



**JEFFERSON COUNTY  
HUMAN SERVICES DEPARTMENT**

**2011 ANNUAL REPORT**



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# JEFFERSON COUNTY HUMAN SERVICES DEPARTMENT

## Serving the Residents of Jefferson County

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May, 2012

Dear Mr. Molinaro, County Board Chair,  
Members of the Jefferson County,  
Members of the Jefferson County Human Services Board,  
Mr. Petre, County Administrator,  
Jefferson County Citizens,  
And other interested parties,

I am delighted to present the 2011 Jefferson County Human Services Department annual report. This report provides an in-depth summation of 2011 while reviewing yearly goals and establishing new ones. I would like to succinctly provide you with the major trend for each division in the last year.

- The Aging and Disability Resource Center Division provides services for people who are elderly or disabled. In 2011, the ADRC experienced a 29% increase in client contacts. Referrals to the division on behalf of individuals with dementia also rose. These trends are expected to continue for many years due to the rapidly aging baby boom generation.
- Our Administrative Services Division provides all the maintenance, support, and fiscal duties required to operate the department. This division implemented use of an electronic clearing house for insurance billing, and electronic expense reports.
- The Behavioral Health Division provides a full array of mental health and substance abuse services to a variety of consumers. The division experienced a 19.2% increase in the number of client visits and a 10% increase in crisis calls. This division will be working this year to provide clients with more integrated mental health, substance abuse, and primary care.
- The Child & Family Resource Division provides many programs for children and families. In 2011, this division experienced a 40% increase in child welfare reports, more children needing and being on long term care waivers, and an increase in referrals to the Birth to Three program. Staff also explored and found new permanency options for children and reduced their time out of home.
- The Economic Support Division provides resources for low income households and those experiencing financial loss. In 2011, this division reorganized into a consortium with seven other counties and a call center was established for customers while 6% more households were served.

You will see new goals for each team within each division for this year which include continuous quality improvement using the NIATx evidence based practice model. Last year, nearly all established goals were

accomplished. The Department is committed to using best practices and finding efficiencies. This is reflected in the Department returning \$884,018 to the county general fund. This occurred because new approaches were tried and resulted in \$243,969 in Child Alternate Care savings, and \$284,147 hospitalization and doctor savings. The remaining \$485,249 savings was in personnel costs. These efficiencies have now become practice and are therefore reflected in the ongoing budget.

I would like to recognize several people. I would like to commend our employees. As you have seen from the trends noted above, the need for our services is growing. Our staff continues to find ways to meet these needs.

I would like to recognize the members of our Human Services Board for their direction and support. You make it possible to do what we do! We thank you!

Lastly, I would like to recognize our Chairperson, Jim Mode. Mr. Mode went above and beyond in the past year and a half, serving as Chairperson of the Wisconsin County Human Services Association. This organization works with the State to promote best practices, to create professional alliances, and to develop partnerships in service delivery. It has been an enormous commitment on Mr. Mode's part and served the county in a multitude of ways. We thank you!

Please read our entire annual report. We want to be responsive to our community's needs and we need your input to do that. Please contact us anytime at 674-3105. We look forward to hearing from you.

Thank you,

Kathi Cauley  
Director  
Jefferson County Human Services

## **MISSION STATEMENT**

Enhance the quality of life for individuals and families living in Jefferson County,  
by addressing their needs in a respectful manner,  
and enable citizens receiving services to function as independently as possible  
while acknowledging their cultural differences.

## **VISION STATEMENT**

All citizens have the opportunity to access effective and comprehensive  
human services in an integrated and efficient manner.

# HUMAN SERVICES BOARD OF DIRECTORS 2011 – 2012

Jim Mode, *Chair*

Pam Rogers, *Vice Chair*

Richard Jones, *Secretary*

Augie Tietz

John McKenzie

Julie Merritt

James Schultz

## ADVISORY COMMITTEE MEMBERS

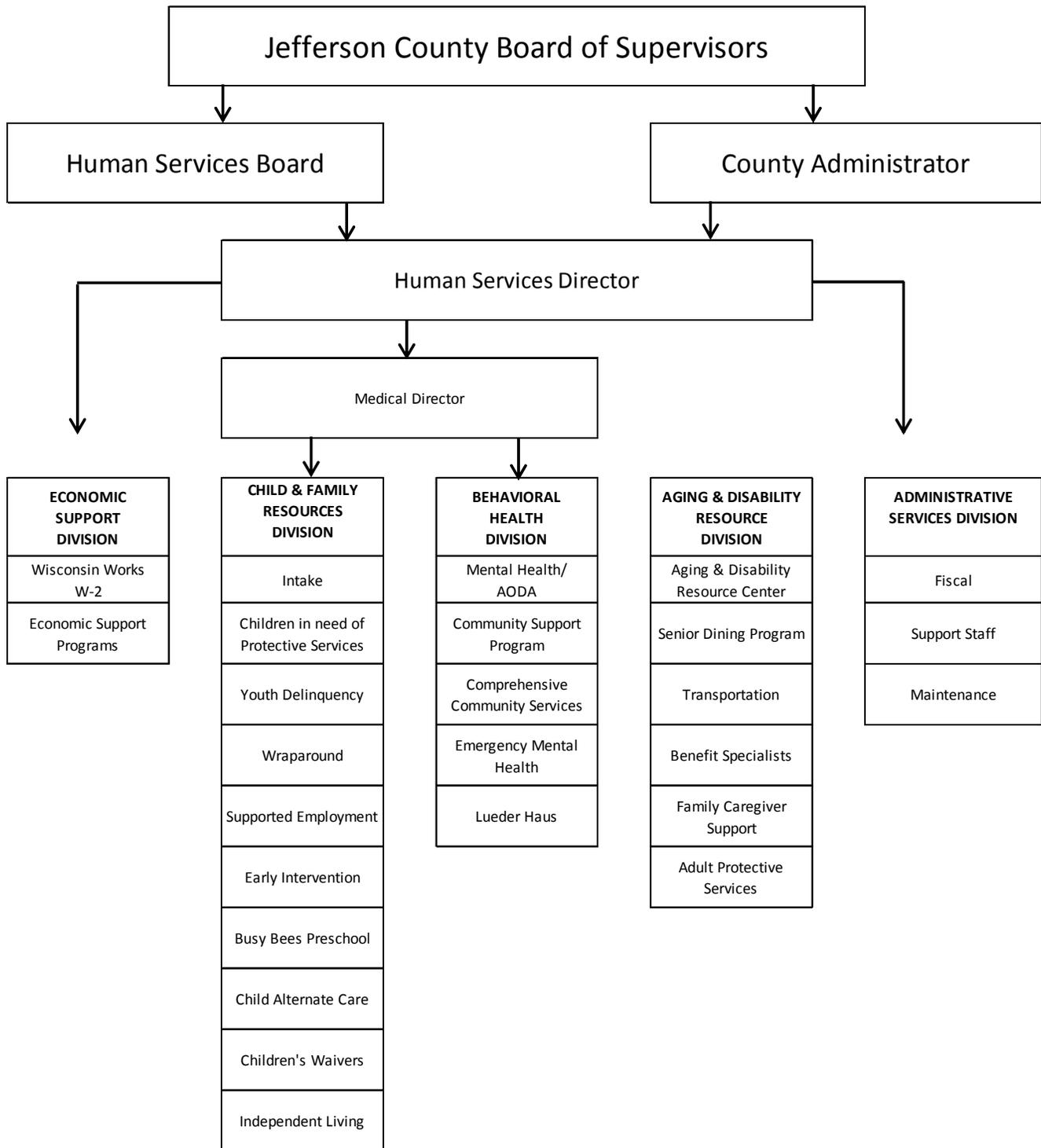
### AGING AND DISABILITY RESOURCE CENTER ADVISORY COMMITTEE

Nancy Haberman, Chair  
Leah Getty  
Richard Jones  
Virgene Lawson  
Jim Mode  
Marion Moran  
Mike Mullenax  
Mary Ann Steppke  
Sharon Van Acker  
Sue Torum, Staff  
Sharon Olson, Staff

### NUTRITION PROJECT COUNCIL

Marcia Bare  
Dorothy Christianson  
Rita Kannenberg  
Carolyn McCleery  
Judy Pinnow  
Audrey Rimmel  
Joan Simdon

# ORGANIZATIONAL CHART



## ECONOMIC SUPPORT DIVISION

*~ Providing and Coordinating Resources to Strengthen Families~*

Access to quality customer service, timely, accurate processing and connections to resources are the main priorities of the Economic Support Unit.

The Economic Support Programs for Jefferson County are administrated at the Workforce Development Center. The location of Economic Support programs at the Workforce Development Center provides staff with the ability to coordinate the services of the on-site providers: Job Services, Department of Vocational Rehabilitation, Opportunities, Inc., WorkSmart Programs, Jefferson County Economic Development Consortium and UW-Extension. Community Partners result in improved service coordination. These partners include: Community Action Coalition, Madison College, local School Districts, PADA, food pantries, Faith Based Organizations, St. Vincent de Paul and local employers. Employment services are provided regionally to facilitate coordination of customers who live in one county and are employed in another.

If you are interested in learning more about the current job listings available to meet your workforce needs, you can visit the website of [www.jobcenterofwisconsin.gov](http://www.jobcenterofwisconsin.gov) for a statewide listing of employment opportunities. We also provide monthly calendars at the WDC showing the dates of employment workshops, skills training and job fairs. In 2011, 22,118 visitors accessed the WDC services. If you have questions, please contact our office at 920-674-7500.

In December of 2011, our Economic Support programs provided assistance to 6,020 Jefferson County households. Per the 2010 Census data the percentage of households in Jefferson County whose income is below the poverty level was at 9%. Customers may be receiving assistance from Medicaid, BadgerCare Plus, FoodShare, Wisconsin Shares, Wisconsin Works, and/or Kinship. Further, our customers may receive financial assistance from St. Vincent de Paul or Energy Assistance.

Following is a brief description of each program and the number of customers who received these benefits in 2011.

### **WISCONSIN WORKS (W-2)**

Jefferson County has administered the W-2 program since its inception in 1997. The W-2 program focuses on alleviating the specific employment barriers a family member may have by providing intensive case management and service coordination. The W-2 program determines how a customer's strengths can be enhanced, employment obtained and maintained, while stabilizing the household income and guiding the family to self-sufficiency.

W-2 customers may have complex circumstances and a Financial Employment Planner (FEP) will develop an individual employability plan that isolates the household's employment barriers. These barriers could be transportation, education, training, physical or mental disabilities, or the care of a child under the age of 8 weeks. The FEP uses a variety of tools, including work experience, employment workshops, career development, one to one counseling and coordination of services for housing, literacy and life skills. Through strong case management, the goal is for the customer to successfully return to the workforce with the supportive programs of BadgerCare Plus and FoodShare providing the continued stabilization needed.

Customers enrolled in the W-2 Program are required to participate in specific developed activities each week. After complete participation, the customer will receive a monthly payment of \$608.00 or \$653.00 per month depending upon their employment placement.

The number of yearly participants in the W-2 program continues to increase slowly since the participation requirements are intense and the customer's needs may be able to be met through other financial assistance programs in lieu of W-2. The website for the Department of Children and Families is [www.dcf.wisconsin.gov](http://www.dcf.wisconsin.gov).

#### Unduplicated W-2 Participants

	2009	2010	2011
<b>Participants</b>	56	58	63

## Economic Support Programs

The Economic Support Programs serve to provide greater financial stability for low income households and those experiencing a financial loss. Often our services are necessary to meet an emergency need such as homelessness or medical needs. Each program serves a specific population and has different income guidelines and requirements. The self-sufficiency of Jefferson County households and individuals is the ultimate program goal. The number of customers requesting financial assistance from Economic Support Programs continues to grow each year.

#### Caseload Growth

2008	4,710 households receiving assistance
2009	5,237 households receiving assistance
2010	5,676 households receiving assistance
2011	6,020 households receiving assistance

Requests for program assistance are made by contacting the Workforce Development Center at 920-674-7500 and asking to speak to an intake worker, coming into the agency, or calling Southern Consortium Call Center at 1-888-794-5780. The Financial Employment Planners serve as the first point of contact for all customers. They assess the customer's needs, initiate the application process and coordinate the appropriate referrals to community resources. You may also use the ACCESS website at [www.access.wisconsin.gov](http://www.access.wisconsin.gov) to learn about programs, apply or update your status on line.

**MEDICAL ASSISTANCE-** is a State and Federally funded program that provides the low income customer comprehensive, affordable healthcare. Numerous individual programs are included in the umbrella of Medical Assistance including; BadgerCare Plus, BadgerCare Core Plan, Medicaid Purchase Plan, Family Planning Waiver, Medicare Beneficiary and Family Care. Each program has its own specific non financial criteria for eligibility. The eligible customer receives a white Forward card which is taken the Health Care provider to verify coverage. Most Medical Assistance customers must participate in a Health Management Organization. The

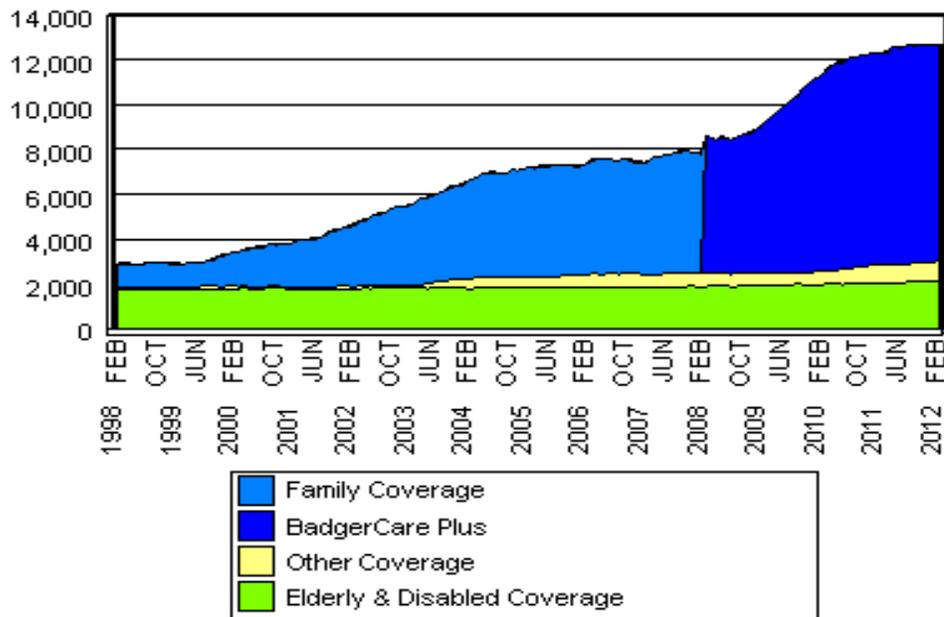
Medicaid website is <http://dhs.wisconsin.gov> where you can access information on individual program benefits and requirements.

The following chart shows a continuous increase in the number of customers receiving Medical Assistance in Jefferson County. In 2010, we provided Medical Assistance coverage to 12,356 customers. In 2011, the number of customers eligible for benefits increased to 12,718.

The graph displays the increase of eligible households from 2008 to present.

### Recipients of Medical Assistance

Caseload on December 30	Families	Nursing Home	Disabled	Totals
2008	6,753	315	1,797	8,865
2009	8,354	271	1,906	11,110
2010	10,117	243	1,976	12,356
2011	10,331	243	2,139	12,713



**FOODSHARE-FOOD STAMPS** - is a Federal Program that provides a monthly Foodshare allotment to low income customers. Eligibility is based upon income, household composition and shelter expenses. The eligible customer receives a QUEST card that is used to purchase food at local grocery stores. Customers in search of employment may volunteer to participate in the FSET program and work in coordination with a Financial Employment Planner to develop their employability resources. Similar to the Medical Assistance Programs, Foodshare participation continues to increase. The Foodshare caseload in 2010 was 10,511 recipients with a total average monthly benefit issuance of \$753,849 to be used to purchase food in our local communities. In December 2011, the caseload was 11,499 recipients with a monthly benefit issuance of \$827,231. The chart below shows the increase in the number of Foodshare customers from 2008 to 2011 in Jefferson County. The Foodshare website is <http://dhs.wisconsin.gov/foodshare>.

**FOODSHARE**

Year	All Recipients	Adults	Children	Groups
2008	6,376	3,209	3,204	2,610
2009	8,594	4,369	4,282	3,457
2010	10,511	5,334	5,246	4,137
2011	11,499	5,964	5,627	4,649

**WISCONSIN SHARES-CHILD CARE** - is a program that provides child care subsidies for low income working families to assist in their payment of child care expenses. The subsidy payment is made to the child care provider, with the family responsible for the co-payments. In 2010, the monthly average of families receiving child care assistance was 254 households. In 2011, the average monthly of families receiving assistance remained the same at 254 households. Additionally, the Child Care case managers certify in home child care providers, participate in local children’s fairs, and present trainings for providers. The child care website is <http://dcf.wisconsin.gov/childcare/wishares>.

**KINSHIP** - is a program that provides monthly payments for court ordered non-legally responsible relatives caring for a child. The child may be unable to live with their parents due to incarceration, medical concerns or parenting issues. The relative receives a payment to help with the additional expenses. In 2010, 43 children per month received payments with 14 children on the waiting list. In 2011, 38 children received payments with 15 children remaining on the waitlist. The waitlist is necessary due to limited funding.

**JEFFERSON ST. VINCENT DE PAUL SOCIETY** - provides our division access to local funds for the School District of Jefferson’s customer’s emergency needs such as rent and utilities, unmet by other programs. The household will only receive a specific payment amount once in a 2 year time period. In 2010, St. Vincent de Paul provided

\$21,362.18 for 170 customers. In 2011, 183 customers received \$20,502.31 in emergency funding. Their generosity continues to be greatly appreciated.

**EMERGENCY ASSISTANCE** - is a program designed to meet the immediate needs of an eligible family facing a current emergency of fire, flood, utility disconnect, homelessness or impending homelessness. In 2010, 68 households received \$33,618.07 with an average grant of \$494.38 per household. In 2011, 65 households received \$30,897.86 with an average grant of \$475.35. The need for this program remains consistent as families struggle to meet daily living costs.

**ENERGY ASSISTANCE** - is a program that provides a one time payment during the heating season to low income customers who need help paying their heating costs. The energy payment is made directly to the fuel supplier. Jefferson County continues to contract with Energy Services to administer the program. In 2010, 2,472 households received \$1,247,288 in energy payments with additional crisis funding going to 340 households in the amount of \$131,508. In 2011, 2,702 households received \$1,302,372 in energy payments with crisis funding to 456 households in the amount of \$178,487. Program information can be found at <http://heat.doa.state.wi.us>.

### **2011 Review and Goals**

In 2011, major changes occurred in the administration of the Medical Assistance and FoodShare programs. Customers are now directed to a call center number to report changes, ask questions and apply for benefits. 1-800-794-5780 is the contact number for the Southern Consortium Call Center.

Jefferson County is a member of the seven county consortia with Crawford, Grant, Green, Iowa, Rock and Lafayette County. Each county has staff on the call center full time to meet the customers' needs and all staff have access to make any changes or updates on any case in the consortium. Additionally, the BadgerCare Core customers that were managed at the Enrollment Services Center located in Madison have been returned to the county offices. Much of 2011 was spent in planning, developing and coordinating the change to a consortium. The consolidation has been a challenge to merge different county staff, procedures, and populations (urban and rural) together and still provide consistency for the customer. The consortium continues to be a work in progress as we enhance our knowledge of the other counties' resources and work to provide the customer seamless service. The following are the strategic priorities of the Economic Support Programs.

