county that assigns represented employees to its county health department jointly establish a city–county health department under an agreement specified under sub. (1m), all of the following shall apply, but only if the represented employees at the city health department and at the county health department who perform similar functions are included in collective bargaining units that are represented by the same representative:

(a) The city–county health department shall offer employment to all city and county employees who are represented employees and who perform functions for the city and county that are transferred to the city–county health department in the agreement under sub. (1m).

(b) Notwithstanding s. 111.70 (4) (d), if, in any collective bargaining unit that is initially created at the city–county health department, all of the former city and county employees were represented by the same representative when they were employed by the city or county, that representative shall become the initial representative of the employees in the collective bargaining unit without the necessity of filing a petition or conducting an election.

(c) Unless otherwise prohibited by law, with respect to city–county health department employees who were formerly represented employees at the city or county, the city–county health department shall adhere to the terms of the collective bargaining agreements that covered these employees while they were employed by the city or county until such time that the city–county health department and the representative of the employees have entered into a collective bargaining agreement.

(2) (a) Except as provided in par. (b), in a county with a population of 750,000 or more, the governing body of each city or village shall do one of the following:

1. Establish a local health department that meets the requirements of this chapter.

2. Contract with the local health department of another city or village in the county to have that local health department provide services in the city or village.

(b) In a county with a population of 750,000 or more, the governing body of a city or village may establish, jointly with the gov-

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erning body of another city or village, a multiple municipal local health department that meets the requirements of this chapter.

(3) A county board may, in conjunction with the county board of one or more other counties, establish a multiple county health department, which shall meet the requirements of this chapter. A multiple county health department shall serve all areas of the respective counties that are not served by a city health department that was established prior to January 1, 1994, by a town or village health department established under sub. (3m), or by a multiple municipal local health department established under sub. (3r).

(3m) If a county has a population of at least 100,000 but less than 750,000 and the county board of that county has, by July 1, 1985, abolished a county health commission or committee established under s. 141.10, 1991 stats., a village board in that county may continue and establish as a local board of health a village board of health that was established prior to January 1, 1994, and a town board in that county may continue and establish as a local board of health a town board of health that was established prior to January 1, 1994. A village or town that does so shall establish a local health department and elect a local health officer consistent with this chapter.

(3r) In a county described in sub. (3m), in addition to the local health department required to be established under sub. (3m), the governing body of a city, village or town in that county may, in concert with the governing body of another city, village or town in that county, establish a multiple municipal local health department and elect a local health officer consistent with this chapter.

(3t) The governing body of a city with a city health department, as specified in s. 250.01 (4) (a) 3., may, in concert with the governing body of another city with a city health department, as specified in s. 250.01 (4) (a) 3., in the same county, establish a city–city health department and elect a local health officer consistent with this chapter.

(4) No governing body of a county, city, village or town is required to use the term “local health department” to refer to a local health department that is established under this section.

History: 1993 a. 27; 1999 a. 9, 185; 2001 a. 16; 2003 a. 158; 2011 a. 32; 2017 a. 207 s. 5.

251.03 Local board of health; members. (1) A local board of health shall consist of not more than 9 members. At least 3 of these members shall be persons who are not elected officials or employees of the governing body that establishes the local health department and who have a demonstrated interest or competence in the field of public health or community health. In appointing the members who are not elected officials or employees, a good faith effort shall be made to appoint a registered nurse and a physician. Members of the local board of health shall reflect the diversity of the community. A county human services board under s. 46.23 (4) may act as a county board of health if the membership of the county human services board meets the qualifications specified in this subsection and if the county human services board is authorized to act in that capacity by the county board of supervisors. If a county human services board acts in this capacity, it shall use the word “health” in its title.

(2) The chief executive officer of a city or a village shall appoint members of a local board of health, subject to confirmation by the governing body. In a county with a county executive, the county executive shall appoint members of the county board of health, subject to confirmation by the county board of supervisors. In a county without a county executive, members of the county board of health shall be appointed by the chairperson of the county board of supervisors, subject to confirmation by the county board of supervisors. The person who appoints members of the local board of health may designate certain members to be nonvoting members of the board.

(3) In establishing a city–county or multiple county health department, the relevant governing bodies shall agree on how many members of the local board of health are appointed by each governing body and how many of each governing body’s appoint-

tees shall be members who are not elected officials or employees of the governing body. The members shall be appointed as specified in sub. (2).

(4) Governing bodies of counties, cities or villages that appoint local boards of health shall specify the lengths of terms of members and shall provide for staggered terms.

(4m) Subsections (1) to (4) do not apply to a village or town that establishes a local health department under s. 251.02 (3m). In a village or town that does so, the village board or town board shall establish itself as a local board of health or appoint either wholly or partially from its own members a local board of health that consists of a suitable number of competent persons. A local board of health under this subsection shall elect a chairperson and clerk.

(4r) Subsections (1) to (4m) do not apply to a city, village or town that establishes a multiple municipal local health department under s. 251.02 (2) (b) or (3r), or to cities that establish a city–city local health department under s. 251.02 (3t). In establishing a multiple municipal local health department as described under s. 251.02 (2) (b) or (3r), the relevant governing bodies shall agree on how many members of the local board of health are appointed by each governing body and how many of each governing body’s appointees shall be members who are not elected officials or employees of the governing body. The members shall be appointed by the relevant governing bodies. A local board of health under this subsection shall elect a chairperson and clerk.

(5) No governing body of a county, city, village or town is required to use the term “local board of health” to refer to a local board of health that is established under this section.

History: 1993 a. 27; 1999 a. 9; 2003 a. 158.

251.04 Local board of health; powers and duties.

(1) Except as authorized in s. 251.02 (2) (b), (3m), (3r), and (3t), a city board of health shall govern a city health department, a county board of health shall govern a county health department or multiple county health department, and a city–county board of health shall govern a city–county health department. A city board of health, a county board of health, a city–county board of health, or a board of health for a local health department as authorized in s. 251.02 (2) (b), (3m), (3r), or (3t) shall assure the enforcement of state public health statutes and public health rules of the department as prescribed for a Level I local health department. A local board of health may contract or subcontract with a public or private entity to provide public health services. The contractor’s staff shall meet the appropriate qualifications for positions in a Level I local health department.

(2) A city or county board of health or a board of health for a local health department as authorized in s. 251.02 (2) (b), (3m), (3r), or (3t) shall assure that its local health department is a Level I, Level II, or Level III local health department, as specified in s. 251.05 (1).

(3) A city or county board of health or a board of health for a local health department as authorized in s. 251.02 (2) (b), (3m), (3r), or (3t) may adopt those regulations, for its own guidance and for the governance of the local health department, that it considers necessary to protect and improve public health. The regulations may be no less stringent than, and may not conflict with, state statutes and rules of the department.

(4) A local board of health shall report to the department as required by rule.

(5) A local board of health shall meet at least quarterly.

(6) A local board of health shall:

(a) Assess public health needs and advocate for the provision of reasonable and necessary public health services.

(b) Develop policy and provide leadership that fosters local involvement and commitment, that emphasizes public health needs and that advocates for equitable distribution of public health resources and complementary private activities commensurate with public health needs.

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251.06

(7) A local board of health shall assure that measures are taken to provide an environment in which individuals can be healthy.

(8) Unless the manner of employment is otherwise provided for by ordinance, a local board of health shall employ qualified public health professionals, including a public health nurse to conduct general public health nursing programs under the direction of the local board of health and in cooperation with the department, and may employ one or more sanitarians to conduct environmental programs and other public health programs not specifically designated by statute as functions of the public health nurse. The local board of health shall coordinate the activities of any sanitarian employed by the governing body of the jurisdiction that the local board of health serves. The local board of health is not required to employ different persons to perform these functions.

(9) In counties with a single county health department and either a county executive or a county administrator, the county executive or county administrator may assume the powers and duties of a local board of health under this section. If a county executive or a county administrator elects to assume those powers and duties, the local board of health shall be only a policy-making body determining the broad outlines and principles governing the administration of the county health department.

History: 1993 a. 27 ss. 261, 264, 463; 1997 a. 114; 1999 a. 9, 185; 2001 a. 16; 2003 a. 158.

251.05 Local health department; levels of service; duties. (1) A local health department shall meet the following requirements specified in par. (a) and may, unless sub. (6) applies, meet the following requirements specified in par. (b) or (c):

(a) As a Level I local health department, at least the level of services specified in sub. (2) (a) with a local health officer who at least meets the qualifications specified in s. 251.06 (1) (a).

(b) As a Level II local health department, at least the level of services specified in sub. (2) (b) with a local health officer who at least meets the qualifications specified in s. 251.06 (1) (b).

(c) As a Level III local health department, at least the level of services specified in sub. (2) (c) with a local health officer who at least meets the qualifications specified in s. 251.06 (1) (c).

(2) The services to be provided by the 3 levels of local health departments are as follows:

(a) A Level I local health department shall provide at least surveillance, investigation, control and prevention of communicable diseases, other disease prevention, health promotion and human health hazard control.

(b) A Level II local health department shall provide at least the services under par. (a) and additional services specified by the department by rule under s. 251.20 (3).

(c) A Level III local health department shall provide at least the services under par. (a) and additional services specified by the department by rule under s. 251.20 (3).

(3) A local health department shall:

(a) Regularly and systematically collect, assemble, analyze and make available information on the health of the community, including statistics on health status, community health needs and epidemiologic and other studies of health problems.

(b) Develop public health policies and procedures for the community.

(c) Involve key policymakers and the general public in determining and developing a community health improvement plan that includes actions to implement the services and functions specified under s. 250.03 (1) (L).

(d) Submit data, as requested, to the local public health data system established by the department.

(e) Act as agent of the department, if designated by the secretary under s. 250.042 (1).

(4) Except as provided in sub. (6), a local health department is not required to provide the level of services that is specified in sub. (1) (b) or (c) or to have a local health officer who meets the qualifications specified in sub. (1) (b) or (c).

(5) Except as provided in sub. (6), the department may not require a local health department to provide the level of services that is specified in sub. (1) (b) or (c) or to have a local health officer who meets the qualifications specified in sub. (1) (b) or (c).

(6) A local health department may be required to provide the level of services that is specified in sub. (1) (b) or (c) if and only to the extent that these services and qualifications are funded from state and federal funds that are available and are additional to any funding available on January 1, 1994.

History: 1993 a. 27; 2001 a. 109; 2005 a. 198; 2007 a. 130.

Cross-reference: See also ch. DHS 140, Wis. adm. code.

251.06 Local health officer; qualifications; duties.

(1) (a) 1. Except as provided in subd. 2. or 3., a local health officer of a Level I local health department shall have at least a bachelor's degree from a nursing program accredited by the national professional nursing education accrediting organization or from a nursing program accredited by the board of nursing.

2. A local health officer of a village or town health department established under s. 251.02 (3m) or of a multiple municipal local health department established under s. 251.02 (3r) shall be either a physician or a registered nurse. The local health officer shall be a voting member of the local board of health and shall take an oath of office. With respect to the levels of services of a Level I local health department, as specified in s. 251.05 (2) (a), the local health officer shall be authorized to act by and be directed by the county health officer of the county specified under s. 251.02 (3m).

3. If there is more than one full-time employee of a Level I local health department, including a full-time public health nurse who meets the qualifications specified under s. 250.06, the local health officer may meet the qualifications of a Level II or Level III local health officer.

(b) A local health officer of a Level II local health department shall have at least 3 years of experience in a full-time position with a public health agency, including responsibility for a communicable disease prevention and control program, preferably in a supervisory or other administrative position, and at least one of the following:

1. A bachelor's degree from a nursing program accredited by the national professional nursing education accrediting organization or from a nursing program accredited by the board of nursing, either of which shall include preparation in public health nursing.

2. A bachelor's degree in public health, environmental health, the physical or biological sciences or a similar field.

(c) A local health officer of a Level III local health department shall have at least one of the following:

1. A master's degree in public health, public administration, health administration or, as defined in rules promulgated by the department, a similar field and 3 years of experience in a full-time administrative position in either a public health agency or public health work.

2. A bachelor's degree and 16 graduate semester credits towards a master's degree in public health, public administration, health administration or, as defined in rules promulgated by the department, a similar field and 5 years of experience in a full-time administrative position in either a public health agency or public health work.

3. A license to practice medicine and surgery under ch. 448 and at least one of the following:

a. Three years of experience in a full-time administrative position in either a public health agency or public health work.

b. Eligibility for certification by the American board of preventive medicine in public health or general preventive medicine.

c. A master's degree in public health, public administration, health administration or, as defined in rules promulgated by the department, a similar field.

(d) Notwithstanding pars. (a) to (c), relevant education, training, instruction, or other experience that an applicant obtained in connection with military service, as defined in s. 111.32 (12g),

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counts toward satisfying the requirements for education, training, instruction, or other experience to qualify as a public health officer if the applicant demonstrates to the satisfaction of the department that the education, training, instruction, or other experience that the applicant obtained in connection with his or her military service is substantially equivalent to the education, training, instruction, or other experience that is required to qualify as a public health officer.

(2) (a) Except as provided in pars. (b) and (c), a local health officer shall be a full-time employee of a local health department.

(b) A local health officer of a county health department in a county under s. 251.02 (3m) shall be a full-time employee of the county who meets the qualifications of a local health officer of a Level I local health department.

(c) A local health officer of a local health department of a village or town established under s. 251.02 (3m) or a local health officer of a multiple municipal local health department established under s. 251.02 (3r) shall be one of the following:

1. An employee of the local health department of the village or town or an employee of the multiple municipal local health department.

2. A full-time employee of a local health department other than that specified in subd. 1.

3. The local health officer under par. (b).

4. The employee of a hospital, who provides, on a full-time basis, the services under s. 251.05 (2) (a), (b) or (c).

(3) A local health officer shall:

(a) Administer the local health department in accordance with state statutes and rules.

(b) Enforce state public health statutes and rules.

(c) Enforce any regulations that the local board of health adopts and any ordinances that the relevant governing body enacts, if those regulations and ordinances are consistent with state public health statutes and rules.

(d) Administer all funds received by the local health department for public health programs.

(e) Appoint all necessary subordinate personnel, assure that they meet appropriate qualifications and have supervisory power over all subordinate personnel. Any public health nurses and sanitarians hired for the local health department shall meet any qualification requirements established in rules promulgated by the department. "Subordinate personnel" under this paragraph may include any of the following:

1. A public health educator who meets qualifications that the department shall specify by rule.

2. A public health nutritionist, who is a certified dietitian, as defined in s. 448.70 (1m), is credentialed as a registered dietitian by the Commission on Dietetic Registration, and meets qualifications that the department shall specify by rule.

3. A public health dental hygienist, who is licensed as a dental hygienist under s. 447.04 (2) (a) or (b), and who meets qualifications that the department shall specify by rule.

(f) Investigate and supervise the sanitary conditions of all premises within the jurisdictional area of the local health department.

(g) Have access to vital records and vital statistics from the register of deeds, as specified in ch. 69.

(h) Have charge of the local health department and perform the duties prescribed by the local board of health. The local health officer shall submit an annual report of the administration of the local health department to the local board of health.

(i) Promote the spread of information as to the causes, nature and prevention of prevalent diseases, and the preservation and improvement of health.

(4) (a) Except as provided in pars. (b) and (c), a local health officer shall be appointed in the same manner as are members of a local board of health under s. 251.03 (2).

(b) In any county with a county executive that has a single county health department, the county executive shall appoint and supervise the county health officer. The appointment is subject to confirmation by the county board unless the county board, by ordinance, elects to waive confirmation or unless the appointment is made under a civil service system competitive examination procedure established under s. 59.52 (8) or ch. 63. The county health officer appointed under this paragraph is subject only to the supervision of the county executive. In a county with such a county health officer, the local board of health shall be only a policy-making body determining the broad outlines and principles governing the administration of the county health department.

(c) A local health officer of a village or town health department established under s. 251.02 (3m), of a multiple municipal local health department established under s. 251.02 (2) (b) or (3r), or of a city-county local health department established under s. 251.02 (3t) shall be appointed by the local board of health.

History: 1993 a. 27 ss. 203, 209, 266, 465; 1993 a. 106; 1995 a. 201; 1997 a. 114; 1999 a. 9; 2003 a. 158; 2007 a. 130; 2011 a. 120.

Cross-reference: See also ch. DHS 139, Wis. adm. code.

This section does not require that a county create a stand-alone county health department and does not preclude the county human services director from exercising any managerial authority over the county health officer with respect to the operation of county health department programs. Because the transfer of the functions of a county health department to the county human services department is expressly authorized under s. 46.23 (3) (b) 1. bm. and c., a county that has a county executive is not required to create a stand-alone county health department. OAG 7-08.

251.07 Certain physicians; state agency status. A physician who is not an employee of the local health department and who provides services, without compensation, for those programs and services provided by a local health department that require medical oversight is, for the provision of the services he or she provides, a state agent of the department of health services for the purposes of ss. 165.25 (6), 893.82 (3), and 895.46.

History: 2007 a. 20 s. 9121 (6) (a); 2007 a. 130; 2009 a. 276.

251.08 Jurisdiction of local health department. The jurisdiction of the local health department shall extend to the entire area represented by the governing body of the county, city, village or town that established the local health department, except that the jurisdiction of a single or multiple county health department or of a city-county health department does not extend to cities, villages and towns that have local health departments. Cities, towns and villages having local health departments may by vote of their local boards of health determine to come under the jurisdiction of the county health department. No part of any expense incurred under this section by a county health department may be levied against any property within any city, village or town that has a local health department and that has not determined to come under the jurisdiction of the county health department.

