

Mayo Clinic Child and Family Advocacy Center

*OLMSTED COUNTY
MULTI-DISCIPLINARY TEAM PROTOCOL
NOVEMBER 2012*

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Introduction

A. Background and Mission Statement

A multidisciplinary response in child abuse cases has been found to be effective in reducing trauma to children, promoting successful legal intervention, and ensuring the availability of appropriate follow-up services for children and their families.

The mission of the Mayo Clinic Child and Family Advocacy Center (“the Center”) is to offer an efficient, culturally sensitive and child-centered response to child abuse in Southeastern Minnesota and in other locations served by the Mayo Clinic Health System. The Center brings together a Multidisciplinary Child Protection Team (“MDT”) that includes law enforcement, county lawyers, victims’ advocates, health care providers and child protection officials to work together to investigate cases of child abuse and care for victims. The Olmsted County Board has formally approved the creation of the Child Advocacy Center Multidisciplinary Child Protection Team pursuant to Minn. Stat. §626.558 [see **Appendix A**].

Besides helping victims, the Center is also a resource for other communities to further professional and community education and training in child abuse reporting, awareness and prevention. The Olmsted County partners who are members of the MDT hope to pool their resources through the Center to serve the families and children in Olmsted County affected by all forms of child abuse, and to reduce further victimization in the community.

B. Olmsted County Multidisciplinary Team Protocol

The purpose of this protocol is to define the collaborative response among law enforcement, child protection, prosecution, medical, mental health and victim advocacy professionals in Olmsted County in a clear and concise manner. Developed through a cooperative effort by members of all participating agencies in the MDT, this protocol aims to clarify the roles of each discipline, coordinate the activities of each agency, reduce duplication of effort, and center activities on the needs of the child. As a procedural guide, the protocol will be used by Center staff and partners to assist in intake, coordination, investigation, treatment and follow-up procedures and be a component of new-hire training.

While the protocol attempts to be as comprehensive as possible, it cannot address every situation that may arise. In situations not covered by this document, the Center staff and MDT will use their good judgment, adherence to MDT values of cooperation and communication, and reach consensus to determine the best course of action.

Chapter 1: Organizational Structure

A. Staff

Mayo Clinic maintains financial and administrative responsibility for the Center. Center staff are employees of Mayo Clinic, with requisite salaries and benefits, and are governed by the policies and procedures of Mayo Clinic. Currently, the Center is staffed by a Medical Director, Program Coordinator and Administrative Assistant, who are all employees of Mayo Clinic. The Program Coordinator and Administrative Assistant are fully committed to the Center, while all other staff have responsibilities outside of the Center.

B. Executive Advisory Committee

The Center's Executive Advisory Committee ("Advisory Committee") provides advisement on program service components of the Center and oversight related to the Center's MDT functions. The Advisory Committee is also charged with the responsibility of evaluating protocols on a yearly basis and recommending necessary changes to the Operations Workgroup. The Committee will meet regularly to review special matters and service issues brought forth by MDT members or the Operations Workgroup to collaboratively seek solutions.

The Advisory Committee is comprised of the administrative leads and heads of community agencies interested in child abuse issues in the community. Currently, the committee is comprised of members from Olmsted County. As the Center expands in scope and services, the Advisory Committee may include members from other counties and surrounding regions.

Composition of Advisory Committee

- Chair: Medical Director of the Center
- Child Protective Service Representative
- Victims Services Representative
- City Law Enforcement Representative
- County Law Enforcement Representative
- County Attorney's Office Representative
- Public Health Representative
- Ex-officio member: Center Coordinator

For the most recent list of Advisory Committee members, see **Appendix B**.

C. Operations Workgroup

The Operations Workgroup implements MDT functions and special programs of the Center as determined by the Advisory Committee and raises or addresses Center program service issues as they may arise. The Operations Workgroup works collaboratively to ensure that the necessary updates to protocols are made on a yearly basis as recommended by the Advisory Committee and meets regularly to ensure that its duties are completed. The group also monitors client satisfaction, provides feedback to the Center Coordinator, and informs key stakeholders on an on-going basis on progress of the committee.

Composition of Operations Workgroup

- Facilitator: Center Staff
- Child Protective Service Representative
- Victims Services Representative

- City Law Enforcement Representative
- County Law Enforcement Representative
- County Attorney's Office Representative
- Public Health Representative
- Ex-officio member: Center Coordinator

For the most recent list of Operations Workgroup members, see **Appendix B**.

D. The Olmsted County Multidisciplinary Team

The Olmsted County Multidisciplinary Team consists of a group of specified individuals assigned to respond together to allegations of abuse and work cooperatively to manage interventions and periodically review the case. An annual Interagency Memorandum of Understanding ("MOU") and confidentiality agreement is signed by the directors of each agency supporting the Center [See **Appendix J** and **Appendix L**], While all MDT members remain employees of the respective organizations they belong to and are bound by the individual rules and policies of their employers, they agree to abide by these agreements and follow the protocols. The Olmsted County Multidisciplinary Team will be coordinated by Center Staff. MDT members assigned to a particular case will be routinely involved in the investigation and/or team intervention as agreed upon in the signed MOU. Peripheral members may participate in the MDT if necessary to enhance the team's mission. Peripheral members are not required to sign the MDT Protocol or MOUs, but will be expected to sign confidentiality agreements.

Goals of the MDT

- To investigate reported cases of **child sexual abuse** in Olmsted County, including both caregiver and non-caregiver allegations;
- To investigate any case of **serious physical abuse** or other **child victimization** referred by a member of the team;
- To ensure the safety and well-being of children and families;
- To resolve all cases in a manner that promotes protection of the child and the best interest of the families and community;
- To hold the offender legally accountable in the civil and/or criminal justice systems whenever possible;
- To formally review cases on a regular basis with other members of the MDT to monitor the victim and assess effectiveness of the multidisciplinary approach; and
- To keep the Center informed about case information and updates in a timely manner.

Composition of the MDT

The team may be composed of representatives of the following agencies and disciplines:

- MDT Facilitator;
- Mental Health / Trauma Focused Trained Provider;
- Olmsted County Child Protective Services;
- Olmsted County Sheriff's Office or Rochester City Police Department;
- Olmsted County Victim Service;
- Olmsted County Attorney's Office;
- Center Medical Provider; and
- Other peripheral members, including but not limited to: Olmsted Medical Center, Olmsted County Public Health, local schools, community mental health providers and other actors identified on a case-by-case basis.

Scope of the MDT

The Olmsted County Multidisciplinary Team serves clients living in Rochester, Minnesota and all communities in Olmsted County.

E. Meetings

In order to facilitate the efficient functioning of the Center and to improve the response of the MDT to child abuse in the community, members of participating organizations and various teams and committees will meet on a regular basis. All meetings are coordinated by the Program Coordinator or Administrative Assistant and will be held at the Center Building, located at 2720 N. Broadway, Rochester, MN. During emergency situations or holidays, the administrative assistant may update members on any changes to the meeting schedule or location.

Scheduled Meetings:

- Members of the Advisory Committee meet on monthly basis to review special matters and service issues brought forth by MDT members or the Operations Workgroup and seek solutions to any issues in a collaborative manner.
- Members of the Operations Work Group meet on every second Wednesday of the month from 11:00 A.M. to Noon to discuss daily operations, operating procedures, information sharing, training and the overall management of the Center. The operational meetings provide a forum for collective problem solving, innovative thinking and improving the efficacy of the MDT response to child abuse.
- Members of the MDT meet on every third Wednesday of the month from 10:00 A.M. to Noon to discuss open cases, developments and staffing for new cases [for more information, see Chapter 8:

F. Screening

Criminal background and child abuse registry checks are conducted on all board members, MDT members and Center Staff by their respective employing agencies. Each agency conducts its own background checks per its internal procedures prior to or during employment, and therefore no additional background checks are performed at the Center. No volunteers are employed at the Center. The background checking policies of partnering agencies are as follows:

Mayo Clinic:

- Mayo Clinic contracts with Verified Credentials Incorporated (VCI) to conduct the following background check on all new hires: Education; Criminal Check; Employment; Government Watch List; National Criminal Database; National Sex Offender Public Registry; and Professional License (if applicable)
- Furthermore, if the position requires direct patient care, Mayo Clinic also performs a Minnesota Background Study which checks to see if the person is authorized to work around vulnerable adults.

Olmsted County Child and Family Services:

- New Hires: Standard criminal background checks are conducted for top candidates for all posted positions in the County. Olmsted County Human Resources provide a standard BCA criminal background check on the top 1-5 final candidates for a posted position in all county departments. Hiring department determines which employment/volunteer/contractor

candidates are checked, and will complete appropriate forms for Human Resources to request the BCA check.

- Maltreatment Checks for Potential Employees: Child protection and Vulnerable Adult protection maltreatment checks are done by a staff member in the social services support unit of Olmsted County Community Services. The requesting department needs to provide a list of current and previous counties of residence for the applicant. Community Services staff checks the statewide database for confirmed maltreatment findings against the individual. It will show other reports of abuse or neglect that were unconfirmed.
- Sexual abuse disclosure law checks are performed on all social workers

Rochester Police Department:

- All Rochester Police officers have an active POST license per Minnesota state law. Furthermore, the Rochester Police Department conducts thorough background investigations on all prospective employees, including interviews with friends, relatives, teachers, references, co-workers, supervisors, landlords, etc. In addition to interviews, the Department also looks into Criminal history, Civil issues/history/judgments, Proof of citizenship, Education, Any other names the prospective employee has used, Driver's license information and driving record, Social security information, Military records, Prior addresses (investigating prior addresses includes checking with the agencies in that area to see if they have had any contact with the candidate), Vehicle records and accidents, Education, Drug issues/history, Organizations or civic groups they have or currently belong to, Employment and/or Volunteer records, Prior background investigations that may have been completed by other agencies, Any prior police contacts they may have had, either as a witness, victim, suspect or complainant, and Banking information.

Sheriff's Office:

- Prior to hire, the Sheriff's Office conducts a very thorough background investigation of the prospective employee. This investigation includes a criminal history check, sex offender registry check and an examination of the individual's driving record. Random continual background checks are performed on all Sheriff's Office employees.

Victim Services:

- Criminal background checks on all Victim Services staff and volunteers, which includes a Bureau of Criminal Apprehension check as well as a check of local records. All staff are fingerprinted. The background checks are performed at the time of initial employment.

Attorney's Office:

- The Olmsted County Attorney's Office does not conduct formal background checks. Attorneys need to be licensed or licensable to work at the Office. The Minnesota Supreme Court oversees licensure.

Chapter 2: The Center Facility

The Mayo Clinic Child and Family Advocacy Center Building (“Center Building”), located at 2720 N. Broadway, Rochester, MN, is designed to create a physically and psychologically safe environment for children and their non-offending caregivers. It is a comprehensive, child-focused setting for all the services a child and his or her family may need during the course of a child abuse investigation. It includes several separated waiting areas for children and families, two forensic interview rooms, two forensic interview observation rooms, two therapy rooms, two medical exam rooms, one large conference room for MDT meetings and office space for staff and MDT members. The premises are child-friendly and wheelchair accessible. Special attention was given to the design and layout of the Center in order to create a neutral, culturally-sensitive and balanced atmosphere. No offender interviews are conducted at the Center in order to ensure the separation of alleged perpetrators and victims. Only the non-offending caregiver(s) are permitted on the premises with the child.

A. Entrance

The Center Building is a secure facility. Families enter the building from the West (Main) entrance by pushing a door bell for entry. A staff member present at the reception will unlock the automated doors for them. Staff and MDT members will enter the building from the South (Employee) entrance of the building by pushing a door bell. MDT members and staff will have access to an AIPHONE which is connected to an installed camera and microphone at the building’s entrances. Upon identification, a door unlock button can be pushed, allowing the door to open. Access to the building will be controlled and monitored by Center staff and Mayo Clinic Security.

B. Safety and Security

All Mayo Clinic fire and building safety standards have been adhered to in the construction of the Center Building. Fire extinguishers located throughout the building, an AED is located on the premises, and Center Staff are certified in basic life support training. A copy of the Center Building Emergency Preparedness Plan is available at the reception desk. Administrative Mayo Clinic policies are available at <http://mayoweb.mayo.edu/policies/>. In case of emergencies, the building is wired to Mayo Clinic Security and panic alarms can be activated quickly. Panic alarms are located at the reception desk and in both the therapy rooms. The Center aims to create a child-friendly and non-threatening environment and the firearm policy of the MDT Protocol reflects that concern. Law enforcement members of the MDT who are meeting with children for an interview will place their firearms in a locked box located inside the South employee entrance for the duration of the meeting. The law enforcement officer will carry a key to the locked box and retrieve his or her weapon upon completion of the meeting or departure from the premises.

C. Off-Hours Medical Exam

During work hours and for all scheduled cases, the Center Building will be used for medical examinations. During off-hours, weekends, holidays and other emergency situations, the St. Mary’s Emergency Department will be used for medical exams. Center medical providers are on call 24-hours a day, 7-days a week to assist the St. Mary’s Emergency Department [for more information, see **Chapter 5: Medical Examination Protocol**; and **Appendix C**].

Chapter 3: Referral Protocol

A. Types of Cases Referred to Center

There are two categories of cases that the MDT can take action on—those cases that *will* be referred for an MDT response per the terms of the MDT Protocol, and those that *may* be referred for an MDT response at the discretion of the referring agencies. Upon consultation with the MDT, it may be possible that no action is taken on any particular case that is referred to it.

Category 1 – Cases that Will Be Referred for an MDT response

- Cases of alleged sexual abuse under investigation by one of the team agencies that involve a child. [For definitions of “child” and “sexual abuse,” see relevant Minnesota Statutes listed in **Appendix D**].
- Cases of egregious harm allegedly committed by a caregiver, relative, guardian, or other person responsible for the care of a child. [For definition of “egregious harm,” see **Appendix D**].

Category 2 - Cases that May Be Referred for an MDT Response

- Cases of alleged sexual assault of minors that don’t involve a Significant Relationship and/or a Position of Authority [see **Appendix D**].
- Cases of child maltreatment fatalities with surviving siblings.
- Other criminal cases when the alleged offender is not in a Significant Relationship and/or in a Position of Authority over the child victim, and doesn’t meet any of the above definitions. These cases include but are not limited to:
 - medical neglect
 - neglect/abandonment
 - kidnapping
 - child exploitation or prostitution
 - the trafficking of children
 - child witnesses to injury or violent crime, including domestic violence and homicide.

B. Making a Referral

The Center is open for referrals by MDT members from Monday through Friday, from 8 A.M. to 5 P.M., except for holidays. Referrals can be made by contacting the Center at 507-266-0443. Center staff will then contact the MDT to facilitate intake, interviews and other logistics. The Center does not accept direct referrals from the public. However, Center staff members are mandated reporters, and communication of alleged child maltreatment received from third parties may be referred to Olmsted County law enforcement and/or child protective services. Law enforcement, the County Attorney’s Office, and/or Child Protective Services may then follow the referral process laid out in this protocol and their internal guidelines [See **Appendix D, E and F**].

In addition, for potential sexual or physical abuse cases seen at any Rochester Mayo Clinic facility or ED, internal Mayo Clinic Protocols for referral to the Center will be followed [see **Appendix C**].

C. Referral Process

Case Initiation

- Initial reports are typically received by the Olmsted County Child Protection and/or Rochester Police Department or the Olmsted County Sheriff's Office.
- Contact will be made as soon as possible between the law enforcement agency with jurisdiction over the case, and the child protective service representative assigned investigative responsibility for the case.
- After following its internal screening protocols, the initiating agency will contact Center staff with case referral information [see **Appendix G**]. Information will be given verbally and by email or fax and will include demographic information, information about the allegation(s), and identify special needs or accommodations if necessary [see **Appendix H**].
- Center staff will contact the MDT members to coordinate and schedule the initial meeting.
- Initiating agency will contact the family and assist with coordination/scheduling of visit to the Center. Family may be given information regarding MDT, flow of visit; payment issues, etc.

Note: If a forensic interview occurs off-site, a referral to the Center may be appropriate and an MDT staffing can be organized by the Center staff.

Initial MDT Meeting

- At the initial MDT meeting, team members will discuss any past or existing information available within the involved agencies that may assist with the case. Information may include but is not limited to mental health concerns or developmental delays/cognitive function of the child, prior reports of abuse, previous trauma history or any relevant medical history.
- During the initial MDT meeting, the non-offending caregivers and child will be waiting in the waiting room and will fill out check-in paperwork which will allow the MDT to better understand the case and provide assistance [see **Appendix H**]
- At the conclusion of the initial MDT meeting, the non-offending caregivers and child are ready to begin the forensic interview, medical examination, and/or other steps.

Note: Initial face to face contact with the family will meet the statutory obligation to ensure child/family safety. The primary fact-finding interview, called the forensic interview, will typically be conducted at a later time and should be consistent with the guidelines listed below. In cases involving multiple victims, additional team members may be asked to participate in the investigation.

D. Non-MDT Interviews

The Mayo Clinic and Family Advocacy Center is a safe and neutral environment for children and their non-offending caregivers. As such, children and their non-offending caregivers may benefit from having their children interviewed at the CAC on non-MDT required cases. Law Enforcement and Child Protection Investigators may request to use the CAC building to conduct non-offending child interviews that don't require the staffing of an MDT. When a request is made to the CAC to conduct a non-MDT interview the CAC staff will check to see if

an interview room is available. If an interview room is available the non-MDT interview can take place there. It should be noted that category 1 and MDT case interviews take a priority over non-MDT interviews.

The types of non-MDT cases that can be referred to the CAC for an interview include, but are not limited to:

- Courtesy interviews for other jurisdictions with non-offending children
- Category 2 cases that are not referred for an MDT (See Chapter 3 section A for definition of Category 2 cases).

E. Chapter 4: Forensic Interview Protocol

A. Purpose of Forensic Interview

The purpose of the forensic interview is to obtain a statement from a child, in a developmentally and culturally sensitive, unbiased, and fact-finding manner that will support accurate and fair decision-making by the MDT in the criminal justice and child protection systems. In order to facilitate the investigation process, investigative interviews of children will be conducted as soon possible. Furthermore, multiple interviews of the child will be avoided unless exigent circumstances require or if the MDT determines that an additional interview is necessary to provide further information following a team consultation. It is important to note that the forensic interview and mental health treatment are completely separate processes and should not be confused in their purposes. The forensic interview is intended to be a purely investigative process, whereas mental health services are intended to be therapeutic only.

B. Location of Child Forensic Interviews

Decisions regarding the interview location are made depending on what is in the best interest of the child. Planned interviews should preferably be conducted at the Center building, where two interview rooms equipped with state of the art audio and video recording technology are available in a child-friendly setting. Each interview room is equipped with a covert video and audio system to record the forensic interview. For privacy purposes each interview room is sound proof. An observation room is available for comfortable and interactive viewing by select MDT members.

They are able to observe and hear the interview through the covert audio and video system that is transmitted to the Observation Room on a large television monitor. The medical staff is also able to observe and hear the in progress interview on the computer in their office. The multidisciplinary team can covertly communicate with the forensic interviewer at any time. The forensic interviewer wears a listening device in his/her ear that receives information provided by the multidisciplinary team in the observation room. Utilizing this method allows the interview to be conducted in a manner that is responsive to the various needs of the authorities present and not disrupting the interview.

However, in emergency situations or situations where there is a safety concern, it may be necessary to conduct the interview at a separate location. This decision will be made at the discretion of the investigating law enforcement agency. If an interview is conducted at a separate location, the chosen environment will be as neutral and child-friendly as possible. Every effort will be made to ensure that children are not interviewed in the home or environment where the abuse took place. If the initial interview did not take place at the Center, every effort will be made to conduct subsequent interviews at the Center. Center staff will be available to assist forensic interviewers at the Center from 8:00 A.M. to 5:00 P.M. Monday through Friday, or at other times by appointment.

C. Child Forensic Interview Procedures

Forensic interviews of children conducted by MDT members should be non-duplicative, non-leading, and neutral. Interviews at the Center will be conducted in a manner consistent with established best practices for child forensic interviews. It is the expectation that law enforcement, child protection and Center staff representatives of the MDT assigned to a particular case are present at the forensic interview. Other members of the MDT are encouraged to observe the interview, but are not expected to attend. In particular, the medical provider is encouraged to observe the interview in order to assist in his or her medical evaluation and avoid duplication [see

Chapter 5: Medical Examination Protocol.

Selection of Child Forensic Interviewer

Child forensic interviews should be performed by a representative of the MDT who is specifically trained in current best practices for child forensic interviews and acting in accordance with the case specific investigative plan. At a minimum, all interviewers will have completed a 5-Day, 40-Hour Forensic Interviewing Training. If a case involves a non-relative as the perpetrator, the case falls under the jurisdiction of law enforcement, and a law enforcement forensic interviewer will interview the child. If the alleged abuse involves a family member, the case falls under the jurisdiction of child protection, and they conduct the forensic interview. Developmental and cultural factors that may influence communication between the child and the interviewer are considered in the selection of an appropriate forensic interviewer. All interviewers will participate in peer review. Peer review is available the third Wednesday of each month from 12:00-1:30 p.m. at 2117 Campus Drive SE, Rochester, MN.

Developmental and Cultural Sensitivity

Developmental and cultural factors that may influence communication between the child and the interviewer should be considered and appropriately addressed. Alleged child victims will be interviewed using language appropriate to their individual developmental level, and procedures in place for interviewing hearing-impaired or non-English speaking victims will be followed [see **Chapter 11: Cultural Sensitivity, Competency and Awareness**]. The Center provides forensic interviews to a bi-lingual child through the use of interpreters. The child who is bilingual is always given a choice of which language to use during the interview.

Prior to the Interview

Prior to the interview, the interviewers will determine who should take the lead in the interviewing process on a case-by-case basis. Ideally, the child will only be interviewed by one interviewer while others observe from the observation room. When joint jurisdiction applies, however, it is preferable to conduct the forensic interview jointly with law enforcement and child protective service social representative.

During the Interview

Other investigative MDT members will observe the interview from the Observation Room. The forensic interviewer will communicate with MDT members throughout the interview and they may provide guidance to the interviewer. This avoids future duplication, facilitates peer review on the quality of the interview, and improves information gathering efforts.

Following the Interview

After completion of the forensic interview, the forensic interviewer meets with the MDT in attendance, in order to share information and collaborate to provide the most appropriate action plan. Multiple interviews of the child will be avoided unless exigent circumstances require or if the MDT team determines that an additional interview is necessary to provide further information following a team consultation. If all MDT members are not present during a forensic interview or if a forensic interview occurs off-site, a referral to the CAC for

a post staffing with the MDT will only occur if there is a disclosure, or if there is going to be additional investigation or services. It is the understanding that both Law Enforcement and Child Protection will attend all post staffing meetings when the interview occurs off site.

D. Documentation of Child Forensic Interview

All forensic interviews whether they occur in at the Center building or in another location, will be audio and video taped per Minnesota Law [see **Appendix D**]. If drawings or other tools are used to help a child in giving his or her statement, the original images will be maintained by law enforcement. A video of the forensic interview will be made available on a DVD upon completion of the interview at the Center. This DVD will leave the Center building with the law enforcement officer having jurisdiction over the case, in accordance with chain of custody requirements. The audio and video recording of the forensic interview and other information pertaining to it will be kept on the Center's server for no longer than 60 days.

E. Interviews of Offenders and Other Non-Victims

Under no circumstances will the alleged offenders be interviewed at the Center Building. Alleged offenders will be interviewed in a location dictated by the specific facts of the case, at the discretion of the investigative law enforcement agency. Out of custody alleged offenders may be interviewed anywhere and in custody offenders will be interviewed at the law enforcement center. If it is a joint investigation and the case facts allow, the interview will be coordinated with both law enforcement and child protection present.

During the course of the investigative process or the forensic interview, law enforcement, in consultation with the multidisciplinary team, may determine the need to forensically interview the siblings residing in the home. These interviews may be conducted at the Center after consultation with the MDT.

Chapter 5: Medical Examination Protocol

A. Purpose

The purpose of the medical exam is to ensure the safety and health of the child; diagnose, document and address medical conditions resulting from abuse; differentiate medical findings that are indicative of abuse from those which may be explained by other medical conditions; assess these other medical conditions and treat or refer for further evaluation; assess the child for any developmental, emotional, or behavioral problems needing further evaluation and treatment and make referrals as necessary; and to provide reassurance regarding normal findings and interpretation of abnormal findings. A Center medical provider will participate on the MDT and be present at the MDT case initiation and case review meetings. Medical staff may also watch the forensic interview to gather needed information so that duplication of history taking and/or questions to the child about his or her abuse can be avoided. A Center medical provider will also provide MDT education on child abuse issues and be a resource to caregivers and the MDT for medical or health related questions. Families will have access to appropriate medical evaluation and treatment regardless of their ability to pay.

B. Medical Exam Staff

All Center medical providers will have child abuse expertise via sub-board eligibility, pediatric Sexual Assault Nurse Examiner (SANE) training or formal medical training. All Center medical providers participate in on-going abuse training and peer review.

C. Medical Exam Procedures:

Based on the information obtained during the initial MDT case meeting and possible observation of the forensic interview, the medical provider will discuss the need for a medical exam to the non-offending caregiver(s). Medical exams during business hours will occur at the Center as part of the MDT response. After hour medical exams occur at St. Mary's Emergency Department [see **Appendix B**].

Non-emergent Sexual abuse medical exam:

- If the allegation of abuse is not acute, that is, if the alleged abuse occurred more than 72 hours ago, and there is no significant anogenital pain, bleeding or injury, the medical examination can be scheduled at the Center building and performed by a Center medical provider. The medical provider will be informed of any disclosure of sexual contact made during the forensic interview (via viewing of interview or update provided by MDT).
- During the medical exam, the medical provider will obtain a medical history from the child and non-offending caregiver(s) that may include non-leading questions regarding abuse, but will not duplicate the full investigative interview conducted with the child.
- The medical provider will utilize appropriate exam techniques, colposcopy and video; with patient and/or caregiver written consent to obtain appropriate information. Video recordings will be utilized to review findings with colleagues if necessary (see **Appendix V**) and potentially if court proceedings demand description of any abnormal findings.
- The medical provider will obtain and provide appropriate diagnostic studies and treatment based on findings.

