PARTNERSHIP FOR ACTION

A SINGLE INTEGRATED PLAN FOR:

HUMAN SERVICES

COMMUNITY HEALTH

FAMILY SERVICES COLLABORATIVE

2015-2019

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) – January 21, 2015
- Strategic Plan Reporting – March 18, 2015
- Quality Improvement Plan Reporting – February 18, 2015

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.

INTRODUCTION
Community Health Improvement Plan (CHIP) 2015 to 2019
March 18, 2015

This CHIP covers the counties of Faribault and Martin in South Central Minnesota.

County Demographics

Our counties are rural counties with a combined population of 34,613 (US Census 2013). We exceed the state percentage of persons over the age of 65. The ethnic profile of both counties is generally Caucasian, however, the population of individuals identifying themselves as Latino in Faribault County is higher than the state average. Faribault County has higher than the state average for the number of children under the age of 18 who are living in single parent households. Both counties exceed the state average for the percentage of births to unmarried mothers. Both counties have a median per capita and total income less than the state average. Over 13 percent of Faribault County residents are living below federal poverty level. Both counties have higher childhood poverty rates than the state and have a high percent of children receiving Supplemental Nutrition Assistance Program and Free and Reduced Lunch. Our uninsured rate is close to the state rate. We have a lower rate of practicing Dentists than the state as a whole and the majority of our dental providers do not accept clients with Medical Assistance as a payment source. In terms of medical providers, we have several clinics that bring specialist (neurologist, dermatologist, etc.) into our counties. However, these appointments fill up quickly resulting in long delays for service. We do not have a local pediatrician or obstetrician. Transportation is an issue for accessing out of town/county providers.

Focus Group Results

We completed five focus groups as a part of our SHIP (Statewide Health Improvement Program) evaluation process. These focus groups included young families, youth, seniors, and persons with mental illness. Some of the focus group participants said that accessing primary health care is a challenge, but said they were able to access care when they need it.

Other participants said it is difficult to access primary care services for their families, and that they often have to go to the emergency room because they cannot get an appointment. The biggest barriers to accessing health care are:

- **Lack of providers.** The participants feel there are not enough doctors in the area to meet the need. This means they have to schedule doctor visits three or four months in advance. They said providers are only at the clinic on certain days and those appointments fill up quickly. They shared that there is not a pediatrician in town, and that makes it difficult to meet their children's health care needs. They said the Smart Clinic and walk-in clinic at Walmart are often full, so they have to take their children to the hospital for minor illnesses. They also said there are limited options for people who have county medical assistance. Participants said many providers come to the local clinics from other areas, including the psychiatrists that serve the area. This makes it difficult for them to contact providers for follow up or referrals, because they cannot just call the clinic to get in touch with the doctor.

- **Cost**. The participants said that higher copays and the cost of medications make it difficult for them to get health care. Some participants shared that, because they have limited incomes, they have to choose between food and medicine.

- **Navigating the system**. The participants said it is easy to go to the doctor, but difficult to get prescriptions filled, particularly if they need to get prior authorization for a prescription. Several participants talked about getting "stuck in a loop" trying to get prescriptions or diabetes testing supplies because they do not know how to contact their doctors. Once they are in this loop, it can take months or even a year to get prescriptions filled.

- **Transportation.** The participants said they sometimes need to go to other cities to get care, but because there are doctors in the area they are not able to get their transportation costs covered. They also shared that transportation is an issue for people who have to travel to another town by ambulance, because they cannot get transportation home.

- **Clinic hours.** The clinics are only open during the day. The participants said they are not able to schedule appointments in the evenings, which means they have to miss work to go to the doctor.

Community Health Assessment

Please see our agency website at www.fmchs.com for the complete Community Health Assessment. This document in DRAFT form was the tool used to share Community Health Assessment information with stakeholders and to request input on the assessment process from stakeholders.