**\*\*\*\*QUALITY CUSTOMER SERVICE \*\*\*\*** This priority continues to be a challenge due to the increasing number of customers seeking assistance. The on-line ACCESS system and call center process has reduced the time to complete an initial application or review, but the customer must still submit the verifications. Staff continue to develop strong organizational systems to be able to meet the processing needs and also to provide one to one contact with the customer that is so important. Explaining the programs and benefits in detail helps the customer have a greater understanding and reduces the number of phone calls. There is a cost savings when we provide quality customer service because we are then able to reduce future medical expenses, homelessness, prevent utility disconnects and provide emergency food.

Our success in meeting our 2011 goal for quality customer service has been accomplished and is shown by our W-2 customer satisfaction performance standard. A private company interviews our W-2 customers to determine their level of satisfaction. On a scale of 1.00 to 4.5 we achieved a rate of 4.3 for W-2 customers. We also continue to send an internal agency survey and the responses are overwhelmingly positive. Simple statements such as "I was surprised the attention and time that the caseworker took with me and my case" and "My caseworker has always been very helpful/ friendly/prompt and professional." These comments reflect our positive contribution.

**\*\*\*\*TIMELY AND ACCURATE PROCESSING OF BENEFITS \*\*\*\*** This priority focuses on a well trained staff. We have weekly staff meetings; review policy processes and participate in all required trainings. Staff share caseload responsibilities providing us the ability to adjust workloads easily and compensate during staff absences. Our cases are continually monitored for accuracy through a State Quality Control system as well as a monthly internal process. According to the most recent data completed by State Quality Control from January 2011 to December 2011, Jefferson County had 272 cases pulled for review with an error rate of 3.9%. Our accurate benefit processing remains an integral cost savings.

**\*\*\*\*ACCESS TO RESOURCES FOR EMPLOYMENT AND OTHER FINANCIAL SUPPORTS \*\*\*\***This priority provides the customer with the strong knowledge of the entire staff located at the Workforce Development Center. Economic Support staff continue to work together with all WDC partners to provide easy access and coordinated services to the customer. Those applying for financial supports are given access to the employment workshops and other programs available to enhance their employment search. These may include weekly available job listings, monthly calendars with activities, and direct contact with partner staff. This coordination is another example of cost effectiveness as the customer is able to return to employment quicker and accordingly the amount of benefit dollars spent is reduced.

#### **THE ECONOMIC SUPPORT DIVISION'S 2012 GOALS:**

1. Develop a short, comprehensive reference guide for the customer explaining the different ways to apply and maintain their benefits, complete reviews and report changes.
2. Build relationships with two new community agencies to enhance the service coordination for our customers.
3. Re-establish the Workforce Development Center committees to be assured all center staff know of available resources and how the customers can access those resources
4. Continue to enhance the Income Maintenance call center coordination between the seven consortium counties.
5. Complete assessments on training needs of the Economic Support staff.

The challenges in 2012 continue with potential program and benefit changes due to limited funding at both the State and National level. Additionally, consolidation of resources through the development of county consortiums creates new procedural considerations. We are prepared to meet these challenges and to provide needed benefits and services to the low income customers in Jefferson County.

## CHILD & FAMILY RESOURCES DIVISION

*~ We value keeping families together and assisting them to live in their own communities ~*

The Child & Family Division provides assistance to families in Jefferson County through a variety of programs and teams. These teams work across disciplines to create a seamless array of services that support families to move towards self-sufficiency and independence while maintaining safety for the children in the least restrictive settings. The teams that make up this division include; Intake and Assessment, Early Intervention, Pre-school, Alternate Care, Youth Delinquency, Children in Need of Protective Services, Wrap-around, Children's Waivers and Independent Living.

The Child & Family Division staff continue to focus on well being, permanency, and safety for children. Children have the right to live in a safe environment that is expected to last until they reach adulthood. This may include their birth family, relatives, foster care, guardianship or adoptive homes. The division continues to provide best practices across all teams to address the needs of children and families.

The staff of the Child & Family Division is dedicated to the community, their colleagues, the agency and most of all to the children of Jefferson County.

### THE CHILD & FAMILY RESOURCE DIVISION INCLUDES:

- Intake
  - Children in Need of Protective Services
- Youth Delinquency, which includes the Delinquency Prevention Council, Restorative Justice, and the Agency Delinquency Team
  - Wraparound
  - Early Intervention and Preschool
    - Children's Alternate Care
    - Children's Waivers
    - Independent Living

## INTAKE

*~Information must be gathered during the investigation process, including the strengths, needs, and limitations of all household members~*

The Intake Unit at Jefferson County Human Services Department performs many different tasks, including receiving and screening access reports regarding child welfare and juvenile justice, conducting child welfare assessments, conducting child abuse and neglect investigations, referring families to services, and processing juvenile justice referrals. As of 2011, the Intake Unit is comprised of one Supervisor, one Access Worker, four Initial Assessment Workers, two Juvenile Court Intake Workers, and three after hour Intake Workers who are co-supervised by the Emergency Mental Health Supervisor.

The question of whether or not a parent or caregiver has protective capacities is essential to the purpose and reason for Child Protective Services (CPS) intervention. CPS provides intervention in a child and family's life when there are allegations of child maltreatment and/or danger threats to a child have been identified. As outlined in last year's Annual Report, since 2001 the Wisconsin Department of Children and Families continually implements policies and standards in child welfare practice. There are CPS Investigation and Safety Standards that guide the intervention process. The protocol includes interviews with all household members and a home visit on all investigations regarding allegations of child maltreatment by a primary caretaker. The standards outline that certain information must be gathered and assessed during the investigation process, including child and adult functioning, parenting and disciplinary practices, and overall family functioning. And should a child be placed under protective custody, the standards, protocol, and paperwork requirements increase significantly. While the Intake Unit at Jefferson County Human Services Department has always strived to be diligent in our CPS investigations, the mandated standards and protocol undeniably add to the casework demands.

Prior to 2011, all of the day staff in the Intake Unit rotated the duty of taking access reports; however, the number of access reports being received coupled with the high casework demands for each worker led to the creation of a full-time Access Worker position. The Access Worker position is solely dedicated to receiving reports as they relate to child welfare and juvenile justice and reviewing these with the Intake Supervisor in order to make screening decisions. In addition, because of the high casework demands in child welfare, a fourth Initial Assessment Worker has been created within the last year. Having both a full-time Access Worker and a fourth Initial Assessment Worker has in turn given the Initial Assessment Workers more time to devote both to their direct work on the cases they are assigned, as well as on the subsequent paperwork demands.

In addition to conducting CPS investigations, the Intake Unit also conducts Child Welfare Assessments on referrals where there are identified concerns for children and families but there are no child danger threats identified to warrant CPS intervention. The goal of Child Welfare Assessments is to provide preemptive intervention and services to families with the hope that the identified concerns can be effectively addressed at this level and not escalate to a need for CPS intervention.

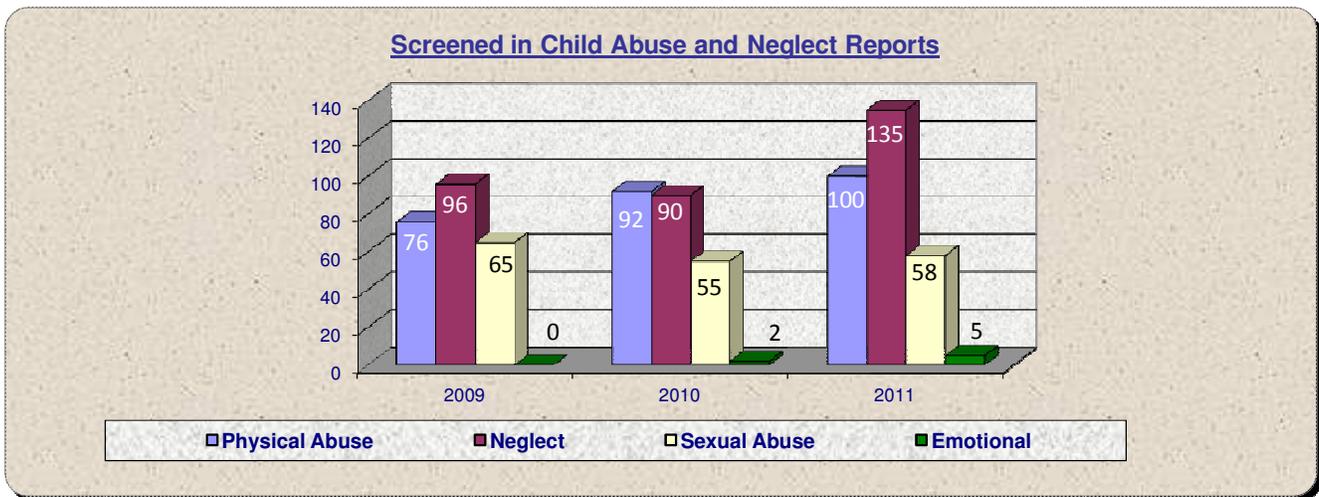
While CPS investigations and Child Welfare Assessments are a main focus of the Intake Unit, the unit is also responsible for processing Juvenile Justice and Truancy Referrals. These Referrals are generated by local law enforcement and schools. Processing these referrals includes meeting with the juvenile and his or her family at which time the referral is discussed at length, social information on the juvenile and family is gathered, case disposition is discussed, and the Juvenile Delinquency Risk Assessment is completed. The Juvenile Court Intake Workers then forward these cases onto the District Attorney's Office with their recommendations for how each case should be addressed. Such recommendations can include dismissal of a case, filing of a Deferred Prosecution Agreement, or filing of a Delinquency Petition which initiates formal court action. Should a

juvenile be placed on a Deferred Prosecution Agreement or a formal Court Order, the case is then transitioned to the Juvenile Justice Integrated Services Team for ongoing case management.

While the statistics for CPS Reports have essentially remained the same between 2010 and 2011, there has been a steady increase in cases involving drug affected infants due to AODA use by expectant mothers, as well as cases involving parents with AODA issues that impact the safety of their children. In these types of cases, it has been found that both illicit drugs and medications are being abused. These cases are investigated as Child Neglect and are categorized as such in the statistical findings.

Per the statistical findings, there was a 40% increase in Child Welfare Reports between 2010 and 2011. As noted in last year's report, while Child Welfare Reports are conducted to provide preemptive services and intervention, they can be just as meaningful and challenging as CPS investigations. Such Child Welfare Reports can include concerns regarding mental health issues of a child or parent, concerns of parent-child conflict, and concerns of inappropriate parenting or disciplinary practices. The outcome of these cases can include such things as connecting families with mental health services, parenting classes, AODA treatment, and financial assistance.

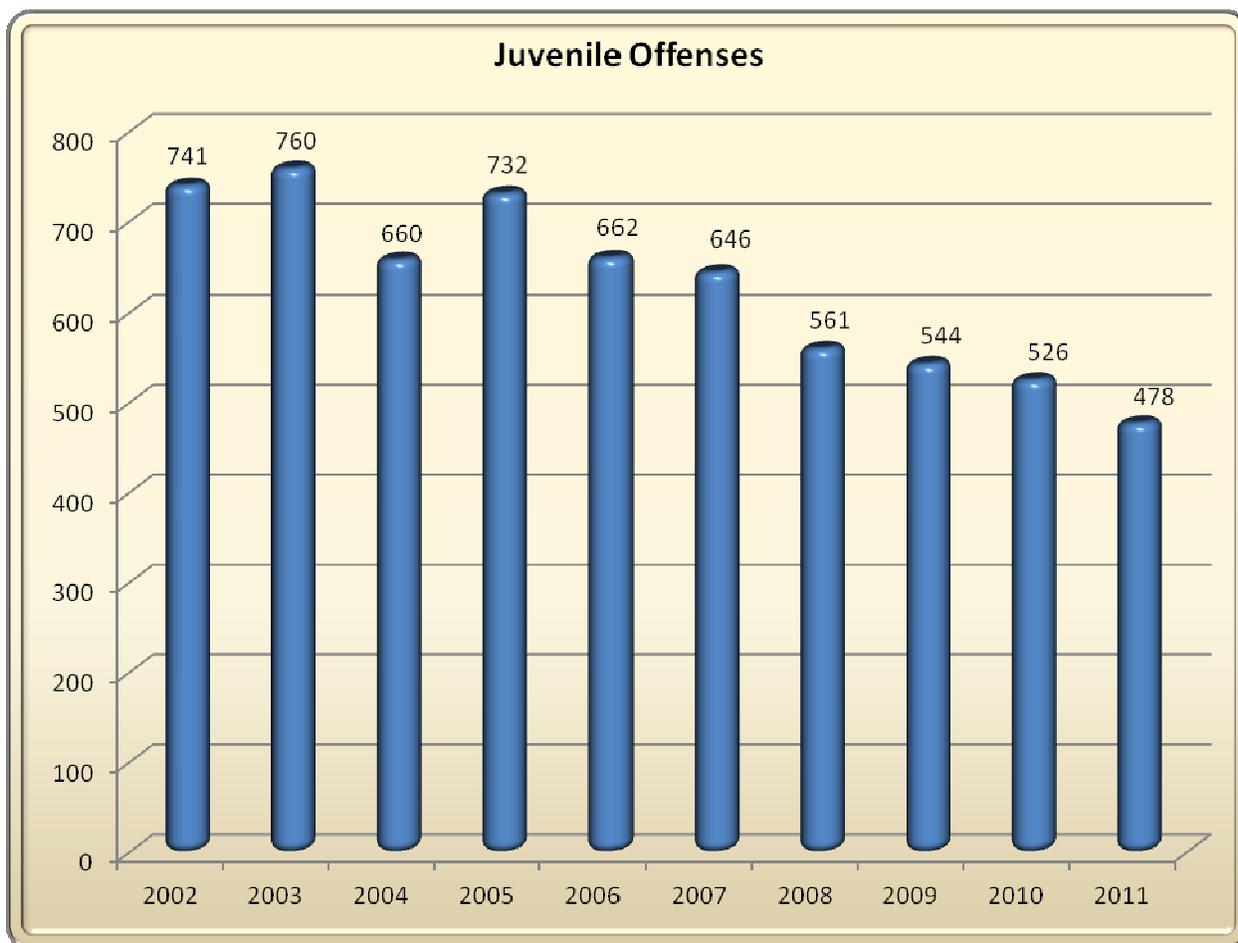
<b>Screened In Child Abuse and Neglect Reports</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Physical Abuse	76	92	100
Neglect	96	90	135
Sexual Abuse	65	55	58
Emotional	0	2	5



As reflected on the chart & graph below, juvenile justice offenses show that there has been a 9% decrease in the number of referrals made between 2010 and 2011. One of the main goals of the Intake Unit and the Juvenile Justice Integrated Services team has always been to reduce recidivism through a balanced and restorative approach that makes the victim, offender, and community whole again. It is believed that this goal is steadily being achieved as the number of juvenile justice referrals decline.

### Juvenile Offenses

2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
741	760	660	732	662	646	561	544	526	478



## 2012 Intake Team Goals

- Maintain compliance with all CPS and Juvenile Justice State and Federal Standards and Timelines.
- Create a “Community Pool of Resources”. Become well-versed and updated on the services and resources available, both within the Agency and the community. This can be accomplished through each member of the team researching and becoming familiar with certain services or resources and subsequently sharing this information with the team. The goal is that each month one person from the team will research a particular resource or service and present this at a team meeting.
- Reduce Truancy referrals and subsequent formal court action by collaborating with families and schools during the referral process in order to focus on solutions that address the underlying issues while preventing court intervention.
- Learn and apply all Supervisor Safety Decision Making (SSDM) information and training that is attained through the SSDM Program through transfer of learning, shadowing/mentoring, and related activities.
- All IA/Afterhours Workers attend Stepwise Trainings and other relevant trainings that will enhance proficiency.
- Juvenile Justice Intake Workers will review the Risk Assessment Tool that is currently being utilized and determine what updates could be made to enhance its use.
- More participation in CAP Month. The Intake Team would like to introduce \$1 Blue Ribbons at local businesses to help promote awareness and raise money. The Intake Team would also like to be involved with other community awareness and fund raising opportunities, such as distributing flyers, etc.
- Continue focus and efforts on placing children with relatives when out-of-home placement is necessary.
- Initiate a change team and use the NIATx model to find efficiencies.

## CHILDREN IN NEED OF PROTECTION AND SERVICES (CHIPS)

*~A team of social workers are specifically trained to help families improve their lives while protecting children~*

**MISSION STATEMENT:** *Empowering families to achieve permanency for the children of Jefferson County through collaboration and partnership with the Circuit Courts, individual families, contracted and agency providers, and community resources.*

Child Abuse is a major concern and precursor to many other life problems. Child abuse reports are received from members of the public, including neighbors, relatives and friends of families where abuse or neglect is a concern or potential concern. A large number of reports are also received from schools, police departments, physicians and other service providers or professionals. Each report is handled according to the state legal requirements for child abuse investigation and child protection. Once a report is made, our Intake staff handle the investigations through the court disposition.

Child abuse records in Wisconsin are registered and tracked in a computer based system known as WISACWIS, (Wisconsin Automated Child Welfare Information System). This system provides a very detailed computerized system for documenting and reporting child welfare referrals and providing on-going services, including out of home placements. In addition to this, due to federal audits of Wisconsin's Child Welfare System, there is additional training, practice and recording requirements for Wisconsin Counties. More time is now required on a per case basis to perform the necessary work and to produce the required documentation. Our workers are required to constantly make judgments that deeply affect the lives of children and their families. These decisions can include removing children from their homes in cases of severe danger, and requesting intervention of the Court. While other cases can involve no action on our part at all, both types of decisions carry potential benefits and consequences for families and for the Department. Once a dispositional finding is made, the Children in Need of Protection Services (CHIPS) team is involved. In 2011, the Intake and CHIPS teams began working on and recently implemented a comprehensive case transfer policy whereby ongoing case managers are assigned during the court process as a means of becoming more familiar with the needs of the families at the earliest possible opportunity.

The Children in Need of Protection and Services (CHIPS) Team is comprised of a supervisor, eight ongoing case managers, one family development worker, and one foster care coordinator. These workers are responsible for monitoring the ongoing CHIPS orders, and forming collaborative plans with families to meet both the elements of the court order and the family's goals.

Once the case is transferred to the CHIPS Team, an ongoing case manager is assigned and a case plan for the child(ren) and parents is developed. Each case is unique with overriding factors such as poverty, domestic abuse, unmet mental health treatment needs, failure to thrive, reactive attachment disorder, chronic homelessness, criminal charges and sentences, and immigration to name a few. The CHIPS Team works closely to address these issues with internal Human Service providers such as the Workforce Development Center (WDC), Comprehensive Community Services (CCS), Community Support Program (CSP), the Aging and Disability Resource Center (ADRC), Children's Waiver Program (CLTS), and the Mental Health Clinic as well as agency Medical Director, Dr. Mel Haggart. The CHIPS Team also works closely with community providers including area hospitals and clinics, People Against Domestic Abuse (PADA), local law enforcement agencies, the State Public Defenders Office, and private child placement agencies.