Emergent Sexual Abuse Exam:

- If an allegation indicates that sexual abuse occurred within the past 72 hours and there is probable exchange of bodily fluids or significant, anogenital pain, bleeding or injury, the child should be promptly examined at the Center building by the Center medical provider. If this is not possible because it is the weekend, middle of the night, etc., then the child should be seen in the St. Mary's Emergency Department (ED).
- The St. Mary's Emergency Department physician examining the child is directed by a sexual abuse algorithm to contact the on-call Center provider based on the call schedule on record in the ED [see **Appendix B**]. The Medical exam will include visual inspection, photo documentation of exam (Mayo photography if exam occurs in the ED), possible evidence collection (completion of sexual assault kit with or without SANE nurse assistance) and medical infection and pregnancy screening and treatment if indicated.
- If the MDT is not able to meet prior to a needed medical exam, the medical provider will ensure that the information gathered will focus on obtaining a medical history and may include limited non-leading questions of the child regarding his or her abuse. This information should not duplicate the forensic interview of the child.

Physical Abuse/Neglect Exam

- In physical abuse or neglect cases, the medical exam will be performed either at the Center building, Community Pediatric and Adolescent Medicine clinic, or St. Mary's Hospital.
- The medical provider will be informed of the abuse allegations during the initial MDT meeting or referral. The medical exam will include a physical exam with special attention to areas of concern, photo documentation of any injuries or findings, laboratory testing or imaging and treatment recommendations as directed by case information and findings.
- The referrals and appointments for medical evaluation of physical abuse are set up as needed by the Center coordinator. Physical abuse and neglect cases seen at the center are those that are non-urgent. Other cases may be seen in the outpatient Community Pediatric and Adolescent clinic or St. Mary's Hospital. Consultative services are available by our team at request of the hospital service. Access for referral is done electronically and is immediately sent to a pager. Same day consultative services are generally provided.
- Photo documentation of injuries is obtained by contacting Mayo Photography. If further testing is needed, the patient is referred to the Mayo Family Clinic Northeast where labs and x-rays can be obtained. Documentation of history, exam and medical plan is completed in the Mayo medical record.

Hospitalized Children

If the child is hospitalized, recommendations by Center medical providers will be carried out in collaboration with the primary hospital service medical team. Medical documentation will kept be in the Mayo Clinic electronic medical record.

D. Documentation of Findings

All medical findings is documented according to professional standards and shared with the MDT by the medical provider as appropriate. All medical care at the Child Advocacy Center becomes a permanent part of the Mayo medical record. The documentation includes a medical history as well as physical exam findings and treatments outlined. These records are marked as confidential in the child's medical record and are password protected. Data regarding whether an exam was conducted, the medical provider's name and location, and any findings are documented in the case tracking system. Confidentiality of patient records will follow Mayo Clinic policies and HIPAA guidelines. If colposcopic video or images are obtained, the video or images are downloaded immediately to a DVD. The copy of the DVD is located at the Child Advocacy Center in a locked cabinet and kept indefinitely.

If forensic evidence is collected, it is immediately labeled. Evidence collection is completed following SANE protocol. Following chain of custody requirements, the kits are kept in a locked refrigerator until law enforcement acquires the kit. The key is kept by the provider until the kit is collected.

Urine samples can be collected at the center (non-forensic) and sent to lab by a Mayo Clinic courier. These results are documented in the medical record. Positive results pertinent to the case are relayed to the caregiver and MDT members investigating the case.

Mayo Photography provides all still photography. These images are stored digitally and are only accessed with approval by the Child Advocacy Center staff. Furthermore, three sets of prints are made of the images and sent to the Administrative Assistant. The Assistant forwards a copy to CPS and/or LE, and keeps the remaining set of print/s in a locked file cabinet for three months before they are destroyed. Still photography is generally used for physical abuse and neglect cases.

E. Follow-Up Exams

Follow up medical examinations for all cases will be conducted at the Center building at the discretion of the Center's medical provider involved in the case.

F. Ability to Pay

The medical evaluation is available to all children regardless of their ability to pay. The payment may be processed by submitting a claim to the child's medical insurance carrier. If a family identifies a financial hardship due to lack of insurance, being under-insured, or having an inability to pay the deductible or co-payment, they may contact the child advocacy staff who will contact the Mayo business office to assist in payment. In addition, local victims services have access to Crime Reparations state funds and can assist the family in applying for reimbursement.

Chapter 6: Mental Health Protocol

A. Role of the Mental Health Professional

Child abuse often represents a difficult and traumatic experience for the child and caregivers or caregivers. Mental health professionals can assist them in understanding the abuse, restoring the family to pre-crisis functioning, promoting healthy development and identifying other resources that the family can rely on for support. Mayo Clinic mental health providers are able to provide services at the Center in child-friendly and culturally sensitive therapy rooms. The mental health component is completely separate from the forensic interview and investigative process and intended to be entirely for the therapeutic benefit of the child and his or her non-offending caregivers(s).

B. Mental Health Services

Families will have access to appropriate mental health evaluation and treatment regardless of their ability to pay. A mental health provider who is trained in Trauma Focused Cognitive Behavioral Therapy or other evidenced based modalities for trauma will participate at the initial MDT meeting and all subsequent case review meetings. All mental health services provided at Mayo Clinic Child and Family Advocacy Center are provided by persons with a Master's level degree or a graduate level student in good standing supervised by a Master's level professional. All master's level providers at the child advocacy center providing services or supervision, will also have the appropriate licensure in good standing.

Currently, Mayo Clinic Child and Family Advocacy Center has no contract therapist(s) or linkage agreements with other agencies. In the future all agencies and/or individual providers that Mayo Clinic Child and Family Advocacy Center refers clients and/or non-offending caregiver(s) to for mental health services will have signed a memorandum of understanding/linkage agreement stating that any individual providing mental health services, either as an individual or agency representative will meet at least one of the training standards noted within the linkage agreement and agree to see patients regardless of their ability to pay.

On occasion, the MDT may refer a client to an agency and/or individual provider who has not signed a memorandum of understanding/linkage agreement with the child advocacy center. This may be due to the client and non-offending caregiver(s) living in a distant county or state. A referral or recommendation may also be given when the client and/or non-offending caregiver(s) may be currently receiving mental health services from an institution, individual provider and/or agency that MDT members, and the child's non-offending caregiver(s) agree are in the best interest of the child client and/or caregiver to continue.

On-going training and education for mental health staff will be held in conjunction with monthly case review and at other times throughout the year. Mayo Clinic will make available providers and/or interpreter services to those children and families who do not speak English [see

Chapter 11: Cultural Sensitivity, Competency and Awareness]. A list of community providers will also be available [see **Appendix I**].

C. Mental Health Process

During the forensic interview of child, the mental health provider will join the Victim Advocate and speak with the non-offending caregiver(s) in the Family Room. He or she will collect information regarding child's current and past mental health issues and treatment and to answer caregiver's initial questions regarding any available or necessary mental health treatment.

All therapeutic contact with the child will occur after the forensic interview. Mental Health providers will not view the forensic interview and will make appropriate assessments for on-going treatment based on evidenced based indicators gathered during interview with caregivers and individual assessment with the child subsequent to the forensic interview.

Recommendations may include as assessment for need of Trauma Focused- Cognitive Behavioral Therapy, other appropriate therapy modalities or further assessment options. The mental health provider will also provide referral information as requested by the family and make available a list of mental health providers in the community, including a list of providers offering non-offending caregiver support [see **Appendix I**]. MDT members will not be present for individual client mental health sessions and/ or services.

D. Information Sharing

Mental health information will be shared with the multidisciplinary team pursuant to the signed MDT confidentiality agreement [see

Chapter 9: Information Management and **Appendix J**]. If mental health services are provided by a Mayo Clinic provider then confidentiality of patient records will follow Mayo Clinic policies and HIPAA guidelines.

Chapter 7: Victim Advocacy Protocol

A. Purpose

The primary role of a Victim Advocate (“advocate”) is to provide advocacy and support to the child and his or her caregiver(s) throughout the course of a Center case. An advocate is present to assist the child and family from the point of the initial report, during the medical exam, through the pending investigation and prosecution, and post-conviction if necessary.

Victim Services of Olmsted County Staff and volunteer advocates are available 24 hours a day, 7-days a week to respond to the Center or other location, and can be reached at 507-289-0636. A staff advocate will be present at all MDT cases and monthly case review meetings. Volunteer advocates may respond to cases after-hours and have completed the 40-hour sexual assault advocacy training in addition to having successfully completed a period of direct supervision prior to responding independently. A staff advocate is always available to consult and direct volunteers. At any time, a member of the Center may ask that a volunteer check-in with the staff advocate on call. Ongoing training, case consultation, and supervision are required of staff and volunteer advocates.

B. During the Initial Report

Beginning at the point that an initial case is referred to the Center, the advocate will participate in the MDT briefing about the incoming case and may become acquainted with any identified needs of the family. While the child is being interviewed in the Interview Room, the advocate will meet with the non-offending caregiver or caregiver to inform and educate them about the dynamics of abuse, the Center process and purpose, talk about next steps, provide brief safety planning if appropriate, and identify any unmet needs of the family. The mental health provider will also be present to assess information about the family related to the trauma.

The advocate will further describe the role of other Center providers to ensure that caregiver(s) are informed about services that will be made available through the Center, such as medical examination and trauma focused counseling. The advocate will explain the rights of the caregiver(s) as well as any limits to confidentiality and the ongoing sharing of information between Center providers. The advocate will assist with obtaining a restraining order if requested or appropriate and ensure access to services and coordinate referrals to community resources for housing, public assistance, domestic violence programming, transportation, safety planning, and legal resources.

C. During the Medical Exam

A staff or volunteer advocate is available to accompany the victim and/or the secondary victims to the pediatric or SANE nurse exam when requested. The role of the advocate during the medical procedure is to provide information and support for both the children and their non-offending caregivers or caregiver. In partnership with the medical provider, the advocate can also ensure that the victim understands rationale for various parts of exam and evidence collection, and exam findings and recommendations. Given the importance of consistent follow-up with the victim, the advocate will also reinforce the importance of follow-up exam.

D. During the Pending Investigation

During the pending investigation, the advocate will ensure victims and their caregivers know and understand their rights as victims of crime. The advocate will serve as a liaison between the

victim/victim's family and law enforcement regarding the criminal investigation. In cases where child protection is also involved, advocates will maintain linkages with the social representative assigned. Furthermore, the advocate will inform the victim or victim's family when the investigation is complete and case is being forwarded to the County Attorney's office for potential criminal charges. If a case is declined for prosecution, the advocate will offer to arrange a meeting with the prosecutor so the decision may be explained directly to the victim and/or caregiver. The advocate will also provide information and assistance in making applications to the MN Reparations Board or for emergency funds if appropriate.

E. During the Court Process

The advocate assists in tracking the case throughout the court process; notifying the child and his or her family or caregivers of all hearing dates and times as well as any changes in court schedule. The advocate serves as a liaison between the victim and the County Attorney. Throughout the process, the advocate will explore options with the victim/victim's family to ensure that he or she is able to make informed decisions. The advocate ensures that the victim and family are offered the opportunity to give input into plea offers prior to the offer being made to the defense and are informed about the process to express an objection to the plea agreement if the victim disagrees with the plea agreement. The advocate also assists the County Attorney's office in preparing victims for trial or testifying and supports victims and caregivers during the trial. He or she can arrange for a meeting with the probation officer who is preparing the pre-sentence investigation for the court, assist with completion of the affidavit for restitution to be filed with the court, assist the victim and caregivers in preparing a victim impact statement, and at the victim's request, support the victim in reading the statement at sentencing and/or read the statement on his or her behalf. During the court process, an advocate can also explain sentencing options including the MN Sentencing Guidelines, terms of incarceration, probation, supervised release and the rights of victim notification. The advocate will assess the victim's needs for ongoing support and make referrals as necessary to community resources.

F. Post-Sentencing Services

Following sentencing, the victim advocate can assist with the offender release notification process. Register a victim or caregiver to receive notification and other offender updates through MN Choice. The advocate can assist in developing a safety plan around an offender's release back to the community, notify the victim or caregiver in the event that an offender has been referred for civil commitment and provide support and information throughout the commitment process, and notify the victim or caregiver in the event that an offender is designated a level three offender at release. The advocate will also notify the Center coordinator of case disposition.

Chapter 8: Case Review Protocol

A. Purpose

Monthly case review meetings are critical to the proper functioning of the MDT and assist members in fulfilling their individual agency goals as well as the Center's mission to approach child abuse in a collaborative, efficient and timely manner. Through case review, members are able to assess child abuse investigations under review by the MDT, agree on a plan of action to protect the child from further abuse, recommend and implement services for the child and his or her family, enhance investigative, prosecutorial, medical and mental health procedures, reduce duplication and trauma to the child and family, review the status of ongoing cases, discuss changes in the status or important developments relevant to the MDT, and assist in the collection of data and information sharing for case tracking purposes and to improve services by the Center and MDT members.

B. Case Review Participants

The following MDT members will participate in regular case review meetings: Law Enforcement Officer; Child Protective Services Representative; County Prosecutor; Mental Health Provider; Medical Provider; Victim Advocate; and the MDT Facilitator.

C. Case Review Meetings

Case review meetings are held every third Wednesday of the month from 10:00-Noon at the Center building. MDT members are asked to block their calendars for monthly case review. MDT Case review is facilitated by the Center staff. Center staff will send out an agenda prior to the meeting with a list of cases to be staffed. The MDT Facilitator will ensure that cases are tracked and added to case review agendas as appropriate. All individuals directly involved in a scheduled case should attend the case review meeting. If a particular MDT member is unable to attend case review, he or she bears the responsibility to provide case updates to another MDT member from the agency and ensure the MDT gets timely updates. The MDT member substituting should provide recommendations and feedback from case review to his or her respective counterparts that may have been absent on the given day. Cases scheduled for review may include all newly referred cases to the Center, recently investigated cases, ongoing cases, and other cases in order to share updates, such as:

- Cases involving court action and/or law enforcement action, including updates on arrest of a suspect, charging decision by county attorney, settlement of case, trial or disposition.
- Cases involving updates from Mental Health, Medical and/or Child Protection Investigation
- Any other case requested by a team member to be brought to case review by contacting the Center Coordinator.

D. Case Review Feedback

All members of the MDT are encouraged to provide updates on cases and input as well as feedback to other members regarding case decisions, questions, and process issues. The MDT facilitator will ensure that all members of the team will participate in the review of each case. Representatives bringing a case for review specifically for support or guidance will inform the group of their needs. The group will respectfully assist with the information requested. The case review forum will all be used to educate team members on a variety of topics including diversity issues on a monthly basis. Quarterly educational sessions will be coordinated by Center Staff. All MDT members are encouraged to provide feedback about MDT functions and the case review process as needed. Questionnaire may be distributed to gather this feedback annually.

Chapter 9: Information Management Protocol

A. Team Information Sharing

Information about child abuse allegations, investigations, charges, and any evidence collected will be shared among the team members in accordance with Minnesota General Statutes including Minnesota Statute § 626.558 [see **Appendix D**]. All proceedings of team meetings will be confidential and signed statements of confidentiality will be maintained for each case reviewed by the team. Legal, ethical, and professional standards of practice will be upheld to ensure client privacy. Children and their caregiver(s) are given notice of their confidentiality rights and obligations on the check-in forms [see **Appendix H**]. The Victims Advocate is also available to explain these policies to the family and answer any questions they may have about how their information may be gathered, retained and used.

B. Confidentiality

Annual confidentiality agreements are signed by the Advisory Committee [see **Appendix J**]. Confidential data sharing agreements are also signed by MDT members during each monthly MDT Case Review meeting [see **Appendix J**]. Copies of these agreements can be found with the Center Administrative Assistant. Any requests for information related to the forensic interview will be forwarded to the appropriate law enforcement or child protective services entity. Medical and Mental Health information may be available upon request by going through the appropriate channels at Mayo Clinic to access a patient's medical record. Confidentiality of patient records will follow Mayo Clinic policies and HIPAA guidelines.

C. Record Retention

Data from intake forms will be entered in the NCATrak system within one week. The paper copies of the forms will be shredded once the data has been entered into the case tracking system, and access to NCATrak data is restricted to the security officers of the system who are members of Center staff [for more information, see **Chapter 10: Case Tracking**].

Any and all recordings made of forensic interviews, including the content and physical copies are the property and responsibility of law enforcement partners and/or child protective services. If drawings or other tools are used to help a child in giving his or her statement, the original images will be maintained by law enforcement and/or child protective services. A video of the forensic interview will be made available on a DVD upon completion of the interview at the Center. This DVD will leave the Center building with the law enforcement officer having jurisdiction over the case, in accordance with chain of custody requirements. The iRecord system utilized at the Center will keep the recorded interview on its internal server for a period of 60 days before the audio and video recording of the forensic interview and other information pertaining to it is purged.

Per the Protocol, all medical care at the Child Advocacy Center becomes a permanent part of the Mayo medical record. The documentation includes a medical history as well as physical exam findings and treatments outlined. Medical and mental health information will be stored in accordance with Mayo Clinic policies and protocols and applicable HIPAA guidelines. These records are marked as confidential in the child's medical record and are password protected. If colposcopic video or images are obtained, the video or images are downloaded immediately to a DVD. The copy of the DVD is located at the Child Advocacy Center in a locked cabinet and kept indefinitely.

If forensic evidence is collected, it is immediately labeled. Evidence collection is completed following SANE protocol. Following chain of custody requirements, the kits are kept in a locked refrigerator until law enforcement acquires the kit. The key is kept by the provider until the kit is collected.

Urine samples can be collected at the center (non-forensic) and sent to lab by a Mayo Clinic courier. These results are documented in the medical record. Positive results pertinent to the case are relayed to the caregiver and MDT members investigating the case.

Mayo Photography provides all still photography. These images are stored digitally and are only accessed with approval by the Child Advocacy Center staff. Furthermore, three sets of prints are made of the images and sent to the Administrative Assistant. The Assistant forwards a copy to CPS and/or LE, and keeps the remaining set of print/s in a locked file cabinet for three months before they are destroyed. Still photography is generally used for physical abuse and neglect cases.

Chapter 10: Case Tracking Protocol

A. Purpose:

Cases are tracked in order to serve children and their families in a thorough, culturally sensitive and timely manner. This information is also useful in order to produce statistical reviews, improve the quality of services provided, and maintain historical data of the clients served by the Center. Case tracking information is completely separate from the medical record and is only accessible by Center staff and MDT members either by request, or during monthly case review meetings.

B. Case Tracking Procedure:

All cases received by the Center are tracked by NCATrak. NCATrak is a computerized, web-based case tracking system developed by the National Children's Alliance to help Child Advocacy Centers track case specific information in a safe and user-friendly manner. Center staff members are responsible for oversight over data collection. Information is gathered throughout the life of the case beginning with referral and ending at its conclusion. All intake and check-in data will be entered into the system within one week of referral and regular updates will be made as needed. The paper copies of the forms will be destroyed once the information has been entered into the system. Information captured by these forms includes: demographics, history of abuse, interview details, family assessment, recommendations and service referral. The NCATrak system also captures information on case disposition, services offered, any special needs of the child, and action planning, which are entered during or following the case review meeting.

C. Information & Retention:

All identifying information stored in NCATrak is secure. Access to the Center database is restricted to the security officers of the system. Currently, the Center Program Coordinator and Administrative Assistant are the security officers, and MDT members can request specific information or ask for updates to be made to the database by contacting either of the two security officers.

National Children's Alliance (NCA) requires quarterly data submission regarding cases seen at a child advocacy center. Information gathered by the NCA through the NCATrak is non-identifying and includes characteristics such as age and gender of child, age and gender of the alleged offender, relationship of the offender to the child, type of abuse, race, etc. [for details, see **Appendix K**]. The information stored in NCATrak database is kept indefinitely.

Chapter 11: Cultural Sensitivity, Competency and Awareness

A. Vision

Mayo Clinic Child and Family Advocacy Center (Center) will deliver services that are responsive and inclusive to all individuals of diverse ethnic cultural backgrounds. All Center staff in dealing with each other, clients, MDT members, the Advisory Board and the public in general not only value diversity but also:

- Are aware of differences in values, communication styles, spirituality, and definitions of family AND are accepting of those differences.
- Are aware of one's own cultural values and identity and understand how cultural conditioning influences our beliefs about human behavior, values, communication, biases, etc.
- Are conscious of the dynamics that are inherent when cultures interact.
- Share cultural knowledge.
- Develop necessary adaptations when delivering services which reflect an understanding of diversity between and within cultures.

These elements are demonstrated in all services that the Center delivers. They are also reflected in the practices and policies of the Center as well as in the attitudes of Center staff.

In order to accomplish these goals, the Center provides a system of care that displays cultural sensitivity and competence. This system of care encompasses a number of elements, including environment of care, staff knowledge, skill and attitudes, tools used in the service delivery process and personnel management.

B. Purpose

Mayo Clinic is committed to building a caring service environment that encompasses a deep regard for human diversity, and a genuine understanding of the many differences, including race, ethnicity, gender, age, socio-economic status, national origin, sexual orientation, disability and religion that will allow all staff to achieve and contribute to their fullest potential. In conjunction with this commitment, Mayo Clinic's goal is to serve patients, families and one another with respect, concern, courtesy and responsiveness. Inclusion is a core element for successfully achieving diversity and a climate and culture of belonging, respect, and value for all. An inclusive climate that nurtures, supports and respects the individuality and contributions of everyone and encourages engagement and connection throughout the institution is essential to Mayo Clinic's success in patient care, education and research. It is a duty and obligation of all who provide services and pursue education at Mayo Clinic to share in this responsibility of creating and maintaining a multicultural environment in which the dignity and support of the individual is respected.

C. Policy

Mayo Clinic selects persons for appointment, employment or admission and, promotes, transfers and compensates such persons on the basis of individual capability, potential or contribution to the programs and goals of the institution. In making these selections and subsequent personnel decisions, Mayo Clinic actively encourages the recognition, development and optimal use of the capabilities of all staff and students, regardless of sex, age, religion, national origin, marital status, color, creed, sexual orientation, disability (physical and mental), genetic information, veteran status, and status with regard to public assistance.

Equal opportunity in employment and education at Mayo Clinic is a moral and legal obligation. Mayo Clinic is also committed to upholding federal and state laws prohibiting discrimination towards any individual as well as preventing discrimination towards any individual. An inclusive climate will be supported through professional development, education, policy, and practice.

The Mayo Clinic Diversity and Inclusion Committee, appointed annually by the Executive Committee, in coordination with the Diversity and Inclusion Subcommittees at the Arizona and Rochester sites, oversee Mayo Clinic activities in support of diversity and inclusion. The Committee's role is to coordinate, communicate, and stimulate ongoing efforts throughout Mayo Clinic. The Committee's liaisons with various departments, such as the Department of Human Resources and other appropriate departments and committees, address the primary responsibilities vested in them for monitoring related activities and compliance related to personnel and academic policies.

Per Mayo Clinic policy and in compliance with federal and state laws, the Center does not discriminate on the basis of race, gender, age, religion, national origin, marital status, color, creed, sexual orientation, physical and mental handicap, veteran status, and status with regard to public assistance. The Center advocates for policies and practices which are sensitive and responsive to the ethnic and cultural diversity of children and their families in Olmsted County. Center staff and MDT members maintain responsibility for enhancing cultural sensitivity, competency and awareness. Each child and caretaker entering the Center is treated with consideration and respect for personal dignity, autonomy and privacy. During the case management process, cross-cultural issues, special needs and disabilities are addressed by team members.

D. Interpreter Services

The Center works closely with team members to help determine if the child and his/her family have communication needs. If there is a language difference, an interpreter will be brought in to help with services any time the family is on-site. The Center is able to access and utilize the certified interpretation services of IMAA, The Language Line for phone interpretation in over 100 languages, or Mayo Clinic interpreting staff when needed for those families whose primary language is not English. For hard of hearing or deaf clients and/or family members, a Mayo Clinic sign language interpreter is used. Interpreters are available through Mayo Clinic Language Department by contacting the Center to assist with coordination and scheduling. Interpreters may also be available through contracts already in place with Olmsted County Community Services and Law Enforcement. If Mayo interpreters are utilized, the Center will cover the cost associated with their use. If non-Mayo providers are utilized, the cost will be the responsibility of the initiating agency. Olmsted County uses the following interpreter services:

Primary: IMAA
2500 Valleyhigh Drive NW
Rochester, MN 55901
Phone number: 507-289-5960 | Fax number: 507-289-6199

Secondary: Garden and Associates
Daytime number 877-859-8800 | After 5:30 P.M. 612-619-6030 | Pager: 952-235-1716

Sign Language (ASL): Southern MN Interpreter Referral
Phone number: 866-333-9275

E. Cultural Competency Plan

Definitions

BIOLOGICAL RACIAL GROUPS COMMON TO OLMSTED COUNTY: There exist natural, physical divisions among humans that are hereditary, that are roughly but correctly captured by terms like African, Asian and Pacific Islanders, Hispanic and European. These are not genetically distinct branches of humankind.

- Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.
- Black or African American: A person having origins in any of the black, racial groups of Africa.
- Caucasian/White: A person having origins in any of the original peoples of Europe or North Africa.
- Middle Easterners: People from the "Middle East" are from a huge region that includes the Arabian Peninsula, Turkey, Iran, Iraq, Syria, Lebanon, and Jordan.
- Multiracial: Those people who belong to two or more of the federally designated racial categories.
- Native American Indian or Alaska Native (INUITS): A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
- Native Hawaiian or other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

CULTURE- The customary beliefs, social forms, and material traits of a racial, religious, or social group.

CULTURAL COMPETENCE – An acceptance and respect for difference, a continuing self-assessment regarding culture, a regard to the dynamics of difference, engagement in ongoing development of cultural knowledge, and resources and flexibility within service models to work toward better meeting the needs of the minority populations. The cultural competency of an organization is demonstrated by its policies and practices.

CULTURALLY COMPETENT SERVICES: The delivery of services that are responsive to the cultural concerns of racial and ethnic groups, including their language, histories, traditions, beliefs and values is central to the provision of culturally competent care. Culturally competent services embrace the principles of equal access and non-discriminatory practices in service delivery. Culturally competent organizations work in conjunction with natural, informal support and helping networks within culturally diverse communities (e.g. neighborhood, civic and advocacy associations; local/neighborhood merchants and alliance groups; ethnic, social, and religious organizations; and spiritual leaders and healers) to enhance consumer centeredness and improve overall care.

CULTURAL DIVERSITY – Refers to differences in race, ethnicity, language, nationality, religion, age, disability, gender, sexuality, or family situation among various groups within a community.

DIVERSITY: Individuals are exposed to many differences, such as language, race, ethnicity, religion, sexual orientation, socio-economic status, age, geographic location, physical ability, etc. Diversity between groups must be recognized, but also the diversity within them must be recognized, as individuals may share nothing beyond similar physical appearance, language, or beliefs. These differences may affect health beliefs, practices, and behavior on the part of both the consumer and the organization. This may also influence the expectations that consumers and the organization may have of each other.