History: 1993 a. 27 s. 213; 2001 a. 16.

251.09 Joint services. Local health departments jointly may provide health services as agreed upon under s. 66.0301, unless, notwithstanding s. 66.0301, the agreement conflicts with a provision of this chapter.

History: 1993 a. 27 s. 271; Stats. 1993 s. 251.09; 1999 a. 150 s. 672.

251.10 County health department, how financed. The county board shall appropriate funds for the operation of a single county health department that is established under s. 251.02 (1) and determine compensation of county health department employees. The local board of health shall annually prepare a budget of the proposed expenditures of the county health department for the ensuing fiscal year.

History: 1993 a. 27.

251.11 City-county health department and multiple county health department, how financed. (1) The local board of health of every multiple county health department established under s. 251.02 (3) and of every city-county health department established under s. 251.02 (1m) shall annually prepare a budget of its proposed expenditures for the ensuing fiscal year and determine the contribution from each participating county or city

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in a manner agreed upon by the relevant governing bodies. A certified copy of the budget, which shall include a statement of the amount required from each county and city, shall be delivered to the county board of each participating county and to the mayor or city manager of each participating city. The appropriation to be made by each participating county and city shall be determined by the governing body of the county and city. No part of the cost apportioned to the county shall be levied against any property within the city.

(2) The local board of health of a multiple county health department established under s. 251.02 (3) shall, under this section, determine the compensation for the employees of the multiple county health department. The local board of health of a city-county health department established under s. 251.02 (1m) shall, under this section, determine the compensation for the employees of the city-county health department.

History: 1993 a. 27 ss. 207, 216, 217; 2001 a. 16, 104; 2015 a. 175; 2017 a. 6.

251.115 Multiple municipal local health department and city-county local health department; how financed.

The governing body of every multiple municipal local health department established under s. 251.02 (2) (b) or (3r) and of every city-county local health department established under s. 251.02 (3t) shall annually prepare a budget of its proposed expenditures for the ensuing fiscal year and determine the contribution from each participating municipality in a manner agreed upon by the relevant governing bodies. A certified copy of the budget, which shall include a statement of the amount required from each municipality, shall be delivered to the governing body of each participating municipality. The appropriation to be made by each participating municipality shall be determined by the governing body of the city, village, and town.

History: 2015 a. 175; 2017 a. 6.

251.12 City health department, how financed. The common council shall appropriate funds for the operation of all of the following:

(1) A city health department that is established as specified in s. 251.02 (1) and (2) (a).

(2) A multiple municipal local health department that is established as specified in s. 251.02 (3r).

(3) A multiple municipal local health department that is established as specified in s. 251.02 (2) (b).

(4) A city-county local health department that is established as specified in s. 251.02 (3t).

History: 1993 a. 27; 1999 a. 9; 2003 a. 158, 326.

251.125 Village health department, how financed. If a village health department is established under s. 251.02 (2) (a) or (3m), if a multiple municipal local health department is established as specified in s. 251.02 (3r), or if a multiple municipal local health department is established as specified in s. 251.02 (2) (b), the village board shall appropriate funds for the operation of the department.

History: 1993 a. 27; 1999 a. 9, 185; 2003 a. 158.

251.127 Town health department, how financed. If a town health department is established under s. 251.02 (3m) or if a multiple municipal local health department is established under s. 251.02 (3r) by the governing body of a town in concert with the governing body of another town or a city or village, the town board shall appropriate funds for the operation of the department.

History: 1993 a. 27; 1999 a. 9.

251.13 City-county health department and multiple county health department, joint funds. For each multiple county or city-county health department, a joint health department fund shall be created either in the treasurer's office where the principal office of the health department is located or in the office of the city treasurer of a city within the health department's jurisdiction, as determined by the local board of health. The treasurer

of each county and city participating in the health department shall annually pay or cause to be paid into the fund the share of the county or city. This fund shall be expended by the treasurer in whose office the fund is kept in the manner prescribed by the local board of health pursuant to properly authenticated vouchers of the health department signed by the local health officer.

History: 1993 a. 27 s. 218.

251.135 Publication and effective date of orders and regulations. The orders and regulations of a local board of health shall be published as a class 1 notice, under ch. 985, and shall take effect immediately after publication. No local board of health is required to use the term "regulation" to refer to a regulation that is published under this section.

History: 1993 a. 27 s. 211; Stats. 1993 s. 251.135.

251.14 Gifts. A local board of health may receive gifts and donations for the purpose of carrying out the provisions of this chapter.

History: 1993 a. 27 s. 215.

251.15 Withdrawal of counties, cities, villages, or towns. (1) After establishing a multiple county health department under s. 251.02 (3), any participating county board may withdraw by giving written notice to its county board of health and the county boards of all other participating counties, except that participating county boards may, in establishing a multiple county health department under s. 251.02 (3), establish an initial minimum participation period of up to 5 years. If a multiple county health department is established with an initial minimum participation period under this subsection, a participating county may not withdraw during that initial minimum period unless withdrawal is necessary to meet statutory requirements for a Level I health department under s. 251.05.

(2) A city that had established a local health department prior to deciding to participate in a city-county health department established under s. 251.02 (1m) may withdraw from the city-county health department if the common council of the city gives written notice to the county board of the participating county, except that participating cities and counties may, in establishing a city-county health department under s. 251.02 (1m), establish an initial minimum participation period of up to 5 years. If a city-county health department is established with an initial minimum participation period under this subsection, a participating city or county may not withdraw during that initial minimum period unless withdrawal is necessary to meet statutory requirements for a Level I health department under s. 251.05.

(2m) After establishing a multiple municipal local health department under s. 251.02 (2) (b) or (3r) or a city-county local health department under s. 251.02 (3t), the governing body of any participating city, village, or town participating may withdraw by giving written notice to the local board of health and to the governing bodies of all other participating cities, villages, and towns, except that participating cities, villages, and towns may, in establishing a multiple municipal local health department under s. 251.02 (2) (b) or (3r) or a city-county local health department under s. 251.02 (3t), establish an initial minimum participation period of up to 5 years. If a multiple municipal local health department or city-county local health department is established with an initial minimum participation period under this subsection, a participating city, village, or town may not withdraw during that initial minimum period unless withdrawal is necessary to meet statutory requirements for a Level I health department under s. 251.05.

(3) The notice under sub. (1), (2), or (2m) shall be given at least one year prior to commencement of the fiscal year at which the withdrawal takes effect. Whenever the withdrawal takes effect, all relevant provisions of law relating to local boards of health and local health officers shall immediately become applicable within the withdrawing county, city, village, or town.

History: 1993 a. 27 s. 220; 2001 a. 16; 2003 a. 158; 2015 a. 175.

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251.16 Local health department; evidence. The reports and employees of a local health department are subject to s. 970.03 (12) (b).

History: 1979 c. 221; 1985 a. 267 s. 3; 1993 a. 27 s. 221; Stats. 1993 s. 251.16.

251.20 Rule making. The department shall promulgate rules that specify all of the following:

(1) Required services for each of Levels I, II and III local

health departments under s. 251.05 (2).

(3) Additional required services for Level II and Level III local health departments under s. 251.05 (2) (b) and (c), including services that the department of health services determines appropriately address objectives or services specified in the most recent public health agenda under s. 250.07 (1) (a).

History: 1993 a. 27; 2005 a. 198; 2009 a. 180.

Cross-reference: See also ch. DHS 140, Wis. adm. code.

CHAPTER 252

COMMUNICABLE DISEASES

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Cross-reference: See definitions in s. 250.01.

252.01 Definitions. In this chapter:

(1c) “Advanced practice nurse prescriber” means an advanced practice nurse who is certified under s. 441.16 (2) to issue prescription orders.

(1g) “Emergency medical responder” has the meaning given in s. 256.01 (4p).

(1m) “HIV” means any strain of human immunodeficiency virus, which causes acquired immunodeficiency syndrome.

(2) “HIV infection” means the pathological state produced by a human body in response to the presence of HIV.

(2m) “HIV test” means a test for the presence of HIV or an antibody to HIV.

(3) “Municipality” means any city, village or town.

(4) “Peace officer” has the meaning given in s. 939.22 (22).

(6) “State epidemiologist” means the individual appointed by the state health officer under s. 250.02 (1) as the state epidemiologist for acute and communicable diseases.

(7) “State patrol officer” means an officer of the state traffic patrol under s. 110.07 (1) (a).

(8) “Validated HIV test result” means a result of an HIV test that meets the validation requirements determined to be necessary by the state epidemiologist.

History: 1993 a. 27 ss. 281, 283, 320, 338, 339, 341; 1993 a. 252; 2005 a. 187; 2009 a. 209; 2011 a. 161; 2017 a. 12; 2021 a. 23.

252.02 Powers and duties of department. (1) The department may establish systems of disease surveillance and inspection to ascertain the presence of any communicable disease. Any agent of the department may, with a special inspection warrant issued under s. 66.0119, enter any building, vessel or conveyance to inspect the same and remove therefrom any person affected by a communicable disease. For this purpose, the agent may require the person in charge of the vessel or conveyance, other than a railway car, to stop the same at any place and may require the conductor of any railway train to stop the train at any station or upon any sidetrack, for such time as may be necessary.

(2) In an emergency, the department may provide those sick with a communicable disease with medical aid and temporary hospital accommodation.

(3) The department may close schools and forbid public gatherings in schools, churches, and other places to control outbreaks and epidemics.

(4) Except as provided in ss. 93.07 (24) (e) and 97.59, the department may promulgate and enforce rules or issue orders for guarding against the introduction of any communicable disease into the state, for the control and suppression of communicable diseases, for the quarantine and disinfection of persons, localities

and things infected or suspected of being infected by a communicable disease and for the sanitary care of jails, state prisons, mental health institutions, schools, and public buildings and connected premises. Any rule or order may be made applicable to the whole or any specified part of the state, or to any vessel or other conveyance. The department may issue orders for any city, village or county by service upon the local health officer. Rules that are promulgated and orders that are issued under this subsection supersede conflicting or less stringent local regulations, orders or ordinances.

(5) If any public officer or employee or any person in charge of any building, vessel, conveyance, jail, state prison, mental health institution or school fails to comply with a rule promulgated or order issued under sub. (4), the department may appoint an agent to execute its rules or orders. Expenses that an agent incurs shall be paid by the unit of government that employs the person or of which the public officer is a member. If the building, vessel, conveyance, mental health institution or school is privately owned the state shall pay the expenses that the agent incurs.

(6) The department may authorize and implement all emergency measures necessary to control communicable diseases.

(7) The department shall promulgate rules that specify medical conditions treatable by prescriptions or nonprescription drug products for which pharmacists and pharmacies must report under s. 450.145 (1).

History: 1981 c. 291; 1993 a. 27 s. 284; Stats. 1993 s. 252.02; 1999 a. 150 s. 672; 2001 a. 109; 2005 a. 198; 2015 a. 55.

Cross-reference: See also ch. DHS 145, Wis. adm. code.

An order issued by the Department of Health Services confining all people to their homes, forbidding travel, and closing businesses exceeded the statutory authority of this section. *Wisconsin Legislature v. Palm*, 2020 WI 42, 391 Wis. 2d 497, 942 N.W.2d 900, 20–0765.

252.03 Duties of local health officers. (1) Every local health officer, upon the appearance of any communicable disease in his or her territory, shall immediately investigate all the circumstances and make a full report to the appropriate governing body and also to the department. The local health officer shall promptly take all measures necessary to prevent, suppress and control communicable diseases, and shall report to the appropriate governing body the progress of the communicable diseases and the measures used against them, as needed to keep the appropriate governing body fully informed, or at such intervals as the secretary may direct. The local health officer may inspect schools and other public buildings within his or her jurisdiction as needed to determine whether the buildings are kept in a sanitary condition.

(2) Local health officers may do what is reasonable and necessary for the prevention and suppression of disease; may forbid public gatherings when deemed necessary to control outbreaks or epidemics and shall advise the department of measures taken.

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(3) If the local authorities fail to enforce the communicable disease statutes and rules, the department shall take charge, and expenses thus incurred shall be paid by the county or municipality.

(4) No person may interfere with the investigation under this chapter of any place or its occupants by local health officers or their assistants.

History: 1981 c. 291; 1993 a. 27 s. 285; Stats. 1993 s. 252.03.

Although the Wisconsin Supreme Court's decision in *Palm*, 2020 WI 42, is not directly controlling on powers of local health officers under this section, it is advisable to limit enforcement under this section to ordinances or administrative enforcement. Also, local authorities should ensure that any measures that direct people to stay at home, forbid certain travel, or close certain businesses speak specifically to the local authority's statutory power under subs. (1) and (2) to "prevent, suppress and control communicable diseases" and "forbid public gatherings when deemed necessary to control outbreaks or epidemics." OAG 3–20.

252.04 Immunization program. (1) The department shall carry out a statewide immunization program to eliminate mumps, measles, rubella (German measles), diphtheria, pertussis (whooping cough), poliomyelitis and other diseases that the department specifies by rule, and to protect against tetanus. Any person who immunizes an individual under this section shall maintain records identifying the manufacturer and lot number of the vaccine used, the date of immunization and the name and title of the person who immunized the individual. These records shall be available to the individual or, if the individual is a minor, to his or her parent, guardian or legal custodian upon request.

(2) Any student admitted to any elementary, middle, junior, or senior high school or into any child care center or nursery school shall, within 30 school days after the date on which the student is admitted, present written evidence to the school, child care center, or nursery school of having completed the first immunization for each vaccine required for the student's grade and being on schedule for the remainder of the basic and recall (booster) immunization series for mumps, measles, rubella (German measles), diphtheria, pertussis (whooping cough), poliomyelitis, tetanus, and other diseases that the department specifies by rule or shall present a written waiver under sub. (3).

(3) The immunization requirement is waived if the student, if an adult, or the student's parent, guardian, or legal custodian submits a written statement to the school, child care center, or nursery school objecting to the immunization for reasons of health, religion, or personal conviction. At the time any school, child care center, or nursery school notifies a student, parent, guardian, or legal custodian of the immunization requirements, it shall inform the person in writing of the person's right to a waiver under this subsection.

(3m) Any government entity; public or private elementary, middle, junior high, or senior high school; childcare center or nursery school; or health care provider, as defined in s. 146.81 (1), that sends a piece of mail containing information that could disclose another person's immunization status, including immunization reminders sent by U.S. mail, shall ensure that any information that could disclose a person's immunization status or otherwise allow someone to infer a person's immunization status is enclosed and sealed within the piece of mail and that no such information is visible on the outside of the piece of mail.

(4) The student, if an adult, or the student's parent, guardian, or legal custodian shall keep the school, child care center, or nursery school informed of the student's compliance with the immunization schedule.

(5) (a) By the 15th and the 25th school day after the date on which the student is admitted to a school, child care center, or nursery school, the school, child care center, or nursery school shall notify in writing any adult student or the parent, guardian, or legal custodian of any minor student who has not met the immunization or waiver requirements of this section. The notices shall cite the terms of those requirements and shall state that court action and forfeiture penalty could result due to noncompliance. The notices shall also explain the reasons for the immunization requirements and include information on how and where to obtain the required immunizations.

(b) 1. A school, child care center, or nursery school may exclude from the school, child care center, or nursery school any student who fails to satisfy the requirements of sub. (2).

2. Beginning on July 1, 1993, if the department determines that fewer than 98 percent of the students in a child care center, nursery school, or school district who are subject to the requirements of sub. (2) have complied with sub. (2), the child care center or nursery school shall exclude any child who fails to satisfy the requirements of sub. (2) and the school district shall exclude any student enrolled in grades kindergarten to 6 who fails to satisfy the requirements of sub. (2).

3. Beginning on July 1, 1995, if the department determines that fewer than 99 percent of the students in a child care center, nursery school, or school district who are subject to the requirements of sub. (2) have complied with sub. (2), the child care center or nursery school shall exclude any child who fails to satisfy the requirements of sub. (2) and the school district shall exclude any student enrolled in grades kindergarten to 6 who fails to satisfy the requirements of sub. (2).

4. No student may be excluded from public school under this paragraph for more than 10 consecutive school days unless, prior to the 11th consecutive school day of exclusion, the school board provides the student and the student's parent, guardian or legal custodian with an additional notice, a hearing and the opportunity to appeal the exclusion, as provided under s. 120.13 (1) (c) 3.

(6) The school, child care center, or nursery school shall notify the district attorney of the county in which the student resides of any minor student who fails to present written evidence of completed immunizations or a written waiver under sub. (3) within 60 school days after being admitted to the school, child care center, or nursery school. The district attorney shall petition the court exercising jurisdiction under chs. 48 and 938 for an order directing that the student be in compliance with the requirements of this section. If the court grants the petition, the court may specify the date by which a written waiver shall be submitted under sub. (3) or may specify the terms of the immunization schedule. The court may require an adult student or the parent, guardian, or legal custodian of a minor student who refuses to submit a written waiver by the specified date or meet the terms of the immunization schedule to forfeit not more than \$25 per day of violation.

(7) If an emergency arises, consisting of a substantial outbreak as determined by the department by rule of one of the diseases specified in sub. (2) at a school or in the municipality in which the school is located, the department may order the school to exclude students who are not immunized until the outbreak subsides.

(8) The department shall provide the vaccines without charge, if federal or state funds are available for the vaccines, upon request of a school district or a local health department. The department shall provide the necessary professional consultant services to carry out an immunization program, under the requirements of sub. (9), in the jurisdiction of the requesting local health department. Persons immunized may not be charged for vaccines furnished by the department.