The CHIPS Team approaches each case with goals aimed at ensuring the safety of the children involved while at the same time providing for their permanence. Permanence options include: maintaining children in home with their parent(s) or guardian if the children were placed in home at the time of Court disposition; if the

children were placed outside the home at the time of disposition, permanence options include reunification with parent(s) or guardian, Ch. 48 Subsidized Guardianship, or Termination of Parental Rights and Adoption.

In 2011, the CHIPS Team was fortunate enough to enter into a consortium with Green and Rock Counties to conduct Permanency Roundtables (PRT's). This program, as implemented by The Wisconsin Department of Children and Families, is designed to formally study permanency on cases where perceived outcomes are rated as poor or uncertain. Permanency Roundtables are a structured, professional case consultation designed to expedite permanency for children and youth in out-of-home care through innovative thinking, the application of best practice, and the "busting" of systematic barriers. Roundtable participants include the case manager, supervisor, a policy expert, an outside permanency consultant, and state of Wisconsin Permanency Consultants. These cases are then tracked by the team until the permanency outcomes for the child(ren) improve or until permanency is achieved. The team is slated to "roundtable" nine cases in 2012 with the aim of achieving permanency for the child(ren) in a more timely manner.

Another valuable tool implemented in 2011 by the Wisconsin Department of Children and Families is the Subsidized Guardianship program. This program provides a clear legal avenue to place children with fit, willing, and previously licensed caretakers on a long term basis thereby achieving permanence without further agency intervention. The Jefferson County Human Services CHIPS team was one of the first in the state to process one of these types of Guardianships and the team is looking closely at current cases to determine if other situations fit the criteria in 2012.

***In 2011, when fully staffed, the eight ongoing case managers carried an average of 13.06 cases. At the end of 2011, the average caseload was comprised of 12.25 children being monitored in home and 11.62 children placed outside the home. In 2011 the CHIPS team worked with 195 parents and 154 children as in an effort to provide safety, permanence and well being. In 2011, 17.40% of children placed outside the home were not reunited within their family within 12 months. This is a positive product of the previously mentioned Permanency Roundtables, legal contract for Termination of Parental Rights (T.P.R) and the subsidized guardianship opportunities. This is well below the state average of 24.574%, and indicates a continued positive decrease from 19.52% in 2010.***

## **REVIEW OF 2011 GOALS**

**Mission Statement: *Empowering the families of Jefferson County to remain together and keep children safe while drawing on the support of all possible family and community resources.***

**1. Continue to implement evidence based practice which incorporates behavioral changes and interventions rather than incident focused or compliance based interventions.**

- All case managers utilize the Protective Capacities Family Assessment (PCFA) model to approach both practice and documentation which is a behavioral rather than service driven model of practice.
- All case managers have been trained and will implement the Child and Adolescent Strength and Needs Assessment (CANS) tool. This comprehensive assessment tool allows agency staff to match child(ren) needs with the abilities of placement providers. This model will be used continuously to monitor the strengths and needs of a child(ren) as these strengths and needs change and emerge throughout the life of a child in placement.
- All Case managers and agency staff continue to move towards a Family Teaming model in combination with the PCFA model as the need emerges within applicable cases.

- All CHIPS staff members use the EWISACWIS Child Welfare Informational System, which interconnects with all seventy-two Wisconsin Counties, to document case activities and case plans. As EWISACWIS continues to evolve and implement new functions, CHIPS staff members will be continually trained and updated on policy and procedural driven program changes.
- Case managers and family development workers continue to implement Incredible Years material. The Incredible Years series is an evidence-based parent education program, which is designed to advance the social and emotional behavior of children of all ethnic groups through a series of interlocking teaching programs. Case managers and family development workers deliver teaching programs, groups, and materials which foster the development of positive parent child relationships.
- CHIPS team will promote these concepts by discussing them during team meetings, supervision and staffing of cases. They will observe other case managers' documentation, family team meetings and home visits in order for further growth.

***In 2011, the CHIPS team continued to utilize the Protective Capacities Family Assessment (PCFA) model when dealing with families and children. This strength based, safety driven model provides good direction in terms of best practice and positive case outcomes. Throughout the course of 2011, all case managers became Child and Adolescent Strength Needs (CANS) certified and this tool is used continuously throughout the life of a child in placement in terms of assessing needs, rate setting, and service implementation. EWISACWIS continues to evolve and in 2011, one case manager was designated as a "Superuser" which allowed for more direct and frequent training in terms of EWISAWIC functionality. This worker then attended trainings and shared changes with other staff through transfer of learning. In the last year, nearly every case manager has taken a role in the Incredible Years parenting program and one case manager served as an instructor.***

## **2. Focus on improving safety for the children of Jefferson County.**

- All CHIPS staff members will attend upcoming trainings related to anticipated changes in Child Protective Services safety standards and definitions.
- Use CHIPS team meeting time to have regularly scheduled informational sessions to facilitate a transfer of learning.
- CHIPS staff members will attend regularly scheduled District Attorney roundtable discussions, portions of which will be centered around child safety.
- CHIPS staff members will attend regularly scheduled roundtable discussions with the presiding Juvenile Court Judge. During these discussions, stakeholders including Judges, attorneys, and CHIPS staff members will incorporate the Child's Safety Guide for Judges and Attorneys as authored by the American Bar Association. This guide encourages critical thinking and analysis by all stakeholders to enhance child safety, with the goal of strengthening child safety outcomes.
- CHIPS team members will use safety language when discussing safety with other professionals, community members, court officials and in documentation.
- The CHIPS team utilizes a Placement Response Team Staffing (PRTS), including the participation of the agency director, agency medical director, supervisory staff, and members of the CHIPS team in order to streamline meaningful services and remove barriers to ensure safety of abused and neglected children in Jefferson County.

***In 2011, all CHIPS staff were regularly updated on anticipated changes in the Safety Standards. All CHIPS staff have attended, or are scheduled to attend the updated Safety Foundation training. Throughout the year, transfer of learning was promoted during the CHIPS Team Meeting with guests ranging from State Permanency Consultants to other internal service providers such as CLTS, CCS, and CSP. The Children's Service Division Manager and CHIPS Ongoing Supervisor regularly attended all Judges Roundtable and District Attorney meetings. The CHIPS team continued to utilize team staffings and both the ongoing and access teams updated the case transfer policy. Also, the CHIPS Supervisor became a part of the County Child Death Review Team.***

### **3. Expedite permanency for children placed in out-of-home care through Jefferson County.**

- Schedule regular team model staffings for cases that incorporate all county service providers to ensure accuracy of services, reduce overlap of services, and monitor both permanency and concurrent planning. Discussions will include but not be limited to topics of safety, permanency, services provided, and responsibilities of the staff involved on the case.
- Engage all CHIPS team members in the implementation, licensure, and monitoring the Levels of Care (LOC), formally known as kinship care. Additionally, one staff person will be trained to oversee the LOC program in its entirety.
- The CHIPS team utilizes a Placement Response Team Staffing (PRTS), including the participation of the agency director, agency medical director, supervisory staff, and members of the CHIPS team in order to address issues related to permanence. These staffings may address barriers to permanency including problems with housing, transportation, communication, and other basic needs.

***The CHIPS team scheduled and completed over 100 "Superstaffings" in 2011. These staffings at times included parents, children, internal and external service providers. These staffings proved extremely beneficial in case planning and treatment team coordination. The Children's Service Division Manger, Ongoing CPS Supervisor, Intake Department, and Foster Care Coordinator developed and implemented policy throughout 2011 as it relates to Level of Care. Also, one CHIPS case manager is now assigned to oversee the LOC program in its entirety to assure timely licensing of "Level One" homes.***

### **4. Increase collaboration with community partners to help families achieve their goals and keep children safe in Jefferson County by educating the community and asking them to be a part of the solution.**

- Increase the amount of Child Abuse Prevention Month (April) activities each year to continue to promote community awareness and involvement. This will include two agency sponsored trainings per year to educate the community on child abuse related issues.
- The CHIPS team will accept any invitation to participate in community meetings, initiatives, etc.
- Promote the Incredible Years model by recruiting community partners to co-facilitate the curriculum.
- The CHIPS Team will partner with Fort Atkinson Memorial Hospital staff to identify vulnerable children and families in providing them with education and services necessary to prevent child abuse and neglect as part of the Circle of Success program.

***In 2011, the CHIPS Team once again promoted Child Abuse Prevention month (April) through the use of signage, apparel sales, a local radio interview with team staff, newspaper articles and participation in the Watertown Children's Fair as well as the Fort Atkinson Children's Fair.***

**5. Increase the knowledge base and training needs of the CHIPS team members as they become increasingly involved in Emergency Mental Health Services.**

- Through core training, all case managers become certified to perform Emergency Mental Health Services (EMH) under HFS 34. This ongoing training model gives case managers the knowledge and skill to respond to emergency mental health crisis both in the community and within their caseloads. The goal of the response plan is to make necessary referrals, reduce or eliminate a person's distress, de-escalate the present crisis, and help the person return to a safe and more stable level of functioning.
- Increase the use of EMH services and methods for children and families with mental health needs. This includes training staff on the use of Jefferson County's internal program, AS400, and other related EMH documents in order to ensure well informed and timely responses to any EMH crisis.
- Train one staff person to have the ability to case manage CHIPS cases and facilitate Comprehensive Community Services cases.

***In 2011, the CHIPS Team experienced a noted increase of case assignments where child and parent mental health issues were more apparent than not. All new staff undergo core mental health trainings under HFS 34. Additionally, CCS, CSP, and Emergency Mental Health staff regularly attend Superstaffings to coordinate care and services and to respond to the mental health crises as they arise on cases. The CHIPS Team was not able to cross train a case manager in CCS due to staff shortages.***

## **CHIPS TEAM MISSION AND GOALS 2012**

**MISSION STATEMENT:** *Empowering families to achieve permanency, well being, and safety for the children of Jefferson County through collaboration and partnership with the Circuit Courts, individual families, contracted and agency providers, and community resources.*

1. Continue to enhance ongoing case management staff knowledge and skills through ongoing education in collaboration with The Southern Partnership, community partners, and individual workshops.
2. Continue ongoing training with the Child and Adolescent Strength and Needs Assessment (CANS) tool. Implement yearly recertification schedule for all staff and use tool to better match the needs of children in placement with providers. Engage providers directly in the CANS rating process.
3. All ongoing case management staff shall complete Safety Foundation training to become aware of changes made to the Safety Threshold Criteria. This training will ensure compliance with ongoing safety standards.
4. Use CHIPS team meetings to have regularly scheduled informational sessions to facilitate transfer of learning. For 2012, schedule trainings related to co-sleeping, PADA collaboration, and document production have been scheduled.
5. All ongoing staff shall complete an interactive RAD (Reactive Attachment Disorder) training or seminar.
6. Continue to engage in the State of Wisconsin Permanency Roundtable (PRT) series as part of a consortium with Rock and Green counties. Schedule nine cases for review by the end of 2012.
7. Start a change team process and use the NIATx model to find efficiencies and continue quality improvement.

# **YOUTH DELINQUENCY**

## **Restorative Justice Programs**

Jefferson County Human Services contracts with Opportunities Inc. to provide Restorative Justice Program options to youth who have offended to ensure they are positively restored to their communities. Exciting changes are planned for 2012. A new more seamless partnership with Jefferson County holds the opportunity to enhance youth accountability and improve program outcomes. The Restorative Justice Programs include:

**Teen Court**

**Service to Community**

**Restitution**

**Educational Programs**

**Victim Offender Conferencing**

### **Teen Court**

Teen Court is a community based program for first time and minor repeat offenders. It offers eligible youth an opportunity to receive a meaningful sentence from a jury of their peers in lieu of appearing in circuit court and paying their citation. Youth who successfully complete the program will have the charge dismissed from their record.

### **Now and Then**

The Jefferson County Teen Court program began in 1998, holding just 13 trials. Teen Court continues to grow each year, and has now held a total of 662 youth trials since its inception. In 2011, 36 monthly teen court proceedings were held in Jefferson, Whitewater, and Watertown.

### **Value beyond the Dollar**

A 2005 cost-benefit analysis concluded that the Teen Court Program resulted in a net present value to Jefferson County of at least \$75,400 annually but the value of Teen Court shouldn't be measured by just the dollar savings. When obtaining feedback from participants on the impact Teen Court had on their lives, one youth stated, "I learned that it is not always about you, it's about others. I loved serving my hours and I am going to continue volunteering. It taught me a lesson about what I did was wrong. Taking a few hours out of my day to help others was easy and felt good."

### **Success through Numbers**

In 2011, there were 34 new referrals and 18 carry over (2010) referrals to the Teen Court program. Of those 52 referrals, 41 cases were closed successfully and nine cases will carry over into 2012. This demonstrates a 95% success rate.

### **Service to Community**

While performing Service to Community, juveniles are being held accountable for their actions while restoring the community in a positive manner. Staff assist youth through planning and facilitating options to reach their commitment to community service.

### **Now and Then**

The Restorative Justice Program of Jefferson County has been providing service to community supervision to youth since 1997. Since that time, 1955 youth have been referred to this program and 43,155.00 hours of service to community have been performed in Jefferson County. Since 1997, a total of 1,248 youth have completed their orders successfully, resulting in a 64% overall successful completion rate.

### **Value beyond the Dollar**

An evaluation was provided to all service-to-community locations to assess their satisfaction with the work completed by the youth and the impact this program had on the lives of others in the community. Of the 8 site surveys, 6 returned the completed evaluation forms. On a scale of 1.5, one being least satisfied and five being most satisfied, the evaluation average level of satisfaction was 4. Some comments made by the sites representative included:

- “We appreciate the help. It saves our teachers a lot of time”
- “Bridges the generational gap between our residents and the kids”
- “Extremely valuable asset. Our residents love the visit”

### **Success through Numbers**

In 2011, 84 youth of Jefferson County were referred and of all program participants, 1,960.5 hours of service to community were completed. These youth performed service to community throughout Jefferson County. In 2011, the Restorative Justice Program offered 13 different regularly scheduled supervised services to community sites for youth to attend across the county, with 8 sites per week on average. Youth participated in recreational activities with the residents of assisted living facilities, helped at various community activities in places like the Health and Wellness Center of Watertown, Bread and Roses, the Fort Atkinson Food Pantry and Head Start in Watertown. Additionally, youth helped with community events during the Children’s Fair in Fort Atkinson and Watertown, the Boys and Girls Club Wings and Wheels event, Fort Atkinson’s ½ marathon, and the Literacy Council’s Ride the Rock.

### **A New Approach**

In 2012, the Restorative Justice Specialists and the case managers from Jefferson County Human Services will team up together to conduct joint planning meetings with youth and their families. With this new team approach, all parties will be involved in the planning process, which in turn should lead to more successful outcomes. In addition, the Restorative Justice Program plans to continue to offer a diverse range of service-to-community choices in an effort to help youth complete their obligations successfully in a timely manner.

### **Restitution**

The Restitution program facilitates planning with youth to help ensure victims are compensated for monetary damage.

### **Now and Then**

The restitution monitoring component of the Restorative Justice Program has been in place since 1996. Since that time, 946 youth have been referred and over \$255,464.85 has been collected in restitution. During 2011, Restorative Justice Staff assisted youth in completing their court ordered requirements by providing them with local resources, support and guidance in order to successfully restore the youth and make the victim whole.

### **Value beyond the Dollar**

An evaluation was completed by victims who were paid back in full during 2011. Of the victim’s surveyed, all of them reported feeling satisfied with the process. Some comments made by victims included:

- “This is a great program. Thank you for making the kids accountable for their actions”

- “I was surprisingly impressed with the results. Thank you for your work”
- “It was great to get our money back”

### **Success through Numbers**

In 2011, a total of \$10,324.94 was collected in restitution, an increase of over \$800 compared to the previous year. This money was repaid to the victims of crimes in an effort to compensate them for monetary damages caused by the juvenile. Over the past fifteen years, 623 of the 945 youth referred have successfully completed their court ordered commitments, resulting in a success rate of 66%.

### **A New Approach**

In 2012, staff will create joint case plans with Jefferson County Human Services in an effort to make youth accountable and to increase the amount of money repaid to victims. The value of work will be an emphasis by assisting youth with employment searches and applications, in addition to providing employment opportunities at our Fort Atkinson location for eligible individuals. Through this focus, the Restorative Justice Program intends to prepare youth for the future by developing employability skills and a work ethic.

### **Educational Programs**

#### **First Offender Program**

Using the evidenced based Aggression Replacement Training (ART) curriculum, this class teaches three main components that include Skill Streaming, Anger Management, and Moral Reasoning. Skills include but are not limited to: Beginning Social Skills, advanced Social Skills, Skills for dealing with feelings, Skill Alternatives to Aggression, Skills for dealing with Stress, and Planning Skills. Students also participate in moral reasoning discussion scenarios where students learn appropriate/mature ways of handling tough situations. Each class session is chosen specifically for the current participants, resulting in the class targeting certain learning skills that each participant can benefit from. The majority of the class time is devoted to role-playing, helping to keep the youth fully engaged. In 2011, nine youth were signed up to complete First Offender Program. Three youth successfully completed the class, four were closed out due to non-compliance, and two continued programming into 2012.

#### **Alcohol, Tobacco and Other Drug Abuse (ATODA) Awareness Program**

The Alcohol, Tobacco and Other Drug Abuse Awareness curriculum was first offered by the Restorative Justice in 2007 and utilizes the PRIME for Life curriculum. PRIME for Life is an alcohol and drug program for people of all ages. It is designed to gently but powerfully challenge common beliefs and attitudes that directly contribute to high-risk alcohol and drug use. The program goals are to reduce the risk for health problems and impairment problems by increasing abstinence, delaying initial use and decreasing high-risk choices. Opportunities, Inc. will continue to provide the class to Teen Court participants, Pre-expulsion referrals and students in the Youth Apprenticeship Program.

#### **Pre-Expulsion Program**

The Fort Atkinson and Lake Mills School district has collaborated with the Restorative Justice Program to provide services to youth who commit alcohol and drug related offenses on school grounds. By providing this alternative to expulsion, youth are given a chance to make amends for their actions and learn about the dangers of drug and alcohol use. The youth referred are required to complete up to 30 service-to-community hours and participate in the ATODA Awareness class. The sanctions are given, in addition to other stipulations delegated by the school district in an effort to promote substance abuse cessation and encourage youth to get help for any substance abuse issues. In 2012, 8 school districts in Jefferson County are partnering with Restorative Justice Program to offer the Pre-Expulsion Program in their schools.

## **Victim Offender Conferencing**

The Victim Offender Conferencing (VOC) program gives victims the opportunity to meet face to face with the youth to discuss the crime and why it happened. VOC has been available in Jefferson County since 1997 and the Restorative Justice Team continues to educate and attempt to engage victims in this process. VOC not only benefits the victim, but is also restorative for the youth offender and the community as a whole.

The victim benefits from the mediation by being provided a chance to express their feelings about the event at hand, thus allowing the victim a voice. The youth benefits from the mediation by being provided an opportunity to understand and make amends for the damage caused to the victim and/or the community at large. Finally, the community benefits from the mediation by repairing the harm done to the relationships affected by promoting nonviolent forms of conflict management, and potentially preventing the juvenile from offending again.