ETHNIC GROUP: In the US Census, only the Hispanic group is treated as "ethnic" and not "racial". It includes a person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin, regardless of race. The term "Spanish origin" can be used in addition to "Hispanic or Latino."

HEALTH DISPARITIES: Population-specific differences in the presence of disease, health outcomes, or access to health care.

RELIGION: A set of beliefs concerning the cause, nature, and purpose of the universe, usually involving devotional and ritual observances, and often containing a moral code governing the conduct of human affairs. Aspects of religion include narrative, symbolism, beliefs, and practices that are supposed to give meaning to the practitioner's experiences of life. Whether the meaning centers on a deity or deities, or an ultimate truth, religion is commonly identified by the person's or group's rituals, ethics, convictions, lifestyle, traditions, music and art, among other things, and is often interwoven with society and politics. It may focus on specific supernatural, metaphysical, and moral claims about reality (the cosmos and human nature) which may yield a set of religious laws, ethics, and a particular lifestyle.

TOLERANCE – The capacity for or the practice of recognizing and respecting the beliefs or practices of others.

Cultural considerations include but are not limited to: ethnicity, race, age, gender, primary language and communication considerations, sexual orientation, life style preference, immigration status, spiritual beliefs and practices, physical abilities and limitations, literacy, employment, and socioeconomic status.

Cultural Diversity Training

All Center members are required to participate in educational experiences that address cultural diversity throughout the year. Training may occur in the MDT members agency of employment, in the community or be provided by the Center. The Center keeps MDT members informed about local trainings throughout the year. The Mayo Clinic Language Department has been contacted to see if they can assist in training. The Diversity Council has been contacted to tour the Center, and see if they can provide bi-annual education to the MDT. Olmsted County Community Service require staff have to attend 5 week mandatory Diversity training that is put on by internal and external staff. They are also encouraged to do a yearly training of their choice. Staff at Mayo Clinic also work with the Office of Diversity and Inclusion and have opportunities throughout the year to participate in training. Because Mayo Clinic is recognized by patients, employees, peer institutions, and the community as the leading model for diversity and inclusion, the Diversity and Inclusion Roadmap is a guide [See **Attachment Q**: Diversity and Inclusion Roadmap].

Center and MDT Response

The Center makes every attempt to cater to a diverse population. There is a diverse selection of toys, books, magazines, and movies provided in the Center's waiting areas. The forensic interview dolls utilized are of many ethnicities and ages. The interiors of the Center premises are neutral and welcoming to diverse populations and age groups.

Services provided by the Center are made available to families regardless of their ability to pay. All services conducted by a Mayo Clinic medical provider, must be billed. However, if the Center identifies that charges will cause a significant financial hardship to the family, the Mayo Clinic Business Office will be contacted by the CAC and assist the family according to their needs.

During initial contacts with the family, it will be asked if the alleged victim or non-offending caregiver has a disability or special need. Information will be gathered about the nature of the disability/need, including the type and extent of impairment. If accommodations are needed, arrangements will be made prior to the appointment.

- **Adaptive Equipment** - If the child uses adaptive equipment, such as hearing aids, wheelchairs, or helmets, it is important to recognize that this equipment may be seen as an extension of the body and should be treated as such.
- **Cognitive Impairment** - Severity of impairment should be determined to the extent possible and questions should be adjusted to reflect the child's mental age, rather than chronological age. Despite knowledge of a child's mental age, the interviewer should not assume that a child has an understanding of a specific word. The interviewer should assess the child's use of words during rapport building and capitalize on the words the interviewer is sure the child understands.
- **Learning Disabilities** - If the child is reported to have learning disabilities, it is important to understand the extent of the learning disability (if possible). It is possible for a child to have a focal deficit in one area of learning or information processing. If this is the case, questioning should be adjusted to accommodate this disability.
- **Behavioral Concerns** - Certain disabilities will include stereotypic (repetitive) behaviors, such as rocking, hand flapping, head hitting, and etc. If these behaviors become excessive during the appointment, this may be a sign of stress, and the child should be reminded that he/she could ask for a break or stop at any time. It is important that children with disabilities be frequently reminded that they can and should disagree if anything said is either wrong or misunderstood.
- **Interpreters** - The investigators, child protection social workers, and/or Center staff will ensure that provisions are made for non-English speaking and deaf or hard of hearing children and their non-offending family members throughout the investigative process. For purposes of forensic interviewing, it is recommended that a neutral interpreter agreed upon by the team conduct interpretation. Family members should not be used. If utilizing an interpreter, the interpreter must be seated in the interview room in such a manner that the interpreter's face and gestures may be seen at the same time as the child's. When a referral is received and a translator is required, an appropriate translator will be contacted by and MDT member and informed of the date and time of the forensic interview, including the pre-interview. Staff will provide a tour of the Center, and introduce them to the forensic interviewer and MDT members to review the forensic interviewing protocol and any services the family may need [See also **Protocol: Chapter 4**].

- **Emotional Disabilities** - Many individuals with emotional/mental health challenges lack adequate coping mechanisms under stress, and may demonstrate more acute post-traumatic stress symptoms during the interview. If the interviewer suspects this, the pace of the interview must be adapted and/or stopped to prevent overwhelming the child. If the child has an emotional disability, attempts to make the interviewing environment as comfortable as possible may be useful. It is the policy that parents not be allowed in the interview room during the interview, they may be allowed as last resort, with instructions to not talk during the interview and to not attempt to guide the child's response in any way.
- **Medication** - During coordination, it is important to determine if the child is currently taking any medicine and what, if any, side effects are present. Parents should be asked about the best time for an appointment for the child, considering the child's routine and the effects of the medicine. It is important to remind the parent to be sure that the child receives his/her medicine on the day of the appointment.

If family members need mental health services that are unique to their particular culture, the MDT will make a referral to a local mental health counselor or therapist with the training and skills relevant to the family member's culture.

Cultural Diversity Assessment and Planning

Olmsted County Demographics:

The Child Advocacy Center serves Olmsted County. Demographics are from the 2010 US Census.

Total population of MN:	5,344,861	
Total population of Olmsted County, MN:	144,248	
Under the age of 19:	8,826	
Caucasian (Not categorized as Hispanic):	123,605	85.7%
Hispanic/Latino (of any race):	6,801	4.2%
Black/African American:	6,870	4.8%
American Indian/Alaskan Native:	353	0.2%
Asian:	7,806	5.4%
Some Other Race:	2,368	1.6%
Two or more Races:	(3,181)	2.2%
Foreign Born:	13,305	9.4%

In Olmsted County, 10,990 (8.8%) of residents over the age of 5 are designated with a disability. Approximately 8.4% live in poverty. Whites are the largest group in our community. However, Somalis make up the largest minority group. While English is the primary language spoken in Olmsted County, 12.2% of people over the age of five speak a language other than English. There are 50-60 different languages spoken at home and in our schools according to the Diversity Council of Rochester.

Clients Seen at the Center:

Of the children served by the Center in 2012, 22% were under the age of 5 and 78% between the ages of 5 and 18. Female clients made up 78%. Male clients made up 22%. Caucasian children made up 74% of those seen, and 13% of children were Hispanic. All other races and unknown

made up less than 13% of children seen. Less than 1% needed an interpreter of any kind. Based on these demographics, the Center has done special training with the language department at Mayo to interpret during forensic interviews in both Spanish and Somali. Furthermore, Child Protection is currently actively recruiting a Spanish-speaking forensic interviewer for 2013. This forensic interviewer would improve the MDT experience for Hispanic children and their families in Olmsted County.

Composition of the Board and Staff:

Center staff is 66% female and consists of 100% staff members that are Caucasian. We have four trained interpreters that work directly with our team from Hispanic and Somali backgrounds. The Center Advisory Board is 43% female and 57% male. The board includes members of varied age groups and educational and professional backgrounds. We will continually strive to diversify our board as opportunities arise.

Depending on the cultural, economic, social or legal needs of each family, the Center Staff can connect the child and his/her non-offending caregiver(s) to various resources in the Rochester Area [See **Appendix L: Olmsted County Community Connections 2012-2013**].

Program Specific Goals for 2013:

1. **April 2013:** Invite Savita Katarya from the Diversity Council of Rochester, MN to tour the Center and provide recommendations and feedback about our facility and our policies and procedures. Email invitation has been sent.
2. **June 2013:** Spirituality and religion are important components of diversity in Olmsted County. To better serve the various faiths and spiritual needs of clients and their families, the Center will attempt to establish relationships with faith-based community organizations, including Mayo Clinic Chaplain Services.
3. **August 2013:** Perform outreach to the African Development Center, Alianza Chicana Hispana Latino Americana (Alliance of Chicanos, Hispanics, and Latin Americans), and the Somali Community Service Organization. Center Staff will conduct a presentation by June 2013 on child abuse and the MDT approach to audiences and provide a tour of the Center facility. At the conclusion of the presentation, audience members fill out a survey about their views on the presentation, how the MDT and the Center can improve itself to better serve that particular community and any other cultural concerns or issues they may have [See **Appendix P: Draft Minority Feedback Form**]. Results from this feedback will be collected at used at the end of 2013 to improve the services of the Center and inform program goals for 2014.
4. **December 2013:** Recruit a Spanish-speaking forensic interviewer to better serve the Hispanic clients seen at the Center. This is an on-going goal with Olmsted County.

Outcome Evaluation Process

The cultural competency plan is a work in progress and will be subject to on-going evaluation and revision and will be updated yearly. The Center advisory board will devote a meeting at the end of each year to evaluating the cultural competency plan and set goals for the following year. Evaluation will take into consideration the caregiver and agency surveys, the feedback from diverse population and completion of our stated goals. The evaluation will include identifying successes and gaps within the cultural competency plan.

Chapter 12: Staff Development & Training

Education and training of MDT members and Staff are critical to the success of the Center's mission of assisting children and families who have been victims of child abuse. The various partner agencies in Olmsted County represented at the Center provide an invaluable resource for community education as well as professional development. The Center will promote staff and team development by offering a variety of on-going educational opportunities targeting the various professional disciplines represented on the MDT.

A. New Member Training

New members of the MDT will be required to complete a training session regarding MDT process/protocols and responsibilities. This training will be created with input from MDT members and will be updated annually or as needed. Each individual agency may continue to remain responsible for any internal agency-specific new-hire training.

B. Education Calls

Every month, the Midwest Region Children's Advocacy Center (MRCAC) Education Calls Schedule will be incorporated into the Center calendar and MDT members and staff will be notified of the numerous educational modules via email so that they may take advantage of opportunities. The Program Coordinator may notify the MDT about Education Calls of particular importance to Olmsted County and facilitate group participation and training.

C. Diversity Training

The Center may partner with the Diversity Council of Rochester or other local agencies to offer diversity training sessions to Center staff and MDT members. In keeping with the mission of the Center to promote cultural sensitivity and diversity in all aspects of case management, all MDT members will be encouraged to attend at least one session of diversity training annually.

D. Forensic Interview Training:

Forensic Interviewers should maintain their interview skills by periodically participating in refresher training relevant to best practices for child forensic interviews. All forensic interviewers will participate in peer review. Peer review is available the 3rd Wednesday of each month from 12:00- 1:30 at 2117 Campus Dr. SE Rochester, MN.

Chapter 13: Conflict Resolution

A. General Feedback

Members of the MDT are encouraged to provide feedback and suggestions regarding Center operations, utilization, equipment etc. This can be done by contacting the Program Coordinator who may then bring those items to the attention of the Operations Workgroup and/or the Advisory Committee. The Protocol will be reviewed on an annual basis providing an additional opportunity for MDT members to discuss concerns, highlight what is working well, and make suggestions for improvements.

The NCA Outcome Measurement System will be used to gather feedback regarding the functioning of the MDT processes. [see Appendix MJ]. The MDT will receive a general survey two times throughout the year in June and December. These will be given to the Operations Workgroup for distribution to their respective staff members on the MDT. Surveys can be returned to the lock box in the reception area or in a postage paid envelope upon request. Case specific surveys will be filled out by the MDT for the first four cases of each month. These surveys will be given during the pre-staffing meeting and should be returned to the lock box in the reception area following the post-staffing meeting.

The survey box in the lobby will be emptied every Friday by the receptionist/administrative assistant. The results will be tallied and forwarded to Minnesota Children's Alliance Executive Director. Feedback will also be provided to the Operations Workgroup to guide future protocol and program changes.

B. Grievance Procedure

In order to foster and support an environment of multidisciplinary cooperation, MDT members and staff are encouraged to candidly discuss any issues or disagreements during group meetings. As conflicts arise, the individual MDT member is encouraged to respectfully discuss the concerns with the parties involved. The Center Coordinator is available to assist MDT members in facilitating discussions or resolving these issues. Once the issue has been addressed between the involved MDT members, the conflict and/or the resolution of that conflict may be addressed by the Operations Workgroup.

Disagreements that cannot be resolved in this informal manner may be resolved through two formal channels:

1. Disagreements or grievances about case disposition should be brought to the attention of the supervisor of the organization against which the team member/s have an issue, either verbally or in writing. The grievance should also be brought to the attention of the individuals against whom the grievance is being lodged, so that internal agency conflict resolution procedures can be followed.
2. Disagreements or grievances about an individual MDT member should be brought to the attention of the supervisor of that team member, either verbally or in writing, so that internal agency conflict resolution procedures can be followed.

C. Conflict of Interest

Child abuse is a serious and widespread phenomenon within the community. As such, a child or family referred to the Center may have pre-existing relationships with partner agencies, Center

staff or MDT members. A conflict of interest may arise when the victim, non-offending caregiver or alleged offender has a relationship with Center staff or MDT members that could reasonably impact the function or decision making process of the Center. If a perceived conflict of interest arises with a particular agency, it is the responsibility of the particular individual to discuss whether there is a conflict of interest with his or her agency. Each agency's internal conflict of interest policies will inform its decision whether a Center referral is appropriate. Center referrals may still be made even though a particular agency has recused itself. Any member of the MDT may recuse him or herself from a case for a perceived conflict of interest per his or her agency guidelines at any time and without consequence.

Note: If a family voices concerns or refuses to be seen by a Mayo Medical Provider on the MDT, a Center referral may still be made but a discussion about medical care will occur at the time of the referral between the worker aware of the concern and Center staff. If a family voices concerns or refuses to participate in the MDT process, law enforcement and child protection will continue to utilize the center for the investigative components of the case.

D. Program Evaluation

NCA Outcome Measurement System is used to gather information about the experiences of the caregiver and client child seen at the Center. The receptionist will give the caregiver survey to each child's caregiver at the conclusion of the CAC case. The surveys will be returned to the locked survey box in the lobby or by the caregiver in a postage paid envelope given at the end of the visit. A six month follow up survey will be mailed out to each family by the administrative assistant with a self-addressed and postage paid envelope enclosed.

The survey box in the lobby will be emptied every Friday by the receptionist/administrative assistant. The results will be tallied and forwarded to Minnesota Children's Alliance Executive Director. Feedback will also be provided to the Operations Workgroup to guide future protocol and program changes.

Appendices

Appendix A: County Board Request and Approval

REQUEST FOR COUNTY BOARD ACTION

AGENDA DATE: July 12, 2011

REQUESTED BY: Mark Ostrem, Olmsted County Attorney

STATE ITEM OF BUSINESS WITH BRIEF ANALYSIS AND ACTION REQUESTED OF THE COUNTY BOARD:

Request the creation of the Child Advocacy Center Multidisciplinary Child Protection Team pursuant to Minn. Stat. §626.558. The creation of this team will further Olmsted County's goals in:

- (1) Investigating child sex abuse, child physical abuse, missing and abducted children;
- (2) Identifying offenders and presenting evidence for the prosecution of violators of laws of the State of Minnesota with the least amount of trauma to the child victims; and
- (3) Providing services and facilitating available resources to the victims and their families.

BACKGROUND:

Minn. Stat. §626.558 provides that "a county *shall* establish a multidisciplinary child protection team." Minn. Stat. §626.558, subd. 1 (2011). The "multidisciplinary child protection team may provide public and professional education, develop resources for prevention, intervention, and treatment, and provide case consultation to the local welfare agency or other interested community-based agencies." Minn. Stat. §626.558, subd. 2 (2011).

In June of 2010, the Mayo Clinic approached Olmsted County with an interest in establishing a multidisciplinary child protection team to serve southeast Minnesota. Since then, the Mayo Clinic, in collaboration with several Olmsted County agencies, has been working to meet the standards needed to become an accredited chapter member of the National Children's Alliance. For the past few months, the collaborative effort has been successful in promoting a protocol to best address the concerns surrounding child victims.

The County Board is now asked to formally establish this collaborative team pursuant to Minn. Stat. §626.558.

COUNTY BOARD ACTION REQUESTED:

Pursuant to Minn. Stat. §626.558, create the Child Advocacy Center Multidisciplinary Child Protection Team.

Reviewed With Additional Material Provided: _____
County Administrator

County Board Minutes for July 12, 2011

<p>Approved the one-year lease agreement for Friendship Place to occupy space at 1429 4th Avenue SE in Rochester. This lease will be in effect from July 1, 2011, through June 30, 2012, at the rate of \$1,000/month for a total rent sum of \$12,000 with one monthly payment waived at the direction of the Olmsted County Board.</p>	<p>Appr Friendship Place lease agmt</p>
<p>Approved the creation of the Child Advocacy Center Multidisciplinary Child Protection Team pursuant to Minn. Stat. §626.558. Since June of 2010, Several Olmsted County agencies and Mayo Clinic have been working to meet the standards needed to become an accredited chapter member of the National Children's Alliance.</p>	<p>Appr Child Advocacy Ctr Multidisciplinary Chld Prtctn Tm</p>
<p>Approved the participation in the FY2011 Edward Byrne Memorial Justice Assistance Grant (JAG) and the Memorandum of Understanding contract with the City of Rochester. The City of Rochester will act as the fiscal agent for this grant. This year the City of Rochester has been allocated \$35,887 but Olmsted County is not eligible for a direct allocation because we are considered to be in a disparate jurisdiction. The JAG requires the City of Rochester and Olmsted County remain partners for the purposes of this grant.</p>	<p>Appr JAG & MOU w/City of Rochester</p>
<p>Approved the 2011 Chester Woods Park Deer Hunt to be held November 19-27, 2011. During this timeframe, there will be a suspension on the enforcement of the Chester Woods Park regulations prohibiting firearms and hunting. This hunt authorizes the selection of approximately 54 hunters by lottery for permission to hunt within the park and to close the park to all other users during that time period.</p>	<p>Appr 2011 Chester Woods Park Deer Hunt</p>
<p>CONSENT CALENDAR MOTION: Ayes 6, Nays 0</p>	
<p>DISCUSSION/DECISION</p>	
<p>Bier moved; Brown seconded, to award Contract #11-136S to A&B Welding & Construction, Inc. in the amount of \$77,056 for the OWEF Boiler #1 Cladding and Screen Tube Modifications and also for the Project Manager's change order authority to be in the amount of \$10,000. MOTION: Ayes 6, Nays 0</p>	<p>Awd cntrct 11-136S to A&B Welding & Cnstrctn</p>
<p>Bier moved; Perkins seconded, to authorize the County Administrator to sign the Determination of Responsible Government Unit agreement with Mn/DOT designating Olmsted County as the Responsible Governmental Unit (RGU) for review of the state Environmental Assessment Worksheet (EAW) for the TH 63 South Subarea Transportation Study and Corridor Preservation Plan. MOTION: Ayes 6, Nays 0</p>	<p>Appr Dtrmtn of Rspnsbl Govt Unit agmt</p>
<p>Richard Devlin, County Administrator, addressed the Board with a review and recommendations for the County with the State shutdown still in effect. Paul Fleissner, Community Services Director; and Judy Voss,</p>	<p>State shtdwn update</p>

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Appendix B: 2012-2013 Committee Members

Executive Committee Members

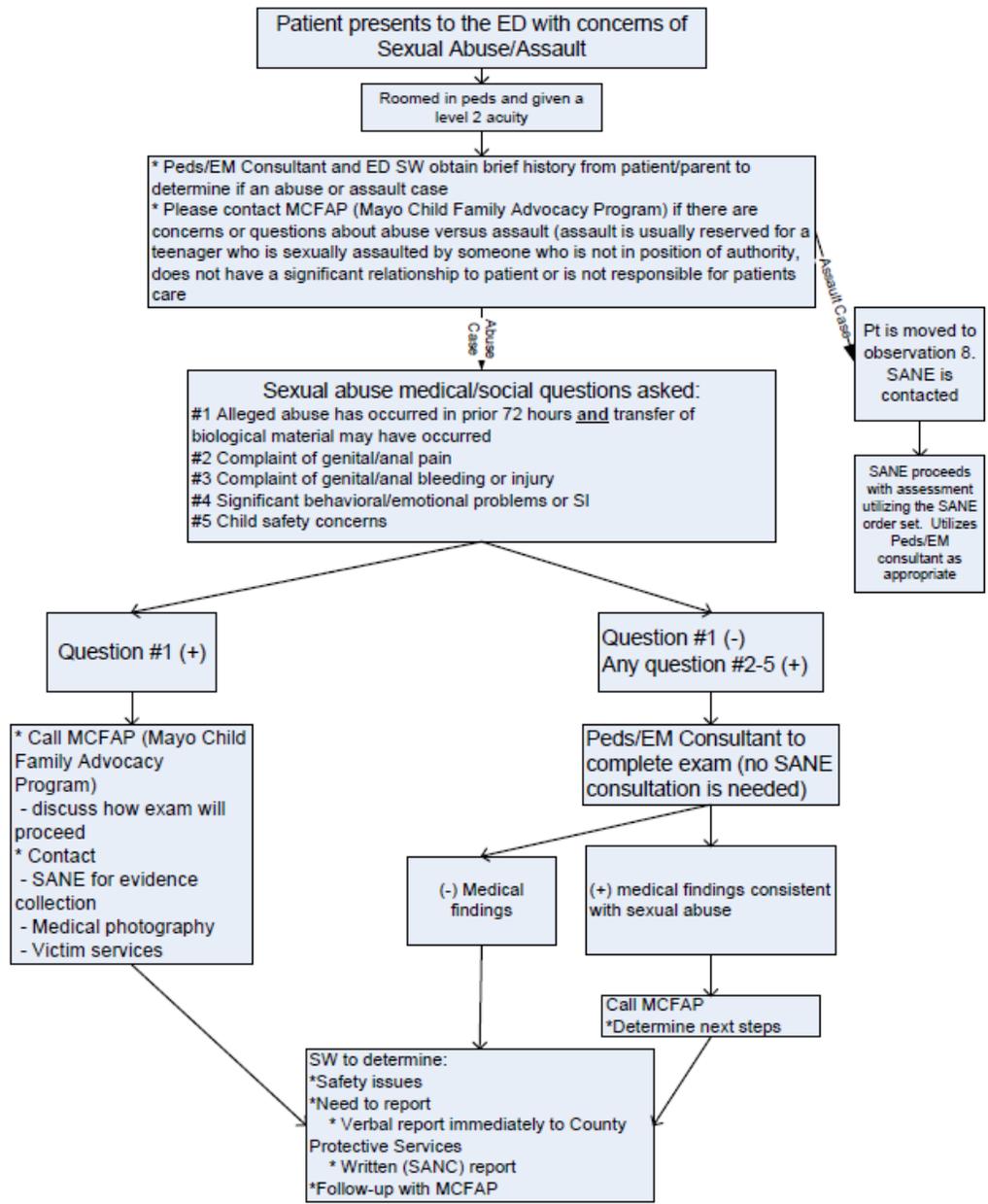
- Dr. Daniel Broughton (Mayo Clinic)
- Chief Roger Peterson (Rochester Police Department)
- Sheriff Dave Mueller (Olmsted County Sheriff's Office)
- Jodi Wentland (Child and Family Services)
- Mark Ostrem (Olmsted County Attorney's Office)
- Jeanne Ronayne (Victim Services)
- Margene Gunderson (Public Health)
- Kory Schmitt (Mayo Clinic)

Operations Workgroup

- Lisa Fink
- Lt. Casey Moilanen
- Investigator Anne Johnson
- Captain Bill Reiland
- Jessie Stratton
- Kris Giere
- Kathy Wallace
- Amy Thompson
- Marilyn Deling
- Kory Schmitt

Appendix C: Mayo Clinic Emergency Department Algorithm

Pediatric Sexual Abuse/Assault Cases Process Flow Within the ED (≤ 17 years of age)



Appendix D: Statute Citations

260C.007 Definitions

Subd. 4. Child.

"Child" means an individual under 18 years of age. For purposes of this chapter and chapter 260D, child also includes individuals under age 21 who are in foster care pursuant to section 260C.451

Subd. 14. Egregious harm.

"Egregious harm" means the infliction of bodily harm to a child or neglect of a child which demonstrates a grossly inadequate ability to provide minimally adequate parental care. The egregious harm need not have occurred in the state or in the county where a termination of parental rights action is otherwise properly venued. Egregious harm includes, but is not limited to:

(1) conduct towards a child that constitutes a violation of sections 609.185 to 609.21, 609.222, subdivision 2, 609.223, or any other similar law of any other state;

(2) the infliction of "substantial bodily harm" to a child, as defined in section 609.02, subdivision 7a;

(3) conduct towards a child that constitutes felony malicious punishment of a child under section 609.377;

(4) conduct towards a child that constitutes felony unreasonable restraint of a child under section 609.255, subdivision 3;

(5) conduct towards a child that constitutes felony neglect or endangerment of a child under section 609.378;

(6) conduct towards a child that constitutes assault under section 609.221, 609.222, or 609.223;

(7) conduct towards a child that constitutes solicitation, inducement, or promotion of, or receiving profit derived from prostitution under section 609.322;

(8) conduct towards a child that constitutes murder or voluntary manslaughter as defined by United States Code, title 18, section 1111(a) or 1112(a);

(9) conduct towards a child that constitutes aiding or abetting, attempting, conspiring, or soliciting to commit a murder or voluntary manslaughter that constitutes a violation of United States Code, title 18, section 1111(a) or 1112(a); or

(10) conduct toward a child that constitutes criminal sexual conduct under sections 609.342 to 609.345.