(9) (a) An immunization program under sub. (8) shall be supervised by a physician, selected by the school district or local health department, who shall issue written orders for the administration of immunizations that are in accordance with written protocols issued by the department.

(b) If the physician under par. (a) is not an employee of the county, city, village or school district, receives no compensation for his or her services under par. (a) and acts under par. (a) in accordance with written protocols issued by the department, he or she is a state agent of the department for the purposes of ss. 165.25 (6), 893.82 (3) and 895.46.

(c) The department may disapprove the selection made under par. (a) or may require the removal of a physician selected.

(9m) A pharmacist or pharmacy that administers a vaccine under this section to a person 6 to 18 years of age shall update the

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Wisconsin Immunization Registry established by the department within 7 days of administering the vaccine.

(10) The department shall, by rule, prescribe the mechanisms for implementing and monitoring compliance with this section. The department shall prescribe, by rule, the form that any person immunizing a student shall provide to the student under sub. (1).

(11) Annually, by July 1, the department shall submit a report to the legislature under s. 13.172 (3) on the success of the statewide immunization program under this section.

History: 1993 a. 27 ss. 181, 470; 1995 a. 32, 77, 222; 2009 a. 185; 2015 a. 55; 2021 a. 81.

Cross-reference: See also chs. DHS 144 and 146, Wis. adm. code.

252.041 Compulsory vaccination during a state of emergency. (1) Except as provided in sub. (2), during the period under which the department is designated as the lead state agency, as specified in s. 250.042 (2), the department, as the public health authority, may do all of the following as necessary to address a public health emergency:

(a) Order any individual to receive a vaccination unless the vaccination is reasonably likely to lead to serious harm to the individual or unless the individual, for reasons of religion or conscience, refuses to obtain the vaccination.

(b) Isolate or quarantine, under s. 252.06, any individual who is unable or unwilling for reasons specified under par. (a) to receive vaccination under par. (a).

(2) The department shall promulgate rules that specify circumstances, if any, under which vaccination may not be performed on an individual.

History: 2001 a. 109; s. 35.17 correction in (1) (b).

252.05 Reports of cases. (1) Any health care provider, as defined in s. 146.81 (1) (a) to (p), who knows or has reason to believe that a person treated or visited by him or her has a communicable disease, or having a communicable disease, has died, shall report the appearance of the communicable disease or the death to the local health officer. The health agency of a federally recognized American Indian tribe or band may report this information to the local health officer. The local health officer shall report this information to the department or shall direct the person reporting to report to the department. Any person directed to report shall submit this information to the department.

(2) Each laboratory shall report as prescribed by the department those specimen results that indicate that an individual providing the specimen has a communicable disease, or having a communicable disease, has died, or that the department finds necessary for the surveillance, control, diagnosis, and prevention of communicable diseases.

(3) Anyone having knowledge or reason to believe that any person has a communicable disease shall report the facts to the local health officer or to the department.

(4) Reports under subs. (1) and (2) shall state so far as known the name, sex, age, and residence of the person, the communicable disease and other facts the department or local health officer requires. Report forms, including forms appropriate for reporting under s. 95.22, may be furnished by the department and distributed by the local health officer.

(5) All reports shall be made within 24 hours, unless otherwise specified by the department, by telephone, telegraph, mail or electronic means or by deposit at the office of the local health officer.

(6) Any local health officer, upon receiving a report, shall cause a permanent record of the report to be made and upon demand of the department transmit the original or a copy to the department, together with other information the department requires. The department may store these records as paper or electronic records and shall treat them as patient health care records under ss. 146.81 to 146.835.

(7) When an outbreak or epidemic occurs, the local health officer shall immediately report to the department, and shall at all

times keep the department informed of the prevalence of the communicable diseases in the locality in the manner and with the facts the department requires.

(8) The department shall print and distribute, without charge, to all local health departments and, upon request, to health care providers and facilities a chart that provides information about communicable diseases.

(9) Any person licensed, permitted, registered or certified under ch. 441 or 448 shall use ordinary skill in determining the presence of communicable diseases. If there is a dispute regarding disease determination, if the disease may have potential public health significance or if more extensive laboratory tests will aid in the investigation, the local health officer shall order the tests made by the state laboratory of hygiene or by a laboratory certified under 42 USC 263a.

(11) If a violation of this section is reported to a district attorney by a local health officer or by the department, the district attorney shall forthwith prosecute the proper action, and upon request of the department, the attorney general shall assist.

History: 1971 c. 164 s. 91; 1981 c. 291; 1993 a. 16; 1993 a. 27 ss. 286 to 291, 293, 294, 471; Stats. 1993 s. 252.05; 1993 a. 183; 2001 a. 109; 2005 a. 198; 2007 a. 97; 2009 a. 28.

252.06 Isolation and quarantine. (1) The department or the local health officer acting on behalf of the department may require isolation of a patient or of an individual under s. 252.041 (1) (b), quarantine of contacts, concurrent and terminal disinfection, or modified forms of these procedures as may be necessary and as are determined by the department by rule.

(3) If a local health officer suspects or is informed of the existence of any communicable disease, the officer shall at once investigate and make or cause such examinations to be made as are necessary. The diagnostic report of a physician, the notification or confirmatory report of a parent or caretaker of the patient, or a reasonable belief in the existence of a communicable disease shall require the local health officer immediately to quarantine, isolate, require restrictions or take other communicable disease control measures in the manner, upon the persons and for the time specified in rules promulgated by the department. If the local health officer is not a physician, he or she shall consult a physician as speedily as possible where there is reasonable doubt or disagreement in diagnosis and where advice is needed. The local health officer shall investigate evasion of the laws and rules concerning communicable disease and shall act to protect the public.

(4) (a) If deemed necessary by the department or a local health officer for a particular communicable disease, all persons except the local health officer, his or her representative, attending physicians and nurses, members of the clergy, the members of the immediate family and any other person having a special written permit from the local health officer are forbidden to be in direct contact with the patient.

(b) If s. 250.042 (1) applies, all of the following apply:

1. No person, other than a person authorized by the public health authority or agent of the public health authority, may enter an isolation or quarantine premises.

2. A violation of subd. 1. is subject to a fine not to exceed \$10,000 or imprisonment not to exceed 9 months, or both.

3. Any person, whether authorized under subd. 1. or not, who enters an isolation or quarantine premises may be subject to isolation or quarantine under this section.

(5) The local health officer shall employ as many persons as are necessary to execute his or her orders and properly guard any place if quarantine or other restrictions on communicable disease are violated or intent to violate is manifested. These persons shall be sworn in as quarantine guards, shall have police powers, and may use all necessary means to enforce the state laws for the prevention and control of communicable diseases, or the orders and rules of the department or any local health officer.

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(6) (a) When the local health officer deems it necessary that a person be quarantined or otherwise restricted in a separate place, the officer shall remove the person, if it can be done without danger to the person's health, to this place.

(b) When a person confined in a jail, state prison, mental health institute or other public place of detention has a disease which the local health officer or the director of health at the institution deems dangerous to the health of other residents or the neighborhood, the local health officer or the director of health at the institution shall order in writing the removal of the person to a hospital or other place of safety, there to be provided for and securely kept. Upon recovery the person shall be returned; and if the person was committed by a court or under process the removal order or a copy shall be returned by the local health officer to the committing court officer.

(10) (a) Expenses for necessary medical care, food and other articles needed for the care of the infected person shall be charged against the person or whoever is liable for the person's support.

(b) The county or municipality in which a person with a communicable disease resides is liable for the following costs accruing under this section, unless the costs are payable through 3rd-party liability or through any benefit system:

1. The expense of employing guards under sub. (5).
2. The expense of maintaining quarantine and enforcing isolation of the quarantined area.
3. The expense of conducting examinations and tests for disease carriers made under the direction of the local health officer.
4. The expense of care provided under par. (a) to any dependent person, as defined in s. 49.01 (2).

(c) All expenses incurred by a local health department, or by an entity designated as a local health department by a federally recognized American Indian tribe or band in this state, in quarantining a person outside his or her home during a state of emergency related to public health declared by the governor under s. 323.10 and not reimbursed from federal funds shall be paid for under either of the following, as appropriate:

1. If the governor designates the department as the lead state agency under s. 323.10, from the appropriation under s. 20.435 (1) (c).
2. If the governor does not designate the department as the lead state agency under s. 323.10, from the appropriation under s. 20.465 (3) (e).

History: 1981 c. 291; 1983 a. 189 s. 329 (19); 1993 a. 27 s. 295; Stats. 1993 s. 252.06; 2001 a. 109; 2003 a. 186; 2009 a. 42.

NOTE: 2003 Wis. Act 186, which affected this section, contains extensive explanatory notes.

Cross-reference: See also ch. DHS 145, Wis. adm. code.
Due Process in the Time of Coronavirus. Killoran & Wittenberg. Wis. Law. Apr. 2020.

252.07 Tuberculosis. (1g) In this section:

(a) "Infectious tuberculosis" means tuberculosis disease of the respiratory tract, capable of producing infection or disease in others as demonstrated by the presence of acid-fast bacilli in the sputum or bronchial secretions or by chest radiograph and clinical findings.

(b) "Isolate" means a population of mycobacterium tuberculosis bacteria that has been obtained in pure culture medium.

(c) "Isolation" means the separation from other persons of a person with infectious tuberculosis in a place and under conditions that prevent the transmission of the infection.

(d) "Suspect tuberculosis" means an illness marked by symptoms and laboratory tests that may be indicative of tuberculosis, such as a prolonged cough, prolonged fever, hemoptysis, compatible roentgenographic findings or other appropriate medical imaging findings.

(1m) Infectious tuberculosis and suspect tuberculosis are subject to the reporting requirements specified in s. 252.05. Any laboratory that receives a specimen for tuberculosis testing shall

report all positive results obtained by any appropriate procedure, including a procedure performed by an out-of-state laboratory, to the local health officer and to the department.

(1p) Any laboratory that performs primary culture for mycobacterium tuberculosis complex using an approved rapid testing procedure specified by the department by rule.

(1t) Any laboratory that identifies mycobacterium tuberculosis shall ensure that antimicrobial drug susceptibility tests are performed on the initial isolate. The laboratory shall report the results of these tests to the local health officer and the department.

(2) The department shall identify groups at risk for contracting or transmitting mycobacterium tuberculosis and shall recommend the protocol for screening members of those groups.

(5) Upon report of any person under sub. (1m) or (1t), the local health officer shall at once investigate and make and enforce the necessary orders. If any person does not voluntarily comply with any order made by the local health officer with respect to that person, the local health officer or the department may order a medical evaluation, directly observed therapy or home isolation of that person.

(8) (a) The department or a local health officer may order the confinement to a facility of an individual who has a confirmed diagnosis of infectious tuberculosis or suspect tuberculosis if all of the following conditions are met:

1. The department or local health officer notifies a court in writing of the confinement.
2. The department or local health officer provides to the court a written statement from a physician, physician assistant, or advanced practice nurse prescriber that the individual has infectious tuberculosis or suspect tuberculosis.
3. The department or local health officer provides to the court evidence that the individual has refused to follow a prescribed treatment regimen or, in the case of an individual with suspect tuberculosis, has refused to undergo a medical examination to confirm whether the individual has infectious tuberculosis.
4. In the case of an individual with a confirmed diagnosis of infectious tuberculosis, the department or local health officer determines that the individual poses an imminent and substantial threat to himself or herself or to the public health. The department or local health officer shall provide to the court a written statement of that determination.

(b) If the department or local health officer orders the confinement of an individual under this subsection, a law enforcement officer, or other person authorized by the local public health officer, shall transport the individual, if necessary, to a facility that the department or local health officer determines will meet the individual's need for medical evaluation, isolation and treatment.

(c) No individual may be confined under this subsection for more than 72 hours, excluding Saturdays, Sundays and legal holidays, without a court hearing under sub. (9) to determine whether the confinement should continue.

(9) (a) The department or a local health officer may petition any court for a hearing to determine whether an individual with infectious or suspect tuberculosis should be confined for longer than 72 hours in a facility where proper care and treatment will be provided and spread of the disease will be prevented. The department or local health officer shall include in the petition documentation that demonstrates all of the following:

1. That the individual named in the petition has infectious tuberculosis; that the individual has noninfectious tuberculosis but is at high risk of developing infectious tuberculosis; or that the individual has suspect tuberculosis.
2. That the individual has failed to comply with the prescribed treatment regimen or with any rules promulgated by the department under sub. (11); or that the disease is resistant to the medication prescribed to the individual.

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3. That all other reasonable means of achieving voluntary compliance with treatment have been exhausted and no less restrictive alternative exists; or that no other medication to treat the resistant disease is available.

4. That the individual poses an imminent and substantial threat to himself or herself or to the public health.

(b) The department or local health officer shall give the individual written notice of a hearing at least 48 hours before a scheduled hearing is to be held. Notice of the hearing shall include all of the following information:

1. The date, time and place of the hearing.
2. The grounds, and underlying facts, upon which confinement of the individual is being sought.
3. An explanation of the individual's rights specified under par. (d).
4. The proposed actions to be taken and the reasons for each action.

(c) If the court orders confinement of an individual under this subsection, the individual shall remain confined until the department or local health officer, with the concurrence of a treating physician, physician assistant, or advanced practice nurse prescriber, determines that treatment is complete or that the individual is no longer a substantial threat to himself or herself or to the public health. If the individual is to be confined for more than 6 months, the court shall review the confinement every 6 months.

(d) An individual who is the subject of a petition for a hearing under this subsection has the right to appear at the hearing, the right to present evidence and cross-examine witnesses and the right to be represented by adversary counsel. At the time of the filing of the petition the court shall assure that the individual who is the subject of the petition is represented by adversary counsel. If the individual claims or appears to be indigent, the court shall refer the individual to the authority for indigency determinations specified under s. 977.07 (1). If the individual is a child, the court shall refer that child to the state public defender who shall appoint counsel for the child without a determination of indigency, as provided in s. 48.23 (4). Unless good cause is shown, a hearing under this subsection may be conducted by telephone or live audiovisual means, if available.

(e) An order issued by the court under this subsection may be appealed as a matter of right. An appeal shall be heard within 30 days after the appeal is filed. An appeal does not stay the order.

(10) Inpatient care for isolated pulmonary tuberculosis patients, and inpatient care exceeding 30 days for other pulmonary tuberculosis patients, who are not eligible for federal medicare benefits, for medical assistance under subch. IV of ch. 49 or for health care services funded by a relief block grant under subch. II of ch. 49 may be reimbursed if provided by a facility contracted by the department. If the patient has private health insurance, the state shall pay the difference between health insurance payments and total charges.

(11) The department may promulgate any rules necessary for the administration and enforcement of this section, including, if necessary to prevent or control the transmission of mycobacterium tuberculosis, rules that require screening of members of specific groups that are at risk for contracting or transmitting mycobacterium tuberculosis.

(12) From the appropriation account under s. 20.435 (1) (e), the department may expend not more than \$81,100 annually to fund targeted prevention activities for populations at high risk for tuberculosis infection.

History: 1971 c. 158; 1975 c. 383 s. 4; 1975 c. 421; 1981 c. 291; 1993 a. 27 s. 296, 472; Stats. 1993 s. 252.07; 1993 a. 490; 1999 a. 9 ss. 2400rg to 2400rp, 2400ru; 2005 a. 187; 2009 a. 28; 2011 a. 161.

The commonly accepted meanings of "facility" and "confined" indicate that the legislature intended jail to be a permissible placement option under sub. (9) (a) for persons with noninfectious tuberculosis who are noncompliant with a prescribed treatment regimen, provided that no less restrictive alternative exists. If conditions at a particular jail are such that proper care and treatment would be unavailable, or contrary to the prevention of the spread of the disease, jail is not authorized under sub. (9) (a). Whether a facility meets these requirements is a fact-intensive question

addressed to the circuit court's discretion. *City of Milwaukee v. Washington*, 2007 WI 104, 304 Wis. 2d 98, 735 N.W.2d 111, 05–3141.

The "no less restrictive alternative" requirement under sub. (9) (a) 3. applies to the place of confinement as well as the fact of confinement. A court must determine that the place of confinement is a facility where proper care and treatment will be provided, spread of the disease will be prevented, and no less restrictive alternative to the proposed placement exists. If after this analysis two or more placement options remain, a court may consider cost as a factor in making its determination. *City of Milwaukee v. Washington*, 2007 WI 104, 304 Wis. 2d 98, 735 N.W.2d 111, 05–3141.

252.09 Meningococcal disease and hepatitis B.

(1) Each private college and university in this state shall do all of the following:

(a) Annually, provide detailed information on the risks associated with meningococcal disease and hepatitis B and the availability and effectiveness of vaccines against the diseases to each enrolled student, if he or she is at least 18 years old, or to the student's parent or guardian, if the student is a minor.

(b) Require a student who resides in a dormitory or residence hall, or the student's parent or guardian if the student is a minor, to affirm that the student received the information under par. (a).

(c) Require a student who resides in a dormitory or residence hall to affirm whether he or she has received the vaccination against meningococcal disease and to provide the date of the vaccination, if any.

(d) Require a student who resides in a dormitory or residence hall to affirm whether he or she received the vaccination against hepatitis B and to provide the date of the vaccination, if any.

(e) Maintain a confidential record of the affirmations and the dates of the vaccinations of each student under pars. (c) and (d).

(2) Nothing in this section requires a college or university to provide or pay for vaccinations against meningococcal disease or hepatitis B.

History: 2003 a. 61.

