



PRIVATE/PUBLIC COMMUNITY CASE MANAGEMENT PROJECT

A demonstration project of: Crow Wing County Public Health, Essentia Health, Cuyuna Regional Medical Center, Lakewood Health System

Abstract

Putting health at the heart of services to high-resource users: By bringing all the partners to the table, we are better able to treat the root problem.

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Public/Private Community Case Management Model (P/PCCMM)

The Problem ...

“Families often come to us as a whole unit. But our county/community health/social service system often dissects them into little pieces and a result is that we are not effective in helping them move up and out of poverty.

We at Crow Wing County need to better coordinate our work within and outside of the county system. We need to work with the whole family and improve our outcomes with these families. We also believe, that by working with the whole family and across systems that we can improve outcomes at a reduced cost.

Let me give you any example. We identified a family that had been spiraling out of control. We learned (from a comprehensive, community case management session where all county providers were in the same room at the same time discussing this case) that the father had recently quit his job to care for his children. We further learned from Essentia Health (with a signed release) that between May 29, 2012 and December 1, 2012 the mother had visited the Emergency Department (ED) 19 times for migraines. The aggregate report for MA use on each family member was received from our Income Maintenance department which prompted us to dig deeper into why the mom’s spending was so much higher.

By bringing all the partners to the table we are better able to treat the root problem. We have helped with the mother’s health issues and helped stabilize the family. The result is that the mother is no longer using the ED as her primary care service, the family has become more stabilized, and the father is looking to return to work.” *Tim Houle, Crow Wing County Administrator*

The Solution: Community Case Management ...

The Public/Private Community Case Management Model is one where all systems (within the county and outside of the county) come together to coordinate care with the goal to:

**Assist families and individuals in gaining stability
& self-sufficiency in Crow Wing County**

Similar efforts have led to significant outcomes:

Frogtown Family Connection. One of the areas the evaluators saw as a key value of the program was that it served clients at the very beginning of their MFIP experience. In many states if a family does not show up for their first meeting they are removed from NANF because they failed to comply with the rules. Case files from Frogtown Family Connections documented that the families that failed to come in for the overview were often overwhelmed, in the depths of despair, struggling with severe mental illness. If the goal of public assistance is ultimately to help families, then taking away resources at a time of crisis seems contradictory to the public goal to provide “temporary assistance to needy families.”

Outcome data show cases where support, and at times very limited support, made a family fully successful. In at least two cases the support from Frogtown Family Connections and the leverage of MFIP and resources from The Saint Paul Foundation Community Sharing Fund made the difference in helping stabilize housing. Both these families are not only “Off Welfare” – off cash assistance – but no longer need help with child care or medical assistance because they are fully employed in living-wage jobs with benefits. An analysis of the savings to Ramsey County showed that the Frogtown Family Connections program saved the county over \$1,730,825 through the fully stabilization of 12 at-risk families.

The program revealed previously unknown issues for some families on welfare. As only one of many examples, an administrator talked about a family with whom the MFIP Job Counselors had worked for some time. They missed an overview and so were referred to Frogtown Family Connections. The Home Visitors uncovered issues of severe mental illness, chemical dependency and domestic violence.¹

Community Action Minneapolis. The evidence from interviews, case file reviews, and a follow-up survey indicate that this is an effective program. In our 25 years of studying anti-poverty programs it is only the second one where we have seen such a strong model, carefully crafted, with program staff able to reach and support those moving out of poverty. It has challenges to continuing viability. Recruitment in the past two years is its weakest link. There is pressure to change the program to decrease its standards regarding recruitment and graduation – pressures we believe need to be resisted. It appears, however, that there are cost savings from the CA Mpls Self-Sufficiency Model. It appears to be working with a population most likely to fail in other programs. It engages families in taking on the hard work needed to move up and out of poverty. Others can learn much from this program.

