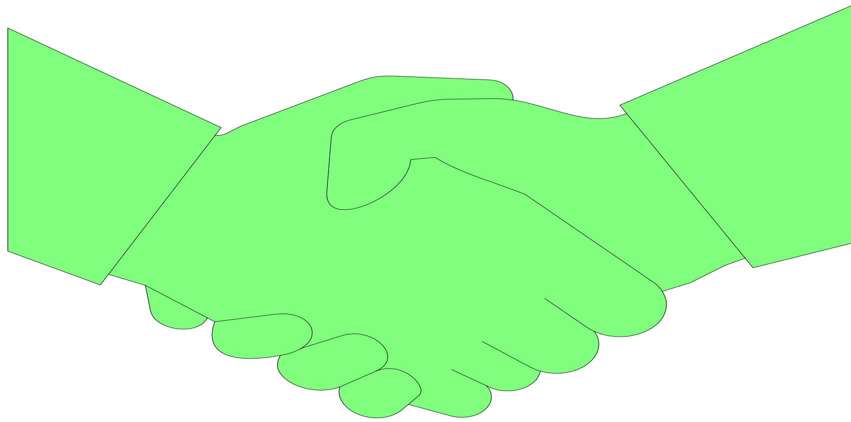

PARTNERSHIP FOR ACTION

A SINGLE INTEGRATED PLAN FOR:

HUMAN SERVICES
COMMUNITY HEALTH
FAMILY SERVICES COLLABORATIVE
2020-2025

FARIBAULT AND MARTIN COUNTIES' PARTICIPANTS:

- HUMAN SERVICES OF FARIBAULT & MARTIN COUNTIES
- FAMILY SERVICES COLLABORATIVE OF FARIBAULT & MARTIN COUNTIES (including Children's Mental Health Collaborative)

PLANS INCLUDED IN THIS DOCUMENT:

- Human Services Performance Management Plan (Social Services, Mental Health, Income Maintenance, and Child Support Performance Measures)
- Family Services Collaborative Plan
- Children's Mental Health Collaborative Plan
- Community Health Improvement Plan (CHIP) – March 2020
- Human Services of Faribault & Martin Counties' Strategic Plan

Human Services of Faribault & Martin Counties

PURPOSE and MISSION:

We endeavor to provide those necessary and beneficial human services that – together with client effort and responsibility, family support, and efforts of the private sector – will offer residents the opportunity to develop, maintain or recapture productive and meaningful lives. Our programs will be responsive to local people's needs with a priority given to those who can least cope for themselves, or find no alternative to governmental intervention.

SUB-SECTION I: INDIVIDUAL NEEDS

I.A. Goals/Desired Outcomes: All residents will safely live within the community and be free to participate at their highest functional level.

- Department of Human Services Performance Management: Outcome 1: Adults and children are safe and secure.
- Statement of Community Issues: Some children and adults experience physical, mental, developmental, and/or emotional issues that impact their ability to function in the community.
- Target Population/Population to be Served: Children and adults with physical, mental, developmental, and/or emotional issues.
- Strategies, Outcome Indicator; Performance Target; Methods of Data Collection

I.A.1. Work with community partners to identify strategies to promote positive mental health among youth; this includes promoting healthy lifestyle, reducing stress through stress management techniques, and increasing availability of counseling for youth struggling with their mental health

I.A.2. Children with disabilities referred for services will be provided information regarding benefits and other resources. For those eligible, 100% will be offered for case management services.

I.A.3. Adult residents will receive coordinated services with community resources to maintain them safely in the community, incorporating regional and statewide initiatives by identifying gaps in service delivery. This includes: addressing adult protection issues; conducting case consultation for at-risk adults with Adult Protection Team; recruiting providers to meet the needs of specific populations; providing MN Senior Health Option (MSHO) program; providing information/referral, assessment, and services for residents at risk of institutional placement (waivers as appropriate), per DHS designated timelines.

I.A.4. Percent of vulnerable adults who experience maltreatment who do not experience a repeat maltreatment of the same type within six months. (Threshold 80%, High Performance Standard 95%)

I.A.5. Engaging in social activities to reduce isolation will be incorporated as a key aspect of comprehensive mental health services for adults and youth.