252.10 Public health dispensaries. (1) A local health

department may request from the department certification to establish and maintain a public health dispensary for the diagnosis and treatment of persons suffering from or suspected of having tuberculosis. Two or more local health departments may jointly establish, operate and maintain public health dispensaries. The department shall certify a local health department to establish and maintain a public health dispensary if the local health department meets the standards established by the department by rule. The department of health services may withhold, suspend or revoke a certification if the local health department fails to comply with any rules promulgated by the department. The department shall provide the local health department with reasonable notice of the decision to withhold, suspend or revoke certification. The department shall offer the local health department an opportunity to comply with the rules and an opportunity for a fair hearing. Certified local health departments may contract for public health dispensary services. If the provider of those services fails to comply, the department may suspend or revoke the local health department's certification. The department may establish, operate and maintain public health dispensaries and branches in areas of the state where local authorities have not provided public health dispensaries.

(6) (a) The state shall credit or reimburse each dispensary on an annual or quarterly basis for the operation of public health dispensaries established and maintained in accordance with this section and rules promulgated by the department.

(b) The department shall determine by rule the reimbursement rate under par. (a) for services.

(g) The reimbursement by the state under pars. (a) and (b) shall apply only to funds that the department allocates for the reimbursement under the appropriation account under s. 20.435 (1) (e).

(7) Drugs necessary for the treatment of mycobacterium tuberculosis shall be purchased by the department from the appropriation account under s. 20.435 (1) (e) and dispensed to patients through the public health dispensaries, local health departments, physicians or advanced practice nurse prescribers.

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(9) Public health dispensaries shall maintain such records as are required by the department to enable them to carry out their responsibilities designated in this section and in rules promulgated by the department. Records may be audited by the department.

(10) All public health dispensaries and branches thereof shall maintain records of costs and receipts which may be audited by the department of health services.

History: 1971 c. 81; 1971 c. 211 s. 124; 1973 c. 90; 1975 c. 39, 198, 224; 1975 c. 413 ss. 2, 18; Stats. 1975 s. 149.06; 1977 c. 29; 1981 c. 20 ss. 1446, 2202 (20) (c); 1983 a. 27; 1985 a. 29; 1991 a. 39, 160; 1993 a. 27 ss. 406, 407, 409, 411 to 414; Stats. 1993 s. 252.10, 1993 a. 443; 1995 a. 27 ss. 6318, 9126 (19), 9145 (1); 1997 a. 27, 75, 156, 175, 252; 1999 a. 9, 32, 186; 2007 a. 20 s. 9121 (6) (a); 2009 a. 28.

Cross-reference: See also ch. DHS 145, Wis. adm. code.

252.11 Sexually transmitted disease. (1) In this section, “sexually transmitted disease” means syphilis, gonorrhea, chlamydia and other diseases the department includes by rule.

(1m) A physician or other health care professional called to attend a person infected with any form of sexually transmitted disease, as specified in rules promulgated by the department, shall report the disease to the local health officer and to the department in the manner directed by the department in writing on forms furnished by the department. A physician may treat a minor infected with a sexually transmitted disease or examine and diagnose a minor for the presence of such a disease without obtaining the consent of the minor’s parents or guardian. The physician shall incur no civil liability solely by reason of the lack of consent of the minor’s parents or guardian.

(2) An officer of the department or a local health officer having knowledge of any reported or reasonably suspected case or contact of a sexually transmitted disease for which no appropriate treatment is being administered, or of an actual contact of a reported case or potential contact of a reasonably suspected case, shall investigate or cause the case or contact to be investigated as necessary. If, following a request of an officer of the department or a local health officer, a person reasonably suspected of being infected with a sexually transmitted disease refuses or neglects examination by a physician, physician assistant, or advanced practice nurse prescriber or treatment, an officer of the department or a local health officer may proceed to have the person committed under sub. (5) to an institution or system of care for examination, treatment, or observation.

(4) If a person infected with a sexually transmitted disease ceases or refuses treatment before reaching what in a physician’s, physician assistant’s, or advanced practice nurse prescriber’s opinion is the noncommunicable stage, the physician, physician assistant, or advanced practice nurse prescriber shall notify the department. The department shall without delay take the necessary steps to have the person committed for treatment or observation under sub. (5), or shall notify the local health officer to take these steps.

(5) Any court of record may commit a person infected with a sexually transmitted disease to any institution or may require the person to undergo a system of care for examination, treatment, or observation if the person ceases or refuses examination, treatment, or observation under the supervision of a physician, physician assistant, or advanced practice nurse prescriber. The court shall summon the person to appear on a date at least 48 hours, but not more than 96 hours, after service if an officer of the department or a local health officer petitions the court and states the facts authorizing commitment. If the person fails to appear or fails to accept commitment without reasonable cause, the court may cite the person for contempt. The court may issue a warrant and may direct the sheriff, any constable, or any police officer of the county immediately to arrest the person and bring the person to court if the court finds that a summons will be ineffectual. The court shall hear the matter of commitment summarily. Commitment under this subsection continues until the disease is no longer communicable or until other provisions are made for treatment that satisfy the department. The certificate of the petitioning officer is prima

facie evidence that the disease is no longer communicable or that satisfactory provisions for treatment have been made.

(5m) A health care professional, as defined in s. 968.38 (1) (a), acting under an order of a court under s. 938.296 (4) or 968.38 (4) may, without first obtaining informed consent to the testing, subject an individual to a test or a series of tests to ascertain whether that individual is infected with a sexually transmitted disease. No sample used for performance of a test under this subsection may disclose the name of the test subject.

(7) Reports, examinations and inspections and all records concerning sexually transmitted diseases are confidential and not open to public inspection, and may not be divulged except as may be necessary for the preservation of the public health, in the course of commitment proceedings under sub. (5), or as provided under s. 938.296 (4) or 968.38 (4). If a physician, physician assistant, or advanced practice nurse prescriber has reported a case of sexually transmitted disease to the department under sub. (4), information regarding the presence of the disease and treatment is not privileged when the patient, physician, physician assistant, or advanced practice nurse prescriber is called upon to testify to the facts before any court of record.

(9) The department shall prepare for free distribution upon request to state residents, information and instructions concerning sexually transmitted diseases.

(10) The state laboratory of hygiene shall examine specimens for the diagnosis of sexually transmitted diseases for any physician, naturopathic doctor, physician assistant, advanced practice nurse prescriber, or local health officer in the state, and shall report the positive results of the examinations to the local health officer and to the department. All laboratories performing tests for sexually transmitted diseases shall report all positive results to the local health officer and to the department, with the name of the physician, naturopathic doctor, physician assistant, or advanced practice nurse prescriber to whom reported.

(11) In each county with an incidence of gonorrhea, antibiotic resistant gonorrhea, chlamydia or syphilis that exceeds the statewide average, a program to diagnose and treat sexually transmitted diseases at no cost to the patient is required. The county board of supervisors is responsible for ensuring that the program exists, but is required to establish its own program only if no other public or private program is operating. The department shall compile statistics indicating the incidence of gonorrhea, antibiotic resistant gonorrhea, chlamydia and syphilis for each county in the state.

History: 1971 c. 42, 125; 1973 c. 90; 1975 c. 6; 1975 c. 383 s. 4; 1975 c. 421; 1981 c. 291; 1991 a. 269; 1993 a. 27 s. 297; Stats. 1993 s. 252.11; 1993 a. 32; 1995 a. 77; 1999 a. 188; 2005 a. 187; 2009 a. 209; 2011 a. 161; 2021 a. 130.

Cross-reference: See also ch. DHS 145, Wis. adm. code.

252.12 HIV and related infections, including hepatitis C virus infections; services and prevention. (1) DEFINITIONS. In this section:

(b) “AIDS service organizations” means nonprofit corporations or public agencies that provide, or arrange for the provision of, comprehensive services to prevent HIV infection and comprehensive health and social services for persons who have HIV infection, and that are designated as such by the department under sub. (4).

(c) “Nonprofit corporation” means a nonstock corporation organized under ch. 181 that is a nonprofit corporation, as defined in s. 181.0103 (17).

(d) “Organization” means a nonprofit corporation or a public agency which proposes to provide services to individuals with acquired immunodeficiency syndrome.

(e) “Public agency” means a county, city, village, town or school district or an agency of this state or of a county, city, village, town or school district.

(2) DISTRIBUTION OF FUNDS. (a) *HIV and related infections, including hepatitis C virus infections; services.* From the appropriation accounts under s. 20.435 (1) (a) and (am), the department

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shall distribute funds for the provision of services to individuals with or at risk of contracting HIV infection, as follows:

1. ‘Partner referral and notification.’ The department shall contact an individual known to have received an HIV infection and encourage him or her to refer for counseling, HIV testing, and, if appropriate, testing for hepatitis C virus infection any person with whom the individual has had sexual relations or has shared intravenous equipment.

2. ‘Grants to local projects.’ The department shall make grants to applying organizations for the provision of HIV and related infection prevention information, the establishment of counseling support groups and the provision of direct care to persons with HIV infection, including those persons with hepatitis C virus infection.

3. ‘Statewide public education campaign.’ The department shall promote public awareness of the risk of contracting HIV and related infections and measures for HIV and related infections protection by development and distribution of information through clinics providing family planning services, as defined in s. 253.07 (1) (b), offices of physicians and clinics for sexually transmitted diseases and by newsletters, public presentations or other releases of information to newspapers, periodicals, radio and television stations and other public information resources. The information shall be targeted at individuals whose behavior puts them at risk of contracting HIV and related infections and shall encompass the following topics:

- a. HIV infection and related infections.
- b. Means of identifying whether or not individuals may be at risk of contracting HIV and related infections.
- c. Measures individuals may take to protect themselves from contracting HIV and related infections.
- d. Locations for procuring additional information or obtaining HIV testing services.

4. ‘Information network.’ The department shall establish a network to provide information to local health officers and other public officials who are responsible for HIV infection and related infection prevention and training.

5. ‘HIV seroprevalence studies.’ The department shall perform HIV tests and, if appropriate, tests for the presence of related infections and shall conduct behavioral surveys among population groups determined by the department to be highly at risk of becoming infected with or transmitting HIV and related infections. Information obtained shall be used to develop targeted HIV infection and related infection prevention efforts for these groups and to evaluate the state’s prevention strategies.

6. ‘Grants for targeted populations and intervention services.’ The department shall make grants to those applying organizations that the department determines are best able to contact individuals who are determined to be highly at risk of contracting HIV for the provision of HIV and related infection information and intervention services.

7. ‘Contracts for counseling and laboratory testing services.’ The department shall distribute funding in each fiscal year to contract with organizations to provide, at alternate testing sites, anonymous or confidential counseling services for HIV, laboratory HIV testing services, and, if appropriate, laboratory testing services for the presence of related viruses.

8. ‘Mike Johnson life care and early intervention services grants.’ The department shall award not more than \$4,000,000 in each fiscal year in grants to applying organizations for the provision of needs assessments; assistance in procuring financial, medical, legal, social and pastoral services; counseling and therapy; homecare services and supplies; advocacy; and case management services. These services shall include early intervention services. The department shall also award not more than \$74,000 in each year from the appropriation account under s. 20.435 (5) (md) for the services under this subdivision. The state share of payment for case management services that are provided under s. 49.45 (25) (be) to recipients of medical assistance shall be paid from the

appropriation account under s. 20.435 (1) (am). All of the following apply to grants awarded under this subdivision:

a. None of the funds awarded may be used to fund AIDS programs, or to develop materials, designed to promote or encourage, directly, intravenous drug use or sexual activity, whether homosexual or heterosexual.

b. None of the funds awarded may be used for political purposes.

c. Funds awarded shall be used to provide medical care and support services for individuals with HIV.

9. ‘Grant for family resource center.’ The department shall award a grant to develop and implement an African–American family resource center in the city of Milwaukee that targets activities toward the prevention and treatment of HIV infection and related infections, including hepatitis C virus infection, of minority group members, as defined in s. 16.287 (1) (f).

(c) *HIV prevention grants.* 1. From the appropriation account under s. 20.435 (1) (md), the department shall award to applying nonprofit corporations or public agencies up to \$75,000 in each fiscal year, on a competitive basis, as grants for services to prevent HIV. Criteria for award of the grants shall include all of the following:

- a. The scope of proposed services, including the proposed targeted population and numbers of persons proposed to be served.
- b. The proposed methodology for the prevention services, including distribution and delivery of information and appropriateness of the message provided.
- c. The qualifications of the applicant nonprofit corporation or public agency and its staff.
- d. The proposed allocation of grant funds to the nonprofit corporation or public agency staff and services.
- e. The proposed method by which the applicant would evaluate the impact of the grant funds awarded.

2. From the appropriation account under s. 20.435 (1) (am), the department shall award \$75,000 in each fiscal year as grants for services to prevent HIV infection and related infections, including hepatitis C virus infection. Criteria for award of the grants shall include the criteria specified under subd. 1. The department shall award 60 percent of the funding to applying organizations that receive funding under par. (a) 8. and 40 percent of the funding to applying community–based organizations that are operated by minority group members, as defined in s. 16.287 (1) (f).

3. From the appropriation account under s. 20.435 (1) (am), the department shall award to the African American AIDS task force of the Black Health Coalition of Wisconsin, Inc., \$25,000 in each fiscal year as grants for services to prevent HIV infection and related infections, including hepatitis C infection.

(3) **CONFIDENTIALITY OF INFORMATION.** The results of any test performed under sub. (2) (a) 5. are confidential and may be disclosed only to the individual who receives a test or to other persons with the informed consent of the test subject. Information other than that released to the test subject, if released under sub. (2) (a) 5., may not identify the test subject.

(4) **DESIGNATION OF AIDS SERVICE ORGANIZATIONS.** The department shall designate AIDS service organizations and specify the geographical area of the state in which they are designated to provide services.

History: 1987 a. 27, 70, 399; 1989 a. 31, 201, 336; 1991 a. 39, 80; 1993 a. 16; 1993 a. 27 ss. 318, 319, 321, 323; Stats. 1993 s. 252.12; 1995 a. 27; 1997 a. 27, 79; 1999 a. 9; 2001 a. 16; 2005 a. 25; 2007 a. 20; 2009 a. 28, 209, 221; 2011 a. 32; 2013 a. 20; 2015 a. 55; 2017 a. 59.

252.13 HIV tests. (1) In this section, “autologous transfusion” means the receipt by an individual, by transfusion, of whole blood, blood plasma, a blood product or a blood derivative, which the individual has previously had withdrawn from himself or herself for his or her own use.

(1m) Except as provided under sub. (3), any blood bank, blood center or plasma center in this state that purchases or

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receives whole blood, blood plasma, a blood product or a blood derivative shall, prior to its distribution or use and in accordance with the conditions under s. 252.15 (2m) (a), subject that blood, plasma, product or derivative to an HIV test. This subsection does not apply to a blood bank that purchases or receives whole blood, blood plasma, a blood product or a blood derivative from a blood bank, blood center or plasma center in this state if the whole blood, blood plasma, blood product or blood derivative has previously been subjected to an HIV test.

(1r) For the purposes of this section, the state epidemiologist shall make separate findings of medical significance and sufficient reliability for an HIV test or a series of HIV tests for each of the following purposes:

(a) Subjecting whole blood, blood plasma, a blood product or a blood derivative to a test prior to distribution or use of the whole blood, blood plasma, blood product or blood derivative.

(b) Providing disclosure of test results to the subject of the test.

(2) If performance of a test under sub. (1m) yields a validated test result positive for the presence of HIV, antigen or nonantigenic products of HIV or an antibody to HIV, the whole blood, blood plasma, blood product or blood derivative so tested with this result may not be distributed or used except for purposes of research or as provided under sub. (5).

(3) If a medical emergency, including a threat to the preservation of life of a potential donee, exists under which whole blood, blood plasma, a blood product, or a blood derivative that has been subjected to HIV testing under sub. (1m) is unavailable, the requirement of sub. (1m) shall not apply.

(4) Subsections (1m) and (2) do not apply to the extent that federal law or regulations require that a blood bank, blood center, or plasma center administer an HIV test to whole blood, blood plasma, a blood product, or a blood derivative.

(5) Whole blood, blood plasma, a blood product, or a blood derivative described under sub. (2) that is voluntarily donated solely for the purpose of an autologous transfusion may be distributed to or used by the person who has donated the whole blood, blood plasma, blood product, or blood derivative. No person other than the person who has donated the whole blood, blood plasma, blood product, or blood derivative may receive or use the whole blood, blood plasma, blood product, or blood derivative unless it has been subjected to an HIV test under sub. (1m) and performance of the test has yielded a negative, validated HIV test result.

History: 1985 a. 73; 1987 a. 70; 1989 a. 201 ss. 9, 36; 1993 a. 27 ss. 325, 473; Stats. 1993 s. 252.13; 2009 a. 209.

252.133 HIV testing for anatomical gifts. (1) Except as provided in sub. (2), a health care provider, as defined in s. 252.15 (1) (ar), who procures, processes, distributes, or uses a human body part or human tissue that is the subject of an anatomical gift under s. 157.06 shall have an HIV test performed on the donor of the body part or tissue in order to assure medical acceptability of the gift for the purpose intended. The health care provider shall use an HIV test that yields a validated HIV test result. If the validated HIV test result of the donor is positive, the human body part or human tissue donated for use or proposed for donation may not be used.

(2) If, as determined by the attending physician of a potential donee of a human body part or human tissue, a medical emergency exists under which a human body part or human tissue that has been subjected to testing under sub. (1) is unavailable, including a threat to the preservation of the life of the potential donee, the requirement of sub. (1) does not apply.