Potential Savings Outweigh Costs. Given the specific situations of the 24 graduates of the CA Mpls program, the cost savings of federal, state, and county resources, after the investment in the CA Mpls Self-Sufficiency Program, could be nearly one million dollars and much higher if government administrative costs were included in the costs for foster care.²

¹ Dr. Stacey Stockdill, Rebecca Anderson, MA, LP; Dr. MaryJo Smith; & Marlene Stoehr, MS. (March 2003). *Final Evaluation Report Regarding: Frogtown Family Connections Program*. Funding for the Frogtown Family Connections and this evaluation provided by grants to Lifetrack Resources from The McKnight Foundation, F.R. Bigelow Foundation, Ecolab Foundation, John S. and James L. Knight Foundation, The Saint Paul Foundation, The Sheltering Arms Foundation, and 3M Foundation.

² Dr. Stacey Stockdill with Dr. Elizabeth Peterson. (2009). *Community Action of Minneapolis: Case Study of their Self-Sufficiency Program*.

Cost Savings from CA Mpls Program		
	Low	High
MFIP	\$1,130,400	\$1,130,400
Incarceration	\$90,000	\$135,000
Mandated Drug Treatment	\$122,103	\$225,000
Foster Care	\$43,800	\$83,856
	\$1,386,303.00	\$1,574,256.00
Less Cost of Program	\$540,000	\$600,000
Savings	\$846,303	\$974,256

However, these programs no longer exist? Why? Because they were dependent upon grant dollars.

Another lesson learned from the **Lifetrack Resources Advancement Plus Program** was that many high-risk families were in need of coordinated health and social services.

Barriers to Success³. Some of the most surprising results continue to come from the examination of disability and mental health data. In the 2004 Comparison Study:

- At least 33% (191 of the 578 trainees) had a learning disability.
- 17.6% (102) of the 578 trainees had a physical disability.
- 36.5% (211) were assessed as having mental illness.
- 25.6% (148) were caring for a disabled family member.
- 13.1% & 76) were caring for an ill/incapacitated family member.

The most startling statistics came when we examined if the MFIP participant had a disability and/or was taking care of a disabled family member. If trainees were counted only once, an unduplicated count, we found:

- 65.6% (379) had a learning disability, a physical disability, or mental illness and/or took care of a disabled family member.
- When the physical limitation and the care of a disabled, ill or incapacitated family member variables were added, the percentage rose to 73.5% (425). IN other words, 425 MIFP individuals included in the study had a learning disability, physical disability, physical limitation, mental health issue and/or took care of a disabled, ill, or incapacitated family member.

The severity of the disabilities can be illustrated with excerpts from selected case histories included in the 2002 report. Questions were raised regarding the degree to which cases such as these were unique. They were not unique. Examples from OT and TBI assessments as well as examples from the random samples drawn for the 2004 Comparison Study also show the severity of physical disabilities, learning disabilities, low IQ and mental illness.

³ Stockdill, S. PHD; Anderson, R., MA, LP; Smith, M., PHD; Stoehr, M., MS; Dean, S.; & Weakly, B. (2004). *2004 Comparison Study: An Evaluation that compares Outcomes for a Multi-Site Transitional Jobs Program with Random Samples of Participants in the Minnesota Family Investment Program (Minnesota's TANF Program)*. Funding for this evaluation provided by a grant to Lifetrack Resources by The Joyce Foundation.

Person D: "Diagnosis – borderline general intelligence. Full scale IQ 74, with related weaknesses in verbal academic and nonverbal domains; personality disorder with passive-aggressive, avoidance and self-defeating features, major depression with accompanying somatic problems, poor sleep hygiene, low energy level, pessimism, hopelessness.

Person I: "Diagnosis – posttraumatic stress disorder secondary to emotional and physical abuse."

Person N: "Psychologist report stated, 'Diagnosis – mild mental retardation, dependent personality type with vulnerable adult status.'

One of the values of having access to health professionals was that they were able to uncover barriers previously not picked up by MFIP or Advancement Plus staff. There are a number of examples – two show that PTSD and issues with diabetes management were not identified by the Financial Worker, Job Counselor, Training Specialist or Line Supervisor. They were referred to the Occupational Therapists because of poor attendance at the work site:

Trainee 1 – Outcome: Uncovered Past history of trauma and torture. To action to have medications evaluated.