In 2012, VOC will be modified to make it more accessible and increase utilization. Options for incorporating the concepts of the Victim Offender Conferencing program will be in three tiers. The intent of this modification is to ensure juvenile offenders have the opportunity to reflect on how their action affected others. The three tiers include:

- Using VOC as a diversion program.
- Incorporating VOC as a component of a Restorative Justice Plan.
- Requiring the youth to write an apology letter to the victim.

## **Youth Leadership Conference**

In June, Jefferson County Connections (formally the Delinquency Prevention Council) held their third annual Youth Leadership Conference for high school youth from throughout the county. This half-day conference focused on helping the youth gain leadership tools to put in their “toolbox.” We were honored to host Carl “Energizer” Olson, a nationally known and respected speaker, trainer and author. Carl founded “Energizer Olson” in 1993, by drawing from his successful background and experience as an educator, coach, administrator, and leadership trainer. The mission of the organization was designed to empower youth for success, using motivation, attitude and sound current theory and practice and empowering youth is exactly what was achieved that day! The youth were engaged in various activities and group work that challenged their comfort zones and thinking patterns to explore their leadership skills. While attending two breakout sessions, youth learned about the dangers of texting and driving, and were taught about respect, resiliency, and conflict resolution.

Conference participants were also invited to join the Jefferson County Connection’s Youth Committee to continue practicing their leadership skills. The members of the Youth Committee are passionate about sponsoring drug and alcohol free events for other youth throughout the county. The committee continued to host a countywide Dodge-ball league that invited high school youth from throughout the county to get involved in an event that didn’t involve destructive behavior.

Youth Committee members are in the process of planning the fourth annual Youth Leadership Conference in June 2012.

## **Drug Free Communities Grant**

Jefferson County was provided funding for five years through a federal Drug Free Communities Grant. This funding ended in the fall of 2010. This grant maintained and sponsored juvenile substance abuse prevention programs facilitated through the Delinquency Prevention Council.

A summary of these initiatives is provided below:

<b>Program/Initiative</b>	<b>Outcome</b>
Juvenile Drug Treatment Court	After extensive research and planning, a Juvenile Drug Treatment Court program was launched in 2010. Jefferson County Human Services sustained the program option through the Juvenile Justice Team.
School-Based Teen Court	This program was piloted in 2008 at Riverside Middle School in Watertown. Known as Panther Court, the school chose to sustain the program internally using written procedures.
Children's Share and Care Fair	Held once a year, the Fair provides families with local community resources to assist with growing children. Jefferson County Human Services Birth-to-Three Committee will continue to plan this event.
Educational Presentations	The Drug Free Committees grant provided funds for county-wide educational offerings on topics such as tobacco, gangs, drug and alcohol awareness, social norms and internet predators. This education is challenging to sponsor without the grant, but the grant helped to solidify partnerships that can be utilized in the future to provide for shared educational needs.
Parent Who Host-Lose the Most	This public awareness campaign was initiated in 2009 through the DFC grant. Efforts related to this campaign continue to be a focus of the ATODA sub-committee of the Delinquency Prevention Council (now known as Jefferson County Connections).
Juvenile Mentoring Program	In 2010, the Big Brother/Big Sisters program agreed to sustain this need to streamline the service for both mentors and mentees.
Alcohol Compliance Program and Beverage Server Training	Initiated in partnership with the Watertown Police Department to research, train and enforce laws controlling underage drinking. This program was sustained through the Watertown Police Department.
Youth leadership Conference	Initiated through grant dollars in 2009, the Jefferson County Connections is partnering to sustain this offering to local youth.

## **Search Survey 2010**

The Drug Free Committee Grant sponsored the completion of a survey of Jefferson County Youth, using Profiles of Student Life: Attitudes and Behaviors in 1997, 2000, 2003, 2006, 2008, and 2010. The data from this survey shows the link between developmental assets (40 were measured) and risk-taking behaviors. The 2010 Search Survey results are summarized below:

Internal Assets:	<ul style="list-style-type: none"><li>• Measured:<ul style="list-style-type: none"><li>○ Commitment to learning</li><li>○ Positive values</li><li>○ Social competencies</li><li>○ Positive identity</li></ul></li></ul>
External Assets:	<ul style="list-style-type: none"><li>• Measured:<ul style="list-style-type: none"><li>○ Support</li><li>○ Empowerment</li><li>○ Boundaries and expectations</li><li>○ Constructive use of time.</li></ul></li></ul>
Statistical Findings:	<ul style="list-style-type: none"><li>• 15 of 20 internal assets saw a statistically significant improvement from 1997 to 2010</li><li>• 16 of 20 external assets saw a statistically significant improvement from 1997 to 2010</li><li>• Six of eight risk-taking behaviors were ranked statistically lower in 2010 than in 1997</li></ul>

## **Jefferson County Connections**

In 2011, the Delinquency Prevention Council completed a review of their program and purpose. The coalition was renamed Jefferson County Connections with a broader purpose of addressing the needs of families in Jefferson County.

## DELINQUENCY

*“The Delinquency Team works closely with Jefferson County Connections and provides both juvenile intake and referral to the court system as well as ongoing supervision and case management.”*

The Delinquency Team provides ongoing case management for youth on Juvenile Delinquency, JIPS, Consent Decree, and Chapter 51 Orders, Deferred Prosecution Agreements and voluntary cases. The Delinquency Team recognizes the dignity of each and every youth. We are treatment focused and work with youth and their families to develop natural supports and teams to enhance the support of our youth.

Our team seeks to meet the unique needs of youth while assuring a safer society. We identify risk factors early on to be effective in preventing juvenile delinquency and future criminal behavior. Some risk factors include: lack of education, learning disabilities, developmental disabilities, mental illness, emotional/behavioral disabilities, poverty, domestic violence, and all forms of abuse and neglect. We understand the importance of working with youth, their families, and their support systems to enhance and encourage success.

Our Delinquency Team continues to focus on ways to provide the most meaningful interventions and services for youth and their families while also ensuring the safety of our community. We have done so through utilizing interventions and services that are research based and supported by empirical evidence. The Delinquency Team continues to explore and utilize both formal and informal resources and programs that lend themselves to delinquency prevention and fewer juvenile placements. We continually strive to enhance our collaboration with community partners in order to pool resources, advance knowledge and practices, and empower everyone to be part of the solution to delinquency prevention. The Delinquency team is comprised of the Division Manager, Program Coordinator, five Case Managers and two Intensive Supervision Workers.

### REVIEW OF 2011

The Delinquency Team directed its focus on developing and building evidence-based, internal programming in 2011. Two of our team members trained in The Incredible Years parenting curriculum and taught the first class that focused on parents of children ages 6 and up. The class was well attended by some of our juveniles' parents, and evaluations indicated that they found the class to be very helpful. Team members also began incorporating the Anger Replacement Training curriculum into the anger management groups and have completed multiple groups in 2011 using that model. Two delinquency team members have completed the Juvenile Cognitive Intervention Program (JCIP) training and are prepared to offer this evidence based curriculum to Jefferson County juveniles. Our team continues to offer the Juvenile Drug Court program to youth who require additional education in the area of alcohol and other drug addictions. In addition to providing those direct services to our consumers, our team continues to collaborate with and utilize various in-home programs, such as Comprehensive Community Services (CCS), Wraparound Program services, the Intensive Supervisor Program (ISP), and in-home therapy through private counseling agencies. We continue to maximize our efforts in providing families with the services and resources they need, specifically through teaming and working across multi-disciplinary teams and systems.

In 2011 our team provided youth with various pro-social and strength based activities, including the ever popular “Paint-a-Pot” activity, and a day trip to the Milwaukee Zoo. These activities offer our juveniles a safe,

supervised and structured way to work on building their social skills, and to participate in activities that they might not be able to do otherwise.

One of our most important areas of focus continues to be permanence for our youth. We remain focused on reducing and preventing placements of our youth (i.e. secure custody and respites) while also ensuring the safety of our community. We continue to do so by collaborating with multi-disciplinary teams that can provide any necessary treatment and services, such as mental health treatment and/or individual and family therapy.

All documentation for the Delinquency Team is now recorded in the statewide eWiSACWIS computer system. This has streamlined our paperwork and has made our case documentation more cohesive. This has not only aided in timely documentation but also provides for better oversight of quality assurance.

The Intensive Supervision Program continues to strategize and find ways to build on youth's strengths, help them make better choices, and prevent respites/detentions when possible. ISP workers meet with juveniles and families on a daily basis and are instrumental in helping families develop effective crisis management plans and communication. In 2011 our ISP workers completed updates to the paperwork and researched updating the electronic monitoring equipment. Due to the high cost of implementing GPS monitors, the team is looking for ways to increase funds to provide this much needed service.

## **GOALS FOR 2012**

This year, the Delinquency Team will continue our work on our prior goals while also embarking on new goals.

- To shift the negative focus of youth associated with the word delinquent to a more positive, treatment-focused term, as of 2012, the Delinquency Team will be identified as the Juvenile Justice Integrated Services Team. The team will publicize the new name in the Jefferson County and Human Services monthly newsletters, will make an announcement at an upcoming Agency Director's meeting, Children's Division meeting and Jefferson County Connections meeting, and will make all necessary changes to all outgoing correspondence.
- To better recognize internal and external stakeholder expectations and understanding of our program, the Juvenile Justice Integrated Services team will participate in a formal program evaluation, facilitated by the UW Extension office.
- To obtain feedback from consumers and improve customer service, the team will implement a quality assurance instrument and utilize the data to evaluate and advance the services offered by the Juvenile Justice Integrated Services Team.
- Services supported by research are at the forefront of our programming. To highlight this value, we will continue to provide evidence-based service delivery, including, but not limited to, Motivational Interviewing, Juvenile Cognitive Intervention Program, Aggression Replacement Training, Incredible Years, PRIME for Life, Juvenile Drug Court and Seeking Safety. The team will also join together with the Restorative Justice Team to offer a comprehensive, team-based approach to working with families, and the Intensive Supervision workers will continue to gather more information on updating our electronic monitoring system. Concurrent to providing these services, each team member will review

research related to pertinent issues, as well as innovative and progressive program models in the juvenile justice field, and take turns presenting their findings at team meetings.

- To encourage positive agency change in the area of our permanency plan review process, select Juvenile Justice Integrated Services Team members will participate in an ad hoc committee of community and agency representatives to evaluate the Permanency Plan administrative review process and make recommendations for improvement.
- To highlight youth strengths, assets, achievements and positive school and community involvement, the Juvenile Justice Integrated Services Team will link youth that are involved in the Juvenile Justice system with the Jefferson County Connections youth committee. Juvenile Justice Team members will inform youth of the meetings and coordinate transportation. In addition, utilizing feedback from surveys based on research from the Search Institute regarding the importance of youth asset building, the Juvenile Justice Integrated Services Team has made a commitment to provide meaningful youth activities. The surveys showed that Jefferson County youth who participated in these activities noted improved assets in the areas of support, empowerment, boundaries, commitment to learning, positive identity and social skills. In 2012, the team will continue to offer approximately five different youth activities. Some of the more popular past activities were Snapper's Game Day, Spa Day, "Paint a Pot" and a trip to the Milwaukee Zoo.
- In an effort to increase the availability of incentive money for the youth activity fund, the Juvenile Justice Integrated Services Team will explore additional means of funding sources, such as local, state and federal grant opportunities, seeking donations from local businesses, and fundraising.
- The Juvenile Justice Integrated Services Team will continue to maintain fiscal responsibility, as evidenced by full compliance of our funding source edicts.

## **Law Enforcement Youth Delinquency Referrals**

**As reflected in the charts on the following pages:**

- 239 different youth were referred for a total of 478 offenses in 2011. This reflects an increase of youth from 2010 of 14 individuals but a decrease of 48 offenses. The statistics for 2010 show a five year pattern of decreasing juvenile delinquent activity.
- 54% of the total referred youth were 14 or younger.
- 14% of youth were referred four or more times and 5% were referred six or more times.
- 10 youth were referred at least six times and 2 youth were referred nine or more times. This represents a decrease in the number of youth who would be considered habitual offenders. This also generally indicates the proportion of youth who require our most intensive services in terms of time and costs.

- The total number of juvenile delinquency referrals in Jefferson County did increase last year but had declined each year over the past decade. We consider this to be a testament to our collaborative efforts within our agency and with our community partners in utilizing best practice models that support our youth and families, provide treatment and supervision, and reduce recidivism.
- The total number of offenses and referrals for younger youth has increased slightly, but the numbers for serious crimes decreased somewhat. Weapon related crimes, gang activity and the impact of alcohol and drug use continue to be a main concern, as they can have a monumental impact on youth, families, and the community as a whole. The Department continues to explore interventions and services that will effectively address these and other serious offenses with the goal of maintaining the youth safely in the community. The Department is increasingly utilizing our Juvenile Drug Treatment Court, as well as other AODA treatment facilities. The Intensive Supervision Program is also being utilized more frequently with the more serious juvenile offenders and we are trying to connect these youth with mentors and peer support specialists.

### 2011 Multiple Juvenile Referrals by Age

		Age <11	Age 11-12	Age 13-14	Age 15	Age 16	Age 17+	Total Juveniles of Arrests per #	% of Total
R e f e r r a l s	1	6	27	30	34	30	4	131	55%
	2-3	5	15	25	16	13	1	75	31%
	4-5	2	2	11	2	4	0	21	9%
	6-8	1	1	2	4	2	0	10	4%
	9+	0	0	2	0	0	0	2	1%
Total Juveniles with Multiple Referrals per Age		14	45	70	56	49	5	239	100%

### 2007-2011 Juvenile Intake by Age

	Age <11	Age 11-12	Age 13-14	Age 15	Age 16	Age 17+	Total Youth
2011	14	45	70	56	49	5	239
2010	13	42	61	50	57	2	225
2009	17	23	56	59	67	4	226
2008	18	29	91	57	48	1	244
2007	10	26	90	47	64	3	240

## JUVENILE CRIMES OF GREATEST CONCERN 2007-2011

OFFENSES	2007	2008	2009	2010	2011
Arson	5	3	7	0	0
Battery	37	42	28	33	31
Burglary	32	18	50	35	43
Crimes Against Children/Other	7	16	15	24	12
Drug Related	90	71	51	55	44
OMVWOC/Other Vehicle	18	22	5	15	5
Sex Offense	34	57	20	44	42
Truancy	21	34	30	37	31
Weapon Related	12	13	19	4	12
<b>TOTALS</b>	<b>256</b>	<b>276</b>	<b>225</b>	<b>247</b>	<b>220</b>

### POLICE REFERRALS for JUVENILE OFFENSES

#### 1 and 5 Year Comparisons

OFFENSES	2011	2010	1 Year (2010-2011) Increase/Decrease	2011	2007	5 Years (2007-2011) Increase/Decrease
Alcohol/Tobacco	2	1	1	2	12	(10)
Arson	0	0	0	0	5	(5)
Battery	31	33	(2)	31	37	(6)
Burglary/Robbery	43	35	8	43	32	11
Burning Materials/Fireworks/Explosives	0	3	(3)	0	7	(7)
Contempt of Court/Violation of Court Orders	0	6	(6)	0	8	(8)
Crimes Against Children/Other	12	24	(12)	12	7	5
Criminal Damage to Property	36	42	(6)	36	45	(9)
Criminal Trespass	6	8	(2)	6	37	(31)
Disorderly Conduct	136	133	3	136	135	1
Drug Related	44	55	(11)	44	90	(46)
Fleeing/Escape	0	9	(9)	0	8	(8)
Forgery	2	0	2	2	4	(2)
Intimidation/Harrassment	2	0	2	2	6	(4)
Obstructing/Resisting Arrest	12	25	(13)	12	33	(21)
OWVWOC/Other Vehicle	5	15	(10)	5	18	(13)
Receiving Stolen Property	2	3	(1)	2	2	0
Reckless Endangerment	2	0	2	2	3	(1)
Sex Offense	42	44	(2)	42	34	8
Theft	58	49	9	58	90	(32)
Truancy	31	37	(6)	31	21	10
Weapon Related	12	4	8	12	12	0
<b>TOTALS</b>	<b>478</b>	<b>526</b>	<b>(48)</b>	<b>478</b>	<b>646</b>	<b>(168)</b>

## WRAPAROUND (CST)

*~To keep children with social, emotional, mental health and cognitive needs in their homes and community~*

**Mission Statement: The Jefferson County Wraparound Project exists to keep children with social, emotional, mental health and cognitive needs in their home and community.**

### **Program Description:**

Wraparound is a voluntary service providing a coordinated team approach that exists to keep children with multiple needs in their home and community. The coordinated services team is a group of individuals, including family members, service providers, and informal sources who work together to respond to the service needs of a child who is involved in two or more systems of care. Through coordinated services, the creation and maintenance of a comprehensive, coordinated and community based system of care centers on strengthening the child and family. Length of services can range from six months to 18 months. The services and resources needed by the child and the child's family through the coordinated services plan shall place emphasis on services and resources that are available within the community and through informal sources.

### **Program Goals:**

#### **Build and maintain positive outcomes for youth**

Build and maintain positive outcomes for youth through community outreach by conducting school visits and providing activities through community integration. Data will be collected and entered by service coordinators at enrollment and every six months through disenrollment in the State DMHSAS reporting system. Identified educational areas are suspensions, grade averages and school settings. Community integration will be evaluated through areas of juvenile offenses and living situation. School suspensions will show a decrease of 75% from enrollment to the end of the year reporting. Grade averages (passing classes) will improve by 75% from enrollment to the end of year reporting. Outcomes will be charted at the end of each year as evidenced by the coordinated service team outcome indicator citrix system.

#### **Maintain children in their biological, relative or adoptive homes**

Through team facilitation, we strive to maintain children in their biological, relative or adoptive home by providing services and resources needed by the child and the child's family through the coordinated services plan. Outcomes will be measured by using the Child and Adolescent Needs and Strengths Assessment - Identified Permanency Resource and Strengths Needs area. Data will be collected at enrollment and every six months until disenrollment in the State DMHSAS reporting system. Outcomes will be charted at the end of each year as evidenced by the coordinated service team CANS outcome indicator citrix system.

#### **Provide family support for the prevention of abuse and neglect**

Through team facilitation Wraparound will provide community-based services designed to promote the safety and well being of children and families by preventing abuse or neglect from occurring 100% of the time.

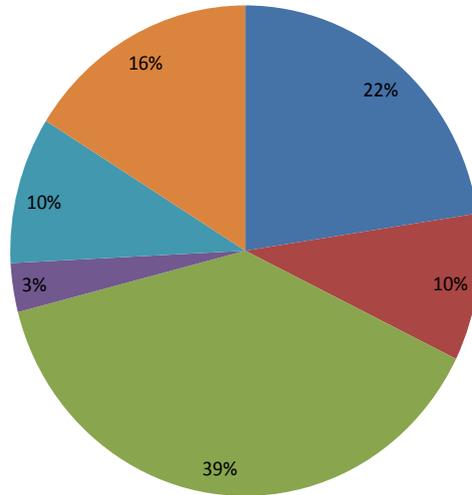
#### **Outcomes from 2011 Reporting**

In 2011, forty six families and 54 children received Wraparound services promoting safety for the well being of the child and family. Several families had multiple children within the family unit that were provided services. Each child had an individual assessment and plan of care completed. Eight families received informal services needing assistance with outside resources through referrals. Through teaming we provided support to 149 family members (including grandparents, aunts, uncles and siblings). These children all met criteria for Wraparound services.