History: 2009 a. 209 ss. 30, 45, 46; 2013 a. 166 s. 77.

252.14 Discrimination related to acquired immunodeficiency syndrome. (1) In this section:

(ad) “Correctional officer” has the meaning given in s. 301.28 (1).

(am) “Fire fighter” has the meaning given in s. 102.475 (8) (b).

(ar) “Health care provider” means any of the following:

1. A nurse licensed under ch. 441.
2. A chiropractor licensed under ch. 446.
3. A dentist licensed under ch. 447.
4. A physician licensed under subch. II of ch. 448.
- 4c. A perfusionist licensed under subch. II of ch. 448.
- 4e. A physical therapist or physical therapist assistant who is licensed under subch. III of ch. 448 or who holds a compact privilege under subch. X of ch. 448.
- 4g. A podiatrist licensed under subch. IV of ch. 448.
- 4m. A dietitian certified under subch. V of ch. 448.
- 4n. An athletic trainer licensed under subch. VI of ch. 448.
- 4p. An occupational therapist or occupational therapy assistant who is licensed under subch. VII of ch. 448 or who holds a compact privilege under subch. XI of ch. 448.
- 4s. A naturopathic doctor licensed under ch. 466.
5. An optometrist licensed under ch. 449.
6. A psychologist who is licensed under ch. 455, who is exercising the temporary authorization to practice, as defined in s. 455.50 (2) (o), in this state, or who is practicing under the authority to practice interjurisdictional telepsychology, as defined in s. 455.50 (2) (b).
7. A social worker, marriage and family therapist, or professional counselor certified or licensed under ch. 457.
8. A speech–language pathologist or audiologist licensed under subch. II of ch. 459 or a speech and language pathologist licensed by the department of public instruction.
9. An employee or agent of any provider specified under subs. 1. to 8.
10. A partnership of any provider specified under subs. 1. to 8.
11. A corporation of any provider specified under subs. 1. to 8. that provides health care services.
12. A cooperative health care association organized under s. 185.981 that directly provides services through salaried employees in its own facility.
13. An emergency medical services practitioner licensed under s. 256.15 (5).
14. A physician assistant.
15. An emergency medical responder.
- (c) “Home health agency” has the meaning specified in s. 50.49 (1) (a).
- (d) “Inpatient health care facility” means a hospital, nursing home, community–based residential facility, county home, county mental health complex or other place licensed or approved by the department under s. 49.70, 49.71, 49.72, 50.02, 50.03, 50.35, 51.08 or 51.09 or a facility under s. 45.50, 48.62, 51.05, 51.06, 233.40, 233.41, 233.42 or 252.10.
- (2) No health care provider, peace officer, fire fighter, correctional officer, state patrol officer, jailer or keeper of a jail or person designated with custodial authority by the jailer or keeper, home health agency, inpatient health care facility, or person who has access to a validated HIV test result may do any of the following with respect to an individual who has acquired immunodeficiency syndrome or has a positive, validated HIV test result, solely because the individual has HIV infection or an illness or medical condition that is caused by, arises from, or is related to HIV infection:
 - (a) Refuse to treat the individual, if his or her condition is within the scope of licensure or certification of the health care provider, home health agency or inpatient health care facility.
 - (am) If a peace officer, fire fighter, correctional officer, state patrol officer, jailer or keeper of a jail or person designated with custodial authority by the jailer or keeper, refuse to provide services to the individual.
 - (b) Provide care to the individual at a standard that is lower than that provided other individuals with like medical needs.

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(bm) If a peace officer, fire fighter, correctional officer, state patrol officer, jailer or keeper of a jail or person designated with custodial authority by the jailer or keeper, provide services to the individual at a standard that is lower than that provided other individuals with like service needs.

(c) Isolate the individual unless medically necessary.

(d) Subject the individual to indignity, including humiliating, degrading or abusive treatment.

(2m) If a person declines to be subjected to an HIV test, a health care provider may not use the fact that the person declined an HIV test as a basis for denying services or treatment, other than an HIV test, to the person.

(3) A health care provider, home health agency, or inpatient health care facility that treats an individual who has an HIV infection or acquired immunodeficiency syndrome shall develop and follow procedures that shall ensure continuity of care for the individual in the event that his or her condition exceeds the scope of licensure or certification of the provider, agency, or facility.

(4) Any person violating sub. (2) is liable to the patient for actual damages and costs, plus exemplary damages of up to \$10,000 for an intentional violation. In determining the amount of exemplary damages, a court shall consider the ability of a health care provider who is an individual to pay exemplary damages.

History: 1989 a. 201; 1991 a. 32, 39, 160, 189, 269, 315; 1993 a. 27 ss. 326 to 331; Stats. 1993 s. 252.14; 1993 a. 105, 190, 252, 443; 1993 a. 490 s. 143; 1993 a. 491, 495; 1995 a. 27 ss. 6322, 9145 (1); 1997 a. 27, 35, 67, 75, 175; 1999 a. 9, 32, 180; 2001 a. 70, 80, 89; 2005 a. 22; 2007 a. 130; 2009 a. 165, 209; 2011 a. 161; 2017 a. 12; 2019 a. 100; 2021 a. 23 s. 71; 2021 a. 123, 130, 131.

252.15 Restrictions on use of an HIV test. (1) DEFINITIONS. In this section:

(ac) “Authorized representative” means any of the following:

1. A health care agent, as defined under s. 155.01 (4), acting in accordance with a power of attorney for health care that is in effect under s. 155.05 (2).

2. A person named by the court under ch. 48 or 54 or ch. 880, 2003 stats., having the duty and authority of guardianship.

3. A parent or legal custodian of a person who is under 14 years of age.

4. For a person who is unable to communicate due to a medical condition, the person’s closest living relative or another individual with whom the person has a meaningful social and emotional relationship.

(ad) “Correctional officer” has the meaning given in s. 301.28 (1).

(af) “Emergency medical services practitioner” has the meaning given in s. 256.01 (5).

(aj) “Fire fighter” has the meaning given in s. 102.475 (8) (b).

(am) “Health care professional” means a physician or physician assistant who is licensed under ch. 448 or a registered nurse or licensed practical nurse who is licensed under ch. 441.

(ar) “Health care provider” means any of the following:

1. A person or entity that is specified in s. 146.81 (1) (a) to (hm) and (i) to (p).

2. A home health agency.

3. An employee of the Mendota Mental Health Institute or the Winnebago Mental Health Institute.

(cm) “Home health agency” has the meaning given in s. 50.49 (1) (a).

(eg) “Relative” means a spouse, parent, grandparent, stepparent, brother, sister, first cousin, nephew or niece; or uncle or aunt within the 3rd degree of kinship as computed under s. 990.001 (16). This relationship may be by blood, marriage or adoption.

(em) “Significant exposure” means contact that carries a potential for a transmission of HIV, by one or more of the following:

1. Transmission, into a body orifice or onto mucous membrane, of blood; semen; vaginal secretions; cerebrospinal, syn-

ovial, pleural, peritoneal, pericardial or amniotic fluid; or other body fluid that is visibly contaminated with blood.

2. Exchange, during the accidental or intentional infliction of a penetrating wound, including a needle puncture, of blood; semen; vaginal secretions; cerebrospinal, synovial, pleural, peritoneal, pericardial or amniotic fluid; or other body fluid that is visibly contaminated with blood.

3. Exchange, into an eye, an open wound, an oozing lesion, or where a significant breakdown in the epidermal barrier has occurred, of blood; semen; vaginal secretions; cerebrospinal, synovial, pleural, peritoneal, pericardial or amniotic fluid; or other body fluid that is visibly contaminated with blood.

6. Other routes of exposure, defined as significant in rules promulgated by the department. The department in promulgating the rules shall consider all potential routes of transmission of HIV identified by the centers for disease control of the federal public health service.

(er) “Social worker” means an individual who is certified or licensed as a social worker, advanced practice social worker, independent social worker, or clinical social worker under ch. 457.

(fm) “Standard precautions” means measures that a health care provider, an employee of a health care provider or other individual takes in accordance with recommendations of the federal centers for disease control for the health care provider, employee or other individual for prevention of HIV transmission in health-care settings.

(2m) CONSENT FOR HIV TESTING. (a) Except as provided in par. (b), and subject to par. (c), a health care provider, blood bank, blood center, or plasma center may not subject a person to an HIV test unless all of the following conditions are satisfied:

1. The health care provider, blood bank, blood center, or plasma center notifies the person or the person’s authorized representative that the person will be subjected to an HIV test unless the person or the person’s authorized representative declines the test.

2. The health care provider, blood bank, blood center, or plasma center offers the person or the person’s authorized representative a brief oral or written explanation or description of HIV infection; HIV test results; requirements under subs. (7) (b) and (7m) for reporting HIV test results; treatment options for a person who has a positive HIV test result; and services provided by AIDS service organizations, as defined in s. 252.12 (1) (b), and other community-based organizations for persons who have a positive HIV test result.

3. If a health care provider offers to perform an HIV test, the health care provider notifies the person or the person’s authorized representative that the person or the person’s authorized representative may decline the HIV test and that, if the person or the person’s authorized representative declines the HIV test, the health care provider may not use the fact that the person declined an HIV test as a basis for denying services or treatment, other than an HIV test, to the person.

4. The health care provider, blood bank, blood center, or plasma center provides the person or the person’s authorized representative an opportunity to ask questions and to decline the HIV test.

5. After complying with applicable conditions under subs. 1. to 4., the health care provider, blood bank, blood center, or plasma center verifies that the person or the person’s authorized representative understands that an HIV test will be performed on the person and that the decision of the person or the person’s authorized representative regarding whether to have an HIV test performed is not coerced or involuntary.

(b) Paragraph (a) does not apply to any of the following:

1. HIV testing of any body fluid or tissue that is performed by the department, a laboratory certified under 42 USC 263a, or a health care provider, blood bank, blood center, or plasma center for the purpose of research, if the testing is performed in a manner

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by which the identity of the test subject is not known and may not be retrieved by the researcher.

2. HIV testing of a resident or patient of a center for the developmentally disabled, as defined in s. 51.01 (3), or a mental health institute, as defined in s. 51.01 (12), if the medical director of the center or institute determines that the conduct of the resident or patient poses a significant risk of transmitting HIV to another resident or patient of the center or institute and if the medical director provides the resident or patient, or the resident's or patient's guardian, an explanation of the HIV test result.

3. HIV testing by a health care professional acting under an order of the court under sub. (5j) or s. 938.296 (4) or (5) or 968.38 (4) or (5). No sample used for laboratory test purposes under this subdivision may disclose the name of the HIV test subject, and the HIV test results may not be made part of the individual's permanent medical record.

4. HIV testing in cases of significant exposure, as provided under sub. (5g) or (5j).

5. HIV testing of a donor of a human body part or human tissue that is required under s. 252.133.

(c) If the subject of an HIV test is a minor who is 14 years of age or older, a health care provider, blood bank, blood center, or plasma center shall provide the notifications and offer the information under par. (a) 1. to 4. to the minor or his or her authorized representative, and only the minor or his or authorized representative may consent to or decline an HIV test under par. (a).

(2r) PROHIBITION AGAINST CONDITIONING HIV TESTING ON DISCLOSURE. A health care provider may not require a person to authorize disclosure of HIV test results as a condition of administering an HIV test to the person.

(3m) CONFIDENTIALITY AND DISCLOSURE OF HIV TEST RESULTS. (a) The subject of an HIV test or the subject's authorized representative may disclose the results of the subject's test to anyone.

(b) Except as provided under par. (d) or (e), a person who is neither the subject of the HIV test nor the subject's authorized representative may not disclose the subject's HIV test results unless the subject of the HIV test or his or her authorized representative has signed authorization for the disclosure that contains all of the following:

1. The name of the subject of the HIV test.
2. Specification of the information that may be disclosed.
3. The name of the person authorized to make the disclosure.
4. The name of the person to whom the disclosure is authorized.
5. The signature of the subject of the HIV test or the signature of the subject's authorized representative.
6. The date the authorization is signed as provided under subd. 5.
7. The time period during which the authorization for disclosure is effective.

(c) If the subject of an HIV test is a minor who is 14 years of age or older, only the minor or his or her authorized representative may exercise the test subject's authority to disclose HIV test results under par. (a) or to authorize disclosure of HIV test results under par. (b).

(d) Except as provided under par. (f), a person who is neither the subject of an HIV test nor the subject's authorized representative may without written authorization from the test subject or authorized representative under par. (b) disclose the subject's HIV test results to the following persons under the following circumstances:

1. To the subject of the HIV test and the subject's authorized representative.
2. To a health care provider who provides care to the subject of the HIV test, including those instances in which a health care provider provides emergency care to the subject.

3. To an agent or employee of a health care provider under subd. 2. who prepares or stores patient health care records, as defined in s. 146.81 (4), for the purposes of preparation or storage of those records; provides patient care; or handles or processes specimens of body fluids or tissues.

4. To a blood bank, blood center, or plasma center that subjected the test subject to an HIV test for any of the following purposes:

- a. Determining the medical acceptability of blood or plasma secured from the subject of the HIV test.
- b. Notifying the subject of the HIV test of the test results.
- c. Investigating HIV infections in blood or plasma.

5. To a health care provider who procures, processes, distributes or uses a human body part that is the subject of an anatomical gift under s. 157.06, for the purpose of assuring medical acceptability of the gift for the purpose intended.

6. To the state epidemiologist or his or her designee, or to a local health officer or his or her designees, for the purpose of providing epidemiologic surveillance or investigation or control of communicable disease.

7. To a funeral director, as defined under s. 445.01 (5) (a) 1. or 2. or (c) or to other persons who prepare the body of the subject of the HIV test for burial or other disposition or to a person who performs an autopsy, or assists in performing an autopsy, on the subject of the HIV test.

8. To health care facility staff committees or accreditation or health care services review organizations for the purposes of conducting program monitoring and evaluation and health care services reviews.

9. Under a lawful order of a court of record except as provided under s. 901.05.

10. Except as provided under par. (g), to a person who conducts research, for the purpose of research, if the researcher:

- a. Is affiliated with a health care provider under subd. 2.
- b. Has obtained permission to perform the research from an institutional review board.

c. Provides written assurance to the person disclosing the HIV test results that use of the information requested is only for the purpose under which it is provided to the researcher, the information will not be released to a person not connected with the study, and the final research product will not reveal information that may identify the test subject unless the researcher has first received informed consent for disclosure from the test subject.

11. To a coroner, medical examiner, or an appointed assistant to a coroner or medical examiner, if one or more of the following applies:

a. The coroner, medical examiner, or an appointed assistant is investigating the cause of death of the subject of the HIV test and possible HIV-infected status is relevant to the cause of death.

b. The coroner, medical examiner, or appointed assistant is investigating the cause of death of the subject of the HIV test and has contact with the body fluid of the subject of the HIV test that constitutes a significant exposure, if a physician, physician assistant, or advanced practice nurse prescriber, based on information provided to the physician, physician assistant, or advanced practice nurse prescriber, determines and certifies in writing that the coroner, medical examiner, or appointed assistant has had a contact that constitutes a significant exposure and if the certification accompanies the request for disclosure.

12. To a sheriff, jailer or keeper of a prison, jail, or house of correction or a person designated with custodial authority by the sheriff, jailer, or keeper, for whom disclosure is necessitated in order to permit the assigning of a private cell to a prisoner who has a positive HIV test result.

13. If the subject of the HIV test has a positive HIV test result and is deceased, by the subject's attending physician, physician assistant, or advanced practice nurse prescriber, to persons, if known to the physician, physician assistant, or advanced practice

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nurse prescriber, with whom the subject had sexual contact or shared intravenous drug use paraphernalia.

14. To a person under s. 938.296 (4) (a) to (e) as specified in s. 938.296 (4); to a person under s. 938.296 (5) (a) to (e) as specified in s. 938.296 (5); to a person under s. 968.38 (4) (a) to (c) as specified in s. 968.38 (4); or to a person under s. 968.38 (5) (a) to (c) as specified in s. 968.38 (5).

15. If the subject of the HIV test is a child who has been placed in a foster home, group home, residential care center for children and youth, or juvenile correctional facility, as defined in s. 938.02 (10p), or in a supervised independent living arrangement, including a placement under s. 48.205, 48.21, 938.205, or 938.21, or for whom placement in a foster home, group home, residential care center for children and youth, or juvenile correctional facility or in a supervised independent living arrangement is recommended under s. 48.33 (4), 48.425 (1) (g), 48.837 (4) (c), or 938.33 (3) or (4), to an agency directed by a court to prepare a court report under s. 48.33 (1), 48.424 (4) (b), 48.425 (3), 48.831 (2), 48.837 (4) (c), or 938.33 (1), to an agency responsible for preparing a court report under s. 48.365 (2g), 48.425 (1), 48.831 (2), 48.837 (4) (c), or 938.365 (2g), to an agency responsible for preparing a permanency plan under s. 48.355 (2e), 48.38, 48.43 (1) (c) or (5) (c), 48.63 (4) or (5) (c), 48.831 (4) (e), 938.355 (2e), or 938.38 regarding the child, or to an agency that placed the child or arranged for the placement of the child in any of those placements and, by any of those agencies, to any other of those agencies and, by the agency that placed the child or arranged for the placement of the child in any of those placements, to the child's foster parent or the operator of the group home, residential care center for children and youth, or juvenile correctional facility in which the child is placed, as provided in s. 48.371 or 938.371.