CHIP Planning Process

Our CHIP process included a number of steps. The planning process was announced in public meetings three times. Then, internally we reviewed existing clients, services, outcomes, client survey results, audit results and service mandates (state and federal). We then pulled

together demographic data from a number of sources (census, Kids Count, MDH, SHIP, County Health Rankings, MN County Health Tables, MN Student Survey, SW/SC Adult Health Survey, Mayo Community Survey, etc.). We pulled together the health data showing where Faribault and Martin County had either worse ranking than the state/region or those that were of interest to our communities and decision makers. We then took the information to our community contacts including: SHIP county steering committees, SHIP Community Leadership Team, Citizens' Advisory Committee, Early Childhood Initiative, Human Services Management Staff, Community Health Staff, Human Services Board Executive Committee, and Human Services Board. Membership on all of these groups include: citizens, consumers/clients, providers, elected officials, staff, caregivers, board members, schools, etc. The final step for information collecting was to take the assessment information and, with our SHIP evaluation contractor (The Improve Group), hold focus groups with Young Families (one/county), Senior residents (Martin County), Youth (Both Counties), and persons participating in our Drop In Center for persons impacted by mental illness.

We then took the information back to our SHIP Community Leadership Team and our Citizens' Advisory Committee and prioritized the issues. Prioritization included reviewing numbers of residents impacted, acuteness of impact on residents, prevention, and resources available. Priorities were then written into our Human Services Integrated Plan. Our Plan was reviewed by the Human Services Board and was approved for submission.

The issues identified by stakeholders include:

- Chronic disease/early morbidity and mortality
- Inaccessible services
- Limited services (provider numbers and variety)
- Poverty as it relates to poor health outcomes especially for children and elderly
- Limited resources in the public and private sectors

Top community health needs/priorities and justification:

- Elderly and disabled resident issues and needs. This is a priority because of our high percentage of elderly and because of the lack of services.
- Residents experiencing pregnancy, delivery, child rearing and childhood obesity. This is a priority because of our high percentage of children living in poverty, our high single women deliveries and the poor health outcomes associated with poverty. Obesity is an issue for us because of the health risks associated with obesity and our high percentage of childhood obesity.
- Children and their families. This is a priority due to our high incidence of child maltreatment and the poor health outcomes related to maltreatment. It is also a priority due to the information on how increased parental knowledge of child growth/development/parenting can improve children's care, growth and development.
- Community at large health issues. Immunizations continue to be a priority for us. Our vaccination statistics show we need to continue to encourage immunizations especially for the 12-48 month age group. In addition, we need to encourage immunizations for adolescents. Our communities contain many older homes and rental property. We continue to have children with elevated blood leads. We continue to have substandard housing. As rural counties we have limited resources for emergency preparedness.

We have both brand name food/beverage/lodging establishments as well as small local food/beverage/lodging establishments. All wish to do a good job of serving the public and fully participate in licensing and inspection activities in order to improve their customer service and safety. Finally, we are increasing our community work with existing and new partners to identify and reduce barriers to people receiving health care.

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.

- 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 sleep habits, reducing stress through stress management techniques, and increasing availability of counseling for at-risk students.

I.A.2. At least 75% of high school children eligible to receive Rule 185 services have a transition plan that includes involvement with a county case manager by their junior year of high school. All teenagers with disabilities will be assisted in planning for their future by providing information about benefits and other resources to the teenager and his/her family and offering assistance in coordinating these benefits.

I.A.2. 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) and Special Needs Basic Care (SNBC) programs; providing information/referral, assessment, and services for residents at risk of institutional placement (waivers as appropriate).

I.A.3. Consumers of adult mental health services will participate in social activities to reduce isolation. Upward Bound 5th Street Express activities are full 90% of the time.

I.A.4. At least 80% of adults with serious and persistent mental illness who have open cases will be living in the community. Establish baseline for the percentage of elderly and disabled who are receiving publicly-funded long-term care and live in a community setting (not a nursing home or an ICF/MR).