MN Statute 626.556 Reporting of Maltreatment of Minors

Subd. 2. Definitions

(d) "Sexual abuse" means the subjection of a child by a person responsible for the child's care, by a person who has a significant relationship to the child, as defined in section 609.341, or by a person in a position of authority, as defined in section 609.341, subdivision 10, to any act which constitutes a violation of section 609.342 (criminal sexual conduct in the first degree), 609.343 (criminal sexual conduct in the second degree), 609.344 (criminal sexual conduct in the third degree), 609.345 (criminal sexual conduct in the fourth degree), or 609.3451 (criminal sexual conduct in the fifth degree). Sexual abuse also includes any act which involves a minor which constitutes a violation of prostitution offenses under sections 609.321 to 609.324 or 617.246. Sexual abuse includes threatened sexual abuse which includes the status of a parent or household member who has committed a violation which requires registration as an offender under section 243.166, subdivision 1b, paragraph (a) or (b), or required registration under section 243.166, subdivision 1b, paragraph (a) or (b).

(g) "Physical abuse" means any physical injury, mental injury, or threatened injury, inflicted by a person responsible for the child's care on a child other than by accidental means, or any physical or mental injury that cannot reasonably be explained by the child's history of injuries, or any aversive or deprivation procedures, or regulated interventions, that have not been authorized under section 121A.67 or 245.825.

Abuse does not include reasonable and moderate physical discipline of a child administered by a parent or legal guardian which does not result in an injury. Abuse does not include the use of reasonable force by a teacher, principal, or school

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employee as allowed by section [121A.582](#). Actions which are not reasonable and moderate include, but are not limited to, any of the following that are done in anger or without regard to the safety of the child:

- (1) throwing, kicking, burning, biting, or cutting a child;
- (2) striking a child with a closed fist;
- (3) shaking a child under age three;
- (4) striking or other actions which result in any nonaccidental injury to a child under 18 months of age;
- (5) unreasonable interference with a child's breathing;
- (6) threatening a child with a weapon, as defined in section [609.02, subdivision 6](#);
- (7) striking a child under age one on the face or head;

(8) purposely giving a child poison, alcohol, or dangerous, harmful, or controlled substances which were not prescribed for the child by a practitioner, in order to control or punish the child; or other substances that substantially affect the child's behavior, motor coordination, or judgment or that results in sickness or internal injury, or subjects the child to medical procedures that would be unnecessary if the child were not exposed to the substances;

(9) unreasonable physical confinement or restraint not permitted under section [609.379](#), including but not limited to tying, caging, or chaining; or

(10) in a school facility or school zone, an act by a person responsible for the child's care that is a violation under section [121A.58](#).

MN Statute 609.341

Subdivision 15: Significant relationship.

"Significant relationship" means a situation in which the actor is:

- (1) the complainant's parent, stepparent, or guardian;
- (2) any of the following persons related to the complainant by blood, marriage, or adoption: brother, sister, stepbrother, stepsister, first cousin, aunt, uncle, nephew, niece, grandparent, great-grandparent, great-uncle, great-aunt; or
- (3) an adult who jointly resides intermittently or regularly in the same dwelling as the complainant and who is not the complainant's spouse.

Subdivision 10 Position of authority.

"Position of authority" includes but is not limited to any person who is a parent or acting in the place of a parent and charged with any of a parent's rights, duties or responsibilities to a child, or a person who is charged with any duty or responsibility for the health, welfare, or supervision of a child, either independently or through another, no matter how brief, at the time of the act. For the purposes of subdivision 11, "position of authority" includes a psychotherapist.

MN Statute 609.342 Criminal Sexual Conduct in the First Degree

Subdivision 1. Crime defined.

A person who engages in sexual penetration with another person, or in sexual contact with a person under 13 years of age as defined in section [609.341, subdivision 11](#), paragraph (c), is guilty of criminal sexual conduct in the first degree if any of the following circumstances exists:

- (a) the complainant is under 13 years of age and the actor is more than 36 months older than the complainant. Neither mistake as to the complainant's age nor consent to the act by the complainant is a defense;
- (b) the complainant is at least 13 years of age but less than 16 years of age and the actor is more than 48 months older than the complainant and in a position of authority over the complainant. Neither mistake as to the complainant's age nor consent to the act by the complainant is a defense;
- (c) circumstances existing at the time of the act cause the complainant to have a reasonable fear of imminent great bodily harm to the complainant or another;
- (d) the actor is armed with a dangerous weapon or any article used or fashioned in a manner to lead the complainant to reasonably believe it to be a dangerous weapon and uses or threatens to use the weapon or article to cause the complainant to submit;

Mayo Clinic Child and Family Advocacy Center / Olmsted County MDT Protocol (2012)

- (e) the actor causes personal injury to the complainant, and either of the following circumstances exist:
- (i) the actor uses force or coercion to accomplish sexual penetration; or
 - (ii) the actor knows or has reason to know that the complainant is mentally impaired, mentally incapacitated, or physically helpless;
- (f) the actor is aided or abetted by one or more accomplices within the meaning of section [609.05](#), and either of the following circumstances exists:
- (i) an accomplice uses force or coercion to cause the complainant to submit; or
 - (ii) an accomplice is armed with a dangerous weapon or any article used or fashioned in a manner to lead the complainant reasonably to believe it to be a dangerous weapon and uses or threatens to use the weapon or article to cause the complainant to submit;
 - (g) the actor has a significant relationship to the complainant and the complainant was under 16 years of age at the time of the sexual penetration. Neither mistake as to the complainant's age nor consent to the act by the complainant is a defense; or
 - (h) the actor has a significant relationship to the complainant, the complainant was under 16 years of age at the time of the sexual penetration, and:
 - (i) the actor or an accomplice used force or coercion to accomplish the penetration;
 - (ii) the complainant suffered personal injury; or
 - (iii) the sexual abuse involved multiple acts committed over an extended period of time.

Neither mistake as to the complainant's age nor consent to the act by the complainant is a defense.

MN Statute 609.343 Criminal Sexual Conduct in the Second Degree
Subdivision 1. Crime defined.

A person who engages in sexual contact with another person is guilty of criminal sexual conduct in the second degree if any of the following circumstances exists:

- (a) the complainant is under 13 years of age and the actor is more than 36 months older than the complainant. Neither mistake as to the complainant's age nor consent to the act by the complainant is a defense. In a prosecution under this clause, the state is not required to prove that the sexual contact was coerced;
- (b) the complainant is at least 13 but less than 16 years of age and the actor is more than 48 months older than the complainant and in a position of authority over the complainant. Neither mistake as to the complainant's age nor consent to the act by the complainant is a defense;
- (c) circumstances existing at the time of the act cause the complainant to have a reasonable fear of imminent great bodily harm to the complainant or another;
- (d) the actor is armed with a dangerous weapon or any article used or fashioned in a manner to lead the complainant to reasonably believe it to be a dangerous weapon and uses or threatens to use the dangerous weapon to cause the complainant to submit;
- (e) the actor causes personal injury to the complainant, and either of the following circumstances exist:
 - (i) the actor uses force or coercion to accomplish the sexual contact; or
 - (ii) the actor knows or has reason to know that the complainant is mentally impaired, mentally incapacitated, or physically helpless;
- (f) the actor is aided or abetted by one or more accomplices within the meaning of section [609.05](#), and either of the following circumstances exists:
 - (i) an accomplice uses force or coercion to cause the complainant to submit; or
 - (ii) an accomplice is armed with a dangerous weapon or any article used or fashioned in a manner to lead the complainant to reasonably believe it to be a dangerous weapon and uses or threatens to use the weapon or article to cause the complainant to submit;
- (g) the actor has a significant relationship to the complainant and the complainant was under 16 years of age at the time of the sexual contact. Neither mistake as to the complainant's age nor consent to the act by the complainant is a defense; or

(h) the actor has a significant relationship to the complainant, the complainant was under 16 years of age at the time of the sexual contact, and:

- (i) the actor or an accomplice used force or coercion to accomplish the contact;
- (ii) the complainant suffered personal injury; or
- (iii) the sexual abuse involved multiple acts committed over an extended period of time.

Neither mistake as to the complainant's age nor consent to the act by the complainant is a defense.

MN Statute 609.344 Criminal Sexual Conduct in the Third Degree
Subdivision 1. Crime defined.

A person who engages in sexual penetration with another person is guilty of criminal sexual conduct in the third degree if any of the following circumstances exists:

(a) the complainant is under 13 years of age and the actor is no more than 36 months older than the complainant. Neither mistake as to the complainant's age nor consent to the act by the complainant shall be a defense;

(b) the complainant is at least 13 but less than 16 years of age and the actor is more than 24 months older than the complainant. In any such case if the actor is no more than 120 months older than the complainant, it shall be an affirmative defense, which must be proved by a preponderance of the evidence, that the actor reasonably believes the complainant to be 16 years of age or older. In all other cases, mistake as to the complainant's age shall not be a defense. If the actor in such a case is no more than 48 months but more than 24 months older than the complainant, the actor may be sentenced to imprisonment for not more than five years. Consent by the complainant is not a defense;

(c) the actor uses force or coercion to accomplish the penetration;

(d) the actor knows or has reason to know that the complainant is mentally impaired, mentally incapacitated, or physically helpless;

(e) the complainant is at least 16 but less than 18 years of age and the actor is more than 48 months older than the complainant and in a position of authority over the complainant. Neither mistake as to the complainant's age nor consent to the act by the complainant is a defense;

(f) the actor has a significant relationship to the complainant and the complainant was at least 16 but under 18 years of age at the time of the sexual penetration. Neither mistake as to the complainant's age nor consent to the act by the complainant is a defense;

(g) the actor has a significant relationship to the complainant, the complainant was at least 16 but under 18 years of age at the time of the sexual penetration, and:

- (i) the actor or an accomplice used force or coercion to accomplish the penetration;
- (ii) the complainant suffered personal injury; or
- (iii) the sexual abuse involved multiple acts committed over an extended period of time.

Neither mistake as to the complainant's age nor consent to the act by the complainant is a defense;

(h) the actor is a psychotherapist and the complainant is a patient of the psychotherapist and the sexual penetration occurred:

- (i) during the psychotherapy session; or
- (ii) outside the psychotherapy session if an ongoing psychotherapist-patient relationship exists.

Consent by the complainant is not a defense;

(i) the actor is a psychotherapist and the complainant is a former patient of the psychotherapist and the former patient is emotionally dependent upon the psychotherapist;

(j) the actor is a psychotherapist and the complainant is a patient or former patient and the sexual penetration occurred by means of therapeutic deception. Consent by the complainant is not a defense;

(k) the actor accomplishes the sexual penetration by means of deception or false representation that the penetration is for a bona fide medical purpose. Consent by the complainant is not a defense;

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(1) the actor is or purports to be a member of the clergy, the complainant is not married to the actor, and:

(i) the sexual penetration occurred during the course of a meeting in which the complainant sought or received religious or spiritual advice, aid, or comfort from the actor in private; or

(ii) the sexual penetration occurred during a period of time in which the complainant was meeting on an ongoing basis with the actor to seek or receive religious or spiritual advice, aid, or comfort in private. Consent by the complainant is not a defense;

(m) the actor is an employee, independent contractor, or volunteer of a state, county, city, or privately operated adult or juvenile correctional system, or secure treatment facility, or treatment facility providing services to clients civilly committed as mentally ill and dangerous, sexually dangerous persons, or sexual psychopathic personalities, including, but not limited to, jails, prisons, detention centers, or work release facilities, and the complainant is a resident of a facility or under supervision of the correctional system. Consent by the complainant is not a defense;

(n) the actor provides or is an agent of an entity that provides special transportation service, the complainant used the special transportation service, and the sexual penetration occurred during or immediately before or after the actor transported the complainant. Consent by the complainant is not a defense; or

(o) the actor performs massage or other bodywork for hire, the complainant was a user of one of those services, and nonconsensual sexual penetration occurred during or immediately before or after the actor performed or was hired to perform one of those services for the complainant.

MN Statute 609.345 Criminal Sexual Conduct in the Fourth Degree

Subdivision 1. Crime defined.

A person who engages in sexual contact with another person is guilty of criminal sexual conduct in the fourth degree if any of the following circumstances exists:

(a) the complainant is under 13 years of age and the actor is no more than 36 months older than the complainant. Neither mistake as to the complainant's age or consent to the act by the complainant is a defense. In a prosecution under this clause, the state is not required to prove that the sexual contact was coerced;

(b) the complainant is at least 13 but less than 16 years of age and the actor is more than 48 months older than the complainant or in a position of authority over the complainant. Consent by the complainant to the act is not a defense. In any such case, if the actor is no more than 120 months older than the complainant, it shall be an affirmative defense which must be proved by a preponderance of the evidence that the actor reasonably believes the complainant to be 16 years of age or older. In all other cases, mistake as to the complainant's age shall not be a defense;

(c) the actor uses force or coercion to accomplish the sexual contact;

(d) the actor knows or has reason to know that the complainant is mentally impaired, mentally incapacitated, or physically helpless;

(e) the complainant is at least 16 but less than 18 years of age and the actor is more than 48 months older than the complainant and in a position of authority over the complainant. Neither mistake as to the complainant's age nor consent to the act by the complainant is a defense;

(f) the actor has a significant relationship to the complainant and the complainant was at least 16 but under 18 years of age at the time of the sexual contact. Neither mistake as to the complainant's age nor consent to the act by the complainant is a defense;

(g) the actor has a significant relationship to the complainant, the complainant was at least 16 but under 18 years of age at the time of the sexual contact, and:

(i) the actor or an accomplice used force or coercion to accomplish the contact;

(ii) the complainant suffered personal injury; or

(iii) the sexual abuse involved multiple acts committed over an extended period of time.

Neither mistake as to the complainant's age nor consent to the act by the complainant is a defense;

(h) the actor is a psychotherapist and the complainant is a patient of the psychotherapist and the sexual contact occurred:

Mayo Clinic Child and Family Advocacy Center / Olmsted County MDT Protocol (2012)

- (i) during the psychotherapy session; or
 - (ii) outside the psychotherapy session if an ongoing psychotherapist-patient relationship exists. Consent by the complainant is not a defense;
- (i) the actor is a psychotherapist and the complainant is a former patient of the psychotherapist and the former patient is emotionally dependent upon the psychotherapist;
- (j) the actor is a psychotherapist and the complainant is a patient or former patient and the sexual contact occurred by means of therapeutic deception. Consent by the complainant is not a defense;
- (k) the actor accomplishes the sexual contact by means of deception or false representation that the contact is for a bona fide medical purpose. Consent by the complainant is not a defense;
- (l) the actor is or purports to be a member of the clergy, the complainant is not married to the actor, and:
- (i) the sexual contact occurred during the course of a meeting in which the complainant sought or received religious or spiritual advice, aid, or comfort from the actor in private; or
 - (ii) the sexual contact occurred during a period of time in which the complainant was meeting on an ongoing basis with the actor to seek or receive religious or spiritual advice, aid, or comfort in private. Consent by the complainant is not a defense;
- (m) the actor is an employee, independent contractor, or volunteer of a state, county, city, or privately operated adult or juvenile correctional system, or secure treatment facility, or treatment facility providing services to clients civilly committed as mentally ill and dangerous, sexually dangerous persons, or sexual psychopathic personalities, including, but not limited to, jails, prisons, detention centers, or work release facilities, and the complainant is a resident of a facility or under supervision of the correctional system. Consent by the complainant is not a defense;
- (n) the actor provides or is an agent of an entity that provides special transportation service, the complainant used the special transportation service, the complainant is not married to the actor, and the sexual contact occurred during or immediately before or after the actor transported the complainant. Consent by the complainant is not a defense; or
- (o) the actor performs massage or other bodywork for hire, the complainant was a user of one of those services, and nonconsensual sexual contact occurred during or immediately before or after the actor performed or was hired to perform one of those services for the complainant.

MN Statute 609.3451 Criminal Sexual Conduct in the Fifth Degree **Subdivision 1. Crime defined.**

A person is guilty of criminal sexual conduct in the fifth degree:

- (1) if the person engages in nonconsensual sexual contact; or
- (2) the person engages in masturbation or lewd exhibition of the genitals in the presence of a minor under the age of 16, knowing or having reason to know the minor is present.

For purposes of this section, "sexual contact" has the meaning given in section [609.341, subdivision 11](#), paragraph (a), clauses (i) and (iv), but does not include the intentional touching of the clothing covering the immediate area of the buttocks. Sexual contact also includes the intentional removal or attempted removal of clothing covering the complainant's intimate parts or undergarments, and the nonconsensual touching by the complainant of the actor's intimate parts, effected by the actor, if the action is performed with sexual or aggressive intent.

MN Statute 626.558

Subd. 1. Establishment of Team

A county shall establish a multidisciplinary child protection team that may include, but not be limited to, the director of the local welfare agency or designees, the county attorney or designees, the county sheriff or designees, representatives of health and education, representatives of mental health or other appropriate human service or community-based agencies, and parent groups. As used in this section, a "community-based agency" may include, but is not limited to, schools, social service agencies, family service and mental health collaboratives, early childhood and family education programs, Head Start, or other agencies serving children and families. A member of the team must be designated as the lead person of the team responsible for the

planning process to develop standards for its activities with battered women's and domestic abuse programs and services.

Subd. 2.Duties of team.

A multidisciplinary child protection team may provide public and professional education, develop resources for prevention, intervention, and treatment, and provide case consultation to the local welfare agency or other interested community-based agencies. The community-based agencies may request case consultation from the multidisciplinary child protection team regarding a child or family for whom the community-based agency is providing services. As used in this section, "case consultation" means a case review process in which recommendations are made concerning services to be provided to the identified children and family. Case consultation may be performed by a committee or subcommittee of members representing human services, including mental health and chemical dependency; law enforcement, including probation and parole; the county attorney; health care; education; community-based agencies and other necessary agencies; and persons directly involved in an individual case as designated by other members performing case consultation.

Subd. 2a.Sexually exploited youth outreach program.

A multidisciplinary child protection team may assist the local welfare agency, local law enforcement agency, or an appropriate private organization in developing a program of outreach services for sexually exploited youth, including homeless, runaway, and truant youth who are at risk of sexual exploitation. For the purposes of this subdivision, at least one representative of a youth intervention program or, where this type of program is unavailable, one representative of a nonprofit agency serving youth in crisis, shall be appointed to and serve on the multidisciplinary child protection team in addition to the standing members of the team. These services may include counseling, medical care, short-term shelter, alternative living arrangements, and drop-in centers. A juvenile's receipt of intervention services under this subdivision may not be conditioned upon the juvenile providing any evidence or testimony.

Subd. 3.Information sharing.

(a) The local welfare agency may make available to the case consultation committee or subcommittee, all records collected and maintained by the agency under section [626.556](#) and in connection with case consultation. A case consultation committee or subcommittee member may share information acquired in the member's professional capacity with the committee or subcommittee to assist in case consultation.

(b) Case consultation committee or subcommittee members must annually sign a data sharing agreement, approved by the commissioner of human services, assuring compliance with chapter 13. Not public data, as defined by section [13.02, subdivision 8a](#), may be shared with members appointed to the committee or subcommittee in connection with an individual case when the members have signed the data sharing agreement.

(c) All data acquired by the case consultation committee or subcommittee in exercising case consultation duties, are confidential as defined in section [13.02, subdivision 3](#), and shall not be disclosed except to the extent necessary to perform case consultation, and shall not be subject to subpoena or discovery.

(d) No members of a case consultation committee or subcommittee meeting shall disclose what transpired at a case consultation meeting, except to the extent necessary to carry out the case consultation plan. The proceedings and records of the case consultation meeting are not subject to discovery, and may not be introduced into evidence in any civil or criminal action against a professional or local welfare agency arising out of the matter or matters which are the subject of consideration of the case consultation meeting. Information, documents, or records otherwise available from original sources are not immune from discovery or use in any civil or criminal action merely because they were presented during a case consultation meeting. Any person who presented information before the consultation committee or subcommittee or who is a member shall not be prevented from testifying as to matters within the person's knowledge. However, in a civil or criminal proceeding a person shall not be questioned about the person's presentation of information before the case consultation committee or subcommittee or about opinions formed as a result of the case consultation meetings.

A person who violates this subdivision is subject to the civil remedies and penalties provided under chapter 13.

Appendix E: Law Enforcement Protocol

Case Initiation/Investigation:

- Initial reports of child sexual assault or /abuse and physical abuse will typically be received by Olmsted County Social Services or Law Enforcement although the initial report may also come from other agencies including medical and victim services. .
- Law Enforcement will be the lead investigative agency in sexual assault and serious physical abuse cases involving children/juveniles.
- Upon receiving a report, Law Enforcement and the assigned Olmsted County Social Services Representative will discuss the case.
- Law Enforcement takes the lead on determining how the case will proceed.
- Once it is determined that the case will be referred to the CAC, Law Enforcement will contact the CAC Coordinator, who in turn will contact the other members of the MDT to coordinate an interview date/time.
- In some cases, the Law Enforcement Patrol Division could be the initial responding officer to a child/juvenile sexual assault or sexual abuse and/or serious child physical abuse investigation. In such cases, the responding officer should attempt to gather as much of the following information as possible:
 - Name, address and current location of the victim.
 - Name, address and phone number of the reporter, if other than the victim. ****If the report of the incident was made by someone *other than the victim*, the responding officer should interview the person who made the report *only* ****
 - Determine if emergency medical care is needed.
 - Determine if the suspect is present.
 - Determine where and approximately when the assault/physical abuse took place.
 - Document any other information that would be necessary to conduct a criminal investigation.
 - Law enforcement will make the determination if there is a non-offending parent present and will work with that parent to protect the safety of the child/juvenile.
- The responding officer should speak with the victim or complainant to learn:
 - What type of crime was committed
 - By whom the crime has been committed (to determine if there is a public safety risk).
 - Where the crime took place (to determine jurisdiction, potential crime scenes, and/or evidence to be collected).
 - Approximately how long ago the crime was committed.
 - It should be recognized (for the safety of the victim) that there may be some circumstances where the responding officer may need to conduct a limited interview with the victim to determine:
 - If there is a necessity for securing evidence and/or the crime scene and for the apprehension of a suspect.
- The officer should determine if a medical release is needed and have it signed by the parents or guardians of the child/juvenile victim.
- In all cases, the responding officer should determine if the victim has been offered the services of a Victim Services advocate. If services have not been offered, the responding officer should thoroughly explain the availability of and services provided by Victim Services. If desired by the victim, the responding officer should initiate contact with a Victim Services advocate.

- After an initial report is taken, the responding officer will brief his or her supervisor on the preliminary investigation. The supervisor will contact the Investigations Division Supervisor or the on-call Sergeant/Investigator.
- The Investigative Division response will be determined after consultation with the Patrol Division Supervisor.
- If necessary for the safety of the child/juvenile, law enforcement will determine if there is a need to place the child into protective custody.
- A joint decision between law enforcement and child protection will be made as to the placement of the child/juvenile.
- Children should be interviewed at the Child Advocacy Center (CAC) unless specific circumstances require otherwise. (See Location of Child Forensic Interviews: pg. 13)
- Law Enforcement is responsible for identify and interviewing all witnesses.
- Law Enforcement is responsible for determining when and where to interview the suspect(s).
- Law enforcement will digitally record all statements unless mitigating circumstances prevent recording.
- The assigned Investigator in collaboration with a medical provider is responsible for determining if a sexual assault evidentiary exam should be conducted. This determination should be based on the circumstances of the case. This exam should be conducted by a medical provider or a Sexual Assault Nurse Examiner (SANE Nurse).
- The assigned Investigator is responsible for ensuring that the crime scene is properly processed and evidence collected, including photographing the scene and the victim.
- In some cases, enough evidence and other information can be gathered for immediate arrest of the suspect. The prosecutor should be notified as soon as possible after an arrest has been made.
- If an advocate is assisting the victim, notify the advocate as soon as possible after an arrest is made.
- If there are issues or concerns during an investigation, the concerned individual should contact the lead Investigator of the case or a CAC advisory member to address the issue.

Case Management/Resolution:

- Short of an active homicide investigation or the immediate need to take effective investigative/intervention measures to protect a person from imminent harm, child/juvenile sexual assault and serious child abuse cases should be a priority in an Investigator's case file.
- If an advocate is assisting the child victim, the advocate should be notified of significant changes in case status such as referral for prosecution, arrest of the suspect(s), and delays in the investigation of the case.
- The Multidisciplinary Team will meet on at least a monthly basis to review team cases.

Appendix F: Olmsted County Attorney's Office Protocol

Olmsted County Child Advocacy Center Criminal Prosecution Guidelines

Pursuant to law, and so as to provide assistance to child victims of criminal sexual conduct, the primary responsibilities of the prosecutor assigned to MCFAP are as follows:

- Protect public safety by prosecuting sex offenders.
- Participate in cross training with other agencies involved with victims in criminal sexual conduct cases.
- Adhere to ethical standards in charging cases by requiring that:
 - There is admissible evidence sufficient to establish beyond a reasonable doubt that:
 - (1) A crime has been committed, and
 - (2) That an individual or individuals committed that crime;
 - There is a reasonable chance of obtaining a conviction; and
 - That the interests of justice support prosecution.

Procedures

Intake:

- An Olmsted County Attorney trained in forensic interviewing will attend the team meeting and observe the forensic interview from the control room.
- The attorney will be present for the team meeting with the family following the forensic interview.

Charging:

- Review reports submitted by law enforcement as soon as possible to determine if there is sufficient evidence to charge an individual with a crime.
- When follow-up investigation is required, promptly request specific follow-up by law enforcement. Confer with law enforcement regarding the case.
- When the follow-up investigation is completed, promptly reassess the case for charging:
 - If the matter will be charged, notify law enforcement, the victim advocate if one is involved, and the victim of the decision. Draft the complaint and provide needed copies.
 - If declining prosecution, notify law enforcement, the victim advocate if one is involved, and the victim (or victim's parent or legal guardian) of the decision on charging the reasons for the decision. If the victim requests, meet with the victim and the victim's advocate to discuss the reasons for declining prosecution.
- Protect the identity of the victim in the charging document and wherever else possible.
- After making a decision to charge a suspect, either directly or through Victim Services, the prosecutor may consult with the victim (or victim's parent or legal guardian) at an early stage of the proceedings to:
 - Seek the opinions of the victim.
 - Verify victim's willingness or ability to proceed with the prosecution and to testify.
 - Discuss the reasons why the victim must be a witness and will be subpoenaed.
 - Where appropriate, discuss the strengths and weaknesses of the case.
 - Explain sentencing guidelines and possible outcomes.
 - Explain and discuss plea negotiations and the reasons for it.
 - Explain the victim's rights under the statutes.
 - Explain the legal system and the roles of the various individuals involved.

- Recommend or refer the victim to other services and legal options where appropriate.
- Explain bail and the conditions of release.
- Explain the possible violation of the conditions of release and the consequences.

Case Review:

- Attend and participate in monthly case review when assigned cases are on the agenda.
- If unable to attend case review, provide updated case information to another attorney to attend in your place.