## Breakdown of Multiple Target Groups

- Mental Health/Juvenile Justice
- Mental Health/Children in need of protection and services
- Developmental Disability/Mental Health
- Developmental Disability/Juvenile Justice
- Developmental Disability/Children in need of protection and services
- Developmental Disability/Autism Spectrum Disorder



## COORDINATED SERVICE TEAM OUTCOME INDICATORS

The Jefferson County Coordinated Service Team (CST) reported outcome data to the State Division of Mental Health and Substance Abuse Services (DMHSAS) for 37 children in calendar year 2011.

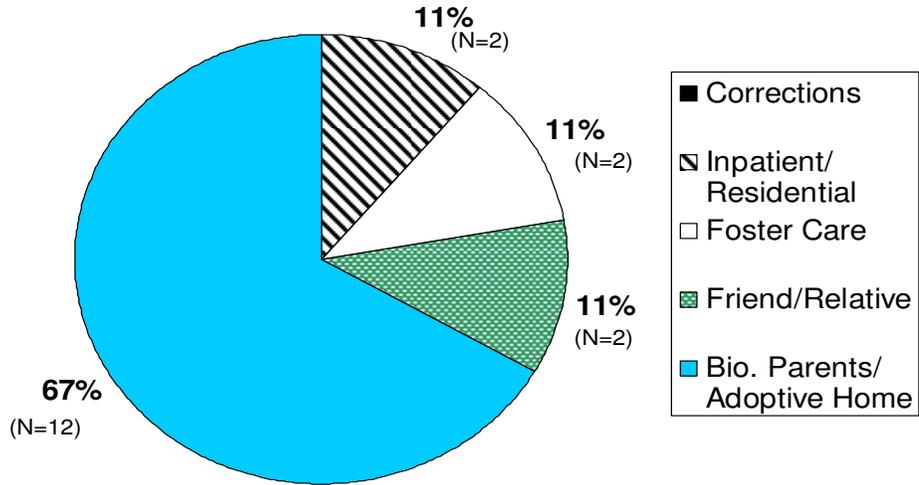
Of the children for whom data was reported to the State DMHSAS in 2011, 24 children continued their CST participation from 2010 and 18 were disenrolled in 2011. The average length of stay for these 18 children was just over 1 ½ years (18.5 months). Thirteen children were newly enrolled in 2011 and 11 of these children continued their participation into 2012.

The results below represent children's final status as they were disenrolled compared to their status at the time of enrollment on indicators describing living situations and educational performance. The results describe outcomes using all available data submitted to the State DMHSAS for the 18 children who were disenrolled in 2011.

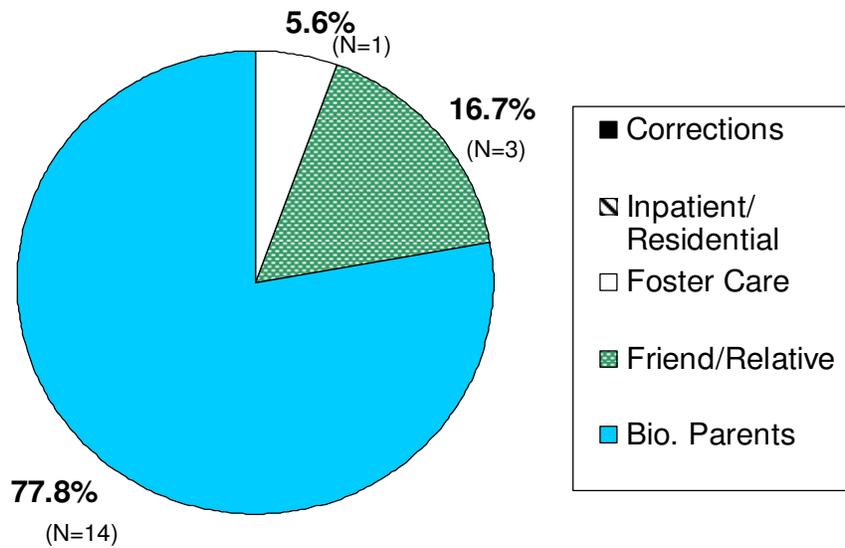
### LIVING SITUATIONS for DISENROLLED CHILDREN

Of the 18 children who were disenrolled in 2011, 67% were living with their biological parents when they were enrolled into the CST initiative. When they were disenrolled, 78% were living with their biological parents and another 17% were living with friends and relatives. Two children were living in inpatient hospital and residential treatment center settings when enrolled into the CST initiative. However, both were living with their biological parents, friends, or relatives when disenrolled from the CST initiative.

### Living Situation at Enrollment (N=18)



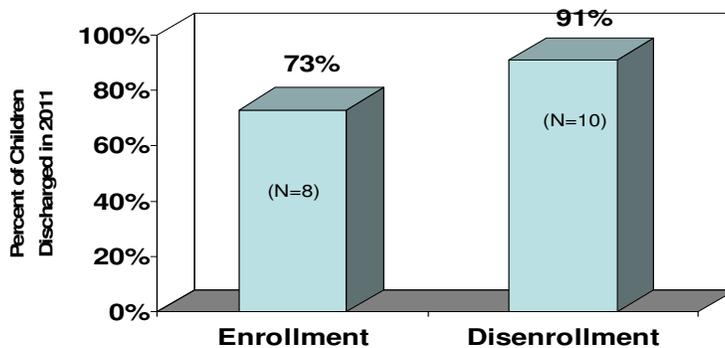
### Living Situation at Discharge (N=18)



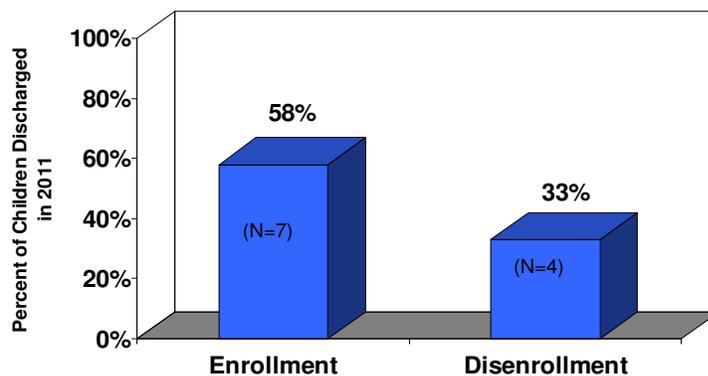
## EDUCATIONAL INDICATORS for DISENROLLED CHILDREN

To measure childrens' educational progress during their participation in the CST initiative, academic performance and special education needs were monitored. The indicators were measured during the school semesters when children were actively participating in the CST initiative. Of the 18 children who were disenrolled in 2011, twelve had complete educational data and were enrolled for at least two school semesters. At the time of enrollment, 73% of children had grade averages of a "C" or higher for the semester. At the time of disenrollment in 2011, 91% had grade averages of a "C" or higher. The use of a special education services in alternative settings and regular schools is also monitored for progress. At the time of enrollment, 58% of children used special education services for less than 50 percent of their school day. At the time of discharge, children were using special education services more frequently as just 33% used special education services for less than 50 percent of their school day.

Children with Grade Averages of "C" or Higher  
(N=11)



Children Spending Less Than 50% of Time  
in Special Education Settings (N=12)



In 2011 Jefferson County Wraparound staff assisted with training Ozaukee, Green, Washington, Grant and Iowa counties with the Wraparound process.

### **What are service providers saying about Jefferson County Wraparound?**

"I feel this program is very beneficial to families in crisis. I watch as the staff work with all parties (school, foster parents, medical, and parents) to secure the welfare of the children involved. Details of outcomes are provided in a clear manner with follow-up notes offered to those in attendance." *Care Manager, Care Wisconsin*

"It was great to have a person who is readily available and knowledgeable about the various resources and services available to the children and family." *In-Home Family Therapist, Foundations*

"As a teacher, I can only do so much and it is great having a team at the house helping to achieve the same goals." *Teacher*

"It gave support to my student and their family in receiving much needed services." *Early Childhood Teacher*

"Working on a team is beneficial because we were able to bounce ideas off of each other." *Head Start Family Advocate*

"It allowed me to be able to share responsibilities, concerns, and achievements with team members. I was able to form new relationships and contacts in the community." *Case Manager, Birth to 3*

**The above information was collected through team member and team effectiveness surveys.**

### **What are family members saying about Jefferson County Wraparound?**

"The support was vital in working through the tough times!"

"It gave support and allowed sharing of ideas toward a goal!"

"We were able to put plan in place to deal with our child's behavior

"It helped our family put goals together so we could achieve them!"

**The above information was collected through parent, guardian, and care giver surveys.**

## **Supported Employment for Transition Age Youth with Disabilities**

Due to the success and positive feedback regarding the Youth Supported Employment program we received an increase in referrals for youth to participate in Job Club. We added a second Job Club to meet the demands of our referrals. Youth were better able to participate with transportation and meals provided. Our Job Club started in October of 2010 and continued to meet weekly through September of 2011 with twenty two youth participating.

Youth were educated in the following areas and worked on the following skills; strategies for finding employment, interviewing skills, tips for maintaining employment, career development, obtaining a work permit, registering on Wiscareers and completion of job applications. Two youth from this group were successfully employed.

Youth continued working on employability skills, touring and job shadowing places that they wanted to pursue their career in. Job shadows and tours included; movie theater, Headstart, frozen pizza factory, veterinary clinic, radio station, Taco Bell and area restaurants.

Youth identified that Job Club helped them be more confident with interviewing and job exploration. They also reported that Job Club assisted them learn how to fill out job applications and understand why appearance is so important.

During the summer months, 13 youth participated in ‘The Guest Chef is ... You’ community cooking class. The class was open to all community residents. Youth were coached in a community setting to develop “on the job” skills. This differed from “Job Club” in that this opportunity allowed the youth to find success in a setting other than the classroom, by doing set up and clean up, assisting with registration and payment for the class, ushering community members to the kitchen, as well as learning appropriate restaurant hygiene as it pertained to the preparation of food and serving others.

We had the opportunity to collaborate with several school districts in the Jefferson county community. We educated schools on the Supported Employment model requesting that youth receive school credit for attending. Lessons were developed, attendance and participation was tracked for school credits. Six youth received credit for attending and participating.

### **Teacher Testimonial**

Job Club appears to be a useful tool during adolescence for various reasons. The perspective of which I have is as the special education classroom teacher where I witness the benefits first hand. Social communication is strengthened due to common experiences of the engaging peers. These kids have a sense of value of themselves and others as they share and develop interpersonal skills.

Parent feedback has been positive in relationship building ways. The family bonding and “set aside time” that these outings require, has emphasized the need to put family as a priority....perhaps the first time in a long time. One of the recent exercises was to build as a team a self standing shelter with newspaper and tape. The skills, in part, for this particular activity that were successfully demonstrated included: team-building, job/role delineation, task-analysis, sequencing and problem solving. Hopefully Job Club will continue to be available for many years to come. Congratulations to all involved!

## EARLY INTERVENTION

*~ Early intervention works in partnership with the family to enhance their child's development and support the family's knowledge, skills and abilities as they interact with and raise their child. ~*

The Jefferson County Early Intervention Program, established in 1979, has a strong commitment to working with families and staff as a team to provide the best-individualized program for each child.

The Mission of the Program states that they are committed to children under the age of three with developmental delays and disabilities and their families. They value the family's primary relationship with their child.

They work in partnership with the family to enhance their child's development and support the family's knowledge, skills and abilities as they interact with and raise their child.

The Program staff consists of speech and language pathologists, physical therapists, occupational therapists, service coordinators, educational specialists, and a supervisor. Consultations are done with many other specialists to meet the needs of the families.

A child qualifies for services one of three ways. The first and most common way is by a 25% delay in one area based on a normative test. The second way is a diagnosis from a physician that meets the criteria for the program. The third way is having an atypical development as determined by the team.

### GUIDING PRINCIPLES

- **High Quality:** A commitment to high quality means that our program will develop policies and practices that are found to build professional skills, including ethics embraced by the fields of child development, family development, and help the community understand the importance of the unique nature of infant and toddler development. Program practices must include awareness of both the opportunities for intervention and the fact that young children are particularly vulnerable to the negative caregiving environment.
- **Children's optimal development** depends on their being viewed first as children, and second as children with a delay or disability.
- **Children's greatest resource** is their family. Children are best served within the context of the family. Young children's needs are closely tied to the needs of their family.
- **Parents are partners** in any activity that serves their children. Parents or primary caregivers have a unique understanding of their children's needs.
- Just as children are best supported within the context of **family**, the family is best supported within the context of the community.
- **Professionals** are most effective when they work as a team member with parents and other team members.
- **Collaboration** is the best way to provide comprehensive services. No single agency is able to provide all services to all children and families. Collaboration with local community agencies and service providers

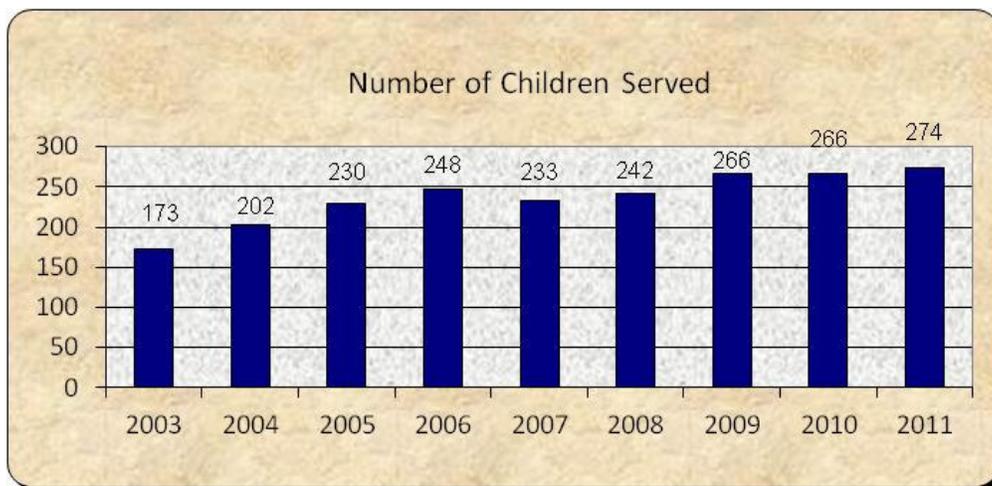
will maximize the resources available to families of young children in a cost-efficient comprehensive manner. No one program can meet all of a child and families' needs and will build strong alliances within the communities they operate.

- **Prevention and Promotion:** The proactive promotion of healthy child development and family functioning begins and continues prenatally, upon birth, and through the early years. It is crucial to emphasize the importance of healthy development and detection of developmental at the earliest possible time. Early intervention enhances the development of children. Early intervention is appropriate for children and families.
- **Our Birth to Three Team** works in the coaching model with the parents to enhance their skills and abilities in helping their child.

After the age of three, a child's education does not end. It is our role to work with the family to find the best "next step" for the child. By age two or before, the discussion of transition begins. A service coordinator will discuss the options. A transition meeting will be held with preschools, HeadStart, Early Childhood, and/or a private agency to discuss the needs of the child and family. A final planning meeting will be held before the child turns three to determine the family's final decision and for the team to finalize coordination of services for the child.

The Early Intervention Program is funded through county, state, federal funds, insurance benefits and the Parental Cost Share. Additionally, we receive funding through the Watertown United Way and other grants.

The chart and graphs below show the enrollment dating back to 2003. It is very important to remember that Early Intervention services are mandated services; therefore, *a program may not have a waiting list*. Every child that qualifies must be served.



	2003	2004	2005	2006	2007	2008	2009	2010	2011
Total Number of Children Served	173	202	230	248	233	242	266	266	274
Hispanic Families Served	24	25	40	41	39	18	23	52	45
Black Families Served	0	0	0	5	3	2	6	8	5
Asian Families Served	0	0	3	4	2	2	3	5	3
Pacific Islander Families Served	0	0	0	0	0	1	0	0	1

In addition to the 274 families that were served in 2011, 98 more families were offered services/provided screenings and evaluations. We have seen a substantial increase in our CAPTA ( Child Abuse Prevention Treatment Act) referrals. These are referrals from our Intake Department that involve child abuse or neglect of a child.

### SUMMARY OF DATA

As shown by the above data, the Early Intervention Program has seen an increase in referrals. The program has more service coordination with families due to the complex issues that face families such as poverty, homelessness, mental health, AODA, job loss and stress. The Department of Health and Family Services has not changed the qualification criteria; therefore, we hope the program will continue to receive many new referrals.

### REVIEW OF 2011

#### All goals established were accomplished including:

- Increased enrollment in the Busy Bees Preschool. *Didn't meet goal of 12 children per day.*
- Participating in Child Find activities. *This goal was met.*
- Providing service coordination to families. *This goal was met.*
- Implementing the Incredible Years Parenting Program. *This was met and our staff was directly involved as leaders and provided child care to the families.*

### GOALS FOR 2012

#### Birth to Three Program & Busy Bees Preschool

A. Continue “**Child Find**” activities under DHS 90. Our goal is to participate in two more awareness activities in the community during the year. This could include: Resource Fairs, School Early Childhood Screenings, Child Care Provider meetings, and other meetings with agencies and teams within the Department of Human Services.

B. Continue to provide service coordination and teaming approach to our families to ensure that families have access to all resources. The program will have 80% billable time. This will be monitored by the EDALS and QA reviews.

C. To have Birth to Three Program staff an active part of the **Incredible Years Parenting Program Team** and implement it within the program and with our families and in the agency.

D. The Birth to Three Team will implement evidenced based practices in Early Childhood intervention. The staff will use the Primary Service Provider/Coaching Approach with our families. The approach is a facilitative

process that enables parents and teams to acquire and improve new and existing skills and help with competence and performance and effectiveness of the child's goals and outcomes in Birth to Three Program.

E. Busy Bees Preschool will complete the YoungStar (Wisconsin's Child Care Rating Program) process and try and receive a 3 or higher rating. This system and the rating are awarded based upon points earned across four categories: education, learning environment and curriculum, professional and business practices and child health and well-being practices. *This was accomplished as of March 2012 with a YoungStar rating of 4.*

F. To continue to have Birth to Three staff work in a collaborative team approach with other agency teams and community partners so that staff are better informed of the current family situations and are able to meet the needs more effectively.



## BUSY BEES PRESCHOOL

*~Busy Bees Preschool provides positive early learning experiences throughout a fun-filled morning with a structured routine and age appropriate activities~*

Busy Bees Preschool is a preschool for two and three year old children that opened in September 2005. The preschool is open four mornings a week from 8:30 a.m. to 11:00 a.m. The students are enrolled in either a Monday/Wednesday or Tuesday/Thursday morning program. The preschool runs from September through May and a summer session is also offered in July and August. Enrollment can be up to twelve children per day. The students who enroll in Busy Bees Preschool are a combination of community peer models and children enrolled in the Birth to Three Program.

Busy Bees Preschool provides developmentally appropriate activities in a seasonal thematic manner. The preschool day is presented with a consistent routine for the young children who attend. The activities emphasize language and concept development through free play, music, finger plays, books, gross and fine motor activities, art experiences, and daily living skills, including a snack time and bathroom routine. The lesson plans incorporate all developmental domains and follow the Wisconsin Model Early Learning Standards.