Trainee 2 – Outcome: Educated trainee about diabetes management. Got trainee to use glucometer.

Another learning was that a number of trainees had Traumatic Brain Injuries. The case notes from the assessment for another Trainee illustrate why these often go undiagnosed.

Trainee 3 – My recommendation was to consider the possibility of obtaining a formal medical diagnosis of a TBI ... Her test scores fit in very well with an anoxic-type injury ... I have targeted memory specifically because functionally that is what affects [this trainee]. She has very good social pragmatic skills and communication skills. Without formal testing, I did see ... confrontational naming which ... means [difficulty in naming objects, readily retrieving the word for that object]. High frequency, low level. A vocabulary that would be expected for somebody with an eighth grade education. I also recommended a psychiatrist and neurology consultant, formal psychology testing as part of pursuing a formal TBI diagnosis...

And then the other piece of this puzzle is that she has recently been diagnosed with diabetes. Because her memory is so impaired she doesn't regularly check her blood sugar ... And she doesn't regularly take her insulin ... and then the ramifications of that are going to be further medical complications which cause her already to have a high absentee rate.

Nobody has identified these problems in all the time she has been on MFIP. She is a perfect example of somebody getting missed because her social skills are so strong ... [Staff were] completely surprised at how low her scores came out because to look at her and to talk with her you would never know. That is very common with a mild to moderate brain injury person.

The Lifetrack Resources Advancement Plus Program also revealed the value of engagement of Speech-Language Pathologists (SLPs) and Occupational Therapists – expertise only found within the health services area.

Value of SLP/OT Pilot. Advancement Plus staff have wanted to ensure that their trainees had access to and benefited from a variety of services. Since the beginning of the program, staff have continually sought ways to increase the likelihood that trainees would succeed.

One innovation has been the use of Speech-Language Pathologists (SLPs), who conduct Traumatic Brain Injury (TBI) Assessment, and Occupational Therapists (OTs). The preliminary data indicate that this strategy has had tangible benefits for trainees ...

Some within the MFIP population have undiagnosed medical conditions and Traumatic Brain Injuries. A brain injury may not be apparent when the individual has strong social skills or if it appears that the individual has a learning disability.

Many trainees can benefit from OT and TBI assessment services.

Trainees may not understand what an OT or SLP can offer and may resist cooperating.

Trusted program staff play a critical role in paving the way for trainees to benefit from OT or TBI assessment services.

Standardized OT assessments may not always be effective. Diagnosing a brain injury requires specialized assessment.⁴

A recent study in St. Paul, MN⁵ of food shelf customers – further substantiates the need for coordinated care and public/private health to be engaged with the community. The survey of all food shelf customers during a 3-week period yielded an 80% response rate. The learning regarding health/disability issues was discussed as follows.

Disability. Nearly half of the 1,274 survey respondents checked “yes” to the question, “Do you have a disability?” There were 132 (10.4%) who checked “yes” to the question “Are you caring for a disabled family member?”

- o 582 (45.7%) have a disability
- o 132 (10.4%) are caring for a disabled family member

When the data were examined to ensure no duplication, it was learned that 654 (51.3%) were disabled or caring for a disabled family member.