16. If the subject of the HIV test is a prisoner, to the prisoner's health care provider, the medical staff of a prison or jail in which a prisoner is confined, the receiving institution intake staff at a prison or jail to which a prisoner is being transferred or a person designated by a jailer to maintain prisoner medical records, if the disclosure is made with respect to the prisoner's patient health care records under s. 302.388, to the medical staff of a jail to whom the HIV results are disclosed under s. 302.388 (2) (c) or (d), to the medical staff of a jail to which a prisoner is being transferred, if the results are provided to the medical staff by the department of corrections as part of the prisoner's medical file, to a health care provider to whom the results are disclosed under s. 302.388 (2) (c) or (f) or the department of corrections if the disclosure is made with respect to a prisoner's patient health care records under s. 302.388 (4).

17. If the subject of the HIV test is a prisoner, by a person specified in subd. 16. to a correctional officer of the department of corrections who has custody of or is responsible for the supervision of the test subject, to a person designated by a jailer to have custodial authority over the test subject, or to a law enforcement officer or other person who is responsible for transferring the test subject to or from a prison or jail, if the HIV test result is positive and disclosure of that information is necessary for the health and safety of the test subject or of other prisoners, of the person to whom the information is disclosed, or of any employee of the prison or jail.

(e) The health care professional who performs an HIV test under sub. (5g) or (5j) on behalf of a person who has contact with body fluids of the test subject that constitutes a significant exposure shall disclose the HIV test results to the person and the person's physician, physician assistant, or nurse.

(f) The results of an HIV test of an individual that is performed under sub. (5g) or (5j) may be disclosed only to the following:

1. The subject of the test.
2. Anyone authorized by the subject of the test.
3. The person who was certified to have had contact that constitutes a significant exposure and to that person's physician, physician assistant, or nurse.

(g) A person who was certified to have had contact with body fluid of an individual that constitutes a significant exposure and has the individual's blood subjected to an HIV test under sub. (5g) or (5j) may not disclose the identity of the test subject to any other person except for the purpose of having the HIV test performed.

(h) A private pay patient may prohibit disclosure of his or her HIV test results under par. (d) 10. if he or she annually submits to the maintainer of his or her HIV test results under sub. (4) (c) a signed, written request that disclosure be prohibited.

(4) RECORD MAINTENANCE. A health care provider, blood bank, blood center, or plasma center that obtains a specimen of body fluids or tissues from a person for the purpose of an HIV test, or offers to subject a person to an HIV test, shall maintain in the person's health care record all of the following:

(b) A record of whether the person or his or her authorized representative consented to or declined the HIV test under sub. (2m) (a).

(bm) A record of any authorization for disclosure of HIV test results that the person or his or her authorized representative has made as provided under sub. (3m) (b).

(c) A record of the results of an HIV test administered to the person, except that results of an HIV test administered under sub. (5g) or (5j) or s. 938.296 (4) or (5) or 968.38 (4) or (5) that include the identity of the test subject may not be maintained without the consent of the test subject.

(5g) SIGNIFICANT EXPOSURE. A person who has contact with body fluid of an individual that constitutes a significant exposure may cause the individual to be subjected to HIV testing and receive the results of the HIV test under sub. (3m) (e) if all of the following apply:

(a) The contact occurred under one of the following circumstances:

1. The person is an emergency medical services practitioner; emergency medical responder; fire fighter; peace officer; correctional officer; person who is employed at a juvenile correctional facility, as defined in s. 938.02 (10p), or a secured residential care center for children and youth, as defined in s. 938.02 (15g); state patrol officer; jailer, keeper of a jail, or person designated with custodial authority by the jailer or keeper and the contact occurred during the course of the person providing care or services to the individual.

2. The person is a peace officer, correctional officer, state patrol officer, jailer, or keeper of a jail, or person designated with custodial authority by the jailer or keeper and the contact occurred while the person was searching or arresting the individual or while controlling or transferring the individual in custody.

3. The person is a health care provider or an employee of a health care provider and the contact occurred during the course of the person providing care or treatment to the individual or handling or processing specimens of body fluids or tissues of the individual.

4. The person is a staff member of a state crime laboratory and the contact occurred during the course of the person handling or processing specimens of body fluids or tissues of the individual.

5. The person is a social worker or an employee of a school district, cooperative educational service agency, charter school, private school, tribal school, as defined in s. 115.001 (15m), the Wisconsin Educational Services Program for the Deaf and Hard of Hearing, or the Wisconsin Center for the Blind and Visually Impaired and the contact occurred while the person was performing employment duties involving the individual.

6. While the person rendered emergency care at the scene of an emergency or accident, if the person is immune from civil liability for rendering the care under s. 895.48 or 895.4802 (2).

(b) If the contact occurs as provided under par. (a) 1. to 5., the entity that employs or contracts with the person to provide the services described under par. (a) 1. to 5. requires, as a general policy, that standard precautions against significant exposure be taken

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during provision of the services, except in those emergency circumstances in which the time necessary for use of the standard precautions would endanger the life of the individual.

(c) A physician, physician assistant, or advanced practice nurse prescriber, based on information provided to the physician, physician assistant, or advanced practice nurse prescriber, determines and certifies in writing that the person has had contact that constitutes a significant exposure. The certification shall accompany the request for HIV testing and disclosure. If the person is a physician, physician assistant, or advanced practice nurse prescriber, he or she may not make this determination or certification. The information that is provided to a physician, physician assistant, or advanced practice nurse prescriber to document the occurrence of the contact that constitutes a significant exposure and the physician's, physician assistant's, or advanced practice nurse prescriber's certification that the person has had contact that constitutes a significant exposure, shall be provided on a report form that is developed by the department of safety and professional services under s. 101.02 (19) (a) or on a report form that the department of safety and professional services determines, under s. 101.02 (19) (b), is substantially equivalent to the report form that is developed under s. 101.02 (19) (a).

(d) The person submits to an HIV test as soon as feasible or within a time period established by the department after consulting guidelines of the centers for disease control of the federal public health service, whichever is earlier.

(e) Except as provided in sub. (5j), the HIV test is performed on blood of the individual that is drawn for a purpose other than HIV testing.

(f) The individual has been given an opportunity to be subjected to an HIV test in accordance with the conditions under sub. (2m) (a) and has declined.

(g) The individual has been informed of all of the following:

1. That an HIV test may be performed on his or her blood.
2. That the HIV test results may be disclosed to the person and the person's physician, physician assistant, or nurse.
3. That, except as provided in subd. 2., the HIV test may not be disclosed to any person.

4. That, if the person knows the identity of the individual, the person may not disclose the identity to any other person except for the purpose of having the HIV test performed.

5. That a record may be kept of the HIV test results only if the record does not reveal the individual's identity.

(5j) COURT ORDER FOR HIV TESTING. (a) A person who may cause an individual to be subjected to HIV testing under sub. (5g) may request the district attorney to apply to the circuit court for his or her county to order the individual to submit to an HIV test if no blood of the individual that was drawn for a purpose other than HIV testing is available for HIV testing. A person making a request to a district attorney under this paragraph shall provide the district attorney the certification under sub. (5g) (c).

(b) Upon receipt of a request and certification under par. (a), a district attorney shall, as soon as possible so as to enable the court to provide timely notice, apply to the circuit court for his or her county to order the individual to submit to an HIV test administered by a health care professional.

(c) The court shall set a time for a hearing on the matter under this subsection within 20 days after receipt of a request under par. (b). The court shall give the district attorney and the individual from whom an HIV test is sought notice of the hearing at least 72 hours prior to the hearing. The individual may have counsel at the hearing, and counsel may examine and cross-examine witnesses. If the court finds probable cause to believe that the person who requested a court order for testing has had contact with body fluid of the individual that constitutes a significant exposure, the court shall, except as provided in par. (d), order the individual to submit to an HIV test. No sample used for laboratory test purposes under this paragraph may disclose the name of the HIV test subject.

(d) The court is not required to order an individual to submit to an HIV test under par. (c) if the court finds substantial reason relating to the life or health of the individual not to do so and states the reason on the record.

(5m) AUTOPSIES; HIV TESTING OF CERTAIN CORPSES. (d) Notwithstanding s. 157.05, a corpse may be subjected to an HIV test and the test results disclosed to a person who has contact that constitutes a significant exposure with body fluid of the corpse or an individual who subsequently dies, if all of the following apply:

1. The contact occurs under any of the following circumstances:

a. While the person, including a person exempted from civil liability under the conditions specified under s. 895.48 or 895.4802 (2) renders emergency care to an emergency or accident victim and the victim subsequently dies prior to performance of an HIV test on the victim.

b. The person is a funeral director, coroner, medical examiner, or appointed assistant to a coroner or medical examiner and the contact occurs while the person prepares the corpse for burial or other disposition or while the person performs an autopsy or assists in performing an autopsy on the corpse.

c. The person is a health care provider or an agent or employee of a health care provider and the person has contact with body fluid of the corpse, or of a patient who dies subsequent to the contact and prior to performance of an HIV test on the patient.

2. A physician, physician assistant, or advanced practice nurse prescriber, based on information provided to the physician, physician assistant, or advanced practice nurse prescriber, determines and certifies in writing that the contact under subd. 1. constitutes a significant exposure. A health care provider who has a contact under subd. 1. c. may not make the certification under this subdivision for himself or herself.

3. The certification under subd. 2. accompanies the request for performance of an HIV test and disclosure.

(e) If the conditions under par. (d) are satisfied, the following person shall order an HIV test of the corpse:

1. If the contact occurs as provided under par. (d) 1. a., the coroner, medical examiner, or physician who certifies the victim's cause of death under s. 69.18 (2) (b), (c), or (d).

2. If the contact occurs as provided under par. (d) 1. b., the attending physician, physician assistant, or advanced practice nurse prescriber of the funeral director, coroner, medical examiner, or appointed assistant.

3. If the contact occurs as provided under par. (d) 1. c., the physician, physician assistant, or advanced practice nurse prescriber who makes the certification under par. (d) 2.

(5r) SALE OF TESTS WITHOUT APPROVAL PROHIBITED. No person may sell or offer to sell in this state a test or test kit to detect the presence of HIV, antigen or nonantigenic products of HIV or an antibody to HIV for self-use by an individual unless the test or test kit is first approved by the state epidemiologist. In reviewing a test or test kit under this subsection, the state epidemiologist shall consider and weigh the benefits, if any, to the public health of the test or test kit against the risks, if any, to the public health of the test or test kit.

(6) EXPANDED DISCLOSURE OF HIV TEST RESULTS PROHIBITED. No person to whom the results of an HIV test have been disclosed under sub. (3m) (a), (b), (d), or (e) or (5m) may disclose the test results except as authorized under sub. (3m) (a), (b), (d), or (e) or (5m).

(7) REPORTING OF POSITIVE HIV TEST RESULTS. (a) Notwithstanding ss. 227.01 (13) and 227.10 (1), for the purposes of this subsection, the state epidemiologist shall determine, based on the preponderance of available scientific evidence, the procedures necessary in this state to obtain a validated HIV test result and the secretary shall so declare under s. 250.04 (1) or (2) (a). The state epidemiologist shall revise this determination if, in his or her opinion, changed available scientific evidence warrants a revision, and

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the secretary shall declare the revision under s. 250.04 (1) or (2) (a).

(b) If a positive, validated HIV test result is obtained from an HIV test subject, the health care provider, blood bank, blood center, or plasma center that maintains a record of the HIV test result under sub. (4) (c) shall report to the state epidemiologist the following information:

1. The name and address of the health care provider, blood bank, blood center or plasma center reporting.
2. The name and address of the subject's health care provider, if known.
3. The name, address, telephone number, age or date of birth, race and ethnicity, sex and county of residence of the test subject, if known.
4. The date on which the HIV test was performed.
5. The HIV test result.
- 5m. The mode of transmission of HIV to the test subject.
6. Any other medical or epidemiological information required by the state epidemiologist for the purpose of exercising surveillance, control and prevention of HIV infections.

(c) Except as provided in sub. (7m), a report made under par. (b) may not include any of the following:

1. Information with respect to the sexual orientation of the HIV test subject.
2. The identity of persons with whom the HIV test subject may have had sexual contact.

(d) This subsection does not apply to the reporting of information under s. 252.05 with respect to persons for whom a diagnosis of acquired immunodeficiency syndrome has been made.

(7m) REPORTING OF PERSONS SIGNIFICANTLY EXPOSED. If a positive, validated HIV test result is obtained from a test subject, the test subject's physician, physician assistant, or advanced practice nurse prescriber who maintains a record of the HIV test result under sub. (4) (c) may report to the state epidemiologist the name of any person known to the physician, physician assistant, or advanced practice nurse prescriber to have had contact with body fluid of the test subject that constitutes a significant exposure, only after the physician, physician assistant, or advanced practice nurse prescriber has done all of the following:

- (a) Counseled the HIV test subject to inform any person who has had contact with body fluid of the test subject that constitutes a significant exposure.
- (b) Notified the HIV test subject that the name of any person known to the physician, physician assistant, or advanced practice nurse prescriber to have had contact with body fluid of the test subject that constitutes a significant exposure will be reported to the state epidemiologist.

(7r) EXPLANATION OF HIV FOR TEST SUBJECTS. The department shall provide to health care providers, blood banks, blood centers, and plasma centers a brief explanation or description of all of the following that a health care provider, blood bank, blood center, or plasma center may provide prospective HIV test subjects under sub. (2m) (a) 2.:

- (a) HIV infection.
- (b) HIV test results.
- (c) Requirements under subs. (7) (b) and (7m) for reporting HIV test results.
- (d) Treatment options for a person who has a positive HIV test result.
- (e) Services provided by AIDS service organizations, as defined in s. 252.12 (1) (b), and other community-based organizations for persons who have a positive HIV test result.

(8) CIVIL LIABILITY. (a) Any person violating sub. (2m), (3m) (b), (d), or (f), (5m), (6) or (7) (c) is liable to the subject of the test for actual damages, costs and reasonable actual attorney fees, plus exemplary damages of up to \$2,000 for a negligent violation and up to \$50,000 for an intentional violation.

(b) The plaintiff in an action under par. (a) has the burden of proving by a preponderance of the evidence that a violation occurred under sub. (2m), (3m) (b), (d), or (f), (5m), (6) or (7) (c). A conviction under sub. (2m), (3m) (b), (d), or (f), (5m), (6) or (7) (c) is not a condition precedent to bringing an action under par. (a).

(9) PENALTIES. Whoever intentionally discloses the results of an HIV test in violation of sub. (3m) (b) or (f) or (5m) and thereby causes bodily harm or psychological harm to the subject of the HIV test may be fined not more than \$50,000 or imprisoned not more than 9 months or both. Whoever negligently discloses the results of an HIV test in violation of sub. (3m) (b) or (f) or (5m) is subject to a forfeiture of not more than \$2,000 for each violation. Whoever intentionally discloses the results of an HIV test in violation of sub. (3m) (b) or (f) or (5m), knowing that the information is confidential, and discloses the information for pecuniary gain may be fined not more than \$200,000 or imprisoned not more than 3 years and 6 months, or both.

(10) DISCIPLINE OF EMPLOYEES. Any employee of the state or a political subdivision of the state who violates this section may be discharged or suspended without pay.

History: 1985 a. 29, 73, 120; 1987 a. 70 ss. 13 to 27, 36; 1987 a. 403 ss. 136, 256; 1989 a. 200; 1989 a. 201 ss. 11 to 25, 36; 1989 a. 298, 359; 1991 a. 269; 1993 a. 16 s. 2567; 1993 a. 27 ss. 332, 334, 337, 340, 342; Stats. 1993 s. 252.15; 1993 a. 32, 183, 190, 252, 395, 491; 1995 a. 27 ss. 6323, 9116 (5), 9126 (19); 1995 a. 77, 275; 1997 a. 54, 80, 156, 188; 1999 a. 9, 32, 79, 151, 162, 188; 2001 a. 38, 59, 69, 74, 103, 105; 2003 a. 271; 2005 a. 155, 187, 266, 344, 387; 2007 a. 97, 106, 130; 2009 a. 28, 209, 302, 355; 2011 a. 32; 2011 a. 260 ss. 42 to 44, 81; 2013 a. 334; 2015 a. 197 s. 51; 2017 a. 12.

No claim for a violation of s. 146.025, 1987 stats., was stated when the defendants neither conducted HIV tests nor were authorized recipients of the test results. *Hillman v. Columbia County*, 164 Wis. 2d 376, 474 N.W.2d 913 (Ct. App. 1991).

This section does not prevent a court acting in equity from ordering an HIV test where this section does not apply. *Syring v. Tucker*, 174 Wis. 2d 787, 498 N.W.2d 370 (1993).

This section has no bearing on a case in which a letter from the plaintiff to the defendant pharmacy contained a reference to a drug used only to treat AIDS, but did not disclose the results of an HIV test or directly disclose that the defendant had AIDS. *Doe v. American Stores, Co.*, 74 F. Supp. 2d 855 (1999).

Confidentiality of Medical Records. Meili. Wis. Law. Feb. 1995.

HIV Confidentiality: Who Has the Right to Know? Krimmer. Wis. Law. Feb. 2003.

New Federal Privacy Rule for Health Care Providers, Part II: Balancing Federal and Wisconsin Medical Privacy Laws. Hartin. Wis. Law. June 2003.

252.16 Health insurance premium subsidies. (1) DEFINITIONS. In this section:

(ar) "Dependent" means a spouse or domestic partner under ch. 770, an unmarried child under the age of 19 years, an unmarried child who is a full-time student under the age of 21 years and who is financially dependent upon the parent, or an unmarried child of any age who is medically certified as disabled and who is dependent upon the parent.