The preschool is staffed by three full time educators with over twenty-five years of combined experience working with young children. All of the teachers obtained Bachelor's Degrees in Education and hold current Wisconsin Teaching Licenses in the area of Early Childhood. The teachers are also part of the Wisconsin Registry for Educators. In addition, licensed speech therapists, an occupational therapist, and a bilingual service coordinator provide support to students who require intervention in order to provide a positive and productive early educational experience at Busy Bees Preschool.

Busy Bees Preschool continues to provide a positive learning experience by providing a fun-filled, enriched morning with structured routine and consistent behavioral limits. Children increase their social skills, self-esteem, and overall confidence through understanding and succeeding at our preschool. It is a place for children to develop independence and learn to BEE themselves!

## CHILD ALTERNATE CARE

*“Alternate Care services were developed to provide for the physical, emotional, and social needs of the child until the child can be reunited with his or her family.”*

Our Alternate Care services provide access to a wide range of services and out-of-home placement options for children. Alternate Care remains a very important priority service and great care is taken in making these placements. These services were developed to provide for the physical, emotional, and social needs of the child until the child can be reunited with his or her family. When this is not possible, other forms of permanency are utilized such as independent living, guardianship, adoption and long-term placement arrangements. It is intended that through respites, short-term placements, regular family interactions, and supportive services, children will be reunited with their families. Out-of-home care providers are an integral part of a team concept working toward the goal of successful permanency. Individuals who need out-of-home placement require a great deal of social work time, effort and funding in order to achieve a successful return to home.

### ALTERNATE CARE PHILOSOPHY

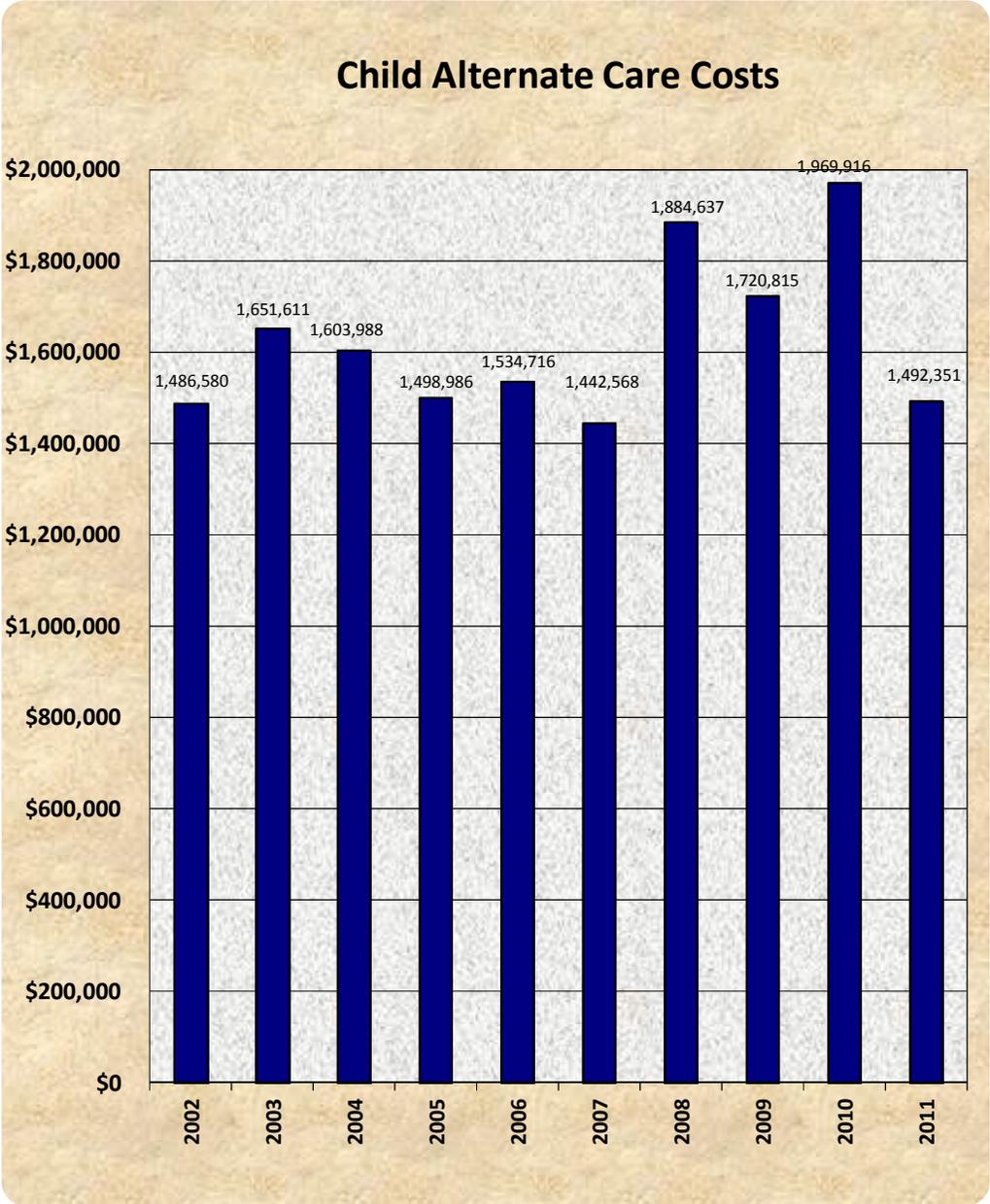
- To avoid placements whenever possible, by providing protection, support and services in our communities.
- To work towards permanence for the child from the moment of out-of-home placement. The first choice is often to strengthen the child’s family system and reunify that child.
- To keep placements short in duration and make them within the community whenever possible.
- To identify the factors in the family that create unsafe situations, as well as the family strengths and resources to build upon positive pre-existing conditions while dealing with the underlying needs.
- To minimize the use of institutional placements by creating unique community options with providers.

In 2011, the number of youth placements decreased from 185 to 147. While some youth had more than one placement, this decrease of 38 youth is substantial. We were also required by state mandate to license kinship homes (children residing with a relative) as “Level One” foster homes. Our department licensed homes and placed 71 children into Level One and/or kinship homes (family members) to avoid a more restrictive placement setting with a caretaker who they are unfamiliar with.

The licensing of these kinship homes has required additional staff time and resources. Additionally, we were required to further implement the levels of care licensing for all children’s alternate care providers. The level of care needed is determined by the child abuse and neglect assessment tool. Rates for all providers are set by the state.

In 2011, the department decreased spending on alternate care for children by \$477,565 or a decrease of 76% from last year. This is of course a huge priority and concern for the department each and every year, both fiscally and for child well being. Children and adolescents need permanence, safety, and well being, and while out-of-home placements and multiple placements are necessary to assure safety at times, we know that these situations can be associated with poor lifetime outcomes for children. The department accomplished this decrease in several ways. We have continued to contract with the state to retain legal counsel for situations that require termination of parental rights. We are continuing to use the Community Recovery Service benefit (C.R.S.) for youth who have mental health needs, which allows for more in home supports. We are increasing

the number of children on long term support waivers and are implementing parenting coaches. In 2011, the department began to utilize subsidized guardianships as an option through Chapter 48 of the children’s code to assist children in achieving permanency through a funded guardianship, in cases that otherwise would result in long term out-of-home placement. Finally, our department relies on the use of respite care to avoid a long term placement by providing a short reprieve for parents and their children. We provided 483 respite opportunities in 2011, with a great deal of youth accounting for multiple respites to avoid high cost and traumatic placements. We are confident these services will provide better outcomes for our the youth of Jefferson County.



The following data exemplifies Jefferson County's placement of youth into some form of out-of-home care from 2004 through 2011. Some individuals required more restrictive placements in institutional settings. However, we continue to take strong measures to avoid these. Because the needs of children who require alternate care are high, programming efforts, particularly mental health services, are used in conjunction with placements.

### ALTERNATE CARE PLACEMENTS - CHILDREN

PROGRAM	2004	2005	2006	2007	2008	2009	2010	2011
Foster Care (In-County)	24	30	28	46	25	34	53	61
Foster Care (Out-of-County)					14	13	16	37
Treatment Foster Care (In-County)	6	12	7	7	2	9	11	3
Residential Care Center (Child Care Ir	17	7	5	8	8	13	18	6
Child Correctional	4	3	1	1	1	1	4	3
Child Mental Health Institute	4	4	3	4	2	2	2	1
Out-of-County Treatment Foster Hon	11	12	21	22	27	33	52	24
Out-of-County Group Homes	17	23	17	12	14	16	29	12
<b>TOTALS</b>	<b>83</b>	<b>91</b>	<b>82</b>	<b>100</b>	<b>93</b>	<b>121</b>	<b>185</b>	<b>147</b>

### Detention Placements

A final related statistic in the Child Alternate Care area is our use of secure detention (locked juvenile detention facilities) for youth. During 2011, 47 youth were placed in these facilities at a cost of \$33,340, which is a decrease from 69 youth in 2010 at a cost of \$78,790. This is a cost savings of \$45,450 or 42%. These placements are either made by the Juvenile Court or by Human Services staff in order to provide community protection or to sanction youth for violation of a court order. Many alternatives to the use of secure detention were utilized to decrease the number of these placements such as Intensive Supervision, electronic monitoring, respite at group homes, and other deterrents made via the case manger and the treatment team.

### DETENTION CENTER PLACEMENTS

COUNTY	NUMBER OF PLACEMENTS	TOTAL COST
Marathon	1	\$ 450.00
Portage	1	\$ 450.00
Rock	63	\$ 73,920.00
Washington	1	\$ 345.00
Waukesha	3	\$ 3,625.00
<b>TOTALS</b>	<b>69</b>	<b>\$ 78,790.00</b>

## CHILDREN'S LONG TERM SUPPORT WAIVER PROGRAM (CLTS)

~ Programs that allow for assessment of the children and family needs and supporting plan for the provision of services~

**Mission Statement:** Assist children with disabilities and their families to remain together and safe in their own homes and communities by providing them with individualized services to meet their needs.

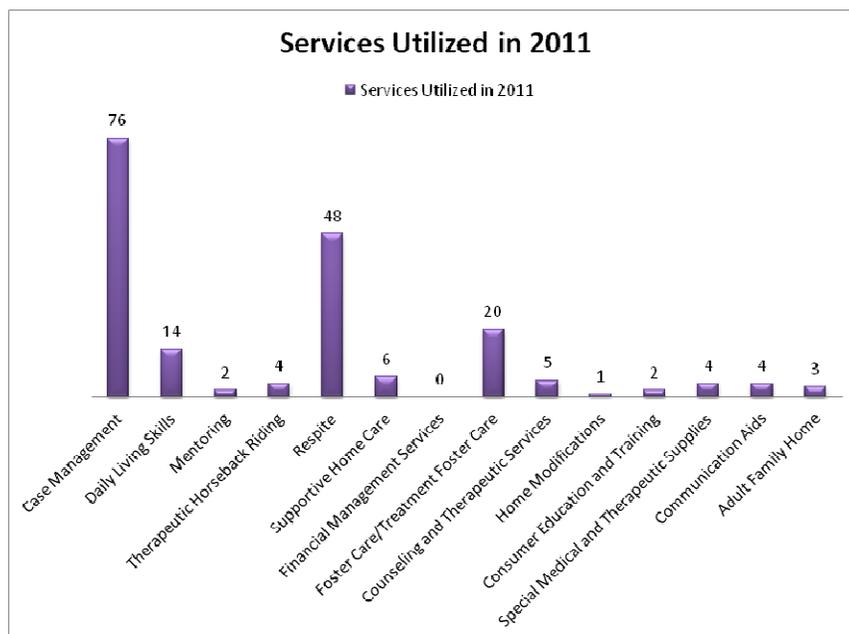
The children's long term support team provides services to children who are eligible for Medical Assistance and have met the criteria as developmentally disabled, physically disabled or are severely emotionally challenging. These children can be served through the children's long term support waiver or the family support program. These are programs that allow for assessment of the children and family needs and supporting plan for the provision of services. The purpose of the waiver is to help families support their children with severe disabilities within their own home.

- In 2011 seventy six children received long term support services compared to sixty nine children in 2010.
- In 2011 the total cost for foster care (waiver children only) was \$481,512

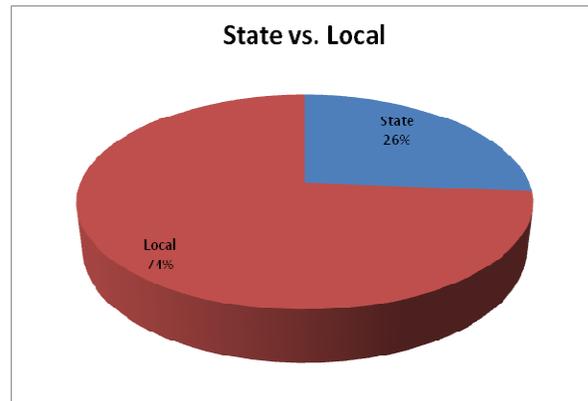
- Federal Share = 60.38% = \$290,736
- Tax Levy = \$190,775

- In 2011 – 2012 there are sixty six children that continue waiting for services

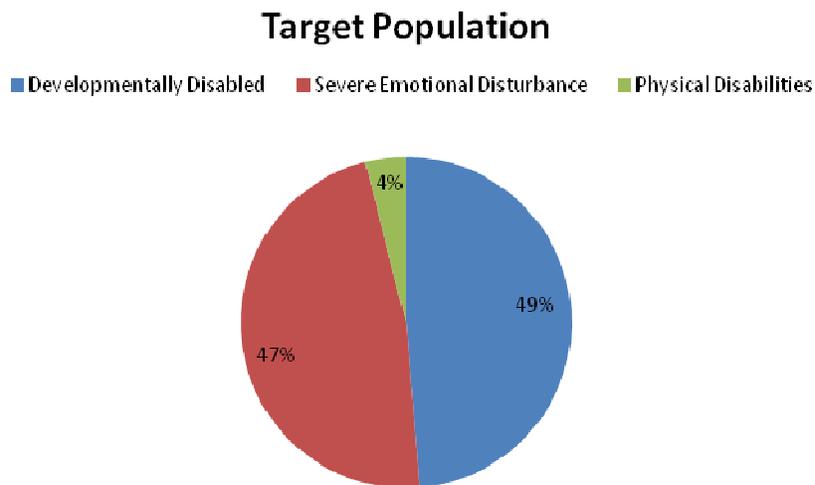
**The CLTS Waivers covered a broad range of services for 2011 depending on the child's and family's identified needs**



## The CLTS Waivers are funded through Medicaid and local funding



The following chart identifies the target population served for 2011



### 2012 Goals:

1. Develop a rate setting tool for consistency of payment for contracted providers
2. Develop a methodology for 100% accuracy for quality assurance of audits internally and externally
3. Use the NIATx to find efficiencies.

## INDEPENDENT LIVING PROGRAM

*~To help young adults become independent, responsible and productive members of society when they reach adulthood~*

### **Youth in out-of-home care ages 15-17**

The Independent Living Program is a partially Federally sponsored program for youth in out-of-home placement to help them enhance personal daily living skills that will help them become independent, responsible, self sufficient and productive members of society when they reach adulthood. This is a mandated service for any youth 15 - 17 yrs of age and 6 months placement in out-of-home care.

Youth in out-of-home placement, ages 15-17, complete a life skills assessment and develop an individual living transitional plan with the assistance of the Independent Living Services Coordinator. Youth develop personal goals and identify individuals who can assist them in reaching their goals while supporting their transition from a youth to a young adult. Services are provided on an individual basis or in a group setting when appropriate. Transition goals are developed by the youth with the assistance of the Independent Living Services Coordinator, on-going case worker, foster parents or group home provider and the youth's natural supports, such as parents, grandparents, aunts and uncles, cousins, friends, teachers, faith providers, and other community members the youth feels makes a positive difference in their lives. Progress is monitored by team members on a regular basis.

For 2011 there were 17 youth ages 15-17 eligible for Independent Living Services. Eight of these youth resided in another county. All of these youth received an Independent Living Services assessment and had face to face contact with the Jefferson County Independent Living Coordinator.

### **Youth ages 18-21 no longer in out-of-home care**

Young adults ages 18-21, who are no longer in out-of-home care, but aged out, complete a life skills assessment to determine the areas of on-going need, identify personal goals and develop a transitional discharge plan. The transitional discharge plan incorporates the youth's on-going needs with their personal goals. The Independent Living Services Coordinator assists the youth with their transitional discharge plan and offers assistance with educational planning, career development, employment, housing, transportation, child care issues, family planning, accessing community resources, managing AODA issues, building healthy relationships, risk prevention as well as other concerns the youth might be experiencing or may be expected to encounter.

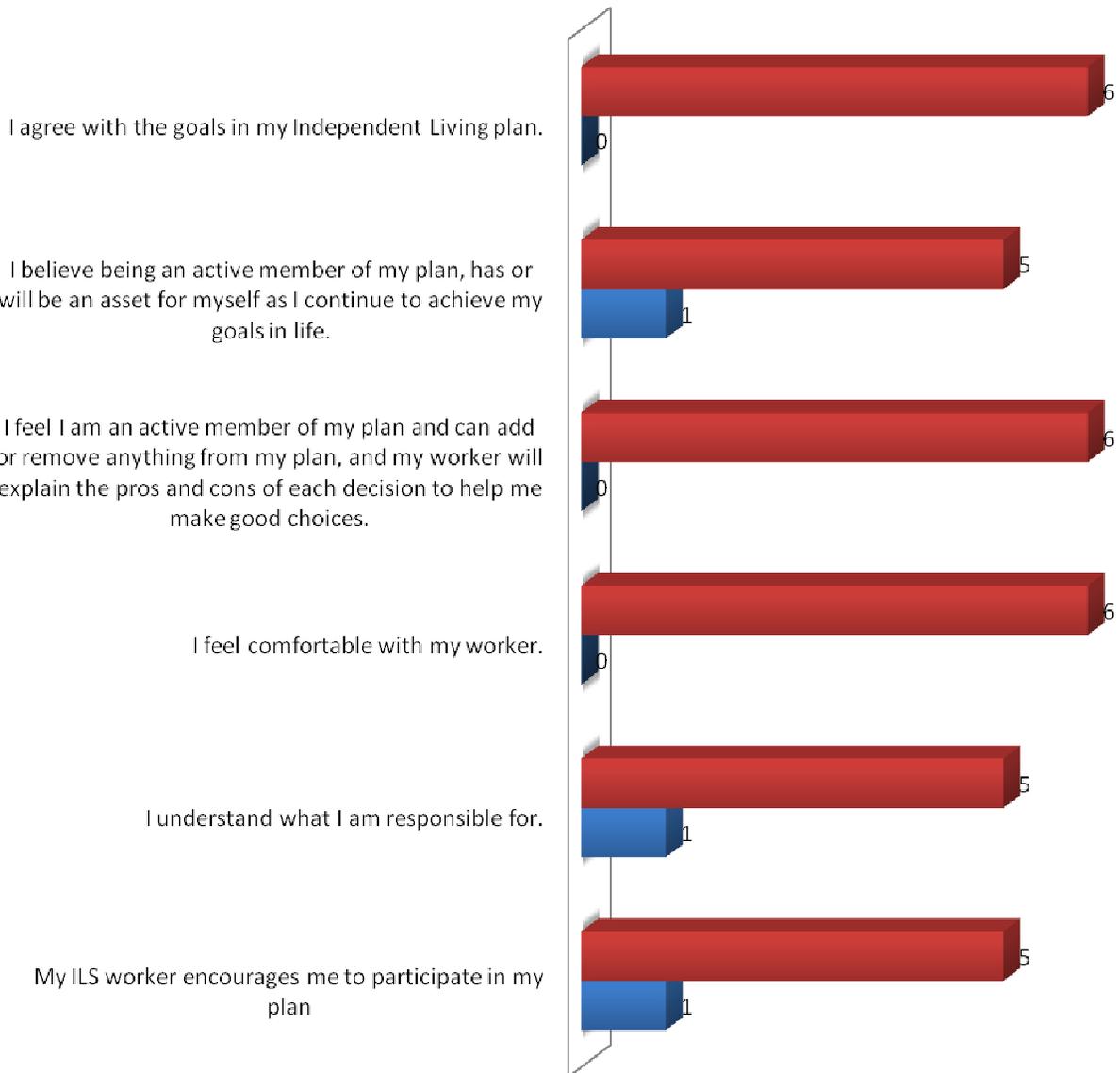
In 2011 there were 7 youth ages 18-21. These youth continue to be supported through the IL program. One youth is attending post secondary education.