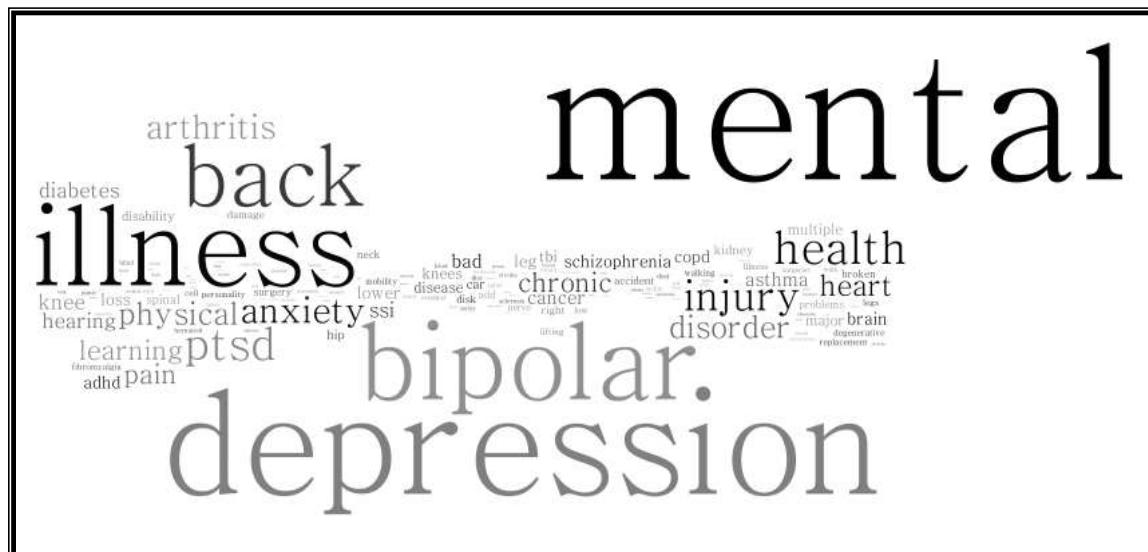
It is not possible to know for certain how many have had a professional “disability” diagnosis. Some clearly have, given the specificity in their response. In most cases, those who reported

⁴ Stockdill, S., PHD; Anderson, R., MA, LP; Smith, M., PHD; Stoehr, M., MS, & Dean, S. (2003). *Occupational Therapy in Transitional Jobs: Innovations to Improve Life Skills*. Program and Evaluation funded by the Joyce Foundation.

⁵ Stockdill, S. PHD; Naylor-Yarger, J., MEd, & Peterson, E., PHD. (2011). *EnSearch & Keystone Community Services Present: Voices of the Hungry*. Study and Report funded by the Greater Twin Cities United Way.

having a disability (582) gave very specific answers in response to the question, "If yes, what is your disability?" Many responses could be classified as follows: "PTSD" (Post Traumatic Stress Disorder), "TBI" (Traumatic Brain Injury), and "ADHD" (Attention Deficit Hyperactivity Disorder).

The frequency of these words is evident when using a Wordle™. This software program essentially counts the number of times a word appears. The words that appear most frequently then become the largest in the picture created. As can be seen, mental, depression, illness, bipolar, back, injury, anxiety, health, and ptsd are most visible because they were included most frequently in the written responses.



The Crow Wing County model where public/private health is engaged in a coordinated way may have significant-long term outcomes. What is needed is a model that uses existing public/private health/social service resources in a more efficient way. The Crow Wing County/Essential Public/Private Community Case Management Model – holds promise for better self-sufficiency/family-stability outcomes with a more efficient (thereby less costly) use of existing resources.

The Community Case Management Model (CCMM) ...

The Public/Private Community Case Management Model operates as follows:

1. HOW: How are we going to assist the family/individual gain stability and self-sufficiency? The first step is to complete a needs assessment:
 - a. Family/Individual Assessment of needs (including, but not limited to)
 - i. Transportation
 - ii. Daycare
 - iii. Health (Lakewood Medical Home model) (Book ‘What To Do When Your Child Gets Sick’)
 - a. Access to Provider & Meds
 - b. Reduce ER visits