I.A.6. Fifty (50) unduplicated individuals will participate in activities at the Upward Bound 5th Street Express (Clubhouse) each quarter. Activities will appeal to a range of consumers and their interests.

I.A.7. At least 80% of adults with serious and persistent mental illness who have open cases will be living in the community.

I.B. Goals/Desired Outcomes: High risk juveniles and adults will develop into productive, law abiding members of the community.

- Statement of Community Issues: Juveniles and adults are at risk of, or involved in, behaviors that put themselves or others in harm's way.

- Target Population/Population to be Served: All citizens

- Strategies, Outcome Indicator; Performance Target; Methods of Data Collection

I.B.1. Staff will utilize available community resources to provide a link to local resources, problem solving techniques, and assign accountability and consequences, such as:
- Local Coordinating Council including BEST (Building and Empowering Students Together
- Mentoring-type programs
- Chemical Awareness Program
- Cognitive skills and Behavior Modification
- Family/Group Conferencing
- Juvenile Treatment Screening Team
- Family Group Decision Making
- Drug Court
- Family Dependency Treatment Court
- Mobile Crisis
- Medical and Mental Health Services
- Healthy lifestyle resources and activities

I.B.2. High risk youth and adults will receive chemical dependency evaluations within 30 days of a court, self, or agency referral.

SUBSECTION II - PERSONS INVOLVED WITH FAMILIES

II.A. Goals/Desired Outcomes: Families will have healthy pregnancies, deliveries, and parenting so all children will grow and develop to their full potential. Help parents prevent overweight in their children by influencing their health-related knowledge, attitudes, and behaviors. Increase the duration of breastfeeding among Minnesota WIC participants.

- Statement of Community Issues: Residents experience poor birth outcomes and unwanted pregnancy. Our children are experiencing unidentified growth and/or developmental delays. Children are experiencing obesity.

- Target Population/Population to be Served: All males and females who are capable of reproduction. All children.

- Strategies, Outcome Indicator; Performance Target; Methods of Data Collection

II.A.1. Implement strategies to improve health outcomes for pregnant and postpartum women and their infants.

- Staff will coordinate 40 Baby Café meetings annually providing breastfeeding support to women.
- Staff will support employer education and adherence to Minnesota breastfeeding laws.
- Staff will provide outreach to 100% of referrals for pregnant or postpartum women, ensuring access to programs and improving program coordination.

II.A.2. 100% of pregnant or parenting teen (age 13-19) referrals will be screened for entry into the Healthy Families America Program. 50% of teens offered services will fully enroll in the program. 100% of teens will successfully complete the HFA program.

II.A.3. Increase the number of participants served through the Women Infant Children (WIC) Nutrition Program to help promote a healthy pregnancy and lifestyle for all eligible mothers and children in our service area.

II.A.4. Develop and implement local intervention to decrease low hemoglobin rates. These interventions include staff training, improved assessment, data review, education with community partners and clients.

II.A.5. Implement strategies and supports to decrease barriers to breastfeeding duration. Staff will implement strategies to reduce identified barriers to breastfeeding. The percentage of infants being breastfed in their third month of life will increase.

II.A.6. 50% of eligible children will participate in Child & Teen Checkup (Federal Goal is 80%). Staff will provide outreach to all medical clinics within Faribault and Martin Counties annually. Staff will offer at least three Child & Teen Checkup clinics in each county, each quarter, to improve access to C&TC services

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II.B. Goals/Desired Outcomes: Children will be raised in a healthy, happy, safe, permanent family environment.

- Department of Human Services Performance Management: Outcome 1: Adults and children are safe and secure. Outcome 2: Children have stability in their living situation. Outcome 3: Children have the opportunity to develop to their fullest potential.

- Statement of Community Issues: Families lack the support and services they need to keep their families together. Some children experience maltreatment. Some parents have ineffective parenting and home management skills.

- Target Population/Population to be Served: Children (prenatal to age 21) and their families.

- Strategies, Outcome Indicator; Performance Target; Methods of Data Collection

II.B.1. Of all children who were victims of a substantiated maltreatment report during a 12-month reporting period, the percent who were not victims of another substantiated maltreatment report within 12 months of their initial report. (Threshold 90.9%, High Performance Standard 90.9%)

II.B.2. Of all children who enter foster care two years prior to the reporting year who were discharged within 12 months to reunification, living with a relative, transfer of permanent and legal custody to a relative or guardianship, the percent of children who re-enter foster care within 12 months of the discharge date associated with the entry episode. (The federal performance measure is <8.3%.)