**ACTIVITIES THAT WERE CONDUCTED DIRECTLY WITH IL YOUTH IN 2011**

<u>Activity</u>	<u>Setting/Structure</u>	<u>Level of Success</u>
Job Club	Career Development – in the community <ul style="list-style-type: none"> <li>➤ Identified strengths</li> <li>➤ Identified skills</li> <li>➤ Completed resume worksheet</li> <li>➤ Job Searching</li> <li>➤ Obtaining a worker permit</li> <li>➤ Practiced interviewing skills</li> <li>➤ Toured facilities for job opportunities</li> </ul>	5 - Youth completed 3 – Have obtained employment
Life Skills Assessment	Foster care, treatment foster care, group home, residential treatment setting, relatives home, library, agency, school	All IL youth have completed their assessment
Job Searching	<ul style="list-style-type: none"> <li>➤ One on one using the customized employment model</li> </ul>	3 – Youth have obtained employment
Housing Assistance	<ul style="list-style-type: none"> <li>➤ One on one with Community Action and other housing resources</li> </ul>	2 - Youth have secured housing
Children’s Come First Conference	<ul style="list-style-type: none"> <li>➤ Foster care youth received Outstanding Youth award</li> </ul>	Youth attended the conference
High School Education	<ul style="list-style-type: none"> <li>➤ Youth received school credits for outside activities completed in the community.</li> </ul>	Youth graduated from High School
Post Secondary Education	<ul style="list-style-type: none"> <li>➤ Touring MATC</li> </ul>	1 – Youth is attending Madison Area Technical College
Cooking Class – The Chef is You...?	<ul style="list-style-type: none"> <li>➤ Focused on teaching basic healthy cooking, eating and food storage techniques.</li> </ul>	This class was held at the Rock Lake Community Center with 4 youth attending

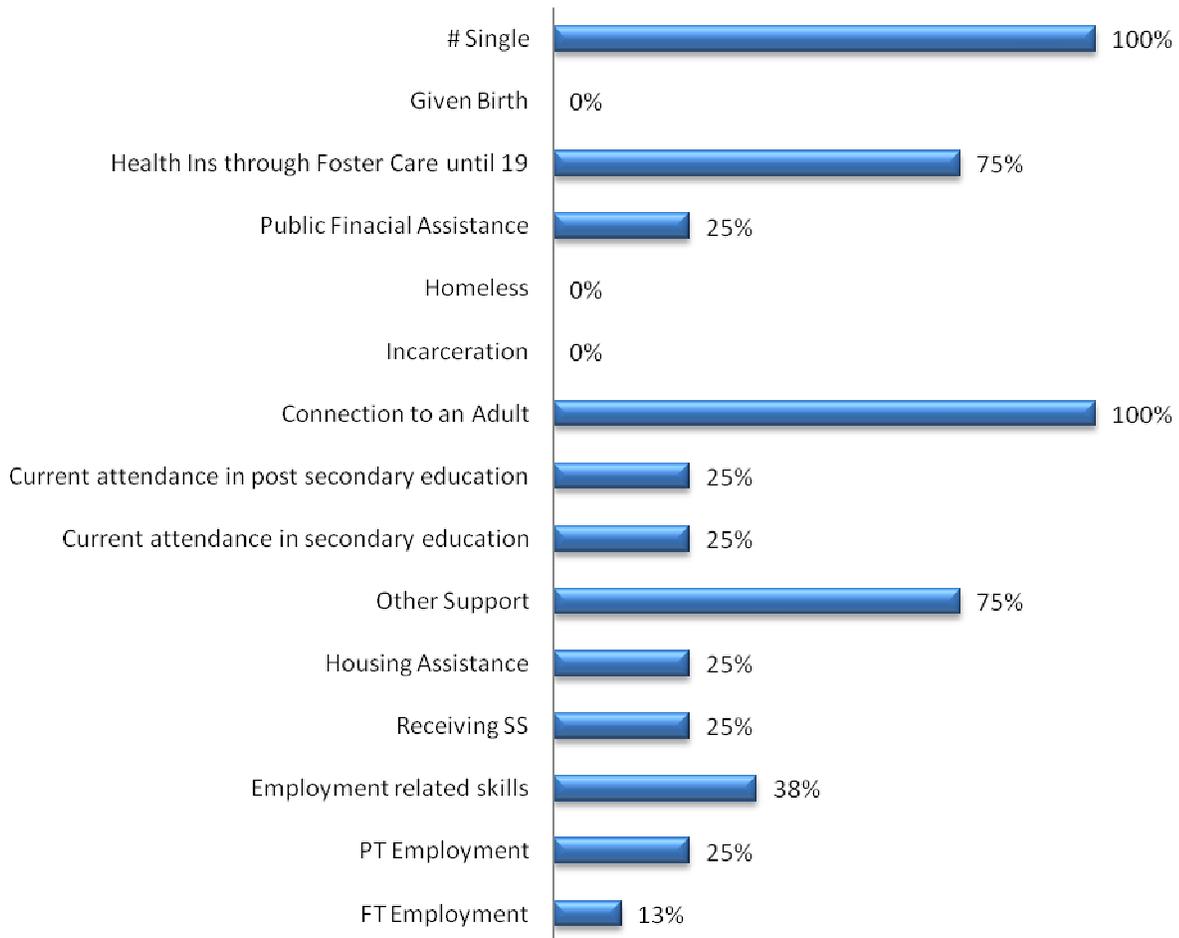
## 2011 Youth Reported Survey Results

■ Strongly Agree/Agree ■ Neutral

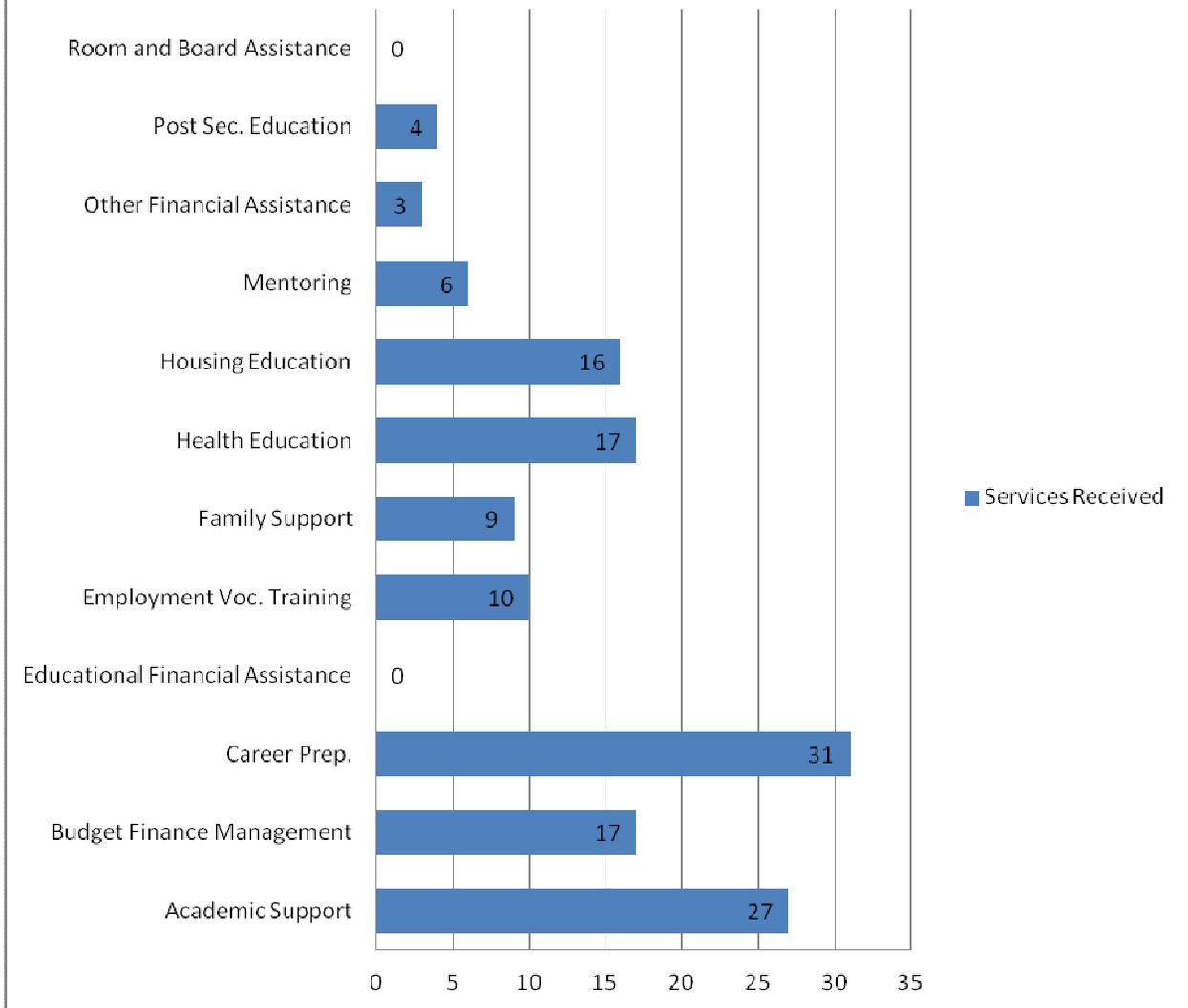


## 2011 Independent Living Services Outcomes for Youth 18-20 Years of Age

■ Youth Responses to Survey



## Services Youth Received in 2011



### 2012 Goals:

1. Develop a resource manual for youth aging out of the foster care system.
2. Increase youth's participation of post secondary education by 15% through touring colleges and technical schools and eliminating barriers for success as evidenced by eWisacwis reporting.

## BEHAVIORAL HEALTH DIVISION

*~ Participants of the program are assessed for strengths and needs; the principles of hope and empowerment are integrated into our service.~*

The Behavioral Health Division continues to be person centered, recovery focused, and committed to delivering evidence based practices. Over the last year, we again experienced an increase in the need and demand from our residents for Mental Health and Substance Abuse services. The chart below is a visual representation of the increase.

### Client Visits for Mental Health Services

2010	9920
2011	11826

### The Behavioral Health Division is organized into four areas:

- Mental Health & Alcohol and Other Drug Abuse Clinics and Intoxicated Driver Program
  - Community Support Program
  - Comprehensive Community Services
    - Emergency Mental Health

### Mental Health/Alcohol and Drug Outpatient Clinic And Intoxicated Driver Program

*~ Participants of the program are assessed for strengths and needs; the principles of hope and empowerment are integrated into each person's plan.~*

The Mental Health, DHS 35/Alcohol and Other Drug (AODA), DHS 75 Outpatient Clinic serves primarily adult Jefferson County residents with mental health and substance abuse concerns. In 2011 there were 198 new consumers opened to the Mental Health clinic and 138 new consumers opened to the AODA clinic. The clinic provided mental health services to 541 individuals and substance abuse services to 225 individuals.

### Number of Clients seen in the outpatient clinics

	2008	2009	2010	2011
<b>MH Clinic</b>	294	332	478	541
<b>AODA Clinic</b>	246	207	217	225
<b>Totals</b>	540	539	695	766

Participants of the program are assessed for strengths and needs; the principles of hope and empowerment are integrated into the clinic service. A treatment plan is created using the consumer's own strengths and resources to increase their potential for leading the life they want. Services are provided in the least restrictive setting; decreasing the disruption of the individual's life while still providing for recovery.

The clinic staff consists of the Medical Director/Psychiatrist, seven full-time staff with master's degrees in Social Work, Counseling or Psychology, one of whom works part-time in the jail, a Community Outreach Worker, and two full-time intake workers through the emergency mental health program. Four clinic staff members have their substance abuse specialty authorization and four staff members are currently in the process of obtaining their authorization.

The clinic is also responsible for overseeing civil commitments and in many cases, providing treatment for the individual. Under WI § 51, persons who are assessed to be dangerous to themselves or others and have a mental health disorder may be detained involuntarily. If the court determines that these persons need to be treated, they are placed under an order for treatment, typically for 6 months. The person can seek treatment from the clinic, or if the person has other resources by another area provider. Clinic staff provided mental health treatment to an average of 231 people on a given month in 2011, an average of 31 of those individuals were court ordered. The clinic (the 51.42 board representative) is responsible for supervising the commitment period and ensuring that the individual is following through with the treatment recommendations regardless of where treatment occurs.

Under WI § 51.45, a person incapacitated by alcohol shall be placed under protective custody by a law enforcement officer and taken to an approved treatment facility. Prior to discharge, the individual is informed of the benefits of further diagnosis and appropriate voluntary treatment. Upon discharge from such facility, the department is then responsible for arranging transportation for such person whether it's via Human Services staff or communicating with and arranging for family to provide transportation. If there is a concern about the individual's well-being, the department intake staff meets with the individual face to face to complete an assessment and the appropriate referral is made; whether it is an emergency detention, voluntary hospitalization, residential treatment, intensive outpatient, or outpatient services to include individual and possibly group therapy.

### **Public Intoxication Data for Jefferson County**

	<b>2010</b>	<b>2011</b>
<b>Admissions</b>	101	122
<b>Individuals</b>	75	91
<b>Individuals with multiple admissions</b>	8	16
<b>Days</b>	113.6	119.64
<b>County Expenditures</b>	\$44,778	\$58,291

In reviewing individuals with multiple admissions; five of those individuals have completed residential AODA treatment and have remained sober since. One individual moved to Dane County and reports sobriety. One individual is actively participating in outpatient AODA treatment and mental health treatment at the outpatient clinic, is attending AA meetings and reports sobriety.

The intoxicated Driver Program (IDP) is mandated under HFS 62. Each county is responsible for establishing and providing substance use assessments of drivers who have received an operating while intoxicated (OWI) ticket. The assessment can be ordered by the court or the Department of Transportation. The IDP assessor completes an assessment using the Wisconsin Assessment tool. A driver safety plan is developed based on the results of the assessment. A person can be sent for either education if a substance disorder is not found or treatment, if a substance disorder is found. The individual is responsible for completing the Driver Safety Plan within a year's time. Failure to complete the driver's safety plan will result in the driver's license remaining revoked. In addition to doing the assessments, the assessor is responsible for monitoring the individual's compliance with the Safety Plan. The clinic has one full time assessor.

In 2011, the IDP program completed 368 assessments and driver safety plans. This was a 7% decrease from 2010. Of those 368 assessments in 2011, 186 were first time offenders, 93 were second time offenders, 52 had three lifetime OWI's, 20 had four lifetime OWI's, and 16 had five or more lifetime OWI's. Group Dynamics is a 24 hour education program for first time offenders. Multiple Offenders is a 36 hour education program for individuals with more than one OWI offense. 156 offenders were referred to Group Dynamics and 40 were referred to the Multiple Offender Program. A total of 172 individuals were referred to outpatient substance abuse treatment. Of those, 65 were referred to the Jefferson County Human Service Outpatient AODA Clinic due to lack of insurance.

### **Consumer Satisfaction**

In 2011 the Outpatient Clinic conducted a consumer satisfaction survey. The ROSI (Recovery Oriented System Indicators) measures the satisfaction of the participant and the degree to which its services are recovery oriented. The survey asks 42 questions regarding the participant's experiences in the past six months. The choice of responses range from strongly disagree to strongly agree and includes an option of does not apply to me. The questions rate 6 areas of service: Person Centered Services, Barriers to Success, Empowerment, Employment, Staff Approach and Basic needs. Consumers were asked to complete the anonymous survey by reception staff, prior to meeting with their clinician/counselor. 53 surveys were completed which is a 44% increase from last year.

## Consumer Survey Results

	ROSI Overall Mean	Scale 1— Person Centered	Scale 2— Barriers	Scale 3— Empowerment	Scale 4— Employment	Scale 5— Staff Approach	Scale 6— Basic Needs
Average for all consumers	3.3	3.6	2.1	3.4	3.5	1.8	2.8
% with mostly recovery- oriented experience	84.9%	90.4%	44.2%	83.0%	72.9%	65.4%	66.0%
% with mixed experience	15.1%	7.7%	36.5%	17.0%	22.9%	17.3%	15.1%
% with less recovery oriented experience	0	1.9%	19.2%	0	4.2%	17.3%	18.9%

In looking at the means, these numbers can range from 1.0 to 4.0 with 4.0 being the highest, although scales 2 and 5 (the shaded areas) are negatively phrased which means a low mean represents a more recovery oriented experience.

Person centered approach continues to be an area of strength and even increased a percentage from last year. Staff continue to support consumers in self-care and wellness. Staff treat consumers with respect; they listen carefully, focus on strengths, and see consumers as an equal partner in their treatment program.

An area of concern is the barriers scale which addresses having the support to function in the community, having good service options to choose from, understanding the consumers experiences, getting services when the consumer needs them, having information or resources needed to uphold clients and human rights. Staff participated in person centered planning training in November of 2011. This training focused on a collaborative strength based approach to treatment planning that is consumer driven. Barriers will also continue to be addressed in 2012 by participating in quality improvement projects looking at staff availability.

### Review of 2011 Goals

1. **The outpatient clinic will continue to address the increased demand for services.** The clinic saw a 67% increase in the demand for their services in 2010. This need was met by the addition of one full time behavioral health specialist.
2. **The outpatient clinic will address staff approach.** All clinic staff participated in a full day of person centered planning training, sponsored by the Division of Mental Health and Substance Abuse Services.

3. **The outpatient clinic will address staff approach** by changing and improving the opening process in 2011. Clinic staff members have been participating in quality improvement projects that have resulted in two changes to the opening process. These quality improvement projects will continue throughout 2012.
4. **The outpatient clinic will address staff approach** by participating in AODA trainings in 2011. Three clinic staff attended the Wisconsin Association on Alcohol and Other Drug Abuse, Inc. Conference in 2011. One staff member attended a 2-day conference on motivational interviewing. Two staff members attended the annual Crisis Conference. Three staff members attended the annual Mental Health and Substance Abuse Conference.