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, do problem solving, assign accountability, and assign consequences, such as:

- Electronic Home Monitoring
- Local Coordinating Council including BEST (Building and Empowering Students Together
- Mentoring-type programs
- Chemical Awareness Program
- Cognitive skills programming
- Behavior modification methods
- Rapid Response Teams
- Family/Group Conferencing
- Juvenile Treatment Screening Team
- Truancy Screening
- Family Group Decision Making
- Teen Court
- Drug Court
- Family Dependency Treatment Court

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. Work with school and community partners to identify and implement policy/system/environment changes (including reliable contraceptive education) aimed at preventing premature sexual activity.

II.A.2. Support pregnant and parenting teens to complete high school and to delay subsequent pregnancies until out of high school. Baseline=2013 % that completed high school without subsequent pregnancies.
2000=44 - 2001=38 ages 14-18 - 2002=42 ages 14-18 - 2003=9 ages 13-18 - 2004=30 ages 13-18 - 2005=18 ages 15-18 - 2006=25 ages 14-18 - 2007=28 ages 14-18 – 2008=21 ages 14-18 – 2009=20 ages 17-18 – 2010=22 ages 16-18 – 2011=22 ages 15-18 - 2012 = 15 ages 16-18 – 2013 = 15 ages 15-18

II.A.3. Maintain WIC (Women/Infant/Children Nutrition) services to facilitate healthy development for children (conception through age 5) via good nutrition as defined by federal WIC program guidelines.

II.A.4. WIC staff will implement childhood obesity prevention activities as described in the WIC Plan. WIC staff will collaborative with SHIP initiative to address obesity in participants in the WIC program. Community Health will collaborate with other community organizations to address childhood obesity.

II.A.5. WIC staff will promote and support breastfeeding and decrease barriers to breastfeeding. 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 and Child & Teen Checkup services in order to provide education/anticipatory guidance, identify abnormal results, and refer for appropriate diagnosis and treatment.

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

- 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. Continue to identify key county specific issues to reduce the recurrence of child abuse/neglect and develop practice standards and policies to maintain that reduction. (National Standard for no repeat maltreatment within six months is ≥96.8%)

II.B.2. Continue to identify key county specific issues to reduce the re-entry to foster care rate and develop practice standards to maintain that reduction. (National Standard for re-entered foster care within 12 months is ≤9.9%)

II.B.3. Improve timeliness of permanency for children in care by identifying key county barriers toward reunification, transfer of legal and physical custody to a relative, and/or adoption. (National Standard for reunified within 12 months is ≥87%. National Standard for adopted within 24 months is ≥52.8%.)

II.B.4. Continue to identify key county specific issues to improve placement stability for children in care and develop practice standards to ensure a county rate is consistent with or higher than the current national standard. (National Standard for two or fewer placement settings within 12 months is ≥87.9%.)

II.B.5. 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. (National Standard for health examination within 12 months is ≥86%.)

II.B.6. 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.7. 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.8. Healthy Families will contact 40% of families delivering infants in the target hospitals, will have 95% acceptance rate of early identification screening and home visiting. Annually Home Visitor families' immunization rate will

improve beyond 85%, 80% of families will follow through on referrals made, and the in-home injury rate is below 3%.

II.B.9. Work with community and school partners to implement strategies aimed at reducing tobacco and marijuana use, especially among youth.

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. In order to increase immunization rates, develop and implement strategies that reduces parental hesitancy with vaccinations. Implement strategies with health care providers and preschools/day care centers.

III.A.2. Reportable communicable diseases that are controlled by immunization will remain at zero (0) reports. Staff will provide education, contact counseling, contact testing, and ongoing follow-up as indicated to persons with tuberculosis and other reportable diseases.

III.A.3. Staff will continue to provide safety information aimed at the elderly and children using home safety checklist, vehicle safety restraint education, and age appropriate safety information.