- iv. Nutrition (knowledge of and implementation)
 - v. Mental Health status
 - a. Access to MH Provider & Meds
 - vi. Education (HS Diploma / GED / Job Skills)
 - vii. Employment/Marketable Skills (Central Lakes College Scholarships)
 - viii. Insurance (MA fall off risk)
2. WHO: Who is going to help the family/individual?
- a. Key Stakeholders - each family/individual will have a slightly different team depending on identified needs.
 - i. Representative from each unit of Crow Wing County Community Services
 - a. Public Health Nurse
 - b. Adult Mental Health social worker
 - c. Chemical Dependency social worker
 - d. Child Mental Health social worker
 - e. Child Protection social worker
 - f. Family Health Nurse
 - g. Daycare
 - h. Child Support worker
 - i. Income Maintenance
 - j. Veteran's Service Officer
 - k. RSVP representative
 - ii. Workforce Center
 - iii. Probation/Parole
 - iv. Crow Wing County Sheriff
 - v. Crow Wing County Jail
 - vi. Crow Wing County Attorney's office
 - vii. Lutheran Social Services
 - a. Housing
 - b. Family home budgeting
 - viii. Community volunteer/mentor
 - ix. Bridges of Hope
 - x. Transportation
 - xi. Central Lakes College
 - xii. Mental Health services
 - xiii. Daycare provider
 - xiv. Essentia Healthcare
 - xv. Cuyuna Regional Medical Center
 - xvi. Apartment Owners Group
 - xvii. Teen Challenge Treatment

3. TOP USERS: Candidates are ones we have classified as "Top users".

CCM- The transition from the RAP model to the Community Case Management model will start by selecting "top user" clients who have recently been incarcerated. We have selected clients from the "Top Users" list who meet this criterion. All have Central Minnesota Community Corrections (CMCC) listed as a program they are using as well as other programs such as Chemical Dependency, Child Protection & Mental Health as well as with or without children. This will also be a smoother transition for the team as they are familiar with developing a care plan for these types of clients from using the RAP model.

4. INDICATORS OF INSTABILITY: What we will learn from the assessment? We will identify the needs of the family or individual are and the variable(s) leading to instability. These might include:
 - a. Transportation- objective: Source of stable transportation
 1. Car
 2. Bike
 3. Walk
 4. Public transportation
 - a. Bus
 - b. Taxi
 - c. Dial-A-Ride
 - d. Employment taxi service
 - e. Car donation program
 - f. Georgia State model
 - g. RSVP driver with county fleet vehicle
 - h. Discount auto maintenance program
 - b. Daycare- objective: Source of stable daycare
 1. No need for daycare- pregnancy prevention
 2. Daycare provider listing
 - i. Waiting list
 2. Time trade (Parent-to-parent)
 3. RSVP as a provider?
 - c. Health- objective: Attain/Maintain health
 - a. Baseline of biological/psychological/social/spiritual health needs - Social determinants of health
 - a. Homelessness
 - b. No transportation
 - c. Jobless
 - b. Refer to appropriate provider immediate needs
 - c. Educate to prevent acute and chronic health issues
 - d. Establish primary care provider
 - e. Secure health insurance
 - f. Educate on appropriate utilization of health care resources
 - i. Emergency room visits
 - ii. Use the "When & Where" handout
5. RESULTS: Quarterly reports will be presented to the board and will include:
 - 1) Identify services used prior to CCM involvement
 - 2) Track services used after CCM begins
 - a. Unemployment
 - b. Housing
 - c. Number of child abuse / neglect reports
 - d. Child Protection interventions
 - e. Health status
 - 3) Compare cost of services provided in the previous period vs CCM pilot period
 - 4) Customer Survey data
 - 5) Indicators of success such as
 - a. Employment status
 - b. Education
 - c. Drug / Alcohol treatment
 - d. Mental Health treatment or counseling

Initial Results: Community Case Management Pilot Project Reports (November 2012 and February 2013) show the model holds promise ...

November 20, 2012. The first report to the Crow Wing County Board of Commissioners indicates that much has been accomplished in these first few months of operation. The report, submitted by Glen Olsen, RN, PHN, CCM Coordinator, on November 20, 2012 follows:

Following the decision by the Crow Wing County Board of Commissioners to proceed with the formation of our Community Case Management Pilot Project much has taken place. In the roughly 3 months since we met with the board we have moved forward as follows:

- 1) A team of county employees was assembled and meets weekly in the conference room of the Public Health Dept.
- 2) The role of the team is to refer those individuals or families which currently receive the greatest number of county services for consideration. Then these same families are reviewed by the team as a whole to determine who does what with and for these families.
- 3) Once this has been done the team collectively determines which county employee is in the best position to approach the family about participating in the CCM pilot project.
- 4) When a family voluntarily agrees to participate the role of the team is then to analyze the services currently being provided by the county and to seek ways to stabilize the family with fewer county services. A quantitative assessment and releases of information are then done. (At this time any of our county staff may do these assessments. But as we get a more comprehensive assessment in place it will require trained staff to complete them.) Wherever county resources such as health care facilities, or local schools, employers, or other non-profits are able to assist or even take over the family support role, the team actively pursues this concept.
- 5) Our stated goal is to work with up to 10 families in the first year. Thus far we have 4 families who have been referred. Two families have gone through the complete process. One of these two families has been reluctant to have yet another county worker enter their home and so there has been no involvement with the program other than what the current social worker is able to offer. The second family is highly motivated and has both met with and completed the quantitative assessment referred to in #4. The third family has had so much turmoil in their lives (as explained by their social worker) that they have been placed on the "back burner" until they gain a little more stability. And the fourth family is a very recent referral that requires a little more exploration before the team can discuss how to proceed.
- 6) In addition to the families we identify within our own organization, we also get referrals from our community partners as well as people who are problematic for their case workers. Of these we have worked with three people thus far and have another individual waiting to visit with us. These are people who need only a little assistance from the county at this time, or who the case worker believes would benefit from a review and possible referral to a community partner. By working with these people now we hope to

lessen the likelihood that they will need greater services in the future. For example, a referral from Essentia resulted simply in finding out the telephone number of the agency that determines when "Restricted MA" is appropriate. In this case, an individual that was misusing MA will be receiving more coordinated and comprehensive care. At the same time restricting the person's ability to jump from doctor to doctor to doctor should see a reduction in MA costs for the county. Another example was a referral from a local employer of an employee who we either assisted to find health insurance, or he would have to resign in order to obtain Medical Assistance. His situation is so severe that he will die without a specific, extremely expensive medication. This is a man in his early 20s who the employer would like to keep as a valued employee. If we are able to assist him he remains employed and self-sufficient. If we do nothing he becomes dependent on the state and county for all his needs.

- 7) From the outset we knew we wanted to work more closely with our community leaders. We want to build bridges and partnerships with as many businesses, organizations, schools, and other stakeholders as possible. It would have been impractical to approach every single employer, school, or other entity in the county to participate as community advisors to this pilot project. Therefore we selected what we believe is a representative sample of businesses as well as representatives from the hospitals, the college, the school district, etc. to participate. Meetings have been set up quarterly and the advisory team requested to meet a week prior to the Board of Commissioners meeting in the same month. This was done so that the advisory team could pass on information or suggestions to the commissioners. It is our hope that as we move forward some simple publicity, visits by myself (Glen) to other businesses, clinics, and schools, as well as word-of-mouth communication will get the message out that we are operational.

- 8) As part of the CCM pilot project we are trying to align ourselves with the upcoming restructuring of Community Services. Indications are that the proposed restructuring will mesh very nicely with our efforts to work more cohesively with one another within Community Services, as well as with our community partners. Specifically we see the concept of a central intake area as a key ingredient for better service and less duplication of work. To that end we are moving as quickly as possible to a comprehensive, quantitative assessment document. At this time the "Parent Survey" appears to be best suited to our needs. Using the Parent Survey will likely entail training up to 6 Community services staff people to perform the assessment in a way that ensures inter-rater reliability over time. This will be our baseline assessment that will become our tool to measure how well a family is doing prior to our involvement, and after our involvement. We have already learned that the Parent Survey works exceptionally well for parents, but not as well for single people without children. After conferring with colleagues in other counties we believe we may be able to use either our existing "Champ" assessment or the new Nightingale Notes assessment for people who do not easily fit the parameters of the parent Survey.

- 9) As a new program there has been varying degrees of "buy-in" from Community Services staff. As would be expected of any new program, some people will be ahead of the curve, wanting not only to participate but also to be able to lead where this program is going. While it is commendable that folks are eager to participate it is also a challenge to keep the participants moving in the same direction. Many people are still unsure how this new program does anything differently from what they are already doing, and so there is more of a "wait and see" attitude. I believe that by gently channeling the energy of the first group while giving the second group the time and space they need to see some positive

results for themselves will ultimately allow this pilot project to become a model for how we want to work in the future.