Pre-Trial/Pre-Plea

- Directly or through Victim Services, continually update victim (or victim's parent or legal guardian) about the various proceedings and posture of the case, including dates of hearings and any delays and the reasons for them.
- Move for a speedy trial where it is in the best interests of the victim and of the prosecution.
- Object to continuances by the defense counsel where they are unnecessary or lengthy.
- Meet with or speak to all witnesses in preparation for trial. Carefully prepare the victim for trial. Explain arrangements for transportation and lodging if needed for trial.
- Notify the court and defense counsel, if appropriate, of any special needs required by the victim at trial (i.e. interpreter services, listening devices for the hearing impaired, reasonable accommodations for victims with physical or mental disabilities, presence of support persons).
- Where appropriate, engage in negotiations with defense counsel in an attempt to resolve the case without the necessity of trial.
 - Factors that may affect plea negotiations are:
 - The victim's willingness and/or ability to testify.
 - The victim's opinion about possible pleas.
 - The presence or lack of corroboration of the victim's testimony.
 - The defendant's criminal record.
 - Problems of proof.

Post-Trial/Post-Plea:

- Notify the victim of the results of the plea negotiation or trial.
- If there is a conviction, inform the victim that a probation officer will be completing a pre-sentence investigation on the defendant and will be contacting the victim for input.
- Present the victim impact statement at sentencing at the victim's request.
- Seek court-ordered restitution for the victim when appropriate.
- Notify the victim of the results of the sentencing.
- Inform the victim of his or her right to retrieve belongings from evidence after the 60 day appeal period has passed. Assist as needed in retrieving those belongings.

Peer Review/On-going training:

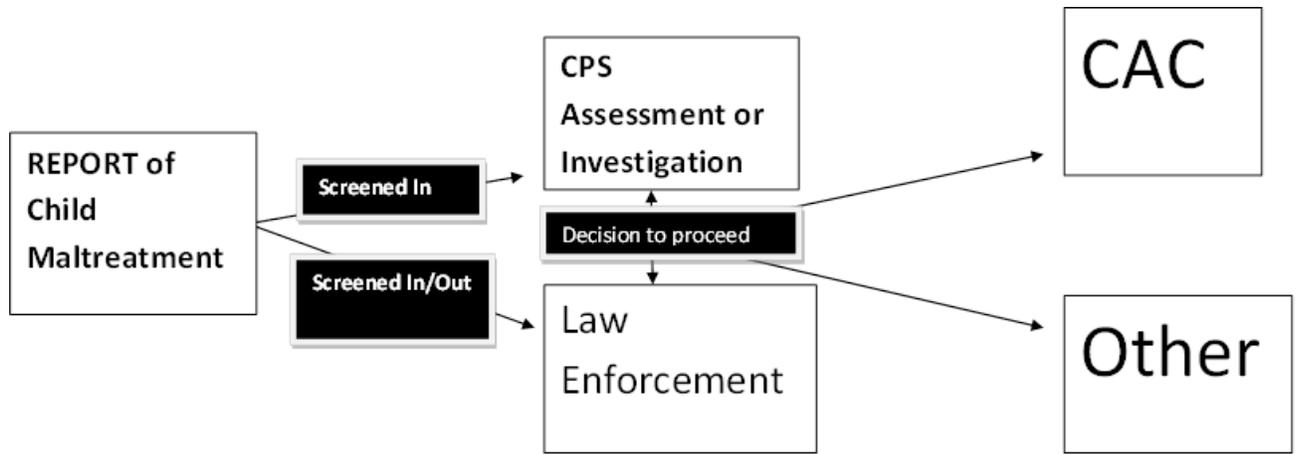
- Participate in monthly forensic interview peer review.

Participate in on-going advocacy center training.

Appendix G: CAC Process Flowchart

Child Advocacy Center Flow

1. CPS or LE receives report
2. Call Jenny (507-266-0443) to schedule case
3. CPS or LE faxes over intake information for NCA track (intake form to be created but will include at least the following)
 - Demographics
 - Allegations
 - Alleged suspects information (age and relationship)
4. MDT Arrives for pre-staffing ½ hour prior to interview arrive from side door (will need to ring bell, receptionist lets them in)
5. Child and non-offending caregiver arrive at center 15 minutes prior to interview
6. Receptionist gives them paperwork, shows them waiting area
7. Interviewer goes to lobby and brings child to interview room.
8. Victim Advocate and Mental Health Provider take family to family waiting room.
9. Medical provider goes to their office to watch interview
10. Victim advocate and mental health provider stay with non-offending caregiver in family waiting area. Interviewer will take child to parent in family waiting area
11. MDT members reconvene back in conference room (post staffing)
12. Facilitator will bring the non-offending caregiver to join the MDT
13. Receptionist sits with child
14. Medical provider will escort child and non-offending caregiver to medical exam rooms.
15. Follow up appointments made if necessary
16. Interviewer will finalize DVD
17. Medical provider processes labs, completes paperwork, and cleans room
18. Data into NCA track by facilitator or administrative assistant



Appendix H: Forms

Center Intake Form



**Mayo Clinic
Child and Family Advocacy Center
Intake Form**

INTAKE INFORMATION

Referral Source: _____ Referral Person _____

Intake form completed by: _____

VICTIM INFORMATION

Full Name: _____ Nickname _____

Current Address: _____

Home Phone: _____ Alternate Phone: _____

Date of Birth: _____ Age at time of referral: _____

Gender (circle one): Male Female Mayo Clinic Number _____

Race: _____ Primary Language: _____

Translator needed? YES or NO

Disabilities: _____

Special Needs: _____

Has child been removed from household? YES or NO

Details: _____

VICTIM FAMILY / HOUSEHOLD INFORMATION

With whom does the child reside? _____

Caretaker's Information

Name: _____ Alias: _____

Relationship to Child: _____ Date of Birth: _____

Current Address: _____

Home Phone: _____ Alternate Phone: _____

Race: _____ Primary Language: _____

Learning Disabilities/Mental Health Issues: _____

Alternate Guardian's Information

Name: _____ Alias: _____
Relationship to Child: _____ Date of Birth: _____
Current Address: _____
Home Phone: _____ Alternate Phone: _____
Race: _____ Primary Language _____
Learning Disabilities/Mental Health Issues: _____

All Others in Child's Household and Relationship to Child

Name _____ Relationship _____ Age/DOB ___/___
Name _____ Relationship _____ Age/DOB ___/___

ALLEGED OFFENDER INFORMATION

Name: _____
Address: _____
Date of Birth: _____ Gender (circle one): Male or Female
Relationship to Child: _____ Race: _____
Does alleged offender have access to alleged victim? YES or NO
Member of victim's household? YES or NO

IF yes, has offender been removed from household, or has child been removed? YES or NO

Does the offender have a history of prior abuse? YES or NO

If yes, what is the prior history of abuse? _____

ALLEGED ABUSE

Check all that apply: Sexual ___ Physical ___ Witness ___ Other _____

Allegations:

Location where abuse took place, including type of location (i.e., victim's home, alleged offender's home, neighbor, school, etc.): _____

MDT

Law Enforcement: _____

CPS: _____

Victim Advocate: _____

County Attorney: _____

Mental Health: _____

Medical: _____

Other: _____

INTERVIEW INFORMATION

Date: _____ **Interviewer:** _____

Start Time: _____ **End Time:** _____

Room # _____ **Disclosure: Yes No or NA/TBD**

Other Information: _____

REFERRALS

Referrals made following interview

Medical Evaluation:

Findings? YES or NO

Follow up needed? YES or NO

Labs ordered? YES or NO

Comments: _____

Mental Health Services referred? YES or NO

If yes, type of services referred: _____

Person making the referral: _____

Person contacted: _____

Date, time and location of appointment: _____

Check-in Form

**MAYO CLINIC CHILD AND FAMILY
ADVOCACY CENTER**

FAMILY INFORMATION

Date: _____

Child's Name: _____ DOB: _____ Gender: M or F

Address: _____

Race: _____ School: _____ Grade: _____

Special Needs/Disabilities: _____

Parent/Guardian #1

Name: (First) _____ (M.I.) _____ (Last) _____

Address: _____

City/State: _____ Zip Code: _____

DOB: _____ Home Phone: _____ Cell Phone: _____

Best time to Reach you: _____

Relationship to Child: _____ Resides with Child: Yes No

e-mail Address: _____

Other Information (*For Statistical Purpose Only*)

Employment: Full time / Part Time / Self-Employed / Unemployed / Disabled / Homemaker

Race: (*Circle all that apply*) African American (Black) / Caucasian (White) /

American Indian / Asian / Hawaiian/Pacific Islander / Hispanic / Other: _____

Highest Level of Education Completed: 9th / 10th / 11th / High School Grad / Some College /

College Grad / Grad School / Associate Degree / Technical School / Other: _____

Parent/Guardian #2

Name: (First) _____ (M.I.) _____ (Last) _____

Address: _____

City/State: _____ **Zip Code:** _____

DOB: _____ **Home Phone:** _____ **Cell Phone:** _____

Best time to Reach you: _____

Relationship to Child: _____ **Resides with Child:** __Yes __No

e-mail Address: _____

Other Information *(For Statistical Purpose Only)*

Employment: Full time / Part Time / Self-Employed / Unemployed / Disabled / Homemaker

Race: *(Circle all that apply)* African American (Black) / Caucasian (White) /

American Indian / Asian / Hawaiian/Pacific Islander / Hispanic / Other: _____

Highest Level of Education Completed: 9th / 10th / 11th / High School Grad / Some College /

College Grad / Grad School / Associate Degree / Technical School / Other: _____

Please list everyone else who lives in your home or has lived in your home in the past 9 months:

Name	Gender	D.O.B	Relationship	Currently Residing in home? Y or N
1. _____	M/F	_____	_____	Y or N
2. _____	M/F	_____	_____	Y or N
3. _____	M/F	_____	_____	Y or N
4. _____	M/F	_____	_____	Y or N
5. _____	M/F	_____	_____	Y or N
6. _____	M/F	_____	_____	Y or N
7. _____	M/F	_____	_____	Y or N

Are there any Custody Issues? _____

What is your understanding of why you came to Mayo Clinic CAC?

How have you/your child been handling this so far?

Do you feel that you have supportive people who you can talk with?

Is your Child Currently Receiving any services?

Are you currently receiving any services?

Has your child had a medical examination, if so where and when? Do you have insurance?

Do you have any financial concerns at this time?

What would you like to see happen now?

Other Children Being Interviewed

Child's Name: _____ **DOB:** _____ **Gender:** M or F

Address: _____

Race: _____ **School:** _____ **Grade:** _____

Special Needs/Disabilities: _____

Child's Name: _____ **DOB:** _____ **Gender:** M or F

Address: _____

Race: _____ **School:** _____ **Grade:** _____

Special Needs/Disabilities: _____

Confidentiality Notice

The Mayo Clinic Child and Family Advocacy Center is committed to protecting the privacy of the child and caregiver(s) and maintaining confidentiality. All information shared, retained, or otherwise used by the Center adheres strictly to state and federal laws. As such, your rights to confidentiality may be limited by state mandatory reporting laws. Confidentiality agreements are signed by members of the Mayo Clinic Child and Family Advocacy Center to preserve client confidentiality and regulate information sharing among the team members. Your information is stored and tracked using the NCATrak system, a computerized and secure web-based case tracking system developed by the National Children's Alliance. All identifying information stored in NCATrak is secure and private. Certain non-identifying information, such as age and gender of child, age and gender of the alleged offender, relationship of the offender to the child, and type of abuse may be submitted to the National Children's Alliance on a quarterly basis. Information collected during the forensic interviews, including any recordings, videos, drawings or other tools are the property and responsibility of law enforcement and/or Child Protective Services and will be maintained by them. Information gathered during examinations for medical treatment and/or mental health services is considered part of patient records and will therefore follow Mayo Clinic policies on medical records and HIPAA guidelines.

The victim advocate is available to answer any questions or concerns about confidentiality issues, explain the rights of the child and caregiver(s), address the limits to confidentiality, and the delineate the ongoing sharing of information between Mayo Clinic Child and Family Advocacy Center providers.

Appendix I: MCFAP Education Statistics

Education Efforts of the Child Abuse Program - 2011

Date	Title / Function	Presenter	Department/ Specialty	# of Attendee	Attendees
01/10/11	Orientation - MCFAP	Kory Schmitt	Social Services	2	Social work Grad students
1/4/2011	MCFAP: Who we are and how we can Help	Dr. Marcie Billings	EM Grand Rounds	50	ED Personnel (Consultants, Residents, Nurses, SW)
1/4/2011	Peds III Conference Round 7	Broughton	Peds III Conference	10	Residents
1/26/2011	William Friedrich Memorial Lecture	Dr. Daniel Broughton	San Diego Conference		
2/14/2011	Pediatric Specialty Days	Lisa Fink	New pediatric nurses	28	Nurses
2/15/2011	Peds III Conference Round 7	Broughton	Peds III Conference	10	Residents
2/22/2011	Medical Evaluation in Child Abuse	Lisa Fink	Winona State univesrity community event in Faribault	25	Students - Undergradn Minor Class
4/5/2011	Sexual Exploitation	Lisa Fink	Community Pediatrics	100	Community Nurses, Appointment Coordinators, Cas
4/7/2011	Child Abuse	Lisa Fink	Mayo Medical Students	10	Med Students
4/12/2011	Sexual Violence in Children	Lisa Fink	Family Med	30	FNP's
4/27/2011	Child Maltreatment	Lisa Fink	Olmsted County Human Services/ Voices for	20	Olmsted County Social/Human Services.
4/20/2011	Sexploitation	Dr. Marcie Billings			
5/1/2011	Child Maltreatment Basics	Lisa Fink	Pediatric Specialty Days	25	
5/23/2011	Peds III Conference Round 7	Broughton	Peds III Conference	10	Residents
5/25/2011	Orientation - MCFAP	Kory Schmitt	Social Services	2	Social work Grad students
6/14/2011	Peds III Conference Round 7	Broughton	Peds III Conference	10	Residents
6/27/2011	Mandated Reporter 101	Kory Schmitt	DAHLC Staff	10	DAHLC staff
7/1/2011	Sexual Abuse Exams	Dr. Marcie Billings	ED SANE Nurses	8	SANE Nurses
7/25/2011	Orientation - MCFAP	Kory Schmitt	Peds Surgery	1	Nurse Practitioner
7/27/2011	Orientation - MCFAP	Kory Schmitt	Social Services	1	Social worker
7/28/2011	Orientation - MCFAP	Dr. Broughton	Social Services	1	Social Worker
8/11/2011	MCFAP - A resource for Child Abuse Issues	Dr. Broughton	Austin Medical	?	?
08/18/11	Child Abuse and MCFAP	Dr. Billings	Pediatric Psych Fellows	5	Fellows

Appendix J: Confidentiality Agreements

Annual Confidentiality Agreement

Multidisciplinary Child Protection Team

Agreement Relating To Protected Nonpublic and Confidential Data

This agreement shall be interpreted pursuant to the laws of the State of Minnesota and shall apply to the Minnesota Department of Human Services (hereinafter "Department") and the undersigned individual who is a member of the Multidisciplinary Team (hereinafter "Member").

WHEREAS, the MEMBER has been appointed to serve on the Multidisciplinary Team pursuant to Minn. Stat. § 626.558; and

WHEREAS, pursuant to Minn. Stat. § 626.558, the MEMBER is authorized to have access to not public data as defined by Chapter 13 of Minnesota Statutes; and

WHEREAS, pursuant to Minn. Stat. § 626.558, data acquired by the Multidisciplinary Team in the exercise of its duties is protected nonpublic or confidential data as defined in Minn. Stat. § 13.02; and

WHEREAS, pursuant to Minn. Stat. § 626.558, the proceedings and records of the Multidisciplinary Team are protected nonpublic data as defined in § 13.02, subd 13; and

WHEREAS, dissemination of each protected nonpublic or confidential data other than authorized by statute may subject the MEMBER and/or the Department to civil or criminal sanctions as set forth in Minn. Stat. § 13.08 and 13.09 (1988);

The MEMBER agrees:

1. That no confidential or protected nonpublic data collected, maintained, or used in the course or performance of my duties as a MEMBER of the Multidisciplinary Team shall be disseminated by me or at my direction, except as authorized by statute, either during my period of service on the Panel or thereafter. Data collected or maintained by MEMBER or MEMBER's facility shall be kept confidential as authorized by state and federal statutes (HIPAA) governing privacy of medical records.

MDT Member

Commissioner of Human Services or Designee

Date

Date

Monthly Confidentiality Agreement

**Olmsted County Multi-Disciplinary Child Protection Team
Data Sharing Agreement**

Subcommittee: Case Review Team

The Olmsted County Multi-Disciplinary Child Protection Team (“MDCPT”) operates under the authority of Minnesota Statutes §626.558. All data acquired by the MDCPT, or any subcommittee of the MDCAT, in exercising case consultation duties, are confidential as defined in Minnesota Statutes §13.02, subdivision 3. This MDCPT data shall not be subject to subpoena or discovery; data otherwise available from original sources remains data of the original source. Members of the MDCPT or a subcommittee shall not disclose what transpired at a meeting of the MDCPT or subcommittee, except as necessary to carry out a case consultation plan. Any person who violates these data sharing restrictions is subject to the civil remedies and penalties provided under Minnesota Statutes Chapter 13. Willful violation of the law is a misdemeanor and may be grounds for suspension or dismissal of a public employee.

I acknowledge reading and understanding the Data Sharing Agreement and agree to comply with the agreement and the applicable provisions of Minnesota Statutes Chapter 13 and section §626.558.

Today's Date: _____

	Agency	Printed Name	Signature
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
13			
14			

MDT Confidentiality Agreement

**Olmsted County Multi-Disciplinary Child Protection Team
Data Sharing Agreement**

Multi-Disciplinary Child Protection Team

The Olmsted County Multi-Disciplinary Child Protection Team (“MDCPT”) operates under the authority of Minnesota Statutes §626.558. All data acquired by the MDCPT, or any subcommittee of the MDCAT, in exercising case consultation duties, are confidential as defined in Minnesota Statutes §13.02, subdivision 3. This MDCPT data shall not be subject to subpoena or discovery; data otherwise available from original sources remains data of the original source. Members of the MDCPT or a subcommittee shall not disclose what transpired at a meeting of the MDCPT or subcommittee, except as necessary to carry out a case consultation plan. Any person who violates these data sharing restrictions is subject to the civil remedies and penalties provided under Minnesota Statutes Chapter 13. Willful violation of the law is a misdemeanor and may be grounds for suspension or dismissal of a public employee.

I acknowledge reading and understanding the Data Sharing Agreement and agree to comply with the agreement and the applicable provisions of Minnesota Statutes Chapter 13 and section §626.558.

Today’s Date: _____

	Agency	Printed Name	Signature
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Appendix K: NCATrak Information made available to the NCA

NCA Statistical Data Form for Accredited and Member Programs

January - June 2012

Organization Name: Mayo Clinic- Rochester, Medical Social Services
Organization Address: 200 First Street SW, Rochester, MN 55905
Primary Contact: CAC Stats Submitter
Contact Information:

	Total
Total number of children served at the CAC during the reporting period:	229
Gender of children:	
Male	85
Female	129
Age of children at first contact with center:	
0-6 years	83
7-12 years	45
13-18 years	85
Total number of alleged offenders:	266
Relationship of alleged offender to child:	
Parent	172
Stepparent	12
Other Relative	22
Parent's boyfriend/girlfriend	10
Other known person	29
Unknown	21
Age of alleged offenders:	
Under 13	2
Age 13 to 17	5
Age 18+	197
Unknown	33
Types of abuse reported:	
Sexual Abuse	51
Physical Abuse	118
Neglect	71
Witness to Violence	0
Drug Endangerment	24
Other	66

Mayo Clinic Child and Family Advocacy Center / Olmsted County MDT Protocol (2012)

Race or ethnicity of total children seen at CAC during reporting period:

White	150
Black/African American	15
Hispanic/Latino	4
American Indian/Alaska Native	1
Asian/Pacific Islander	2
Other	0

Number of the children receiving services during reporting period:

Medical Exam/Treatment	17
Counseling Therapy	0
Referral to Counseling Therapy	0
Onsite Forensic Interviewing	0
Offsite Forensic Interviewing	0

Disposition of Child Protective Services Information:

Unfounded/ruled out	0
Founded/reason to believe	16
Unable to determine	3
Administrative Closure	97
Moved	5
Other	113

Law Enforcement Disposition-Number of cases where charges were filed: 0

Prosecution Disposition

- Cases accepted for prosecution:
- Convictions:
- Pleas:
- Acquittals:

Other Services Provided By CAC (tracked in NCAttrak)

	<u>Children</u>	<u>Adults</u>	<u>Unknown Age</u>	<u>Total</u>
Case Management/Coordination	0	0	0	0
Prevention	0	0	0	0

Appendix L: Interagency Memorandum of Understanding

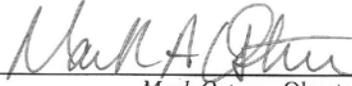
Memorandum of Understanding Olmsted County Child Abuse Multidisciplinary Team December 2012

The Olmsted County Multi-Disciplinary Child Protection Team (MDT) is an interdisciplinary group of professionals who represent various disciplines and work collaboratively with victims and families of child abuse allegations to assure the most effective coordinated response possible for every child. This coordinated intervention within the Mayo Clinic Child and Family Advocacy Center ("the Center") is meant to reduce the potential of trauma to children and families and improve services while preserving and respecting the rights and obligations of each agency to pursue their respective mandates.

By signing this document, each undersigned agency agrees to:

- 1) Support the concept, philosophy, and the implementation of the Center and utilize the Center for all cases that meet criteria (as defined by the Mayo Clinic Child and Family Advocacy Center Protocol)
- 2) Devote sufficient staff and resources to maintain the MDT/Center model and advance the objectives of the MDT
- 3) Respectfully collaborate with other MDT members. In order to do so:
 - a. All members of the MDT are routinely involved in each case
 - b. Informed decision-making occurs at all stages of the case providing a coordinated response to ensure that children and families benefit optimally
 - c. MDT collaboration begins at initial allegation and continues through potential prosecution
 - d. MDT/Center follows an agreed upon process for collaboration across the continuum of all cases
- 4) Exchange relevant information between MDT members in a timely and confidential manner that is consistent with legal, ethical and professional standards of practice.
- 5) Maintain an atmosphere of trust and respect that fosters opportunities for open communication and enables MDT members to share ideas, raise concerns and provide feedback regarding MDT/CAC operations
- 6) Participate in ongoing and relevant training and educational opportunities to further and enhance MDT member skills.

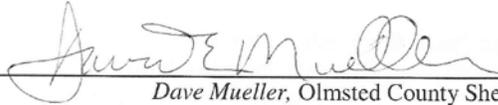
Signed December 2012



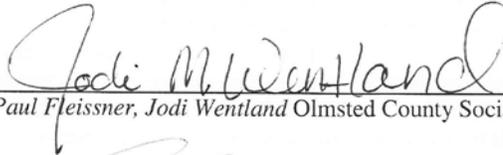
Mark Ostrem, Olmsted County Attorney



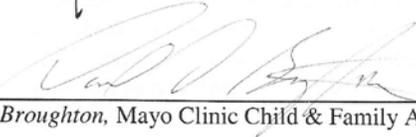
Chief Roger Peterson / Lt. Casey Moilanen, Rochester Police Department



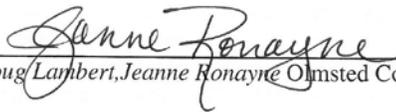
Dave Mueller, Olmsted County Sheriff Department



Paul Fleissner, Jodi Wentland Olmsted County Social Services



Dr. Dan Broughton, Mayo Clinic Child & Family Advocacy Program, Mayo Clinic



Doug Lambert, Jeanne Ronayne Olmsted County Victim's Services

Appendix M: OMS Feedback Surveys 2013

INDICATORS FOR CHILD/CAREGIVER OUTCOME:

INITIAL VISIT CAREGIVER SURVEY: (Questions # 1-3 relate to CHILD's experience; Questions 4-13 relate to CHILD AND CAREGIVER'S EXPERIENCE)

	INDICATOR	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree	I Don't Know
1	My child felt safe at the Center.					
2	My child's questions were answered.					
3	My child was referred to services and/or programs that I feel will meet his or her needs.					
4	The center staff made sure I understood the reason for my visit to the center today.					
5	When I came to the center, my child and I were greeted and received attention in a timely manner.					
6	I was given information about the various services and programs provided by the center.					
7	My questions were answered to my satisfaction.					
8	The process for the interview of my child at the center was clearly explained to me.					
9	I was given information about possible behaviors I might expect from my child after we leave the center today and in the days and weeks ahead.					
10	I was referred to services and/or programs that will help me support my child and meet his or her needs.					
11	Overall, the staff and/or volunteers at the center were friendly and pleasant.					
12	After our visit at the center today, I feel I know what to expect with the situation facing my child and me.					
13	Is there anything that you would like to share with us about your experience at the center?					

INDICATORS FOR CHILD/CAREGIVER OUTCOME:

***CAREGIVER FOLLOW-UP SURVEY: (questions # 1-4 relate to CHILD's EXPERIENCE;
Questions 4-13 relate to CAREGIVER AND CHILD's EXPERIENCE***

	INDICATOR	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree	I Don't Know
1	My child felt safe at the center.					
2	My child's questions were answered to our satisfaction.					
3	My child received services that have helped him or her since our first visit.					
4	REQUEST FOR INPUT re SPECIFIC FOLLOW UP SERVICES UNIQUE TO INDIVIDUAL CENTERS					
5	Overall, the staff and volunteers at the center have been friendly and pleasant.					
6	As a result of our contact with the center, we knew what to expect in the days and weeks that followed.					
7	Since my first contact with the center, my questions have been answered to my satisfaction.					
8	I have been referred to services and/or programs that have helped me deal with my child's situation.					
9	Overall, the services I have received from the center thus far have been helpful to me and my child.					
10	REQUEST FOR INPUT re SPECIFIC FOLLOW UP SERVICES UNIQUE TO INDIVIDUAL CENTERS					
11	I feel I have received information that has helped me understand how I can best keep my child safe in the future.					
12	I feel the center has done everything it can to assist me and my child.					
13	If I knew of anyone else who was dealing with a situation like the one my family faced, I would tell that person about the center.					
14	Anything else you'd like to share...					