II.B.3. Of all children who enter foster care in a 12-month period, the percent who are discharged to permanency within 12-months of entering foster care. (Includes discharges from foster care to reunification with the child's parents or primary caregivers, living with a relative, guardianship, or adoption.) (Threshold 40.5%, High Performance Standard 40.5%)

II.B.4. Of all days that children spent in family foster care settings during the given period, the percentage of days spent with a relative. (Threshold 35.7%, High Performance Standard 45.0%)

II.B.5. Of all children who enter foster care in the year, the number of placement moves per 1,000 days spent in foster care. (Federal Performance Standard is 4.12 moves or less per 1,000 days in care.)

II.B.6. As reported each quarter, 98% of all children in care and/or open for child protection involvement will receive adequate services to meet their physical and mental health needs by compliance with physical health examinations for children in care beyond thirty days, mental health screenings, and/or referral to Interagency Early Identification Committee (IEIC) for those three years old and under.

II.B.7. Each county will establish a multidisciplinary child protection team that may include, but not be limited to, the director or designee, the county attorney or designee, the county sheriff or designee, representatives of health and education, representatives of mental health, or other appropriate human service or community-based agencies, and parent groups. Community based agency representation may include, but not be limited to, schools, social service agencies, family service and mental health collaboratives, children's advocacy centers, early childhood and family education programs, Head Start, and other agencies serving children and families.

II.B.8. For children involved with a school social worker, 80% of identified problems will be reduced or eliminated at the time of program completion and, over 90% of former school social worker cases are not later active with Human Services. {"Active" with Human Services is defined as active within twelve months for maltreatment incidences occurring after completion of school social work program.}

II.B.9. Children in out of home placement, days in placement, and costs associated with placement, by type, will be monitored and alternatives will be explored.

II.B.10. Implement the Healthy Families America Program within Faribault & Martin Counties:

- 100% of prenatal WIC clients served in Faribault & Martin Counties will be screened for Healthy Families America.
- 100% of families who screen positive for the program will be offered services.
- 40% of families offered services will fully enroll in the program.
- 75% of participants will successfully complete the program.
- 90% of target children enrolling prenatally will not be involved in a child protection investigation.

II.B.11. Work with community and school partners to implement strategies aimed at reducing tobacco and marijuana use, especially among youth.

II.B.12. Percent of open child support cases with paternity. (Threshold 90%, High Performance Standard 90%).

SUBSECTION III - COMMUNITY AT LARGE/ENVIRONMENT

III.A. Goals/Desired Outcomes: Residents and visitors are protected from acute communicable diseases and other health threats including unintentional injury.

- Statement of Community Issues: Individuals are at risk of communicable/chronic disease. Our residents experience accidental recreational, agricultural, home, and vehicular injuries. Residents and visitors are at risk of food/beverage/lodging and public health issues.

- Target Population/Population to be Served: All persons living in or visiting Faribault and Martin Counties.

- Strategies, Outcome Indicator; Performance Target; Methods of Data Collection

III.A.1. Implement strategies to increase immunization rates, including offering immunizations for all eligible clients. Staff will provide outreach to all health care clinics annually within the service area.
- 90% of target children enrolled in HFA will be current with immunization schedule
- 75% of medical clinics within the service area will receive immunization outreach annually.
- All children involved in community health services will be assessed for immunization status and offered vaccinations when needed.

III.A.2. Initiate response to all cases of active communicable disease within two business days of notification. Staff will provide education, contact investigation and testing, and on-going follow-up as indicated to persons with reportable disease per Minnesota Department of Health Disease Prevention and Control guidelines.

III.A.3. Implement strategies to reduce unintentional injury among children.
- Implement home safety checklist with 100% of families enrolled in HFA services.
- Offer at least one car seat class quarterly within our service area.
- Distribute car seats to eligible clients per program guidelines annually.

III.A.4. Implement strategies to reduce exposure to lead among children, utilizing the Minnesota Blood Lead Guidelines. Respond to reports of children with elevated blood lead within 5 days.

III.A.5. On an ongoing basis, staff will provide delegated services to food, beverage, and lodging establishments (including schools and jails) ensuring establishment compliance with the Minnesota Food Code.

