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"An Equal Opportunity Employer"

PARTNERSHIP FOR ACTION

A SINGLE INTEGRATED PLAN FOR:

HUMAN SERVICES
COMMUNITY HEALTH
FAMILY SERVICES COLLABORATIVE
2026-2031

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
- Human Services of Faribault & Martin Counties' Strategic Plan

PURPOSE and MISSION:

Embracing respect and integrity, Human Services of Faribault & Martin Counties responds to the needs of all community members and provides health and human services in a dignified and meaningful manner. Through a partnership with those we serve, we strive to improve their current situations and help them live their best life.

SUBSECTION A - INDIVIDUAL NEEDS

A. Goals/Desired Outcomes: All residents will live in safe, supportive environments that empower them to engage fully in community life and achieve their highest level of independence.

- Department of Human Services/Department of Children Youth and Families Performance Management: Outcome 1: Adults and children are safe and secure. Outcome 5: Adults live with dignity, autonomy, and choice.

- 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. 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. Children and adults with physical, mental, developmental, and/or emotional issues.

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

A.1. Collaborate with community partners to implement evidence-based strategies that promote positive mental health among youth. This includes fostering healthy lifestyles, teaching effective stress management techniques, and expanding access to timely, youth-centered counseling and support services.

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.

A.3. Adult residents will receive coordinated, person-centered services in collaboration with community partners to support safe, independent living in the community. This includes aligning with regional and statewide initiatives by identifying and addressing service delivery gaps. Key strategies include:

- Responding to adult protection concerns through timely intervention and case consultation with the Adult Protection Team.
- Recruiting and supporting providers to meet the needs of diverse and underserved populations.
- Delivering the Minnesota Senior Health Options (MSHO) program to eligible residents.
- Providing comprehensive information, referrals, assessments, and services to individuals at risk of institutional placement, including waiver programs, in accordance with DHS timelines.

A.4. Percent of vulnerable adults reported as maltreated with initial disposition for response made within five working days. (Threshold 90%, High Performance Standard 95%)

A.5. At least 80% of adults with serious and persistent mental illness who have open cases will be living in the community. (Living in the community means not in the hospital, in jail, or in a mental health residential treatment setting.) Supports to reduce isolation will be incorporated as a key aspect of comprehensive mental health services for adults and youth and include:

- Drop-In Center for adults. Activities will appeal to a range of consumers and their interests.
- Mental Health nursing services
- Mental Health case management services
- Mental Health Client Assistance Program

A.6. 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
- Substance Abuse Prevention Programs
- 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

SUBSECTION B – FAMILY NEEDS

B. Goals/Desired Outcomes: Support families in achieving healthy pregnancies, safe deliveries, and confident parenting to ensure all children have the opportunity to grow and thrive to their full potential.

- 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

B.1. Implement strategies to improve health outcomes for pregnant and postpartum women and their infants.
  - Staff will provide outreach to 100% of referrals for pregnant or postpartum women, ensuring access to programs and improving program coordination.

B.2. 100% of pregnant or parenting teen (age 13-19) referrals will be screened for entry into the Healthy Families America Program. 100% of teens will be offered services.

B.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.

B.4. 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.
  - Staff will coordinate 40 Baby Café meetings annually providing breastfeeding support to women.
  - Staff will support employer education and adherence to Minnesota breastfeeding laws.

B.5. 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

SUBSECTION C – CHILDREN'S NEEDS

C. Goals/Desired Outcomes: Ensure that every child is raised in a nurturing, positive, and secure family environment that offers lasting stability and promotes lifelong well-being.

- Department of Human Services/Department of Children Youth and Families 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

C.1. Percent of children with a substantiated maltreatment report who do not experience a repeat substantiated maltreatment report within 12 months. (High Standard 90.9%)

C.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 percentage 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%.)

C.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.) (High Performance Standard 40.5%)

C.4. Percent of days children in family foster care spent with a relative. (High Standard 45.0%)

C.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.)

C.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.

C.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.

C.8. For children involved with a School Social Worker, 80% of identified problems will be reduced or eliminated at the time of program completion. 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.}

C.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.

C.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.
- 20% of families offered services will fully enroll in the program.
- 70% of participants will successfully complete the program.
- 90% of target children enrolling prenatally will not be involved in a child protection investigation.

SUBSECTION D - COMMUNITY AT LARGE/ENVIRONMENTAL NEEDS

D. Goals/Desired Outcomes: Ensure all residents and visitors are protected from communicable diseases, unintentional injuries, and other health threats through the consistent delivery of core public health services that promote the overall health and well-being of the community.

- 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

D.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.

D.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.

D.3. Implement strategies to reduce unintentional injury among children.
- Implement home safety checklist with 100% of families enrolled in HFA services.
- Distribute car seats to eligible clients by program guidelines annually.