III.A.4. On an ongoing basis, staff will provide delegated services to food, beverage, and lodging establishments (including schools) aimed at maintaining or improving establishment compliance from last inspection.

III.A.5. On an ongoing basis, investigate and alleviate public health nuisance complaints to determine service levels and possible need to develop resources. Consult/refer on other nuisance complaints as necessary.

III.A.6. Complete Public Health Preparedness activities in order to:
- Maximize the protection of life and property in Faribault and Martin Counties.

- Ensure that the response effort is organized under National Incident Management System (NIMS).
- Ensure delineation of roles and responsibilities for other local governmental and non-governmental agencies participating in a Public Health response. Ensure that Local Preparedness Plan(s) are coordinated and consistent with state and local responder plans.

III.A.7. Continue existing partners and engage new partners to implement policy, system environmental changes to reduce obesity, increase activity, improve nutrition and decrease tobacco use to support a healthy start to life and ongoing wellness for all.

III.A.8. Work with existing and new partners to identify and reduce barriers to people receiving health care (dental, medical, etc.) with special attention to cultural and linguistic issues and looking at ways to foster continuity of care.

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

- 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. This monitoring report allows determinations to be made if families can be added to the program from the waiting list.

III.B.2. The three-year Self-Support Index will be either within or above the range of expected performance on the annualized three-year period. The anticipated target for 2012 is 80% and the anticipated target for 2013 is 80.5%. {To be considered successful under this measure, an adult who has participated in MN Family Investment Program (MFIP) or Diversionary Work Program (DWP) must work an average of 30 or more hours per week or no longer receive cash assistance under MFIP or DWP.} Income Maintenance Department staff will:
- Identify and assess individuals with barriers to obtaining and maintaining employment in the community in order to make referrals to appropriate resources.

- Assist as many people as possible in achieving and maintaining self-sufficiency as a result of case consultation and coordination with the child support enforcement unit.
- Educate the public and private sector about employment barriers facing residents and involve them in planning for and developing resources.

III.B.3. The work participation rate for non-exempt MFIP adults will meet or exceed 39.8% or a 5% improvement from the previous year. The 2012 anticipated target is 55.8% and the 2013 anticipated target is 56%. Income Maintenance Department staff will:

- Ensure clients are participating in the nine (9) categories of activities countable for participation.
- Ensure system coding on MMIS and MAXIS is reviewed for accuracy on a monthly basis.
- Work with social services and community resources to expand and maintain a continuum of quality child care for residents including all shifts, infant care, sick childcare, etc.
- Along with WorkForce Center staff, assist residents in obtaining necessary personal development, skill building, and training to secure employment and reduce dependence on public assistance.

III.B.4. The Child Support Program will meet or exceed the benchmarks set forth by the State of Minnesota and Federal Child Support Program Performance Measures to maximize incentives.

- The cost benefit ratio will meet or exceed $5.00 per case standard.
- Court ordered medical support provisions are entered on PRISM and enforced.
- New court orders are established and meet federal timeframes.
- Court orders are modified appropriately and timely to maximize incentives.
- Paternity is established appropriately and timely to maximize incentives.
- Collections on child support current and arrears cases will meet or exceed state averages.

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

COMMUNITY HEALTH

- QI PLAN

MENTAL HEALTH

- ADULT MENTAL HEALTH
- CHILDREN'S MENTAL HEALTH

SOCIAL SERVICES

- ADULT PROTECTION
- DEVELOPMENTAL DISABILITIES

- CHEMICAL DEPENDENCY
- CHILD PROTECTION (Northstar Care for Children)

INCOME MAINTENANCE

- MNsure
- FRAUD
- COUNTY BURIALS

BUSINESS OFFICE/ADMINISTRATION

- CHILD SUPPORT
- SUPPORT SERVICES
- CHILD CARE
- INFORMATION TECHNOLOGY

FAMILY SERVICES COLLABORATIVE
STRATEGIC PLAN