INDICATORS FOR MDT/CASE OUTCOME:

MDT SURVEY

	INDICATOR	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree	Not Applicable
1	Team members willingly share information relevant to our cases.					
2	I have the opportunity to provide input into the forensic interview process, thereby securing the level of information needed to fulfill my area of responsibility.					
3	Members of the MDT demonstrate respect for the perspectives and informational needs of other team members throughout the process.					
4	The CAC model fosters collaboration.					
5	Team meetings are a productive use of my time.					
6	Case review team meetings are useful in the development of cases.					
7	Other team members demonstrate a clear understanding of my specific agency-related role and turn to me for information, expertise and direction as appropriate.					
8	I believe the clients served through the center benefit from the collaborative approach of our MDT.					
9	My supervisor/agency is supportive of the CAC concept and the work of the MDT.					
10	All members of the MDT, as defined by the needs of specific cases, are actively involved.					
11	The CAC provides resources that help me work on these cases better.					
12	The CAC provides an environment where I feel safe expressing my concerns or making suggestions about the functioning of the MDT.					
13	Please share other comments, opinions, concerns, observations, recommendations.					

Appendix N: Rochester Community Connections 2012-2013

HOUSING	
Community Action Program (CAP) - Housing Assistance/FAM Program	328-6333
Crisis Home	282-1204
Dowdley Day Hospitality House - Temporary shelter	282-5172
First Homes - Home ownership opportunities	287-7117
Habitat for Humanity	252-0489
Heartlight Hospitality Network - Shelter for families	281-3112
LINK Program - Rochester Area V. prson housing to 64-year olds	282-2260 ext. 330
Tenant Issues - Legal Assistance of Olmsted County	287-2036
Rental Assistance Program by Olmsted County HRA:	
Public Housing Units, Section 8 Vouchers	328-7130
Other Rental Assistance Programs:	
Rochester: Hylands	288-4201
Ironbruck	289-1319
Rochester Square	288-9205
Easteridge Estates	283-0022
Eyota: Lifestyle Inc. Management	451-8524
Pine Island: Knolwood	775-2109 ext. 2
Fix Meadows	356-8979
Stewartville Estates Village	533-4953
Rochester Building & Safety	328-2600
Salvation Army Family Emergency Services	288-3603
LANGUAGE BARRIER / RESETTLEMENT SERVICES	
English Speakers of Other Languages	287-1698
Hand-in-Hand - Family literacy centers	328-4456
Homefront Adult Literacy Center	328-4440
Immigration and Naturalization Customer Service	1-800-375-5283
International Mutual Assistance Association (IMAA)	289-5966
New Hope - Counseling, SE Asian	529-4640
Social Community Resettlement Services	361-1414 or 356-9333
Workforce Development, Inc. Literacy Lab	292-5152
LEGAL ASSISTANCE / ADVOCACY	
Child Support Payment Info Line	1-800-434-9393
Child Support Payment Info Line	328-6556
Consumer Product Safety	1-800-638-2772
Human Rights Commission	328-7900
Legal Assistance of Olmsted County	287-2036
Mediation & Conflict Services	285-8400
Memorial Blood Center - Parasite testing	1-612-817-3300
Victim Services Office	328-7270
SE MN Regional Legal Services Out State Centralized Intake/ Hotline (SMRLS)	1-888-575-2954
SPECIAL NEEDS SERVICES	
Ability Building Center	281-6532
Adaptive Recreation	328-2539
ARC SE Minnesota / Family Liaison Project	287-2032
Blind & Visually Handicapped Services	285-2784
Deaf & Hard of Hearing Services	389-1698 Voice 800-311-1148 Voice toll free: 866-266-2461 TTY: 328-4523
Early Intervention - Child Development Centers Coordinator	328-4523
Homes & Heroes, LLC	951-4499
Rochester Early Intervention Program - birth-age 2	328-4545
Rochester Early Intervention Program - age 3-age 7	328-4523
Zumbro Education District (ZED) - birth - age 6	775-2037
Minnesota Children with Special Health Needs (MCSHN)	285-7289
NAME Olmsted County (National Alliance on Mental Illness)	287-1692
Rochester Public Schools - Special Needs Support Group (PAIR)	328-4020
Possibilities of Southern Minnesota	281-6116

ADOPTION COUNSELING / PLACEMENT / FOSTER HOMES	
Catholic Charities	287-2047
Lutheran Social Services	1-888-205-3769
First Care Pregnancy Center	282-3177
Olmsted County Social Services	328-6500
BREASTFEEDING EDUCATION	
La Leche League - Amanda, 796-0688 Aimee, 536-3037	
Mayo Clinic Lactation Consultant (For Mayo Patients)	266-8863
Olmsted Medical Center Lactation Consultant (For OMC Patients)	529-6758
Public Health Nurse - In-Home Education	328-7900
WIC Program Nutritionist	328-7555
CHEMICAL USE / ADDICTIVE BEHAVIORS	
Evaluation / Counseling / Education / Treatment	
Common Ground	281-0023
County Chemical Dependency Provider Network	282-1204
Empower CTC and C.R.A.E.T.	292-1379
Mayo Clinic Adult, Child Addictions, Psychology & Psychiatry	538-3270
Olmsted County Community Services	328-6400
Zumbro Valley Mental Health Center	289-2089
Self Help / 12 Step Program	
Alcoholics Anonymous (A.A.) 24 hr/day	281-1747
Alanon, Alatan	281-4729
Narcotics Anonymous - 24 hr/day	281-2227
Alcohol or Drug Use National Help & Referral Line	1-800-622-2255
Smoking In-treatment - Project Turnabout	1-800-862-1453
CHILD CARE / NURSERY SCHOOL	
Golden Hill Child Care Center - for secondary or post-secondary students who are parents of infants and toddlers	328-3980
Child Care Resource and Referral (CCRR)	287-2020
Civic League Day Nursery - 2 locations (full-time assist. avail.)	285-7232 or 282-5368
Crisis Nursery of Olmsted County (24 hr)	287-1499
Stewartville Child Care Center	533-4545
Extended Day School Age Child Care:	
School Age Child Care (SACC), Rochester	328-4040
Rochester Family Y	287-2280
Byron Project Kids	775-2336
"Tiger Time", school age child care, Stewartville	533-1599
CHILDREN'S / YOUTH SERVICES	
Olmsted Medical Center, BirthCenter	529-6750
Mayo Perinatal Education Program	266-7473
Public Health Nurse - In-Home Education	328-7900
S.E. MN Childbirth Network (donor services) ... Go to member phone # at www.childbirth.net	
CLOTHING / HOUSEHOLD	
Catchmy Thrift	533-4401
Community Clothingline	282-8950
Goodwill Industries	281-9651
Salvation Army Thrift Store	281-1561
Savon	536-2564
Maternity and Children's Clothing:	
Brightlight	288-9374
Children's Maternity Exchange	289-6637
The Lower Room (Maternity)	282-9025
First Care Pregnancy Center	282-3377
Once Upon a Child	252-5090

SMOKING CESSATION	
Mayo Nicotine Dependence Center	266-1936
Quit Plan Helpline	1-888-354-PLAN
Salvation Army Smoking Cessation Clinic	529-4100
SUPPORT GROUPS / PROGRAMS	
Depression After Delivery	1-800-944-4773
Mothers of Multiples	Anne 281-1898
Circle of Parents & Bipolar Support Alliance (Monday Eve)	287-2020
DNISA (Depression & Bipolar Support Alliance) (Monday Eve)	282-8372
Parents of Children with Special Needs (PAIR)	328-4020
PELAG (Parents, Families & Friends of Lesbians & Gays)	282-8874
Compassionate Friends (Fm & Am Friends)	289-8203
PLAG (Parents, Families & Friends of Lesbians & Gays)	287-7161
NAMI (National Alliance on Mental Illness)	287-1692
NAMI Warmline (Th, F, Sat, Sun)	287-7161
Single Parents Support Group (PAIR)	328-4020
Knitap Group	287-2020
Sexual Assault Survivors Support Group	328-7270
Suicide Grief Support Group	Cynthia 292-8877 or Gloria 651-253-6615
TEEN PARENT RESOURCES - See other sections for more resources	
Mayo Clinic - Young Moms Club for Childbirth Education	266-7473
Public Health Nurse - Home Visits, Bright Future	328-7900
Rochester Public Schools - Golden Hill	328-3999
Bright Futures Teen Pregnancy and Support Services	328-6886 or 328-7900
TRANSPORTATION	
Drivers License	285-7412
Rochester City Bus Route Information	283-4353
R&S Transport	289-5080
UTILITIES	
Peoples Cooperative Services	283-4304
Minnesota Energy	1-800-889-9508
Rochester Public Utilities	280-1500
VIOLENCE COUNSELING / SHelters	
Men's Domestic Violence Treatment Group (ZVMHC)	289-2089
Project Reactor - Family Service Rochester	285-2009 or 285-2101
Sexual Assault 24 hr. line - Help, support	289-0636
Women's Shelter - Help, support, protection	285-1010
Empowering Women: To Choose Healthier Relationships (ZVMHC)	289-2089
EMERGENCY PREPAREDNESS	
Ambulance / Fire / Police / Sheriff / State Patrol	911
Olmsted Medical Center Hospital, Emergency Services	529-6650
Saint Marys Hospital Emergency Unit	255-5591
St. Marys of Olmsted County (24 hr)	285-2009 or 285-2101
Crisis Hotline - Suicide, depression, difficulty coping, detoxification	281-6248
Minnesota Poison Control Center	1-800-222-1222
Road Conditions	1-800-542-0220
Sexual Assault 24 hr. line	289-0636
Victim Services Office	328-7270
Child Abuse / Neglect Reporting	328-6400
After 5 p.m. & Weekends	281-6248
FIDUCIARY / REFERRAL	
Disability Helpline Line	1-866-333-2466
United Way 2-1-1	211 or 1-800-543-7709
On-Line Information about services & activities	www.vrochsd.org/211.html

COUNSELING - Cost based on ability to pay or may be at no charge. See other listings in Yellow Pages	
Associates in Psychiatry and Psychology	288-5544
Island Women Info & Education Line	285-1010
Catholic Charities	287-2047
Catholic Charities	287-2010
Family Service Rochester	289-9335
MN Pre-Adoption Counseling	266-5100
Lutheran Social Services	266-5100
Mayo Psychiatry and Psychology	288-5442
Olmsted Medical Center Main Clinic	282-4922
Psychological Consultants	328-6308
Rapid Access Clinic (after hr. emergencies call Crisis Hotline 281-6248)	328-3663
Salvation Army Social Worker	289-0636
Sexual Assault 24 hr line	289-0636
Zumbro Valley Mental Health Center	289-2089
DENTAL CARE	
Apple Tree Dental (Serves underserved adults/children & people w/disabilities)	424-1040
Children's Dental Health Services (Serves children ages 14 & under)	329-0436
Community Dental Care (Serves underserved adults and children) opening Fall 2012	651-925-8400
Good Samaritan Dental Clinic (Serves underserved adults and children)	529-4100
Medical Assistance Programs - Please call customer service number listed on member card	
Rochester Community and Technical College Dental Clinic	280-3169 or 1-800-247-1296
EDUCATION	
Early Childhood Check-In Screening (starting at age 3)	328-4004
Head Start - 3 and 4 year old preschool experience	287-2009
MOPS (Mothers of Preschoolers in Rochester)	282-5566
Rochester Public Schools - Registration / Records	328-4020
Community Education Program	328-4000
Golden Hill ALC (Area Learning Center) - Secondary school for pregnant students	328-3999
Rochester Alternative School options	328-4373
Student Support Services	328-4310
Rochester School Readiness - 3 and 4 year olds	287-2020
Rochester Adult Literacy Program: Adult Basic Education, Work Skills, GED Preparation and Testing, Adult Diploma, English Language	328-4440
Rochester Community and Technical College	285-7210
University of MN - Rochester	800-947-0117
Winona State University - Rochester Center	285-7100
EMPLOYMENT AND VOCATIONAL SERVICES	
CHOICES of SE Minnesota - displaced homemaker program	280-5510
Minnesota Workforce Center	285-7315
Minnesota Vocational Rehabilitation Services	285-7293
Workforce Development, Inc.	292-5152
Y Resource Center - LINK - Life Skills - 16-21 yr	287-2260
FAMILY LIFE	
American Red Cross - CPR, First Aid Classes	287-2300
Boys & Girls Club - After School Youth Development	287-2300
Early Childhood Home Education (ECEFE):	
Byron (ECEFE)	775-2336
Cutfield, Spring Valley (ECEFE)	867-5265
Dove-Fork, Forestry	632-4870
Rochester, PAIR (Parents Are Important In Rochester)	328-4020
Stewartville (Early Childhood Learning Center)	533-1434
Family Nutrition Programs - Nutrition education	529-4171
March of Dimes: Pregnancy & newborn health information	282-0649
Migrant Head Start	251-8532
Olmsted County Extension Service - 4H	328-6214
Playgroups (Infant playgroups)	328-2255
Project H.O.P.E. (Personal & family empowerment)	328-6953
Public Health Nurse - Information and Pregnancy/Parenting education	328-7900
Rochester Area Family Y	287-2260
Rochester Public Library	328-2300

Fall 2012-13 Community Connections

Family Resource Directory
The Rochester area has many agencies, services, and support groups available

City of Rochester

- 1 Olmsted County Public Health Services WIC
- 2 Olmsted Medical Center Hospital
- 3 Olmsted Medical Center Main Clinic
- 4 Mayo Clinic
- 5 Rochester Methodist Hospital
- 6 Saint Marys Hospital
- 7 Government Center

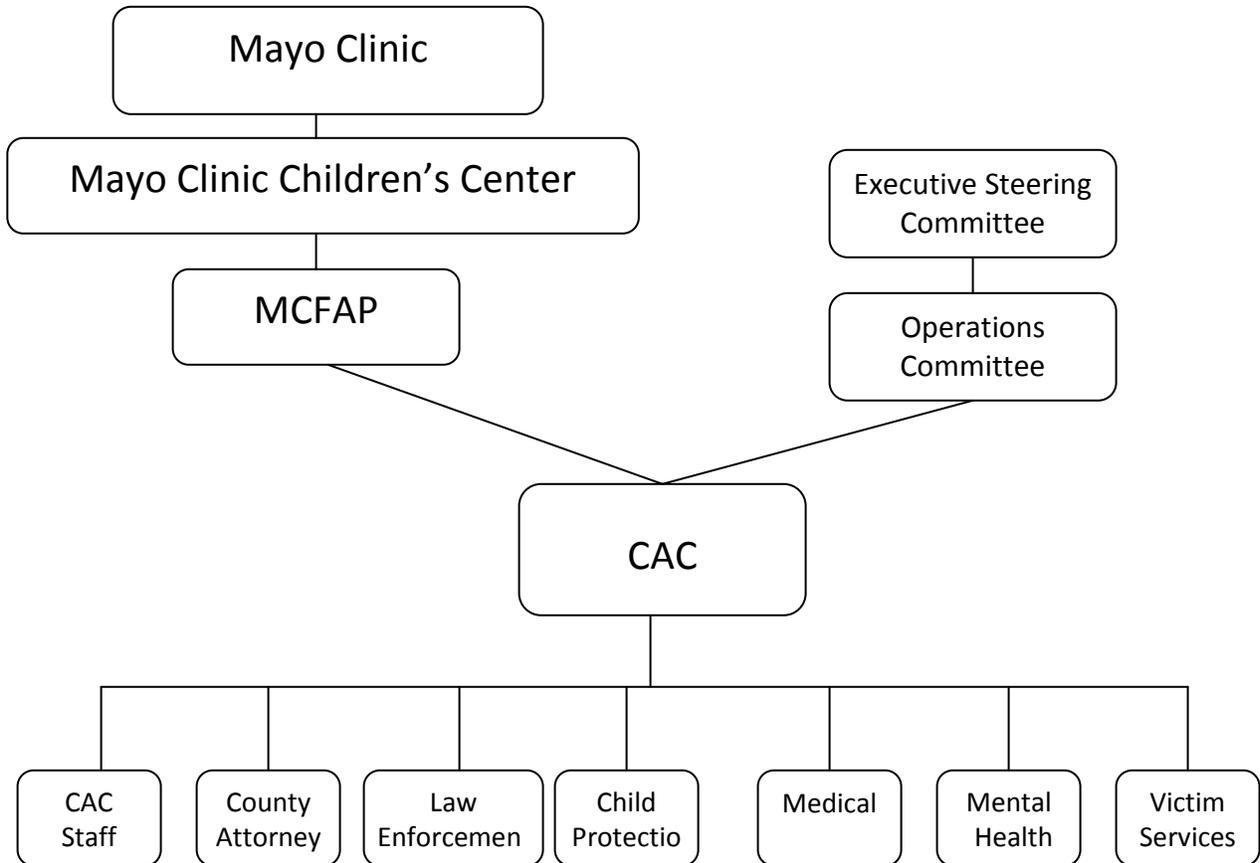
Inclusion of services in this pamphlet does not imply endorsement. You are encouraged to find out as much as possible about an organization before making a decision to use their services. Additional copies available at: www.co.olmsted.mn.us/departments/health/reports_plans_and_statistics.asp

This information was compiled by Olmsted County Public Health Services, 1812 21st Campus Drive S.E., Suite 120 - Rochester, MN 55904-4722 Phone: 607.338.7000

FINANCIAL / INSURANCE SERVICES	
Energy Assistance Program (EAP)	328-6508
Olmsted County Community Services	328-6500
MTRP (General Assistance, Medical Assistance, MinnesotaCare)	328-6500
Child Support and Recovery / Payment Info	328-6500
Social Security, SSI	1-800-772-1213
Salvation Army	288-3663
FOOD	
Angel Food Ministries	261-9753 or 254-7258
Charter One Food Shelf (Hrs. M-Th 8-6; F 8-Noon)	287-2350
Community Food Response - M, W, F 5-7:00 p.m. at Bethel Lutheran Church 810 1st Ave SE	328-6341
Community Action Program (CAP) Food Support Outreach for Seniors	328-6500
Food Stamps	328-6500
Food Shelf - Tues & Friday 10 am - 4 pm	328-6500
Noon Lunch - M-F	328-6500
Saturday Meals, Christ United Methodist Church, 11 am at 400 4th Ave SW	328-6500
Sunday Meals, St. Francis of Assisi Catholic Church, 11:30 at 1114 3rd St. SE	328-6500
Women, Infants & Children (WIC) Nutrition Program	328-7555
HEALTH CARE - CLINICS / HOSPITALS	
Migrant Health Services	529-0503
Mayo NE Clinic	538-8500
Mayo NW Clinic	538-8555
Mayo Medical Center/Mayo Clinic	284-2511
Business Office	287-1819
Community Internal Medicine	284-5278
Community Pediatrics & Adolescent Medicine	284-5233
Family Medicine	284-5300
Gynecology	266-8680
Obstetrics / Pregnancy Testing	284-5135
Rochester Methodist Hospital	266-7800
Labor and Delivery Unit	266-7531
Saint Marys Hospital	255-5123
Olmsted Medical Center Hospital	529-6600
BirthCenter	529-6750
Olmsted Medical Center Main Clinic (ask for area)	328-4400
Internal Medicine/Obstetrics/Gynecology/Pediatrics/Family Medicine	
Lab Desk - Pregnancy Test/Throat Culture	292-7070
Olmsted Medical Center Stewartville	533-4727
Olmsted County Public Health Services	328-7500
Child & Teen Checkups Clinic / Immunization Clinic / Communicable Disease - Information and Screening / Environmental Concerns	
Public Health Nurse - Information, home visits for pregnancy, parenting, newborn, Baby Steps & Bright Futures Programs, School Public Health Nurse	
Pregnancy Testing and STD/HIV Testing Clinic	
Planned Parenthood - Exams, tests, birth control for women and men	288-5186
Good Samaritan Medical Clinic (Salvation Army Free Clinic) call for appt.	
Clinics include: General medical for adult/pediatric/eye/dental/respiratory/hypertension smoking cessation/psychiatry and psychology	529-4100

Appendix O: Center Organizational Structure

**CAC
ORGANIZATIONAL STRUCTURE**



EXECUTIVE STEERING COMMITTEE:

- Advisory Function
- CAC Staffing
- Leaders of respective MDT and Peripheral Groups
- Mayo (MD vs. Admin)

OPERATIONS COMMITTEE:

- Systems
- Guidelines
- Protocols (development and changes)
- Front-line supervisors of MDT and peripheral groups

Appendix Q: Diversity and Inclusion Roadmap



**Office of Diversity and
Inclusion**

Diversity Roadmap Presentation

**Sharonne N. Hayes, M.D.
Fred Wills**

***Diversity and Inclusion Vision: Mayo Clinic will be recognized
by patients, employees, peer institutions, and the community as
the leading model for diversity and inclusion***

DIVERSITY & INCLUSION ROADMAP

Diversity and Inclusion Vision:

Mayo Clinic will be recognized by patients, employees, peer institutions, and the community as the leading model for diversity and inclusion.

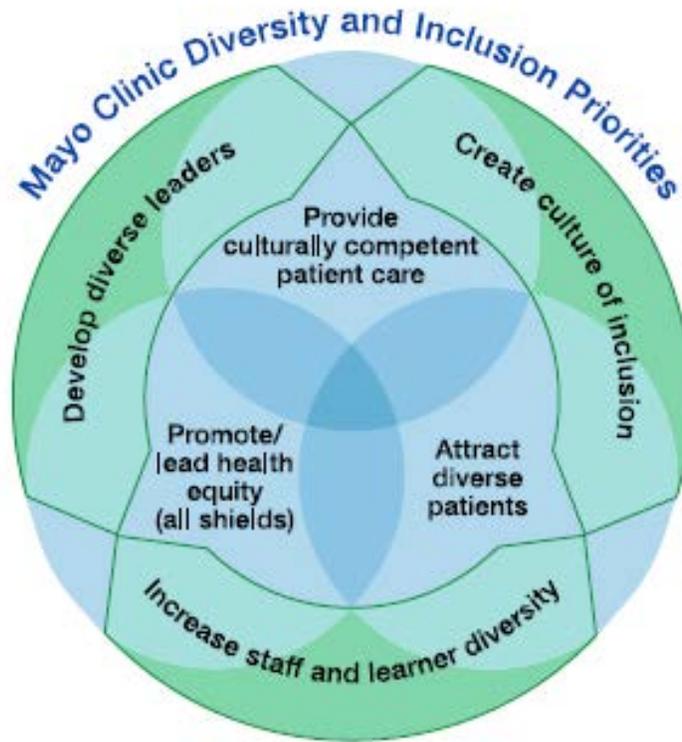
Diversity and inclusion are integral to Mayo Clinic's mission. In order to become the health care organization of choice and optimally meet the needs of our increasingly diverse current and future patients, we must be prepared to provide excellent, culturally relevant care in a welcoming environment to individuals from a wide variety of backgrounds. We must encourage, value and leverage the diversity of skills, ideas, experiences, and contributions of all of our staff in order to nurture the culture of innovation, safety and quality that are critical to Mayo's future and key to meeting our overall strategic goals. Our success will help ensure Mayo Clinic remains a leader in practice, education and research and that by attracting emerging target patients, remains fiscally secure.

Diversity alone (just having it) is insufficient; therefore, Mayo's focus will not be solely about numbers. Our efforts will be directed toward what we "do" with our diversity and capitalizing upon the diversity of thought that comes with every individual's life experiences. Ultimately, we must still address "the numbers" and we must intensify our efforts to recruit, develop and retain the best people who will be intentionally more diverse. Mayo Clinic should reflect the community and our patients. We currently do not, so we must change in order to make it happen.

Each goal and objective in the diversity strategic plan roadmap document is linked and aligned to better meet the needs of Mayo's patients, employees, and learners, current and future, through initiatives outlined in the Mayo Clinic Operating Plan. These goals will be achieved through bold policy and practice changes, partnership development, targeted resource allocation, and leveraging Mayo's strengths to promote a diverse, equitable and inclusive culture. The Office of Diversity and Inclusion will work with groups and individuals across the organization to help meet the evolving medical, cultural and educational needs of our patients and staff. Objectives and metrics will be assigned by leadership to appropriate individuals, groups, shields, and sites and will result in changes in how we teach, learn, practice medicine and perform research, and, importantly, how we lead.

Diversity and Inclusion Goals and Focus Areas for 2012-13

- 1. Provide high quality, culturally appropriate care in a welcoming environment to all patients.**
- 2. Increase the diversity of Mayo Clinic patients.**
- 3. Improve inclusiveness and participation of diverse employees at all levels of the organization.**
- 4. Increase the proportion of women and minority students, faculty, administrators and staff where underrepresented.**
- 5. Increase the proportion of women and minorities in senior leadership.**
- 6. Identify and eliminate health disparities; become a national leader in the science and promotion of health equity.**
- 7. Develop an integrated and formal infrastructure for the Office of Diversity and Inclusion and for coordination and dissemination of diversity values, programs and scholarship activities across sites, shields and externally.**



Diversity and Inclusion Plan

Mayo Clinic Strategic Plan

Diversity and Inclusion Vision

Mayo Clinic will be recognized by patients, employees, peer institutions, and the community as the leading model for diversity and inclusion.

Diversity Roadmap Goals

1. Provide high quality, culturally appropriate care in a welcoming environment to all patients
2. Increase the diversity of Mayo Clinic patients
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4. Increase the proportion of women and minority students, faculty, administrators and staff where underrepresented
5. Increase proportion of women and minorities in senior leadership
6. Identify and eliminate health disparities; become a national leader in the science and promotion of health equity

Priority Activities for 2012-2013

<u>Data Collection and Analysis (patients/employees)</u>	<u>Best Practices Assessment & Implementation</u>	<u>Office of Diversity and Inclusion Infrastructure (enterprise)</u>	<u>Communication (Internal & external)</u>
Methodology/System Support Reporting (gender, race/ethnicity) Diversity climate assessment (employees)	Cultural Competence Recruitment & Hiring Mentor & develop diverse staff Promotion Retention Safety Diversity networking groups	Governance & committees Diversity in Education Partnerships (Internal & external) Metrics & scorecards Diversity consultations, tools, services Resources & staff Fund development	Leadership alignment Stakeholder engagement Business case/ROI for diversity Communication & change management strategy

Appendix P: Draft Minority Feedback Form

Mayo Clinic
Program Evaluation Form

Program Title: _____

Location: _____ Program Date: _____ Session Time: _____

Child Advocacy Center	1 <i>Strongly Disagree</i>	2 <i>Disagree</i>	3 <i>Agree</i>	4 <i>Strongly Agree</i>
a. The Speaker was Knowledgeable of subject				
b. The Teaching Strategies used were appropriate for the content				
c. The content was applicable to my practice/job responsibilities				
d. The Speaker addressed the objectives:				
i) What is a CAC				
ii) What are the benefits				
iii) How to Access Services of CAC				
e. Knowledge of topic Before Presentation				
iv) What is a CAC				
v) What are the benefits				
vi) How to Access Services of CAC				
Speaker/objective Comments:				
Ideas for Future Topics:				
Do you see any barrier for accessing the CAC and its services?:				

	1 <i>Poor</i>	2 <i>Fair</i>	3 <i>Good</i>	4 <i>Excellent</i>
2) Your overall rating of this program				

Thank you!