D.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.

D.5. 100% of food, beverage, lodging and pool inspections delegated to our agency through the MN Department of Health Environmental Health Delegation Agreement will be completed within required time frames and based on current Minnesota Food Code Compliance.

D.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.

D.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.

D.8. Implement strategies which improve equitable access and opportunities for health for all, promote reduction of chronic disease and reduction of tobacco, opioid and cannabis 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.
- Obtain and maintain grant funding to implement community level strategies that support health promotion and prevention efforts.
- 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.

D.9. Implement the Foundational Public Health Responsibilities (FPHR) model to ensure equitable, consistent, and sustainable access to essential public health services for our communities.

- Assess and align agency capacity with FPHR standards to identify service gaps and prioritize resource allocation.
- Build internal infrastructure to support delivery of foundational capabilities such as data collection and analysis, communications, and emergency preparedness.
- Participate in regional partnerships to advance capacity of the agency to meet FPHR standards.
- Strengthen public health workforce through targeted training and recruitment aligned with FPHR model.
- Engage local stakeholders and communities to ensure services meet local needs.
- Establish performance metrics to monitor and implement progress and drive continuous improvement.

D.10. Work with community and school partners to implement strategies aimed at reducing tobacco and marijuana use, especially among youth.

SUBSECTION E - COMMUNITY AT LARGE/ECONOMIC NEEDS

E. Goals/Desired Outcomes: Residents will build economic stability and family resilience by strengthening their resources, overcoming systemic barriers and accessing supportive relationships and opportunities that foster long-term well-being.

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

- Statement of Community Issues: Residents face systemic barriers that limit access to stable employment, reliable childcare, and essential support networks. The community lacks coordinated efforts to address the root causes of poverty and to foster pathways that support personal growth, family resilience, and financial security.

- Target Population/Population to be Served: All residents

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

E.1. Increase the number of licensed childcare providers who accept Childcare Assistance Program (CCAP) by 10% over the next fiscal year and achieve a 15% increase in eligible families utilizing CCAP services through targeted outreach, provider engagement, and community education efforts.

E.2. By fostering a comprehensive support system that builds on individuals' strengths and addresses barriers across all resource domains—financial, emotional, social, and cognitive—participants are empowered to pursue meaningful goals, increase their earning potential, and achieve long-term stability. This approach recognizes that economic success is rooted in access to relationships, opportunities, and community-based supports.

E.3. All applications for Supplemental Nutrition Assistance Program (SNAP) that are received by the Agency will be screened for Expedited Service the same day the application is received. If the application is determined to be eligible for Expedited Service, an instant interview will be attempted in order to issue benefits within seven calendar days (Goal is 96%).

E.4. For households that are facing both food and financial insecurities, Cash and SNAP applications will be processed within 30 days. (Threshold 75%, High Performance Standard 90%).

E.5. 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. (The goal for this measure is a $3 cost benefit ratio.)

E.6. Percent of open child support cases with an order established (Threshold 80%, High Performance Standard 80%).

E.7. Percent of current child support paid. (High Standard 80%)

E.8. Percent of open child support cases with paternity established. (Threshold/High Standard 90%)

SUBSECTION F - AGENCY NEEDS

F. Strategic Plan Priorities

F.1. Foster a healthy, positive work environment.

- Goal 1: Develop opportunities to include staff in agency planning and decision-making whenever possible.

- Goal 2: Improve interpersonal communication and development of a safe working culture within all levels of the agency, including improving relationships between leadership and direct support staff. Create a culture of psychological safety.

- Goal 3: Ensure important communication is consistently delivered utilizing a common communication portal. Utilize and encourage staff engagement in a platform that aims to connect staff and build community.

F.2. Encourage staff retention by promoting mental wellbeing, resiliency and supporting employee needs.

- Goal 1: Review compensation plan and ensure starting wages are comparable to regional counterparts.

- Goal 2: Develop policies and practices that promote a flexible work environment to encourage work-life balance

F.3. Building a culture where training is valued and encouraged.

- Goal 1: Create a training advisory committee within the agency to identify training priorities and opportunities.

- Goal 2: Develop an effective employee onboarding training process

F.4. Center service delivery around the client experience.

- Goal 1: Ensure all staff are training in Bridges out of Poverty – Individual Lens training

- Goal 2: Implement the Bridges out of Poverty concepts within the agency.

F.5. Embed innovation and quality improvement into everything we do.

- Goal 1: Review agency systems and equipment and identify technology improvements to support staff.

- Goal 2: Train staff to facilitate the Collaborative Safety Systems Learning Review and Systems Mapping and begin completing reviews within the agency

F.6. Build a place at the table in the community for health and human services.

- Goal 1: Coordinate community initiatives and coalitions to engage community in the work of health and human services.