III.A.6. Investigate and alleviate public health nuisance complaints to determine service levels and possible need to develop resources. Nuisance complaints are responded to within 10 business days and resolved within 10 days of opening the investigation. Consult/refer on other nuisance complaints as necessary.

III.A.7. Respond to public health emergencies, including but not limited to, medical countermeasures planning for widespread disease outbreak or other biological need for mass dispensing of medications or vaccination.

- 100% of public health staff complete National Incident Management Systems (NIMS) training every three years,
- Staff actively implement work plan requirements set forth by the Minnesota Department of Health,
- Coordinate information sharing among hospital and clinic partners through the Health Alert Network – 80% of clinics and 100% of hospital partners respond to HAN within designated timeframe,
- Review, update and exercise agency plans annually to ensure compliance and preparedness to respond.

III.A.8. Implement strategies which improve equitable access and opportunities for health for all, promote reduction of chronic disease and reduction of tobacco use within our service area.

- Monitor community health data and provide findings to stakeholders annually.
- Develop and foster community coalition charged with overseeing implementation of the Community Health Assessment and Community Health Improvement Plan.
- Implement strategies from the Statewide Health Improvement Partnership (SHIP).
- Work with partners to identify and reduce barriers for people to receive affordable, culturally and linguistically appropriate health care services that foster continuity of care.

III.B. Goals/Desired Outcomes: Residents will be financially secure while also maintaining family stability.

- Department of Human Services Performance Management: Outcome 2: Children have stability in their living situation. Outcome 4: People are economically secure.

- Statement of Community Issues: Residents lack job opportunities and necessary supports to allow for personal/family fulfillment and financial security.

- Target Population/Population to be Served: All residents

- Strategies, Outcome Indicator; Performance Target; Methods of Data Collection

III.B.1. Residents will have access to appropriate child care to allow them to work. Funding has been provided under the Minnesota Family Investment Program to ensure that there is not a waiting list for eligible clients. Basic Sliding Fee (BSF) funds are allocated annually and monitored monthly to determine percent of allocation projected to be spent for the year.

III.B.2. Minnesota Family Investment Program/Diversionary Work Program Self-Support Index (Threshold – Within range of expected performance, Standard – Above range of expected performance). The Self-Support Index measures whether cash assistance participants have been successful in staying off cash assistance over time – look back of one, two, and three years. By providing support services to increase participant employment and earnings, performance is improved.

III.B.3. Percent of expedited Supplemental Nutrition Assistance Program (SNAP) applications processed within one business day. (Threshold 55%, High Performance Standard 83%).

III.B.4. Percent of SNAP and cash assistance applications processed timely (Threshold 75%, High Performance Standard 90%).

III.B.5. All Minnesota Supplemental Aid (MSA) applications will be processed within a 30-day timeline. All Housing Support applications will be processed within a 30-day timeline.

III.B.6 Eligibility for public assistance programs is often complex, confusing, and is not consistent between the various programs. Because of this, staff continually educate applicants and recipients on program and eligibility requirements. Fraud referrals are made in all questionable situations.

III.B.7. Percent of current child support paid (Threshold – Historical, Standard 80%).

III.B.8. Percent of open child support cases with an order established (Threshold 80%, High Performance Standard 80%).

SUBSECTION IV – EXCEPTIONAL PROBLEMS/ISSUES/ACTIVITIES AND SPECIAL PROJECT REPORTING

COMMUNITY HEALTH

- QI PLAN

SOCIAL SERVICES

- ADULT PROTECTION
- DEVELOPMENTAL DISABILITIES
- CHILD PROTECTION
- WAIVER SERVICES

BEHAVIORAL HEALTH

- ADULT MENTAL HEALTH
- CHILDREN'S MENTAL HEALTH
- COMMUNITY SUPPORT SERVICES
- CHEMICAL DEPENDENCY
- RESPITE GRANT USAGE

INCOME MAINTENANCE

- MNsure/METS
- COUNTY BURIALS
- CHILD SUPPORT

BUSINESS OFFICE/ADMINISTRATION

- SUPPORT SERVICES
- INFORMATION TECHNOLOGY

FAMILY SERVICES COLLABORATIVE

STRATEGIC PLAN