**Appendix Q: Diversity and Inclusion
Roadmap**



Office of Diversity and Inclusion

Diversity Roadmap Presentation

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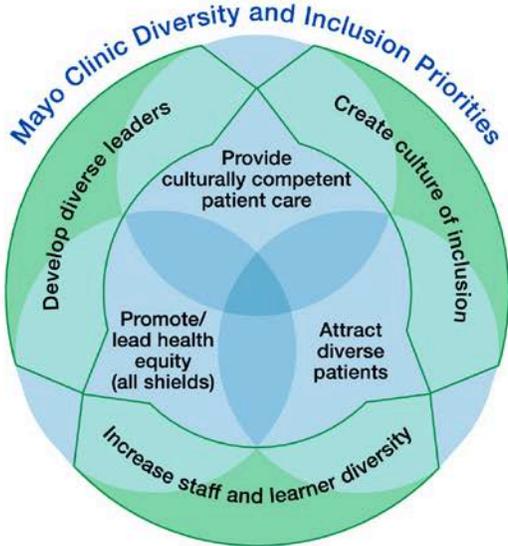
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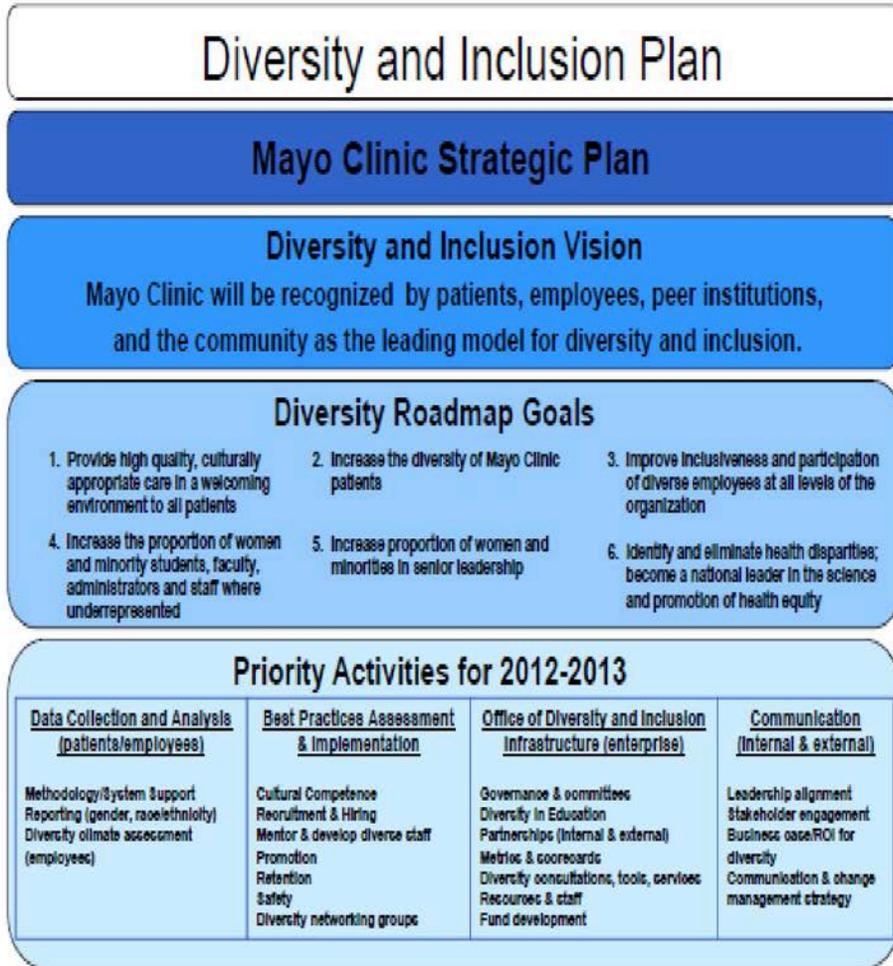
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- 2. Increase the diversity of Mayo Clinic patients.**
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- 4. Increase the proportion of women and minority students, faculty, administrators and staff where underrepresented.**
- 5. Increase the proportion of women and minorities in senior leadership.**
- 6. Identify and eliminate health disparities; become a national leader in the science and promotion of health equity.**
- 7. Develop an integrated and formal infrastructure for the Office of Diversity and Inclusion and for coordination and dissemination of diversity values, programs and scholarship activities across sites, shields and externally.**





Goal 1: Provide high quality, culturally appropriate care in a welcoming environment to all patients

Objectives	Maps To	Metrics	Tactics	Accountable
a) All patient-related metrics (e.g. satisfaction, health outcomes, safety) will be reported and analyzed by age, gender, and race/ethnicity	A1, C2c	<ul style="list-style-type: none"> Percent of patient-related metrics reflected of the metrics on the Mayo Clinic Operating Plan that are reported and analyzed by age, gender, and race/ethnicity 	<ul style="list-style-type: none"> Utilize patient-provided race/ethnicity information (Goal 2b) and other demographics to stratify patients in analyses Include diversity and inclusion perceptual questions in patient satisfaction survey 	<p>Practice</p> <p><i>Responsible</i></p> <ul style="list-style-type: none"> Value Service (Patient Satisfaction) Practice Convergence Committee (common system) Office of Demand Generation eHealth APN ACN Workgroup
b) Increase cultural competency among all staff	A1, C2c, D1b, D3	<ul style="list-style-type: none"> Number of staff participating in cultural competence education Number/percent of staff demonstrating satisfactory cultural competency Diversity of Patient Family Advisory Council membership (feedback loop) Formation of Multicultural PFAC Mayo Employee Resource Group (MERG) Education Measure Cultural Competency metrics and tools 	<ul style="list-style-type: none"> Establish clear expectations that staff will need to adapt their skills to best serve our patients in a diverse health care environment 	<p>Practice</p> <p><i>Responsible</i></p> <ul style="list-style-type: none"> Leadership Education/College of Medicine Accreditation
			<ul style="list-style-type: none"> Broaden cultural competence education and extend to all staff 	<p>Practice</p> <p><i>Responsible</i></p> <ul style="list-style-type: none"> HR Office of Leadership and Organization Development
			<ul style="list-style-type: none"> Include cultural confidence assessment in all staff evaluations 	<p>Practice</p> <p><i>Responsible</i></p> <ul style="list-style-type: none"> HR Personnel Committee

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Goal 1: Provide high quality, culturally appropriate care in a welcoming environment to all patients

			<ul style="list-style-type: none"> Formation of multicultural PFAC Diverse Membership on all PFACs 	<p>Practice</p>
c) Increase health literacy among diverse patients	A1, C2c, C6	<ul style="list-style-type: none"> Number of diverse and non-English speaking patients demonstrating health literacy 	<ul style="list-style-type: none"> Increase culturally relevant offerings for health and healthy living for diverse patients (lifestyle, diet) 	<p>Section of Patient Education</p> <p><i>Responsible</i></p> <ul style="list-style-type: none"> Practice Education
d) Develop initiatives to fully address the health care needs of patients with disabilities	A1, C1a, C2c, C5a, D1b, C6	<ul style="list-style-type: none"> Completion of baseline assessment Initial recommendations brought forward to Practice 	<ul style="list-style-type: none"> Convene taskforce for input regarding health care needs of patients with disabilities 	<p>Practice</p> <p><i>Responsible</i></p> <ul style="list-style-type: none"> Disabilities Workgroup
e) Develop initiatives to fully address the health care needs of GLBTI patients	A1, B3, C1a, C2c, C5a, D1b, C6	<ul style="list-style-type: none"> Completion of baseline assessment Initial recommendations brought forward to Practice 	<ul style="list-style-type: none"> Convene taskforce for input regarding health care needs of GLBTI patients 	<p>Practice</p> <p><i>Responsible</i></p> <p>GLBTI Task Force</p>

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Mayo Clinic Child and Family Advocacy Center / Olmsted County MDT Protocol (2012)

Goal 2: Increase the diversity of Mayo Clinic patients

Objectives	Maps To	Metrics	Tactics	Accountable
a) Increase Mayo Clinic's presence in diverse markets	A3.1, B3.1 B3.2, C5a	<ul style="list-style-type: none"> Percent increase of new, unique, diverse commercial and contract patients 	<ul style="list-style-type: none"> Increase Mayo Clinic's understanding of diverse patient populations and individuals Incorporate diversity and cultural considerations into marketing efforts, product offerings and health care experience Monitor awareness and opinions of Mayo Clinic by diverse patients in target markets Utilize patient-provided race/ethnicity information and other demographics 	Marketing <i>Responsible</i> <ul style="list-style-type: none"> Public Affairs Destination Medical Community workgroup Center for Social Media Enterprise Data Trust (EDT) OCRA (data) Outpatient Care Delivery Platform Office of Access Management Dept. of Medicine/Specialty Councils Data governance EMR & Systems Oversight Committee Alumni Office GBS
b) Collect race/ethnicity information on all patients	C2a, C4a	<ul style="list-style-type: none"> Percent of patient records and intake information that include race/ethnicity information 	<ul style="list-style-type: none"> Educate and assist patients in completion of race/ethnicity information 	Chief Medical Information Officer <i>Responsible</i> <ul style="list-style-type: none"> Enterprise Data Trust (EDT) Practice Data governance EMR & Systems Oversight Committee
c) Strengthen relationships with minority and international alumni	A3, B3.1, B3.2, C5b	<ul style="list-style-type: none"> Percent minority and international patients 	<ul style="list-style-type: none"> Identify minority and international alumni and assess opinions and current level of engagement with Mayo 	Alumni Office <i>Responsible</i> <ul style="list-style-type: none"> Marketing Public Affairs Destination Medical Community workgroup Center for Social Media
d) Strengthen relationships with referring physicians	A3, B3.2, C5b	<ul style="list-style-type: none"> Percent increase of new, unique, diverse commercial and contract patients 	<ul style="list-style-type: none"> Identify, engage and improve and/or develop relationships with current 	Office of Access Management-Referring Physician Office Affiliated Practice Network (APN)

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Goal 2: Increase the diversity of Mayo Clinic patients

who care for diverse patient populations		<ul style="list-style-type: none"> Percent external referred patients by race/ethnicity and gender 	and potential referring physicians who care for diverse populations in target markets	<i>Responsible</i> <ul style="list-style-type: none"> Marketing Public Affairs Destination Medical Community workgroup Contract & Payer Relations Office of Access Management Affiliated Practice Network (APN) Center for Social Media Enterprise Data Trust (EDT) Data governance
e) Leverage community partnerships and local diverse populations to enrich and enhance patient and employee "destination medical community" experience	B3, C5b	<ul style="list-style-type: none"> Community ratings of Mayo Clinic by diverse patients (perception, access, diversity climate, "corporate citizenry") 	<ul style="list-style-type: none"> Increase Mayo's involvement in new, unique, and diverse commercial and contract patients Increase Mayo's involvement in community initiatives that support local diverse populations 	Public Affairs <i>Responsible</i> <ul style="list-style-type: none"> Marketing Destination Medical Community workgroup Practice Employee Diversity Networking Groups Diversity Committees ODI Contracting/Payer Relations
f) Increase diverse patient populations' visibility in Mayo media and publications	B3, D1b	<ul style="list-style-type: none"> Number of diverse patient stories in Mayo publications and media 	<ul style="list-style-type: none"> Focus on identifying diverse patients and staff when selecting subjects for stories and illustrations in Mayo media and publications 	Public Affairs <i>Responsible</i> <ul style="list-style-type: none"> Marketing Destination Medical Community workgroup Practice Center for Social Media Alumni Office Research Communications External Relations

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Mayo Clinic Child and Family Advocacy Center / Olmsted County MDT Protocol (2012)

Goal 3: Improve inclusiveness and participation of diverse employees at all levels of the organization

Objectives	Maps To	Metrics	Tactics	Accountable
a) Diversity and Inclusion representation at individual sites and campuses to provide local input and implementation of organization-wide diversity initiatives	D4	<ul style="list-style-type: none"> Diversity Committee structure and representation implemented enterprise wide 	<ul style="list-style-type: none"> Ensure existence of Diversity Committee or appropriate structure at each site and Mayo Clinic Health System Clearly identify committee roles and responsibilities 	<p>Leadership</p> <p><i>Responsible</i></p> <ul style="list-style-type: none"> ODI HR Personnel Committee
b) Develop and administer an initial comprehensive Diversity Climate Study (Assessment of all employees at all sites in order to achieve a better understanding of current cultural confidence, inclusiveness, and barriers to progress in diversity and inclusion efforts)	D3, D4	<ul style="list-style-type: none"> Diversity Climate Study completed in 2012 Findings and initial recommendations communicated 	<ul style="list-style-type: none"> Develop study instrument and process (Mayo vs. external survey resources, benchmarks, best practices) Where feasible, modify and utilize existing data tools to gain insight and track diversity climate data over time (e.g. All Staff Survey data by demographic segments and organizational levels) 	<p>ODI</p> <p><i>Responsible</i></p> <ul style="list-style-type: none"> HR Personnel Committees Office of Leadership and Organization Development Leadership

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Goal 3: Improve inclusiveness and participation of diverse employees at all levels of the organization

c) Identify and work to close gaps in the perceived inclusiveness of Mayo Clinic's culture among different segments	D3, D4	<ul style="list-style-type: none"> Inclusiveness gaps among different segments of Mayo Clinic's workforce (e.g., demographic segments, organizational levels). 	<ul style="list-style-type: none"> Establish baseline/benchmark for future assessments. 	<p>ODI</p> <p><i>Responsible</i></p> <ul style="list-style-type: none"> HR Office of Leadership and Organization Development Office of Staff Services Leadership
d) Leverage Mayo Employee Resource Groups (MERGs) by positioning them to not only serve individual MERG membership but to help Mayo meet its larger strategic goals.	D3, D4	<ul style="list-style-type: none"> Number of staff participating in MERGS Successful organization-wide implementation of MERG best practices Number of MERG leaders participating in the development activities Number of development activities completed 	<ul style="list-style-type: none"> Establish baseline/benchmark for future assessments Establish infrastructure to optimize participation and effectiveness of MERGs Identify best practices for MERGs Standardize the roles, responsibilities and scope of MERG leaders and membership Provide personal and professional development to MERG leaders 	<p>ODI</p> <p><i>Responsible</i></p> <ul style="list-style-type: none"> HR

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Goal 3: Improve inclusiveness and participation of diverse employees at all levels of the organization

e) Develop enterprise-wide educational offerings to improve understanding and awareness of the importance of diversity and inclusion in meeting our core mission	D3, D4	<ul style="list-style-type: none"> Number of diversity and inclusion classes and programs offered Number and percent of staff participation in classes/programs 	<ul style="list-style-type: none"> Provide educational offerings 	HR/Office of Leadership and Organization Development <i>Responsible</i> <ul style="list-style-type: none"> ODI
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Goal 4: Increase the proportion of women and minority students, faculty, administrators and staff where underrepresented

Objectives	Maps To	Metrics	Tactics	Accountable
a) Women and minority faculty and allied health staff will be representative of the available talent pool	D4	<ul style="list-style-type: none"> Percent of minority and women representation in total number of qualified applicants for faculty, administrators, and staff Percent of departments meeting the 80 percent standard of representation for women and men where underrepresented Percent of departments meeting the 80 percent standard of representation for <u>minorities</u> Percent of all departments where ratio of allied health staff <u>minority</u> new hires >= ratio available in market Percent of women, where under-represented, and minority students and trainees who subsequently become employed at Mayo Clinic Staff turnover by category Percent men, where under-represented 	<ul style="list-style-type: none"> Improve employment recruitment processes via coordination and communication among Personnel Committees, HR, and department leadership 	Department/Division Chairs <i>Responsible</i> <ul style="list-style-type: none"> Personnel Committees Hiring Managers HR Practice
			<ul style="list-style-type: none"> Expand, develop and diversify the pools of qualified underrepresented candidates of women and minority, faculty, administrators, and staff 	<i>Responsible</i> <ul style="list-style-type: none"> Personnel Committees Hiring Managers HR
			<ul style="list-style-type: none"> Identify and implement best practices for hiring and selecting faculty, administrators, and staff 	<i>Responsible</i> <ul style="list-style-type: none"> Personnel Committees Hiring Managers HR
			<ul style="list-style-type: none"> Consider candidates' potential to enhance the diversity and inclusivity of staff during the selection process (holistic review) 	<i>Responsible</i> <ul style="list-style-type: none"> Personnel Committees Hiring Managers HR
			<ul style="list-style-type: none"> Retain and recruit quality diverse students and trainees, and post docs to staff positions through identification and promotion of minority students and 	<i>Responsible</i> <ul style="list-style-type: none"> Program Directors College of Medicine Research Personnel Committee HR

Goal 4: Increase the proportion of women and minority students, faculty, administrators and staff where underrepresented

			trainees as candidates for employment/staff appointment during training	
b) Women and minority students and trainees in the College of Medicine Schools will be representative of the available talent pool	D4	<ul style="list-style-type: none"> Percent of minority and female representation in total number of qualified applicants for faculty and staff in the College of Medicine Schools Percent of minorities enrolled in the College of Medicine Schools where under-represented (by program) Percent of women enrolled in the College of Medicine Schools, where under-represented (by program) 	<ul style="list-style-type: none"> Fully engage training program directors and deans in diversity efforts and hold them accountable for diversity in their programs 	College of Medicine <i>Responsible</i> <ul style="list-style-type: none"> Program Directors Research ODI
			<ul style="list-style-type: none"> Diversify the composition of residency and fellowship selection committees 	<i>Responsible</i> <ul style="list-style-type: none"> Research Program Directors
			<ul style="list-style-type: none"> Seek extramural funds (NIH, ASU, etc.) and leverage internal resources for minority training and recruitment and pipeline programs 	<i>Responsible</i> <ul style="list-style-type: none"> Research
			<ul style="list-style-type: none"> Increase student recruitment for minority training and pipeline programs 	<i>Responsible</i> <ul style="list-style-type: none"> Program Directors Research HR
			<ul style="list-style-type: none"> Build external partnerships and collaborative efforts targeted to recruit minorities and women where underrepresented 	<i>Responsible</i> <ul style="list-style-type: none"> Research HR Program Directors ODI

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Goal 4: Increase the proportion of women and minority students, faculty, administrators and staff where underrepresented

c) Increase the success of women and minorities underrepresented in medicine enrolled in Mayo Clinic College of Medicine Schools	D3	Retention and academic progress, certification, board performance and graduation rates of women and minority students and trainees enrolled in Mayo schools	<ul style="list-style-type: none"> Establish baseline/benchmark for future assessments Identify and implement best practices strategies for retention of women and minorities 	<i>Responsible</i> <ul style="list-style-type: none"> Education Research Department/Division Chairs Program Directors
d) Provide discretionary funds for retaining and hiring of extraordinary talent	D4	<ul style="list-style-type: none"> Number (FTE) extraordinary staff hired in temporary overstaff status 	<ul style="list-style-type: none"> Develop and implement process and budget to facilitate and support temporarily overstaffing for extraordinary talent, including women and minorities where underrepresented 	Department/Division Chairs <i>Responsible</i> <ul style="list-style-type: none"> Personnel Committees Leadership OCG MCR or approving body as appropriate Practice MCAT

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Goal 5: Increase the proportion of women and minorities in senior leadership

Objectives	Maps To	Metrics	Tactics	Accountable
a) Increase the proportion of women and minorities in senior leadership	D4, D5	<ul style="list-style-type: none"> Percent of women and minorities who are in senior leadership positions Percent of women and minorities in leadership pipelines 	<ul style="list-style-type: none"> Identify and employ best practices to fill positions and in the selection of leadership appointments 	Leadership <i>Responsible</i> <ul style="list-style-type: none"> Personnel Committees HR Office of Leadership and Organization Development
			<ul style="list-style-type: none"> Educate search and Personnel Committee members and HR staff regarding best practices 	<i>Responsible</i> <ul style="list-style-type: none"> Personnel Committees HR Office of Leadership and Organization Development
			<ul style="list-style-type: none"> Develop current staff to ensure a diverse, qualified candidate pool for future leadership opportunities 	<i>Responsible</i> <ul style="list-style-type: none"> Department and Division Chairs HR Office of Leadership and Organization Development
b) Identify and address disparities in academic advancement for minority and women faculty	D4, D5	<ul style="list-style-type: none"> Gap (percent) between men and women who hold the academic ranks of associate and full professor Gap (percent) between non-minority and minority faculty holding the academic ranks of associate and full professor Increase in academic rank promotion productivity in women and minorities Percent of Mayo Clinic 	<ul style="list-style-type: none"> Review academic advancement and promotion criteria and process Review criteria, processes and development of candidate pools for Mayo Clinic awards Clarify expectations and 	Education <i>Responsible</i> <ul style="list-style-type: none"> Leadership Academic Advancement and Promotion Committee Office of Leadership and Organization Development <i>Responsible</i> <ul style="list-style-type: none"> Leadership Department/Division Chairs

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Goal 5: Increase the proportion of women and minorities in senior leadership

		<ul style="list-style-type: none"> Awards awarded to women and minorities (e.g., named professorships) Distinguished Clinicians, Investigators awarded to women and minorities Number of peer-reviewed articles per female or minority clinician without base budgets Number of peer-reviewed articles by women and minorities (number and proportion of authors and first authors by division/department) 	<ul style="list-style-type: none"> enhance support and education to department leadership as to their roles/responsibilities for academic advancement for women and minorities 	<ul style="list-style-type: none"> Academic Advancement and Promotion Committee Office of Leadership and Organization Development Personnel committees
			<ul style="list-style-type: none"> Identify and address any unique barriers to academic advancement in women 	<i>Responsible</i> <ul style="list-style-type: none"> Office of Leadership and Organization Development Academic Advancement and Promotion Committee
			<ul style="list-style-type: none"> Develop and fund innovative programs to support women physicians and scientists academically during child-bearing/child-rearing years (e.g. Harvard Claffin Awards) 	<i>Responsible</i> <ul style="list-style-type: none"> Office of Leadership and Organization Development Department/Division Chairs Research HR
c) Increase mentoring, coaching and leadership training opportunities for women and minority staff and allied health	D4, D5	<ul style="list-style-type: none"> Number of women and minority staff participating in internal and external mentoring, coaching, and leadership development opportunities Mentorship awards Number of women and minorities filling positions funded through endowments Total funding for innovative/endowed programs and positions filled with women and minorities 	<ul style="list-style-type: none"> Recognize, support and reward successful mentoring initiatives and individual mentors, including non-traditional mentoring arrangements (peer, multiple, cross discipline, career/personal) Establish institutional endowments to support mentored career development programs to advance careers in leadership, education, research or scholarly clinical practice for women and minority faculty and administrators 	Office of Leadership and Organization Development <i>Responsible</i> <ul style="list-style-type: none"> Department/Division Chairs HR ODI Development

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Goal 6: Identify and eliminate health disparities; become a national leader in the science and promotion of health equity

Objectives	Maps To	Metrics	Tactics	Accountable
a) Create and disseminate new knowledge to improve health equity and help transform health care delivery at Mayo Clinic	A1, C4	<ul style="list-style-type: none"> Number of peer-reviewed articles on health disparity and health equity Number of women and minorities in clinical trials (where under-represented) Grant funding for health disparities/equity research Number of projects addressing health disparities and health equity Grant funding for health disparities/equity research 	<ul style="list-style-type: none"> Promote and coordinate efforts to identify and work to eliminate health disparities across research, practice, and education Pilot projects to fund research and implementation projects targeting health disparities 	Science of Healthcare Delivery <i>Responsible</i> <ul style="list-style-type: none"> MC Cancer Center CTSA Education Practice / Specialty Councils Research Chief Medical Information Officer Center for Regenerative Medicine Center for Individualized Medicine Value/Safety Cancer Centers
b) Increase the proportion and effort of staff and students involved in improvement of the health of underserved/disadvantaged populations	A3, C1, C6	<ul style="list-style-type: none"> Number of partnerships with community groups and minority serving health care and educational institutions Grant funding for health disparities/equity research New protocols and PIs involved in diversity and health equity research Proportion and number of staff and students involved in improvement of the health of underserved/disadvantaged populations 	<ul style="list-style-type: none"> Intentional outreach efforts by staff and students to identify, address, and eliminate health disparities Seek funding for health disparities research 	Research <i>Responsible</i> <ul style="list-style-type: none"> MC Cancer Center CTSA Practice Departments/Specialty Councils Public Affairs Education

Goal 7: Develop an integrated and formal infrastructure for the Office of Diversity and Inclusion and for coordination and dissemination of diversity values, programs and scholarship activities

Objectives	Maps To	Metrics	Tactics	Accountable
a) Develop metrics for diversity and inclusion success	•	<ul style="list-style-type: none"> Total endowed in support of institutional diversity and inclusion goals and programs Total endowed faculty in support of institutional diversity and inclusion goals and programs External recognition of diversity/inclusion efforts by individuals, groups, Mayo Clinic External funding for diversity and inclusion initiatives, faculty development (e.g. benefactors, competitive research and development grants)	<ul style="list-style-type: none"> Implement Diversity Strategic Roadmap 	ODI <i>Responsible</i> <ul style="list-style-type: none"> HR Education Research Practice CALD Office of Organizational and Leadership Development Development Public Affairs Marketing
b) Build awareness of the importance of diversity and inclusion	•	<ul style="list-style-type: none"> Pt Satisfaction Survey data Employee Satisfaction Survey data Diversity Climate Study data Diversity metrics included in the organizational scorecard Number of stories of diverse patient and employee experiences in publications and social media Number of Mayo-authored peer reviewed articles about workplace diversity and inclusion practices Number of funded pilot research and implementation projects assessing the efficacy or impact of novel diversity initiatives 	<ul style="list-style-type: none"> Diversity Roadmap is communicated to all stakeholders and tactics implemented 	ODI <i>Responsible</i> <ul style="list-style-type: none"> Leadership HR Public Affairs Diversity Committees

Mayo Clinic Child and Family Advocacy Center / Olmsted County MDT Protocol (2012)