(b) "Group health plan" means an insurance policy or a partially or wholly uninsured plan or program, that provides hospital, medical or other health coverage to members of a group, whether or not dependents of the members are also covered. The term includes a medicare supplement policy, as defined in s. 600.03 (28r), but does not include a medicare replacement policy, as defined in s. 600.03 (28p), or a long-term care insurance policy, as defined in s. 600.03 (28g).

(c) "Individual health policy" means an insurance policy or a partially or wholly uninsured plan or program, that provides hospital, medical or other health coverage to an individual on an individual basis and not as a member of a group, whether or not dependents of the individual are also covered. The term includes a medicare supplement policy, as defined in s. 600.03 (28r), but does not include a medicare replacement policy, as defined in s. 600.03 (28p), or a long-term care insurance policy, as defined in s. 600.03 (28g).

(d) "Medicare" means coverage under part A, part B, or part D of Title XVIII of the federal Social Security Act, 42 USC 1395 to 1395hhh.

(e) "Residence" means the concurrence of physical presence with intent to remain in a place of fixed habitation. Physical presence is prima facie evidence of intent to remain.

(2) **SUBSIDY PROGRAM.** From the appropriation account under s. 20.435 (1) (am), the department shall distribute funding in each fiscal year to subsidize the premium costs under s. 252.17 (2) and, under this subsection, the premium costs for health insurance coverage available to an individual who has HIV infection and who is unable to continue his or her employment or must reduce his or her hours because of an illness or medical condition arising from or related to HIV infection.

(3) **ELIGIBILITY.** An individual is eligible to receive a subsidy in an amount determined under sub. (4), if the department determines that the individual meets all of the following criteria:

(a) Has residence in this state.

(b) Has a family income, as defined by rule under sub. (6), that does not exceed 300 percent of the federal poverty line, as defined under 42 USC 9902 (2), for a family the size of the individual's family.

(c) Has submitted to the department a certification from a physician, as defined in s. 448.01 (5), physician assistant, or advanced practice nurse prescriber of all of the following:

1. That the individual has an infection that is an HIV infection.
2. That the individual's employment has terminated or his or her hours have been reduced, because of an illness or medical condition arising from or related to the individual's HIV infection.

(dm) Has, or is eligible for, health insurance coverage under a group health plan or an individual health policy.

(e) Authorizes the department, in writing, to do all of the following:

1. Contact the individual's employer or former employer or health insurer to verify the individual's eligibility for coverage under the group health plan or individual health policy and the premium and any other conditions of coverage, to make premium payments as provided in sub. (4) and for other purposes related to the administration of this section.

1m. Contact the individual's employer or former employer to verify that the individual's employment has been terminated or that his or her hours have been reduced and for other purposes related to the administration of this section.

2. Make any necessary disclosure to the individual's employer or former employer or health insurer regarding the individual's HIV status.

(4) **AMOUNT AND PERIOD OF SUBSIDY.** (a) Except as provided in pars. (b) and (d), if an individual satisfies sub. (3), the department shall pay the full amount of each premium payment for the individual's health insurance coverage under the group health plan or individual health policy under sub. (3) (dm), on or after the date on which the individual becomes eligible for a subsidy under sub. (3). Except as provided in pars. (b) and (d), the department shall pay the full amount of each premium payment regardless of whether the individual's health insurance coverage under sub. (3) (dm) includes coverage of the individual's dependents. Except as provided in par. (b), the department shall terminate the payments under this section when the individual's health insurance coverage ceases or when the individual no longer satisfies sub. (3), whichever occurs first. The department may not make payments under this section for premiums for medicare, except for premiums for coverage for part D of Title XVIII of the federal Social Security Act, 42 USC 1395 to 1395hhh.

(b) The obligation of the department to make payments under this section is subject to the availability of funds in the appropriation account under s. 20.435 (1) (am).

(d) For an individual who satisfies sub. (3) and who has a family income, as defined by rule under sub. (6) (a), that exceeds 200 percent but does not exceed 300 percent of the federal poverty line, as defined under 42 USC 9902 (2), for a family the size of the individual's family, the department shall pay a portion of the amount of each premium payment for the individual's health insurance coverage. The portion that the department pays shall be determined according to a schedule established by the department

by rule under sub. (6) (c). The department shall pay the portion of the premium determined according to the schedule regardless of whether the individual's health insurance coverage under sub. (3) (dm) includes coverage of the individual's dependents.

(5) **APPLICATION PROCESS.** The department may establish, by rule, a procedure under which an individual who does not satisfy sub. (3) (b), (c) 2. or (dm) may submit to the department an application for a premium subsidy under this section that the department shall hold until the individual satisfies each requirement of sub. (3), if the department determines that the procedure will assist the department to make premium payments in a timely manner once the individual satisfies each requirement of sub. (3). If an application is submitted by an employed individual under a procedure established by rule under this subsection, the department may not contact the individual's employer or health insurer unless the individual authorizes the department, in writing, to make that contact and to make any necessary disclosure to the individual's employer or health insurer regarding the individual's HIV status.

(6) **RULES.** The department shall promulgate rules that do all of the following:

(a) Define family income for purposes of sub. (3) (b).

(b) Establish a procedure for making payments under this section that ensures that the payments are actually used to pay premiums for health insurance coverage available to individuals who satisfy sub. (3).

(c) Establish a premium contribution schedule for individuals who have a family income, as defined by rule under par. (a), that exceeds 200 percent but does not exceed 300 percent of the federal poverty line, as defined under 42 USC 9902 (2), for a family the size of the individual's family. In establishing the schedule under this paragraph, the department shall take into consideration both income level and family size.

History: 1989 a. 336; 1991 a. 269; 1993 a. 16 ss. 2587, 2588; 1993 a. 27 ss. 386 to 389; Stats. 1993 s. 252.16; 1993 a. 491; 1995 a. 27; 1997 a. 27; 2001 a. 38; 2005 a. 187; 2007 a. 20; 2009 a. 28; 2011 a. 161.

Cross-reference: See also ch. DHS 138, Wis. adm. code.

252.17 Medical leave premium subsidies. (1) **DEFINITIONS.** In this section:

(a) "Group health plan" has the meaning given in s. 252.16 (1) (b).

(d) "Medical leave" means medical leave under s. 103.10.

(e) "Residence" has the meaning given in s. 252.16 (1) (e).

(2) **SUBSIDY PROGRAM.** The department shall establish and administer a program to subsidize, as provided in s. 252.16 (2), the premium costs for coverage under a group health plan that are paid by an individual who has HIV infection and who is on unpaid medical leave from his or her employment because of an illness or medical condition arising from or related to HIV infection.

(3) **ELIGIBILITY.** An individual is eligible to receive a subsidy in an amount determined under sub. (4), if the department determines that the individual meets all of the following criteria:

(a) Has residence in this state.

(b) Has a family income, as defined by rule under sub. (6), that does not exceed 300 percent of the federal poverty line, as defined under 42 USC 9902 (2), for a family the size of the individual's family.

(c) Has submitted to the department a certification from a physician, as defined in s. 448.01 (5), physician assistant, or advanced practice nurse prescriber of all of the following:

1. That the individual has an infection that is an HIV infection.
2. That the individual is on unpaid medical leave from his or her employment because of an illness or medical condition arising from or related to the individual's HIV infection or because of medical treatment or supervision for such an illness or medical condition.

(d) Is covered under a group health plan through his or her employment and pays part or all of the premium for that coverage,

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including any premium for coverage of the individual's spouse or domestic partner under ch. 770 and dependents.

(e) Authorizes the department, in writing, to do all of the following:

1. Contact the individual's employer or the administrator of the group health plan under which the individual is covered, to verify the individual's medical leave, group health plan coverage and the premium and any other conditions of coverage, to make premium payments as provided in sub. (4) and for other purposes related to the administration of this section.

2. Make any necessary disclosure to the individual's employer or the administrator of the group health plan under which the individual is covered regarding the individual's HIV status.

(f) Is not covered by a group health plan other than any of the following:

1. The group health plan under par. (d).

2. A group health plan that offers a substantial reduction in covered health care services from the group health plan under subd. 1.

(g) Is not covered by an individual health insurance policy other than an individual health insurance policy that offers a substantial reduction in covered health care services from the group health plan under par. (d).

(h) Is not eligible for medicare under 42 USC 1395 to 1395zz.

(i) Does not have escrowed under s. 103.10 (9) (c) an amount sufficient to pay the individual's required contribution to his or her premium payments.

(4) AMOUNT AND PERIOD OF SUBSIDY. (a) Except as provided in pars. (b), (c), and (d), if an individual satisfies sub. (3), the department shall pay the amount of each premium payment for coverage under the group health plan under sub. (3) (d) that is due from the individual on or after the date on which the individual becomes eligible for a subsidy under sub. (3). The department may not refuse to pay the full amount of the individual's contribution to each premium payment because the coverage that is provided to the individual who satisfies sub. (3) includes coverage of the individual's spouse or domestic partner under ch. 770 and dependents. Except as provided in par. (b), the department shall terminate the payments under this section when the individual's unpaid medical leave ends, when the individual no longer satisfies sub. (3) or upon the expiration of 29 months after the unpaid medical leave began, whichever occurs first.

(b) The obligation of the department to make payments under this section is subject to the availability of funds in the appropriation account under s. 20.435 (1) (am).

(c) If an individual who satisfies sub. (3) has an amount escrowed under s. 103.10 (9) (c) that is insufficient to pay the individual's required contribution to his or her premium payments, the amount paid under par. (a) may not exceed the individual's required contribution for the duration of the payments under this section as determined under par. (a) minus the amount escrowed.

(d) For an individual who satisfies sub. (3) and who has a family income, as defined by rule under sub. (6) (a), that exceeds 200 percent but does not exceed 300 percent of the federal poverty line, as defined under 42 USC 9902 (2), for a family the size of the individual's family, the department shall pay a portion of the amount of each premium payment for the individual's coverage under the group health plan under sub. (3) (d). The portion that the department pays shall be determined according to a schedule established by the department by rule under sub. (6) (c). The department shall pay the portion of the premium determined according to the schedule regardless of whether the individual's coverage under the group health plan under sub. (3) (d) includes coverage of the individual's spouse or domestic partner under ch. 770 and dependents.

(5) APPLICATION PROCESS. The department may establish, by rule, a procedure under which an individual who does not satisfy

sub. (3) (b) or (c) 2. may submit to the department an application for a premium subsidy under this section that the department shall hold until the individual satisfies each requirement of sub. (3), if the department determines that the procedure will assist the department to make premium payments in a timely manner once the individual satisfies each requirement of sub. (3). If an application is submitted by an individual under a procedure established by rule under this subsection, the department may not contact the individual's employer or the administrator of the group health plan under which the individual is covered, unless the individual authorizes the department, in writing, to make that contact and to make any necessary disclosure to the individual's employer or the administrator of the group health plan under which the individual is covered regarding the individual's HIV status.

(6) RULES. The department shall promulgate rules that do all of the following:

(a) Define family income for purposes of sub. (3) (b).

(b) Establish a procedure for making payments under this section that ensures that the payments are actually used to pay premiums for group health plan coverage available to individuals who satisfy sub. (3).

(c) Establish a premium contribution schedule for individuals who have a family income, as defined by rule under par. (a), that exceeds 200 percent but does not exceed 300 percent of the federal poverty line, as defined under 42 USC 9902 (2), for a family the size of the individual's family. In establishing the schedule under this paragraph, the department shall take into consideration both income level and family size.

History: 1991 a. 269; 1993 a. 16 ss. 2589, 2590; 1993 a. 27 ss. 390 to 394; Stats. 1993 s. 252.17; 1993 a. 491; 1997 a. 27; 1999 a. 103; 2005 a. 187; 2009 a. 28; 2011 a. 161.

Cross-reference: See also ch. DHS 138, Wis. adm. code.

252.185 Communicable disease control and prevention.

(1) From the appropriation under s. 20.435 (1) (cf), the department shall distribute moneys to local health departments to use for disease surveillance, contact tracing, staff development and training, improving communication among health care professionals, public education and outreach, and other infection control measures as required under this chapter. The department shall consider the following factors to establish an equitable allocation formula for the distribution of moneys under this section:

(a) Base allocation, including at least some base amount for each local health department.

(b) General population.

(c) Target populations.

(d) Risk factors.

(e) Geographic area, including consideration of the size of the service area or the density of population, or both.

(2) By January 1, 2019, and biennially thereafter, each local health department shall submit to the division of the department that addresses public health issues a financial statement of its use of funds under this section.

History: 2017 a. 59.

252.19 Communicable diseases; suspected cases; protection of public.

No person who is knowingly infected with a communicable disease may willfully violate the recommendations of the local health officer or subject others to danger of contracting the disease. No person may knowingly and willfully take, aid in taking, advise or cause to be taken, a person who is infected or is suspected of being infected with a communicable disease into any public place or conveyance where the infected person would expose any other person to danger of contracting the disease.

History: 1981 c. 291; 1993 a. 27 s. 299; Stats. 1993 s. 252.19.

252.21 Communicable diseases; schools; duties of teachers, parents, officers.

(1) If a teacher, school nurse, or principal of any school or child care center knows or suspects that

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a communicable disease is present in the school or center, he or she shall at once notify the local health officer.

(6) Any teacher, school nurse or principal may send home pupils who are suspected of having a communicable disease or any other disease the department specifies by rule. Any teacher, school nurse or principal who sends a pupil home shall immediately notify the parents of the pupil of the action and the reasons for the action. A teacher who sends a pupil home shall also notify the principal of the action and the reasons for the action.

History: 1981 c. 291; 1993 a. 27 s. 301; Stats. 1993 s. 252.21; 2009 a. 185.

252.25 Violation of law relating to health. Any person who willfully violates or obstructs the execution of any state statute or rule, county, city or village ordinance or departmental order under this chapter and relating to the public health, for which no other penalty is prescribed, shall be imprisoned for not more than 30 days or fined not more than \$500 or both.

History: 1981 c. 291; 1993 a. 27 s. 300; Stats. 1993 s. 252.25.

This section requires that a departmental order be promulgated using the procedure established by the legislature for rulemaking if criminal penalties are to follow. *Wisconsin Legislature v. Palm*, 2020 WI 42, 391 Wis. 2d 497, 942 N.W.2d 900, 20–0765.



WR WAHLDAB

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1

Protecting and promoting the health and safety of the people of Wisconsin

Focus Areas of Presentation

- Board of Health Requirements
- Requirements of Local Health Departments
- Framework for DHS 140 Reviews
- Types of Local Health Departments

2

Protecting and promoting the health and safety of the people of Wisconsin

Wisconsin Public Health Authorities

The **Department of Health Services** is the lead agency for public health and maintains the public health system.

Local boards of health are the policymaking bodies for local health departments.

Local health departments are responsible for the public health services in their jurisdictions.



3

Protecting and promoting the health and safety of the people of Wisconsin

Board of Health Requirements

- Logistical
 - Membership
 - Meetings
- Roles
 - Assurance
 - Assess and Advocate
 - Develop Policy & Provide Leadership

4

Protecting and promoting the health and safety of the people of Wisconsin

Local Health Departments

- Level I
 - Focus on the public health core functions
 - Must be $\geq$ Level I
- Level II
 - Focus on organizational performance and capacity-building
- Level III
 - Focus on supporting LHD role as health strategists within their communities

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Required Services All Local Health Departments

- Surveillance and investigation
- Communicable disease control
- Other disease prevention
- Emergency preparedness and response
- Health promotion
- Human health hazard control
- Policy and planning
- Leadership and organizational competencies
- Generalized public health nursing services

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Additional Required Services Level II

- **Focus on organizational performance and capacity-building.**
 - Organizational Performance
 - Performance management
 - Quality improvement
 - Workforce development
 - Capacity building

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Additional Required Services Level III

- **Focus on supporting LHD role as health strategists within their communities.**
 - Be community health strategist
 - Provide Population Health Expertise
 - Provide an environmental health program (DATCAP agent status not required)
 - Address social determinants of health

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Framework for DHS 140 Reviews

- Notification
- Five required “documents”
- Prep time dependent on LHD approach
- Question based in-person review (3 hours)
- Report
- Certification

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Types of Health Departments

Jurisdictional

- City
- County
- Multi-city
- Multi-county
- City-county

Departmental

- Public health stand-alone
- Health and human services combined

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Resources

- The Board of Health statute [Wis. Stat. § 251.03 and 04](#).
- The [Wisconsin Admin. Code ch. DHS 140](#): LHD rule requirements
- DHS 140 2019 Requirement Updates ([DHS Website](#))
- 10 Essential Public Health Services ([CDC webpage](#))
- Foundational Public Health Services model ([PHNCI webpage](#))
- DHS 140 Discussion Questions

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Protecting and promoting the health and safety of the people of Wisconsin

DIVISION OF PUBLIC HEALTH

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Scott Walker
Governor



State of Wisconsin
Department of Health Services

Linda Seemeyer
Secretary

Telephone: 608-266-1251
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TTY: 711 or 800-947-3529

October 19, 2017

Lawrence J. Willkom
7712 178th Street
Chippewa Falls, WI 54729

Dear Mr. Willkom:

The Department of Health Services (DHS) congratulates the Chippewa County Department of Public Health for demonstrating the infrastructure and program capacity to be certified as a Level III Health Department. As authorized by state statute and defined in Administrative Rule DHS Chapter 140.07, the department shall direct a process to determine compliance with state statutes and establish the level of services being provided. The Chippewa County Department of Public Health presented to DHS evidence of providing 14 programs or services which address at least 7 focus areas identified in the state health plan: *Healthiest Wisconsin 2020: Everyone Living Better, Longer*. Formulas used by DHS to distribute grant funds provide for additional funds to Level III Health Departments.