The February 14, 2013 report indicates continued success. The report, submitted by Glen Olsen, RN, PHN, CCM Coordinator, on February 14, 2013 follows:

Have our goals been met?

- Our goal was to see at least 10 families or clients in the first year who were identified as those using the greatest number of county services. We have worked with 7 clients in the first 6 months, although they were not the 7 most "costly" clients to the county.
- To date we have worked directly with 7 families or clients, and have indirectly worked with at least 4 others who were brought to our attention by various physicians or other health professionals in the community.
- We wanted to collaborate more closely with businesses and institutions in the county to make better use of tax dollars. This process has been started and has been favorably received by those entities we have contracted.
- We wanted to eliminate or minimize duplication of effort by establishing more open and regular communication among the various stakeholders. This has been started and we have had positive feedback from different sources.

Have our methods been successful?

- From the beginning, we wanted to identify the clients using the highest volume of county services and approach the individual and/or their families to participate in the Community Case Management (CMM) Program. Almost immediately it became apparent that we do not presently have a system or process in place that can easily or quickly identify those customers who use the majority of our services. We are in the process of trying to find computer software that may accomplish this objective.
- We have incorporated education or training and referrals to see to change behavior patterns that are either self-destructive, counter-productive, or unnecessarily expensive to the client and community or county resources.
- We have identified those screening and assessment tools which provide quantifiable and verifiable baseline data. We do not have such tools available for every program, but continue to look for them.
- We have identified CWC-Cs staff who would be open to working on the CCM Team and they have been asked to join. Meetings have been held weekly with only a few exceptions since last September.
- Community business owners and leaders have been asked to form a CCM advisory team and this team meets quarterly.
- Our efforts to engage those families identified have met with limited success. It is clear that a lack of trust exists between those people we serve and Community Services. If a client already had a relationship established with a given CS employee then that employee was generally able to see the client. But in several instances these same clients were very reluctant to visit with anyone they didn't know.
- One of the expectations placed on the CCM Pilot Project was to visit with the CWC Board of Commissioners quarterly. This we have done.

Have our goals been met?

- We wanted no more than 50% unemployment among those clients we worked with. During the past 6 months 3 of the 7 clients (43%) have either obtained work or are seeking work.
- Our goal was that all of our clients have stable housing. After 6 months only 57% of our clients have met this goal.
- We wanted no instances of child abuse or neglect among the clients we served. We saw no evidence of physical child abuse, and only one instance of neglect that required the children be removed from the home for 2 days.
- Another of our goals was that medical services, medications, or treatment be available to every client we worked with. Four of our clients (or their immediate family members) were in need of such attention. Every identified individuals was referred and was able to receive the care needed.
- We wanted to reduce the number and type of MA claims to the county by 20% among the clients we worked with in the first year. Working collaboratively with both Essentia Health and Cuyuna Medical Center, 1 of our 7 clients (14%) had a significant reduction in both the type and number of health care visits. What we did not expect, but which has a positive impact on all parties is that by collaborating with two health care providers we have shared information which enables better care and services while simultaneously reducing the number and type of "clinic" visits. This has resulted in cost savings to the county as well as the health care providers.

Public/Private Health Task Force includes ...

Crow Wing County: Public Health Nurse, Adult Mental Health social worker, Chemical Dependency social worker, Child Mental Health social worker, Child Protection social worker, Family Health Nurse, Daycare, Child Support worker, Income Maintenance, Veteran's Service Officer, RSVP representative, Workforce Center, Probation/Parole, Crow Wing County Sheriff, Crow Wing County Jail, Crow Wing County Attorney's office

And Community Partners: Lutheran Social Services – Housing and Family home budgeting; Community volunteer/mentor; Bridges of Hope, Transportation, Central Lakes College, Mental Health services, Essentia Healthcare, Cuyuna Regional Medical Center, Lakewood Health System, Apartment Owners Group, Teen Challenge Treatment