Goal 7: Develop an integrated and formal infrastructure for the Office of Diversity and Inclusion and for coordination and dissemination of diversity values, programs and scholarship activities

c) Develop necessary infrastructure and tools and improve availability of diversity and inclusion data and metrics	•	<ul style="list-style-type: none"> • Assessment of IT capacity and infrastructure in support of the diversity strategic plan • Number of metrics developed, reported and tracked over time 	<ul style="list-style-type: none"> • Capacity expansion of information technology and services to conduct applied research, self-evaluation, and assessment of workforce data, equity, and diversity and inclusion over time at all sites and across all shields for internal use as well as for external reporting and benchmarking 	<p>ODI</p> <p><i>Responsible</i></p> <ul style="list-style-type: none"> • IT • HR • Public Affairs • Diversity Committees
d) Strengthen fund development for support of equity and inclusion efforts via benefactors, competitive research grants, and development funds.	•	<ul style="list-style-type: none"> • Number and amount of competitive grant requests funded • Amount of Development dollars received for diversity and inclusion initiatives and programs 	<ul style="list-style-type: none"> • Provide Mayo Clinic benefactors with option to support diversity and inclusion initiatives and programs 	<p>ODI</p> <p><i>Responsible</i></p> <ul style="list-style-type: none"> • Development
			<ul style="list-style-type: none"> • Seek development and other external funding sources for support of equity and inclusion 	<p><i>Responsible</i></p> <ul style="list-style-type: none"> • Development • Public Affairs
e) Develop a robust external web site	•	<ul style="list-style-type: none"> • Number of hits by internal and external audiences 	<ul style="list-style-type: none"> • Enhance and upgrade diversity websites organization wide 	<p>ODI</p> <p><i>Responsible</i></p> <ul style="list-style-type: none"> • Public Affairs • GBS

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Goal 7: Develop an integrated and formal infrastructure for the Office of Diversity and Inclusion and for coordination and dissemination of diversity values, programs and scholarship activities

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ACN – Affiliated Care Network
 APN – Affiliated Practice Network
 OCRA – Operations Coordination and Resource Allocation

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Appendix R: NCANet Education Calls



Schedule of 2013 Education Calls:

Calls Held 1-3 p.m. CST

January 9	What is TCFBT? Understanding the Role of Trauma Focused Therapy and Why Is it Important? With Michael de Arellano
January 10	The role of Corroboration in Building a Witness Case with NDAA
January 24	Finding and Helping the "Hidden Victims": Responding to Children at the Scene (DV) with Mark Wynn
February 13	Obesity: The New Failure to Thrive with Nancy Harper, MD
February 14	Preparing Children for the Legal Process in Sexual Assault and Family Violence Cases- Strategies for Success with Roger Canaff
February 28	Law Enforcement's Role in Prevention-Beyond Safety Education with Cordelia Anderson
March 13	Michael Devlin Case Study with Bill Carson
March 14	Investigating and Prosecuting Cases when An Interpreter is Used with NDAA
March 28	Transformational Philanthropy for Nonprofits with Lisa Dietlin
April 10	Anatomy of a Sexual Assault Case from the Defense Point of View with Larry Braunstein
April 11	Starvation, Torture and Scapegoating with Nancy Harper, MD
April 25	Corroboration in Child Abuse Investigations with Julie Kenniston and Chris Kolcharno
May 15	Impact of Culture on the Treatment of Latino Youth Who Witness Domestic Violence With Michael de Arellano
May 16	Prosecution of Cases with Limited Evidence with NDAA

May 30	Craig's List Undercover Investigations with Detective Wayne Nichols
June 12	Evidence-Based Approaches to Assessing and Intervening with Sexually Abused Children With Jeff Wherry
June 13	Most Common Mistakes Made in Forensic Interviews and How to Fix Them with Linda Cordisco Steele
June 27	Behind the Mask of a Child Rapist: Hope's Journey with Jim Holler
July 10	Resiliency 101: From Victim to Survivor with Julie Brand
July 11	Cross Examination of the Irresponsible Expert Witness with NDAA
July 25	Child Interviewing: Update on Research and Practice with Tom Lyon
August 14	Engaging Father's in the Child Welfare System with Kenneth Thompson, Sr
August 15	Reducing Victimization for Individuals with Disabilities, Behavior and Communication With Scott Modell
August 29	Issues of Attachment in Young Traumatized Children and their Caregivers with Anna Smyke
September 11	The Toughest Teens: Medical Needs of Commercially Sexually Exploited Children with Leila Keltner, MD
September 12	Meeting Untrue Defenses in Child Sexual Abuse with Justin Fitzsimmons, NDAA
September 26	the Dynamics of Spirituality: Where Do They Fit in Evidenced-Based Treatment? With Anna Shaw
October 9	The Prepare and Predict Model of Forensic Interviewing with Ale Levi and Diane Siegel
October 10	Teens and Technology-the E-Trade Babies in Action with Stephanie Smith
October 24	Interviewing and Child Trafficking with Katie Connell
November 13	Making It all Fit: How the Doctor Can Help Sort Fact from Fiction in Child Abuse Cases with Suzanne Starling
November 14	The Crawford Case Revisited with NDAA
December 11	Family Engagement and Supporting Nonoffending Caregivers with Jennifer Levy Peck

December 12 How and Why to Protect Young Athletes from Sexual Abuse, Bullying and Harrassment with Katherine Starr

December 19 Developing Nonprofit Board Leadership with BOARD Source-date not confirmed

<p>Sample Agenda:</p> <p>1:00-1:05 p.m. Introductions of site and presenter</p> <p>1:05-2:30 p.m. Presentation of Content by Speaker</p> <p>2:30-3:00 p.m. Question and Answer session</p>

Speaker Biographies and Summaries:

NDAA Staff (various):

The National District Attorneys Association is the oldest and largest professional organization representing criminal prosecutors in the world. Its members come from the offices of district attorneys, state's attorneys, attorneys general and county and city prosecutors with responsibility for prosecuting criminal violations in every state and territory of the United States. Its purposes are:

- to foster and maintain the honor and integrity of the prosecuting attorneys of the United States in both large and small jurisdictions by whatever title such attorneys may be known;
- to improve and to facilitate the administration of justice in the United States;
- to promote the study of the law and research therein, the diffusion of knowledge thereof and the continuing education of prosecuting attorneys, lawyers, law enforcement personnel, and other members of the interested public by various means including, but not limited to, arranging seminars and fostering periodic conventions or meetings for the discussion and solution of legal problems affecting the public interest in the administration of justice;
- to cause to be published and to distribute addresses, reports, treatises, and other literary works on legal subjects or other related subjects;
- to operate the training and education division of the corporation, which has been sponsored by the corporation since 1969;
- to operate the training, research and development division of the corporation. The mission of the institute is to support the objectives of NDAA by providing to state and local prosecutors knowledge, skills and support to ensure that justice is done and the public safety and rights of all are safeguarded. To

Appendix S: Mayo Liability Insurance

CERTIFICATE OF INSURANCE						DATE: 12/5/2012	
PRODUCER 345-949-7988 MARSH MANAGEMENT SERVICES CAYMAN LTD. GOVERNORS SQUARE, BUILDING 4, 2 ND FLOOR 23 LIME TREE BAY AVENUE PO BOX 1051 GRAND CAYMAN KY1-1102 CAYMAN ISLANDS			This certificate is issued as a matter of information only and confers no rights upon the Certificate Holder. This Certificate does not amend, extend or alter the coverage afforded by the policies below.				
INSURED Mayo Clinic (together with the other insured listed on the policy)			COMPANY AFFORDING COVERAGE				
			A MAYO INSURANCE COMPANY LIMITED				
COVERAGES							
This is to certify that the Policies listed below have been issued to the Named Insured above for the Policy Period indicated, notwithstanding any requirement, term or condition of any contract or other document with respect to which this certificate may be issued or may pertain, the insurance afforded by the policies described herein is subject to all the terms, exclusions and conditions of such policies. Limits shown may have been reduced by paid claims.							
TYPE OF INSURANCE	Co LTR	POLICY NUMBER	POLICY EFFECTIVE DATE	POLICY EXPIRATION DATE	LIMITS		
GENERAL LIABILITY	A	272-1-05011/13	1/1/2013	1/1/2014	COMBINED ANNUAL AGGREGATE*	\$20,000,000	
					PRODUCTS-COMP/OP AGGREGATE		
					PERSONAL ADV INJURY		
					EACH OCCURRENCE	\$5,000,000	
					FIRE DAMAGE		
X	COMMERCIAL GENERAL LIABILITY				MEDICAL EXPENSES		
	CLAIMS MADE				EACH MEDICAL INCIDENT	\$10,000,000	
X	OCCURRENCE				COMBINED ANNUAL AGGREGATE*	\$40,000,000	
PROFESSIONAL LIABILITY		A	272-1-05011/13	1/1/2013	1/1/2014		
X	OCCURRENCE						
EXCESS LIABILITY					EACH CLAIM		
	UMBRELLA FORM				COMBINED ANNUAL		
DESCRIPTION OF OPERATIONS/ LOCATIONS/ VEHICLES/ SPECIAL ITEMS (LIMITS MAY BE SUBJECT TO RETENTIONS) Evidencing coverage is in effect for the Certificate Holder.							
CERTIFICATE							
Mayo Clinic (and its affiliated entities) 200 First Street SW Rochester, MN 55905			CANCELLATION				
			Should any of the above described policies be cancelled before the expiration date thereof, the issuing company will endeavor to mail written notice to the certificate holder named below, but failure to mail such notice shall impose no obligation or liability of any kind upon the company, its agents or representatives.				
			AUTHORIZED REPRESENTATIVES				
			<i>Marsh Management Services Cayman Ltd.</i>				



CERTIFICATE OF LIABILITY INSURANCE

DATE(MM/DD/YYYY)
01/07/2013

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Aon Risk Services Central, Inc. Minneapolis MN office 5600 West 83rd Street 8200 Tower, Suite 1100 Minneapolis MN 55437 USA	CONTACT NAME: PHONE (A.C. No. Ext): (866) 283-7122 FAX (A.C. No.): (847) 953-5390	
	E-MAIL ADDRESS:	
INSURED Mayo Clinic and all subsidiaries 200 First Street, SW Rochester MN 55905 USA	INSURER(S) AFFORDING COVERAGE	
	INSURER A: Federal Insurance Company	NAIC # 20281
	INSURER B:	
	INSURER C:	
	INSURER D:	
	INSURER E:	

Holder Identifier :

COVERAGES **CERTIFICATE NUMBER:** 570048785844 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS. **Limits shown are as requested**

INSR LTR	TYPE OF INSURANCE	ADDITIONAL INSURER	SUBROGATION	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
	GENERAL LIABILITY <input type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY <input type="checkbox"/> PROJECT <input type="checkbox"/> LOC						EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG
	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> NON-OWNED AUTOS						COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)
	<input type="checkbox"/> UMBRELLA LIAB <input type="checkbox"/> OCCUR <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> DED <input type="checkbox"/> RETENTION						EACH OCCURRENCE AGGREGATE
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR / PARTNER / EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y / N <input type="checkbox"/> N/A					<input type="checkbox"/> WC - STATUTORY LIMITS <input type="checkbox"/> OTH E.L. EACH ACCIDENT E.L. DISEASE-EA EMPLOYEE E.L. DISEASE-POLICY LIMIT
A	D&O-Primary			81681848 Financial Package - D&O/F	05/01/2012	05/01/2013	D&O limit each polic deductible \$15,000,000 \$2,500,000

Certificate No : 570048785844

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

Proof of Insurance. The Named Insured includes Mayo Clinic and all subsidiaries and controlled entities.

CERTIFICATE HOLDER Mayo Clinic Attn: Dawn Macken, Treasury Services 200 First Street SW Rochester MN 55905 USA	CANCELLATION SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. AUTHORIZED REPRESENTATIVE
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Appendix T: CAC Financial Statement



Patient Care Company Group Financial Statement
 Current Year vs Last Year
MCR-PT-CARE-MCR Patient Care
 Report Run Date: 3/12/2013
 Mayo Clinic Confidential

42066-Child and Family Advocacy Prgm
FA Owner - Essler,Dennis P

	Dec-12	Dec-11	Change from FY	%Change from FY	YTD Dec-12	YTD Dec-11	Change from FY	%Change from FY
	585	1,500	(915)	(61.0)%	20,215	17,678	2,537	14.4%
	(256)	(426)	170	39.9%	(11,391)	(10,831)	(561)	(5.2)%
	329	1,074	(745)	(69.4)%	8,824	6,848	1,976	28.9%
	329	1,074	(745)	(69.4)%	8,824	6,848	1,976	28.9%
	27,122	31,504	(4,382)	(13.9)%	348,161	349,345	(1,184)	(0.3)%
	747	295	451	152.9%	29,226	4,655	24,572	527.9%
	0	41	(41)	(100.0)%	2,019	2,387	(368)	(15.4)%
	312	312	0	0.0%	7,465	22,741	(15,276)	(67.2)%
	106	0	106	0.0%	2,721	100	2,621	2,621.0%
	(1,591)	(1,979)	388	19.6%	(16,270)	(18,281)	2,011	11.0%
	1,421	1,335	86	6.4%	5,410	12,942	(7,532)	(58.2)%
	26,131	916	25,214	2,752.6%	238,215	9,795	228,419	2,332.0%
	54,247	32,425	21,822	67.3%	616,947	383,684	233,263	60.8%
	(53,918)	(31,351)	(22,567)	(72.0)%	(608,123)	(376,836)	(231,287)	(61.4)%
	(16,386.6)%	(2,918.9)%	(13,467.6)%	(13,467.6)%	(6,892.0)%	(5,503.2)%	(1,388.8)%	(1,388.8)%
YTD Detail by Month	4,054	4,364	(310)	(7.1)%	59,542	57,244	2,298	4.0%
13 Month Financials	0	0	0	0.0%	0	(20,000)	20,000	100.0%
Comprehensive Detail								
Budget Financials								
Revenue, Volume and RVU Report								
Paid FTE								
Overhead Allocation								
Alloc & Service Center Offset								

Please contact the Help Desk with any questions regarding this report at MCR 4-5500, MCJ 3-0369, MCA 2-3900 or Eau Claire 8-6999.

Confidential: Use & Dispose Properly

Report # RFN01421
Patient Care Financial Statements Current Year versus Last Year.

Appendix U: Project Charter



Denotes minimal data – Request for Approval to Initiate [Project Charter Reference Document](#)
 Denotes minimal data – Request for Approval to Plan
 Full Charter required for Approval to Proceed

Project Name: Mayo Clinic Child and Family Advocacy Program (MCFAP)

Brief Project Description (255 characters): This project will focus on realizing four goals for the Mayo Clinic Child and Family Advocacy Program. 1. To stabilize the practice by improving operations and developing a staff and allied health staffing plan that meet's the community's current needs and takes into consideration the long-term vision to become a Children's Hospital Association Center of Excellence. 2. To become an accredited Child Advocacy Center with the National Children's Alliance in 2013. 3. Become the leading expert in child abuse and neglect for the Rochester area and MCHS sites. 4. Expand educational outreach and prevention services.

<input checked="" type="checkbox"/> Portfolio: Practice-Rochester	<input checked="" type="checkbox"/> Program: Mayo Clinic Children's Center	EPMO Use Only	
		Project Number:	Project Priority No:

<input checked="" type="checkbox"/> Project Size: ___ Small ___x___ Medium ___ Large ___ Mega Link to Project Sizing Document	<input checked="" type="checkbox"/> Project Tier: (Represents level of project oversight and governance) ___ Tier 1 (BOT, MT, EOT) ___ Tier 2 (Dept./Div.) ___x___ Tier 3 (Section/Work Unit)
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Project Approval Status			
Approvals	Status (In-process, complete)	Approval Person or Group	Approval Date
Approval to Initiate	<input checked="" type="checkbox"/> In process	<input checked="" type="checkbox"/> Children's Center Practice/Exec Ops	<input checked="" type="checkbox"/>
Approval to Plan	<input checked="" type="checkbox"/>		
Approval to Proceed			

Strategic Alignment

People	Processes
<p><i>Create the healthcare workforce of the future that sustains Mayo's values (People)</i></p> <p>D1. Improve staff's ability to deliver high value care</p> <p style="margin-left: 20px;">a. Facilities/Equipment</p> <p style="margin-left: 20px;">b. Training/support for process changes</p> <p>D2. Implement individual provider scorecards including quality and cost metrics (outcomes, safety, service, cost, competence, adherence to standardized practice guidelines)</p> <p>D3. Invest in continuous staff development to improve staff satisfaction and retention</p> <p>D4. Increase diversity of staff and development of diverse staff</p> <p>D5. Improve leadership training and mentoring</p> <p>D6. Increase the number and skill of physicians and clinical and basic scientists engaged in generating new knowledge</p> <p>D7. Increase our capacity and skill in comparative effectiveness and health care delivery research</p>	<p><i>Transform Mayo Clinic's knowledge management and healthcare delivery process (Process)</i></p> <p>C1. Provide solutions and hope for patients</p> <p style="margin-left: 20px;">a. Clinical Trials</p> <p style="margin-left: 20px;">b. Implement individualized Medicine into the practice</p> <p style="margin-left: 20px;">c. Regenerative medicine</p> <p style="margin-left: 20px;">d. Advance commercialization of Mayo discoveries</p> <p>C2. Standardize, improve effectiveness (outcomes, safety, service), and reduce cost</p> <p style="margin-left: 20px;">a. Standardization</p> <p style="margin-left: 20px;">b. Outcomes & Safety</p> <p style="margin-left: 20px;">c. Service</p> <p style="margin-left: 20px;">d. Manage to Reimbursement</p> <p>C3. Explore new payment mechanisms</p> <p>C4. Generate, evaluate, integrate, and manage knowledge and information</p> <p style="margin-left: 20px;">a. Practice Analytics</p> <p style="margin-left: 20px;">b. Information Exchange</p> <p style="margin-left: 20px;">c. Knowledge Management</p> <p style="margin-left: 20px;">d. Decision Support at Point of Care</p> <p>C5. Create global value-adding relationships, alliances, and partnerships</p> <p style="margin-left: 20px;">a. Patients and Consumers</p> <p style="margin-left: 20px;">b. Providers</p> <p>C6. Increase our offerings for health and healthy living</p> <p style="margin-left: 20px;">a. Wellness for Mayo Employees</p> <p style="margin-left: 20px;">b. Wellness for Patients and APN Partners</p> <p style="margin-left: 20px;">c. Wellness Products and Services for Consumer and Clients</p>

Primary Operating Objective (Choose one from above, need sub-objective where applicable): C2c

Secondary Operating Objective Optional (Choose one from above, need sub-objective where applicable): C2b

Adjust use and rigor to the size, scope, and complexity of your projects

Business Need (Problem or Opportunity Statement / Background of Need)
<p>2 In 2011, Mayo Clinic (Rochester) staff reported 493 cases of suspected abuse. Evidence suggests that coordination between medical professional and community agencies involved in the intervention leads to better outcomes for children and families. The state of Minnesota has endorsed a Child Advocacy Center (CAC) model consisting of multidisciplinary teams for the investigation and assessment of child maltreatment. MCFAP has worked with local government agencies to initiate such a program in Olmsted County. However, there is unmet demand for child advocacy services across the region. Some region patients receive specialty care in child abuse in the Twin Cities. However, the distance in and of itself can result in significant difficulty for such families. Relationships with other child abuse centers also may be a reason that counties refer outside of Mayo Clinic. Population incidence rates for Olmsted County alone estimate that in 2012 there will 711 projected cases of child maltreatment. Current staffing models do not allow for MCFAP to meet Olmsted County's needs, let alone work with regional patients. This undermines the ability for MCFAP to expand its reach to include surrounding areas and achieve CAC accreditation and long-term work towards CHA Center of Excellence standards for Child Protection Teams.</p>

Business Value Impact
<p>2 Business Value (choose only one): ___ Transform ___x___ Grow ___ Run</p> <p>2 Brief Description of Business value (how transform, grow, or run): Realizing the three goals listed above will allow MCFAP to grow in the following ways. It will allow for increased grant and funding opportunities external to Mayo Clinic resources. Consistent and increased staffing will allow for increased referrals from Olmsted County. Fully developed and formalized relationships will allow for increased referrals from surrounding counties.</p>

Project Value– Quantitative and Qualitative Metrics of Success		
<i>Critical Success Factor (CSF) (an objective that must be met in order for the project to be considered successful).</i>		
Objective <small>(Includes Internal and external customer goals/expected benefits, limit number of objectives to the top 5)</small>	Metrics/Measurements <small>(Performance, process & counterbalance metrics when applicable; correlate to Balanced Scorecard when applicable)</small>	CSF? (Y/N)
▲ CAC Accreditation	▲ Accreditation status	Y
▲ Staff Stabilization/Succession Planning	▲ Hours of availability for medical exam appointments Visit volumes at the center	Y
Referral Catchment Areas	Memorandums of Understanding complete with surrounding counties	Y

Project Scope (elements that are in & out of scope)
<p>▲ In Scope: Directly serve Olmsted and surrounding counties; focus on education, integration, and prevention with MCHS sites</p> <p>▲ Out of Scope: on-site clinical practice outreach for MCHS, Arizona, Florida; Realizing CHA Center of Excellence for Child Abuse Standards (This will be in Phase II of project)</p>

Project Team - Governance							
Role (Add/delete as applicable)	Name(s) (First initial, Last name, MD)	A	R	C	I	V	D
2 Executive/Physician/Owner/Sponsor/Champion(s): <small>Maximum of 2</small>	2 C. Moir, MD (Children's Center), A. Reed, MD (DPAM Chair)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 Administrative Owner/Sponsor(s): <small>Maximum of 2</small>	2 A. Reed, MD./S. Kline	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▲ Oversight Committee/Group(s): <small>Maximum of 2</small>	▲ Mayo Clinic Children's Center CPC/Exec Ops	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Oversight Committee/Group Sponsor(s): <small>Maximum of 2; 1 per committee/group</small>	Mayo Clinic Children's Center CPC	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Required Committee Approval(s): <small>Maximum of 3 including committees/groups listed above</small>	Mayo Clinic Children's Center CPC	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Additional: e.g. area	D. Broughton, MD, MCFAP Medical Director	<input type="checkbox"/>					

Project Team - Management							
Role (Add/delete as applicable)	Name(s) (Last name, First name, Middle Initial)	A	R	C	I	V	D

Adjust use and rigor to the size, scope, and complexity of your projects

Project Manager: Only 1	Alison Larson	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Business Analyst: Project dependent		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
IT/Technical Lead: Project dependent		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
Additional: e.g. S&P, Quality, Finance		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Initial Business Partners and Resource Requirements Estimate		
Internal/External Partner (e.g. IT, S&P, QMS, Communications, Finance, EP/MO)	Resource Skill Set Needed (e.g. Project Mgr, Business Analyst, Software Architect, Analyst/Programmer)	FTE needed
▲ Research Fellow	CAC application, policies and procedures, integration	0.5
▲		
▲		

Project Financials			
Financial Return (description if not a dollar amount)			
Funding Estimate			
Costs	Recommended Funding Source (if known)	Original Estimate	Budget
▲ Total Capital (C)	▲	▲	
▲ Total Operational Expense (OP)	▲	▲	
▲ Ongoing Annual Expense (OAE)	▲	▲	

Target Timeline Estimate		
Description	Start Date (mm/yyyy)	End Date (mm/yyyy)
<input checked="" type="checkbox"/> Estimated Project Timeline Requested by Proponent	<input checked="" type="checkbox"/> 10/12	<input checked="" type="checkbox"/> 12/13
Overall Project Timeline		
Goal 1: Improving Operations and Stabilize Staffing		
Perform staffing needs assessment	10/12	11/12
Develop organizational structure	11/12	12/12
Define roles and responsibilities	1/12	1/13
Submit organizational structure, and job descriptions for approval	1/12	3/13
Develop consistent staff coverage plan for center	10/12	12/12
Develop succession planning for medical director role/submit proposal for 1.0 FTE board certified child abuse pediatrician	10/12	1/13
Develop consistent mental health service coverage for center	1/12	6/13
Goal 2: Achieve CAC Accreditation		
Protocols completed and approved by MCFAP Exec Committee	07/12	11/12
Olmsted County MOU's signed by MDT members	07/12	11/12
Assign chapters for application packet to be written	10/12	10/12
Write chapters for application packet	10/12	1/13
Obtain example applications from other centers	08/12	10/12
Collect chapters, organize and submit application	10/12	2/13
Pass site visit	TBD	TBD
Receive NCA Board Approval	1/14	3/14
Goal 3: Become leading expert on child abuse		
Integrate policies and standardize approach with MCHS and Rochester Campus for child abuse and neglect	6/13	12/13
Sign County MOU's for MDT members of neighboring counties	1/13	12/13
Goal 4: Expand educational outreach and prevention services		
Develop educational outreach program	6/13	12/13
Expand and develop full prevention program	6/13	12/13

Initial Risks - Threats and Opportunities
Opportunities—

Appendix V: Medical Ongoing Training and Peer Review Protocols

A group of professionals, including members of the Mayo Child and Family Advocacy Program, Mayo Child Psychiatry/Psychology, Mayo Medical Social Services, Nurse Managers from General Pediatric Hospital Service and Pediatric Residents meet weekly to review internal child abuse reports. These weekly reviews allow for consultation and ongoing training among attendees, many of whom are experts in the field of abuse, with considerable experience in the medical evaluation and photo-documentation of children suspected of being abused, and/or are involved in scholarly pursuits and research.

Colposcope images of sexual abuse exams that have positive or questionable findings are peer reviewed between expert medical providers. Any abnormal findings are reviewed internally within 2 business days with Marcie Billings, MD or Lisa Fink, RN, CNP.

Additional, anonymous, 1:1 expert medical peer review is available via Midwest Regional Child Advocacy Center. Normal exam findings are reviewed monthly between Dr. Billings and Lisa Fink. Mayo Child and Family Advocacy medical providers have the option of attending peer review provided by Cincinnati Children's Hospital via web conferencing on a quarterly basis or peer review provided by Midwest Regional Child Advocacy Center four times a month via web conferencing. The nurse practitioner attends Sexual Assault Nurse Examiner peer review and is available for education and training to all Sexual Assault Nurse Examiners. Medical providers participating in the evaluation of sexual abuse at the center maintain a minimum of three hours per every two years of CEU/CME credits in the area of child sexual abuse.

The medical providers at the center are familiar and up-to-date with published research studies on findings in abused and non-abused children, sexual transmission of infections in children, and current medical guidelines and recommendations from national organizations (American Academy of Pediatrics, Centers for Disease Control and Prevention, and American Professional Society on the Abuse of Children).

The CAC will make training available to all members of the MDT. This will include list serve access, web-based CME/CEU's, live conferences and additional education at the center. Ongoing communication will go out to members via email regarding these training opportunities. In addition, Mayo Clinic employees have access to the Mayo Clinic libraries for ongoing pertinent literature notices. Another option for ensuring current practices is review of the "Quarterly Update".