I am happy to report the Chippewa County Department of Public Health provided all services required by statute and rule.

I want to acknowledge the work of the Chippewa County Department of Public Health staff. Angie Weideman, Health Officer, did an excellent job of providing quality evidence of meeting statutes and rules. I also appreciate the support of the Chippewa County Board of Health for maintaining a strong public health department. I am sure that with ongoing support, the Chippewa County Department of Public Health will continue to protect and promote the health of the people in your jurisdiction.

Sincerely,

Karen McKeown, RN, MSN
State Health Officer and Administrator

cc: Angela Weideman, Chippewa County Health Officer
Anson Albarado, Chippewa County Board Chair
Frank Pascarella, Chippewa County Administrator
Tim Ringhand, DPH Western Regional Director

Chapter DHS 140

REQUIRED SERVICES OF LOCAL HEALTH DEPARTMENTS

DHS 140.01 Authority and purpose.
 DHS 140.03 Definitions.
 DHS 140.04 Level I local health department.
 DHS 140.05 Level II local health department.

DHS 140.06 Level III local health department.
 DHS 140.07 Local health officer qualifications.
 DHS 140.08 Local health department level designation.

Note: Chapter HFS 140 was renumbered chapter DHS 140 under s. 13.92 (4) (b) 1., Stats., and corrections made under s. 13.92 (4) (b) 7., Stats., [Register January 2009 No. 637](#).

DHS 140.01 Authority and purpose. This chapter is promulgated under the authority of s. 251.20, Stats., which directs the department to specify by rule required services for each of 3 levels of local health departments. Under s. 251.05 (2), Stats., all local health departments are to provide at least level I services, while level II and level III local health departments are to provide additional services.

History: Cr. [Register, July, 1998, No. 511](#), eff. 8–1–98.

DHS 140.03 Definitions. In this chapter:

(1) “Community health assessment” means the regular, systematic collection, assembly, analysis and dissemination of information on the health of the community.

(1m) “Community health improvement plan” means the written plan developed by a local health department with the involvement of key policy makers and the general public to implement the services and functions specified under s. 250.03 (1) (L), Stats., pursuant to s. 251.05 (3) (c), Stats., and the requirements of this chapter.

(2) “Department” means the Wisconsin department of health services.

(3) “Environmental health program” means the assessment, management, control and prevention of environmental factors that may adversely affect the health, comfort, safety or well-being of individuals within the jurisdiction of the local health department by individuals qualified under s. 440.98, Stats., and ch. [DHS 139](#).

(4) “Epidemiological investigation” means the systematic examination and detailed inquiry into the circumstances and causal factors associated with a given disease or injury.

(5) “General public health nursing program” means the organization and delivery of public health nursing services by public health nurses qualified under s. 250.06 (1), Stats., and s. [DHS 139.08](#) to individuals within the jurisdiction of the local health department.

(6) “Health promotion” means programs and services that increase the public understanding of health, assist in the development of more positive health practices and enhance or maintain the health of the community as a whole.

(7) “Human health hazard” means a substance, activity or condition that is known to have the potential to cause acute or chronic illness or death if exposure to the substance, activity or condition is not abated or removed.

(8) “Local health department” means an agency of local government that has any of the forms specified in s. 250.01 (4), Stats.

(9) “Local health officer” means the person in charge of a local health department who meets the qualifications and is responsible for carrying out the duties established under s. 251.06, Stats.

(10) “Other disease prevention” means programs and services that reduce the risk of disease, disability, injury or premature death

caused by such factors as risky behaviors, poor health practices or environmental agents of disease.

(11) “Public health system” means organized community efforts aimed at the prevention of disease and the promotion and protection of health, including activities of public and private agencies and voluntary organizations and individuals.

(12) “State health officer” means the individual appointed under s. 250.02 (1), Stats., by the secretary of the department to develop public health policy for the state and direct state public health programs.

(13) “Surveillance” means the ongoing systematic collection, analysis, and interpretation of data concerning disease, injuries or human health hazards, and the timely dissemination of these data to persons responsible for preventing and controlling disease or injury and others who need to know.

History: Cr. [Register, July, 1998, No. 511](#), eff. 8–1–98; corrections in (2), (3) and (5) made under s. 13.92 (4) (b) 6. and 7., Stats., [Register January 2009 No. 637](#); [CR 18–014](#); cr. (1m) [Register June 2019 No. 762](#), eff. 7–1–19; correction in (1m) made under s. 35.17, Stats., [Register June 2019 No. 762](#).

DHS 140.04 Level I local health department.

(1) **REQUIRED SERVICES.** A level I local health department shall provide leadership for developing and maintaining the public health system within its jurisdiction by conducting all of the following:

(a) *Surveillance and investigation.* 1. Collect and analyze public health data to do all of the following:

- a. Identify health problems, environmental public health hazards, and social and economic risks that affect the public’s health.
- b. Guide public health planning and decision-making at the local level.

c. Develop recommendations regarding public health policy, processes, programs, or interventions, including the community health improvement plan.

2. Conduct timely investigations of health problems and environmental public health hazards in coordination with other governmental agencies and stakeholders.

3. Establish written protocols for obtaining laboratory services at all times.

(b) *Communicable disease control.* 1. Conduct activities required of local health departments under ch. [DHS 144](#), relating to immunization of students.

2. Comply with the requirements of ch. [DHS 145](#), relating to prevention, monitoring, conducting epidemiological investigations, and control of communicable diseases, including outbreaks.

3. Improve public recognition and awareness of communicable diseases and other illnesses of public health importance.

4. Provide or facilitate community-based initiatives to prevent communicable diseases.

(c) *Other disease prevention.* 1. Develop and implement interventions intended to reduce the incidence, prevalence or onset of chronic diseases or to prevent or ameliorate injuries that are the leading causes of disability and premature death in the local health department’s jurisdiction, as identified in the community health assessment or the most recent state public health agenda.

2. Link individuals to needed personal health services.
3. Identify and implement strategies to improve access to health services.

(d) *Emergency preparedness and response.* 1. Participate in the development of response strategies and plans in accordance with local, state, and national guidelines to address public health emergencies as defined in s. 323.02 (16), Stats.

2. Participate in public health preparedness exercises.
3. Communicate and coordinate with health care providers, emergency service providers, and other agencies and organizations that respond to a disaster, outbreak or emergency.
4. Define the role of public health personnel in responding to a disaster, outbreak, or emergency, and activate these personnel during any such occurrence.
5. Maintain and execute an agency plan for providing continuity of operations during a disaster, outbreak, or emergency, including a plan for accessing resources necessary for response or recovery.
6. Issue and enforce emergency health orders, as permitted by law.
7. Establish processes to ensure the local health department is immediately notified of an actual or potential disaster, outbreak, or emergency.

8. Implement strategies intended to protect the health of vulnerable populations during a disaster, outbreak, or emergency.

(e) *Health promotion.* 1. Develop and implement interventions, policies, and systems to promote practices that support positive public health outcomes and resilient communities.

2. Disseminate relevant, accurate information and evidence-informed prevention guidance to the public health system and community.
3. Use a variety of accessible, transparent, and inclusive methods of communication to convey and to receive information from the public and stakeholders.
4. Provide accurate, timely, and understandable information, recommendations, and instructions to the public during a disaster, outbreak, or emergency.

(f) *Human health hazard control.* 1. Assist in the conduct of activities authorized under ss. 251.06 (3) (f) and 254.59, Stats.

2. Declare dilapidated, unsafe or unsanitary housing to be a human health hazard, when permitted under s. 254.593, Stats.
3. Identify public health hazards through laboratory testing, inspections, reporting, and investigation for the purpose of preventing further incidence of occupational disease, environmental disease, and human health hazard exposure.

(g) *Policy and planning.* 1. Coordinate planning and serve as a source of information and expertise in the development and implementation of policies affecting public health.

2. Foster and support community involvement and partnerships in development, adoption, and implementation of policies affecting public health, including engagement of diverse populations and consideration of adversely impacted populations.

3. Conduct a community health assessment resulting in a community health improvement plan at least every 5 years.

4. Develop a written community health improvement plan at least every 5 years, by assessing applicable data, developing measurable health objectives, and partnering with persons, agencies, and organizations to cultivate community ownership throughout the entire development and implementation of the plan.

5. Engage members of the community in assessment, implementation, monitoring, evaluation, and modification of community health planning.

6. Promote land use planning and sustainable development activities to create positive health outcomes.

(h) *Leadership and organizational competencies.* 1. Establish and sustain relationships with governmental and nongovernmental partners and stakeholders.

2. Engage stakeholders in the development and implementation of the local health department's organizational goals.

3. Use principles of public health law, including local and state laws, in the planning, implementation, and enforcement of public health initiatives.

4. Promote and monitor progress towards achieving organizational goals, objectives identified in community health improvement plan, and identifying areas for improvement.

5. Implement processes within public health programs that create health equity.

6. Maintain a competent and diverse workforce intended to ensure the effective and equitable provision of public health services.

7. Provide continuing education and other training opportunities necessary to maintain a competent workforce.

8. Implement and maintain the technology needed to support public health operations while simultaneously protecting personally identifiable information and other confidential health information, pursuant to ss. 19.21 and 146.82, Stats.

(i) *Public health nursing services.* Conduct a general public health nursing program which shall apply nursing and public health principles to collaboratively assess, develop, implement, and evaluate the services required in pars. (a) to (h), in cooperation with the local board of health.

(2) **ANNUAL REPORTING.** A level I local health department shall submit the following to the department:

(a) By May 1, a copy of the annual report submitted by the local health officer during the previous year, as required by s. 251.06 (3) (h), Stats.

(b) Public health data, in a format prescribed by the department.

Note: Reports and data described in this section must be submitted to the regional office assigned to the local health department's jurisdiction. Information about regional offices may be obtained by accessing: <https://www.dhs.wisconsin.gov/dph/regions.htm>.

(3) **OPTIONAL SERVICES.** A level I local health department may provide any services, in addition to the services required under sub. (1), that a level II local health department is required to provide under s. DHS 140.05 or a level III local health department is required to provide under s. DHS 140.06.

History: Cr. Register, July, 1998, No. 511, eff. 8/2/98; corrections in (1) (b) made under s. 13.92 (4) (b) 7., Stats., Register January 2009 No. 637; CR 18-014: r. and recr. Register June 2019 No. 762, eff. 7-1-19; correction in (1) (f) 1. made under s. 35.17, Stats., Register June 2019 No. 762.

DHS 140.05 Level II local health department.

(1) **REQUIRED SERVICES.** In addition to the level I local health department required services described in s. DHS 140.04, a level II local health department shall do all of the following:

(a) Address communicable disease control, chronic disease and injury prevention, environmental public health, family health, and access and linkage to health services, in addition to services already provided under s. DHS 140.04, by doing all of the following:

1. Identifying and promoting either a community need that has not already been selected as a local priority by the local health department in its most recent community health improvement plan or an objective specified in the department of health services' most recent state public health agenda, developed pursuant to s. 250.07, Stats.

2. Providing support to implement services through leadership, resources, and engagement of the public health system.

3. Utilizing evidence-informed resources and practices to provide services.

4. Evaluating the additional services and reporting to the community and local board of health on progress and performance.

(b) Develop and maintain a plan to employ qualified public health professionals and assure a competent public health workforce by doing all of the following:

1. Including core public health competencies and credentialing requirements in all department job descriptions, unless prohibited by local governing body.

2. Assessing staff core public health competencies every 2 years to identify department training needs.

3. Completing annual performance evaluations and personal development plans, unless prohibited by local governing body.

(c) Conduct quality improvement.

(d) Provide training and resources related to quality improvement to local health department staff and the local governing body.

(e) Establish explicit organizational performance measures for the local health department's mission, vision, values, and strategic goals.

(f) Apply nursing and public health principles to collaboratively assess, develop, implement, and evaluate the services required under pars. (a) to (e).

(2) **OPTIONAL SERVICES.** A level II local health department may provide any services, in addition to the services required under sub. (1), that a level III local health department is required to provide under s. DHS 140.06.

History: Cr. Register, July, 1998, No. 511, eff. 8-1-98; CR 18-014: r. and recr. Register June 2019 No. 762, eff. 7-1-19; correction in (1) (a) 1., (b) 2. made under s. 35.17, Stats., Register June 2019 No. 762; correction in (1) (f) made under s. 13.92 (4) (b) 7., Stats., Register June 2019 No. 762.

DHS 140.06 Level III local health department. In addition to the level I local health department required services described in s. DHS 140.04 and to the level II local health department required services described in s. DHS 140.05, a level III local health department shall do all of the following:

(1) Lead the collection of data to guide public health planning and decision-making at the local level in alignment with the most recent state public health agenda.

(2) Provide public health expertise within the jurisdiction to elected officials, stakeholders, and community partners, including data and research.

(3) Identify and address factors impacting population health by implementing evidence-informed and emerging practices.

(4) Develop, advocate, adopt, and implement policies or strategies to improve the physical, environmental, social, and economic conditions affecting health.

(5) Establish and implement an environmental health program as directed by the local board of health or other local governing body by doing all of the following:

(a) Participating and providing environmental health expertise in the development of community plans.

(b) Providing or arranging for the availability of services authorized under ch. 254, Stats., such as for toxic substances, indoor air quality, animal borne or vector borne disease, and human health hazards.

(c) Collecting, reviewing, and analyzing environmental and community health data, and managing, controlling, and preventing environmental factors that may adversely affect the health, safety, or well-being of individuals or the community.

(d) Implement agreements established with state agencies to provide or arrange for environmental health services.

(e) Administering regulations of the board of health or other local governing body.

(6) Provide or arrange for other services that the local health department determines appropriately address objectives or services in the most recent state public health agenda.

(7) Develop and implement methods to collect performance data, evaluate goals, conduct quality improvement, and report progress to advise organizational decisions.

(8) Develop and implement a plan that integrates quality improvement at the individual, team, and organization levels.

(9) Apply nursing and public health principles to collaboratively assess, develop, implement, and evaluate the services required under subs. (1) to (8).

History: Cr. Register, July, 1998, No. 511, eff. 8-1-98; corrections in (1) (c) and (d) made under s. 13.92 (4) (b) 7., Stats., Register January 2009 No. 637; (1) (d) renun. to SPS 221.065 under s. 13.92 (4) (b) 1., Stats., Register December 2015 No. 720; CR 18-014: r. and recr. Register June 2019 No. 762, eff. 7-1-19; correction made under s. 13.92 (4) (b) 1., Stats., Register June 2019 No. 762; correction in (9) made under s. 13.92 (4) (b) 1., Stats., Register June 2019 No. 762.

DHS 140.07 Local health officer qualifications.

(1) **DEFINITION.** In this section, "similar field" means a field of academic study, or combination of graduate-level courses that the state health officer determines provides the knowledge and skills required to adequately meet the responsibilities of a level I, II, or III local health officer.

(2) **LEVEL I.** A local health officer of a level I local health department shall meet the requirements stated in s. 251.06 (1) (a), Stats., or shall obtain approval in writing from the state health officer indicating that the individual has met the requirements of s. 251.06 (1) (d), Stats.

(3) **LEVEL II.** A local health officer of a level II local health department shall meet the requirements stated in s. 251.06 (1) (b), Stats., or shall obtain approval in writing from the state health officer indicating that the individual has met the requirements of s. 251.06 (1) (d), Stats.

(4) **LEVEL III.** Pursuant to ss. 251.06 (1) (c) and (d), Stats., a level III local health officer shall have any of the following qualifications:

(a) At least 3 years of experience in a full-time administrative position in either a public health agency or public health work and one of the following:

1. A master's degree in public health, public administration, or health administration.

2. Approval in writing from the state health officer indicating that the individual has submitted adequate documentation to demonstrate possession of a master's degree in a similar field.

(b) A bachelor's degree, 5 years of experience in a full-time administrative position in either a public health agency or public health work, and one of the following:

1. At least 16 graduate semester credits towards a master's degree in public health, public administration, or health administration.

2. Approval in writing from the state health officer indicating that the individual has submitted adequate documentation to demonstrate possession of 16 graduate semester credits towards a master's degree in a similar field.

(c) A license to practice medicine and surgery under ch. 448, Stats., and at least one of the following:

1. Three years of experience in a full-time administrative position in either a public health agency or public health work.

2. Eligibility for certification by the American board of preventive medicine in public health or general preventive medicine.

3. A master's degree in public health, public administration, or health administration.

4. Approval in writing from the state health officer indicating that the individual has submitted adequate documentation to demonstrate possession of a master's degree in a similar field.

History: Cr. Register, July, 1998, No. 511, eff. 8-1-98; CR 18-014: r. and recr. Register June 2019 No. 762, eff. 7-1-19; correction in (1) made under s. 13.92

(4) (b) 1., Stats., Register June 2019 No. 762; correction in (1), (4) (c) 3. made under s. 35.17, Stats., Register June 2019 No. 762.

DHS 140.08 Local health department level designation. The department shall review the operations of each local health department at least every 5 years, and based on this review, the state health officer shall issue a written finding as to whether the local health department satisfies the requirements for a level

I, II, or III local health department. In the alternative, the state health officer may determine that the operations of a local health department satisfy the requirements for a level I, II, or III local health department based on a national accreditation process that fulfills the requirements specified under ch. 251, Stats., and this chapter.

History: CR 18-014: cr. Register June 2019 No. 762, eff. 7-1-19; correction made under s. 13.92 (4) (b) 1., Stats., Register June 2019 No. 762.