### **2011 Evidenced Based Practices**

1. Motivational enhancement therapy techniques-- (MET) is an adaptation of motivational interviewing (MI) that includes one or more client feedback sessions in which normative feedback is presented and discussed in an explicitly non-confrontational manner. Motivational interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve their ambivalence and achieve lasting changes for a range of problematic behaviors. This intervention has been extensively tested in treatment evaluations of alcohol and other drug use/misuse. (<http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=107>). The clinic is utilizing this style of therapy in both group and individual sessions.
2. Medication assisted treatment for opioid addiction via the use of Buprenorphine. (<http://www.ncbi.nlm.nih.gov/books/NBK64164/>). The clinic ran approximately four different Buprenorphine maintenance support groups throughout 2011. There was an average of 85 consumers in the Buprenorphine maintenance program.
3. Seeking Safety is a present-focused therapy to help people attain safety from trauma/PTSD and substance abuse. It has been conducted in both group and individual sessions. Seeking Safety consists of 25 topics that can be conducted in any order. At this point, Seeking Safety is the most studied treatment for PTSD-substance abuse. Twelve outcome studies are completed, plus one dissemination study. (<http://www.seekingsafety.org>)
4. Cognitive behavior therapy (CBT) is based on the scientifically supported assumption that most emotional and behavioral reactions are learned. Therefore, the goal of therapy is to help clients *unlearn* their unwanted reactions and to learn a new way of reacting. (<http://www.nacbt.org/whatiscbt.htm>)

### **2012 Goals**

1. Implementation of person centered planning
2. All behavioral health staff trained in Cognitive Behavior Therapy
3. Implement Cognitive Behavioral Therapy into treatment plans
4. Quality improvement initiative by continuing to participate in NIATx projects
  - a. Exploration of electronic health records (STAR SI NIATx project)
  - b. Pre and post data collection examining the implementation of person centered planning
  - c. Examination of waiting times and the opening process
  - d. Clinical outcomes tracking quality improvement project (STAR SI NIATx project)
5. Drug task force training for clinic staff

6. Uniform Placement Criteria (UPC) training for all clinic staff
7. Increase the number of consumer satisfaction surveys received by at least 10%
8. Integrate health care questions into our assessment and facilitate follow-up with primary care provider
9. Implement standardized rating and tracking of consumer outcomes

## **COMMUNITY SUPPORT PROGRAM**

*~CSP has been successful in helping consumers meet their goals and enhance the quality of their lives in the most cost effective manner~*

The Jefferson County Support Program was developed in December of 1996 and began receiving clients in January 1997. This Community Support Program was certified on June 1, 1997 and is certified under HSS 63 as a Community Support Program. The program was audited by the state in May 2010 and was recertified for two years at that time. It will again be audited in spring of 2012.

In its thirteenth year of operation, the Jefferson County Community Support Program provided services to 142 consumers ranging in age from 11 to 76. These consumers had mental health diagnoses such as schizophrenia, schizoaffective disorder, bipolar, major depression and various anxiety disorders. In 2011, 17 consumers were admitted and 9 were discharged.

Jefferson County Human Services CSP has grown significantly. In 1998, it served less than thirty consumers, and employed five and a half staff. In 2011, the CSP staff consisted of a CSP Director/Clinical Coordinator; psychiatrist/medical director; program assistant; part time secretary; two full time and one part time mental health technicians two of whom were also peer support specialists; one vocational specialist; one part time nurse; and eleven case managers/CSP professionals.

Community Support Programs in the state of Wisconsin have an extensive and well researched history. The original CSP started out of Mendota Mental Health Institute in the 1980's and is now known as ACT. The ACT model has received numerous awards from the American Psychological Association for its research. It is now used on a nationwide and international basis to advance the mental health services for people with a severe and persistent mental illness. It has proven effective for reducing symptoms, hospital costs, and improving overall quality of life. The research has shown that for outcome measures to be similar for consumers in other CSP's it is important to have as much fidelity to the ACT model as possible. Jefferson County CSP continues to have very high fidelity to the ACT model and the team functions as an ACT team. It is believed that this led to better outcomes for our consumers.

In accordance with the ACT model, the Jefferson County CSP has the capacity to function as a mobile in-patient unit. The program provides psychiatric services, symptom management, vocational placement and job coaching, supportive counseling, opportunities for social interactions, individual and group psychotherapy, medication management and distribution, education and money management and budgeting, coaching in activities of daily living, including how to maintain a household and homemaking skills, crisis intervention, case management and supportive services to people with severe and persistent mental illness. All consumers in the CSP, at some time, have had acute episodes that have resulted in the need for frequent psychiatric hospitalizations and emergency detentions to institutes for mental disease. Consequently, in the past, their lives were disrupted and they were removed from their community of choice. Presently, CSP services can be titrated up and down quickly as the need for more intensive treatment arises.

Jefferson County's CSP also provides consumers the evidence based practices (please see sections below for detail) of Illness Management and Recovery, Integrated Dual Diagnosis groups for those with substance abuse issues, Supportive Employment, Family Psychoeducation, Seeking Safety, and DBT. Consumers also are encouraged to complete Wellness Recovery Action Plans; these plans specify what is helpful for the person in a crisis situation and function similar to a psychiatric directive.

It is believed that due to these combined efforts, the Jefferson County CSP was successful in helping consumers meet their goals and enhance the quality of their lives in the most cost effective manner.

**Some of the specific accomplishments for the year 2011 include:**

1. Four consumers, who were on Chapter 51 orders, successfully completed his or her court requirements.
2. Two consumers resumed managing their own money as their skills were enhanced and the protective payeeships were dismissed.
3. Twenty percent of consumers worked in a job of their choosing.
4. Twenty one consumers served the community through volunteer work at such places as Fort Atkinson Memorial Hospital, St. Vincent's, nursing homes, the library, CSP consumer council, and Horizons Drop In Center.
5. Five consumers pursued educational goals. Two of the consumers attended the UW Whitewater, two went to MATC, and one pursued an HSED degree from MATC.
6. All goals were met from last year's report. These will be reviewed below in detail.

**Review of Goals from 2011**

**There were eight program goals established for 2011.**

**Goal number one:** Implement the NIATx change model to reduce hospital admissions at the CSP.

The CSP was involved in a NIATx project with the state to reduce hospital readmissions. NIATx is an evidenced based rapid change cycle model where changes are implemented for process improvement. The changes are focused on reducing waiting times and increasing retention in behavioral health treatments. The model consists of four stages including Plan, Do, Study, and Act. In the Act phase a decision is made to adopt, adapt, or abandon the change.

In April, the CSP formed a change team consisting of CSP staff and the Lueder Haus Manager. Baseline hospital admission data was collected for 2010. It was decided to also look at the effects of the change projects on the length of admissions at the Lueder Haus. During the summer, two changes were implemented. The team developed and implemented a standard admission process for the Lueder Haus. They also worked on ensuring that all the treatment goals for the Lueder Haus stay were measurable and specific.

The changes were both deemed to be effective and were adopted as policy. The hospital admissions were reduced from five to four and a half admissions per month. The average Lueder Haus admission was decreased from nine and a half days to seven and a half days. All results were shared with other counties participating in the project at a conference in Madison in October. The team had a positive experience with the process and it was decided to continue the NIATx model in 2012.

**Goal number two:** Monitor the edal records weekly and strive to achieve all staff billing at 80%.

Reports were run of the employee's billable hours. A goal of 80% billable time was set to ensure that each clinician is spending as much time as possible working directly with the consumers to provide effective treatments. A summary of these percentages was sent to the Human Services Director every two weeks. Emails with their progress toward the goal of 80% billable time was sent to each employee with feedback solicited when the goal was not attained. Adjustments to caseloads were made based on the billing numbers. Problem solving was engaged when issues arose. Of the eight existing staff that worked throughout 2011, two met or exceeded the goal. Three new staff were hired and their percentage was lower due to their training period and the progressive development of their caseloads. The team averaged 75% billable hours per week. This monitoring will continue into 2012.

**Goal number three:** Begin accessing CRS and DVR funding resources for people involved in the Supported Employment Program at the completion of the grant.

The grant to fund the supported employment program ran out in 2011. Funding was sought to continue the program and fund the vocational specialist position. Two consumers open to the grant were admitted to the CRS (Community Recovery Services) program which provides funding for vocational supports. DVR (Department of Vocational Rehabilitation) referrals were made for existing and new participants in the supported employment program. There continues to be some issues with this since the goal of the supported employment program is to begin a rapid job search when an individual expresses an interest in work and there currently is a waiting list for DVR services of up to six months at times. When people actually are accepted into the program there has been an improvement in coordination between the two teams.

**Goal number four:** Continue to work toward training staff in and implementing Trauma Informed Care.

On March 30<sup>th</sup>, 2011, seven CSP case managers attended the training "Building a Trauma Informed Community" presented by Dr. Robert Anda and Dr. Bruce Perry, experts in the field. The Supervisor of CSP and the agency Director attended a training on "Clinical Supervision of Trauma-Informed Treatment" led by Laurie Anne Pearlman and Elizabeth Hudson on September 16<sup>th</sup>, 2011. More emphasis continued to be placed on trauma histories and the effect it has on current consumer functioning in the community. This was discussed in team meetings and individual supervision sessions. The mental health team has expressed an interest in doing more training on secondary trauma in 2012 to assist the clinicians in maintaining a wellness perspective to enable them to provide the best services to the consumers in the program.

**Goal number five:** Continue to implement and monitor the fidelity to the Evidence Based Practices.

This goal encompassed advancing our implementation of the evidence based practices and monitoring our fidelity to them. We completed fidelity scales for each of the evidence practices for 2010. A fidelity scale indicates how accurately you adhere to the true model. We did not complete consumer interviews in doing these fidelity scales. We did review charts, discussed with the person providing services, and the program supervisor.

## **2012 Evidence Based Practices Summary**

### **1. ACT Fidelity score: 116**

Our CSP team continues to function as an ACT team. Fidelity is rated on a five point scale, with five meaning full fidelity. We rated 1 in two areas this year. One of these areas is related to staffing patterns. Full fidelity involves having two nurses per one hundred consumers. We only have eight hours of nursing time to provide for the needs of one hundred forty four consumers over the year. Currently there are no plans to address this. The second area involves the number of consumers we have attending monthly treatment groups for dual

diagnosis. We offered a Dual Diagnosis group for the CSP consumers beginning in April of 2011, running through July. Four consumers regularly attended the group. While we see an increase in substance abuse issues for the consumers we are currently serving, many of these individuals remain in the engagement phase of treatment where they are pre-contemplating change. They are not yet ready to engage in a treatment group. The team continues to use Motivational Interviewing to enhance engagement and motivation when working with people with a dual diagnosis. In other areas, the team scored in a three to five range. This indicates very good fidelity to the model.

## **2. Illness Management and Recovery. Fidelity score: 52**

We did not offer this curriculum as a group this year but worked on it with several members of the CSP independently. The team has over the past year worked on completing the Illness Management and Recovery curriculum in whole or in part with a number of individual consumers. Nine individuals worked on Illness Management and Recovery. New admissions to the CSP are encouraged to complete the curriculum. Two issues were rated threes. The first involves using the complete curriculum with each person involved. At times if the person is doing it individually and has had symptom management courses in the past, only selected sections are utilized. The second issue involves using cognitive behavioral techniques in most sessions. This will be addressed in 2012, as the team is being more fully trained in Cognitive Behavioral Techniques.

A DBT group was offered in 2011 in conjunction with the CCS program. This teaches consumers skills in Mindfulness, Interpersonal Effectiveness, Emotion Regulation, and Distress Tolerance. No significant data was identified from reviewing the functional screens. The group retention rate was good. Six people attended the group.

## **3. Family Psycho-education**

In 2011, we continued to implement Family Psycho-education with individual consumers and their families. We work with the families of several adult consumers in the program. We have not rated the fidelity for this since we are in the beginning stages of implementation and are not running a group.

## **4. Integrated Dual Diagnosis Fidelity score: 51**

We continued to use motivational interviewing and approached treatment in stage-wise interventions. We work as a multidisciplinary approach with time-unlimited services. We offer pharmacological treatments and promote health and wellness. We continue to be low in the percentage of people with co-occurring disorders who participate in both treatment and self-help groups. We are seeing an increase in individuals being served who are dually diagnosed. In 2011, a group was offered for individuals that were in the pre-contemplation stage of change. Four individuals attended this group and two are now not actively using substances.

## **5. Supported Employment Fidelity score: 92**

Our CSP and CCS team has one employment specialist, who is fully integrated into the mental health treatment of consumers. The employment specialist does have a small caseload size, and is a generalist, completing all phases of vocational services. Employment searches occur in an individualized manner with a permanent, competitive job being the goal. A rapid job search is conducted. In 2011, the job search began even before DVR services were established with some consumers. There is a significant wait time for DVR services at the present time. Supports follow the person and occur in the community. Now that the grant has ended, the vocational specialist does not spend the majority of his time providing vocational supports. This person does not have a case management caseload.

In 2011, there continues to be an individual working to provide vocational services to CSP and CCS consumers. This program followed the evidenced-based model for supported employment developed by Dartmouth

College. The fidelity score was utilized to focus on areas to improve the program including focusing on a rapid job search, not looking for sheltered employment or volunteer activities and following the consumer for a longer time after the person begins work. These areas were addressed in 2011 and our fidelity was improved by five points from 2010. The supported employment program also served as a vendor for individuals that were in the CSP, and were referred by the Department of Vocational Rehabilitation (DVR). As a vendor of DVR services, the vocational specialist provided services related to vocational assessments, job placement, job coaching, benefit analysis, and job shadows, and assistance in arranging transportation. We continued to have grant funding some of 2011 but looked toward developing funding through CRS and DVR for program participants.

Consumers receiving vocational support learned job skills to obtain and keep employment. They learned these skills through individual sessions and through experience with employers. Supports were offered to the employer as well to maintain the job once the consumer began working.

Many of the consumers served by the vocational program gained or maintained employment. With the consumers already working, twenty nine consumers had employment at some time throughout the year. This led to 20.4 percent of CSP consumers working. Some of the places of employment were at group homes, supported apartments for people with disabilities, restaurants, cleaning at a wayside, peer support specialists through human services, convenience stores, a tire supplier and a spa. The positions that were filled in the community were: grounds maintenance, CNA, nail technician, custodian, group home worker, drivers for people with disabilities, a person who changes oil, van driver, delivery driver, self employment, child care assistant, math tutor, retail associate, repair person, and baker. Other consumers remained employed through Opportunities, Inc. until they could find community employment.

Furthering education continues to be a focus of the CSP vocational program. A total of five consumers from the CSP attended post high school programs in 2011. One consumer attended UW Whitewater pursuing a degree in Psychology. A second consumer is at UW-Whitewater pursuing a degree in education. One attended MATC to work toward becoming an English teacher. One consumer attended MATC for general education to support his goal of self employment. The final CSP consumer attended MATC to obtain his HSED degree. Depending on what the person wanted and needed, CSP staff helped people register for classes, coordinate services with the student disability services, obtain financial aid, manage their symptoms while in classes and provide transportation to school.

In summary, CSP consumers have achieved their employment goals by following the evidence-based model of supportive employment for people who have a severe mental illness.

**Goal number six:** Support the consumer council in meeting monthly and fundraising to support their activities.

The consumer council continued to meet on a regular basis each month of the year in 2011. The consumers took more active roles in the planning and provision of events. Some events included a trip to the Madison zoo, Festa Italiana, a cookout at a local park, a trip to the Dells, Valentine's Day, St. Patrick's Day, and Halloween parties, and a holiday party in December with over eighty people in attendance which the consumers solely planned and ran.

It appears throughout the year that the consumers are feeling more capable of planning and participating in the provision of activities. In the past, they have relied on or sought out a lot of staff support to lead the activities.

We also were able to have several new people begin to attend the meetings and participate in the running of events. There continues to be a staff advisor, although we continue to look for ways to develop leadership among the consumers on the council. They are relying less heavily on staff for support and guidance.

Fundraisers were run including a bake sale, brat sale, baked potato sale, and chili dump. Each activity was supported by a staff advisor but the consumers ran the activity and required significantly less staff support than they have utilized in the past.

**Goal number seven:** Continue to train staff in clinical areas and improve our service provision.

Trainings were begun every other Wednesday afternoon utilizing Judith Beck's book "Cognitive Behavior Therapy: Basics and Beyond." Material was presented and reviewed by CSP supervisor and discussion was held on how to implement the material in working with the CSP consumers. Individual consumers were staffed and consultation was held in how to specifically implement the techniques the team was learning. Staff trainings were also offered by the agency in various areas and CSP staff regularly attended these events.

**Goal number eight:** Track consumers' outcomes utilizing the CSP database and ROSI information.

Closer attention was paid to tracking outcomes in the consumer database. In 2011, one hundred and one emergency visits were tracked for CSP consumers. This averages to .71 visits per each consumer in the CSP in 2011.

Community Support Program consumers had 35 tracked hospital stays in 2011 accounting for 300 hospital days for the year. The average hospital admission lasted 8.6 days. There was an admission rate of one in four consumers for this year.

There were 93 admissions to the Lueder Haus in 2011 for a total of 695 Lueder Haus days. The average admission length was 7.5 days. The admission averaged .65 admissions per each CSP consumer. It is possible that the Lueder Haus admissions were so high because we were diverting more individuals from the hospital to the Lueder Haus based on our NIATx project as well as the medical director no longer admitting directly to St. Mary's.

In 2011, the CSP consumers met 65.6% of their treatment goals that were identified in their individualized treatment plans.

This data will continue to be reviewed and tracked in 2012, with an emphasis on reducing the utilization of the emergency rooms, hospitals, and Lueder Haus while increasing the percentage of treatment plan goals met.

We again decided to implement the Recovery Oriented System Inventory (ROSI). The ROSI is the result of a research project that included consumers and non-consumer researchers and state mental health authorities who worked to operationalize a set of mental health system performance indicators for mental health recovery. The ROSI was developed over several phases with a focus group of consumers who were able to develop a 42 item self report adult consumer survey. A factor analysis resulted in the domains of staff approach, employment, empowerment, basic needs, person centered, and barriers being able to be measured. The ROSI was found to be valid and reliable over the three phases of implementation.

Consumers of the CSP were sent a ROSI survey to complete anonymously. Fifty six consumers completed this survey. The following chart further explains the ROSI and summarizes the results. The questions associated with scales 2 and 5 are worded negatively, so a lower mean is seen as more positive.

**Means and Percentages for ROSI Consumer Survey Scales**

	ROSI Overall Mean	Scale 1 - Person Centered	Scale 2 - Barriers	Scale 3 - Empower	Scale 4 - Employ	Scale 5 - Staff Approach	Scale 6 - Basic Needs
Average for All Consumers	3.3	3.5	2.0	3.4	3.4	1.7	3.2
% w/ Mostly Recovery-Oriented Experience	70.7%	80.7%	43.1%	84.5%	68.4%	69.0%	80.7%
% w/ Mixed Experience	27.6%	15.8%	41.4%	13.8%	26.3%	19.0%	10.5%
% w/ Less Recovery-Oriented Experience	1.7%	3.5%	15.5%	1.7%	5.3%	12.1%	8.8%

**Note:** Means can range from a low of 1.0 to a high of 4.0. However, item wording for the shaded scales are negatively phrased, so a low mean represents a more recovery-oriented experience (meaning the consumer disagreed with the negative statements.) The percentages in Rows 3-5 have been adjusted for Scales 2 and 5 so they have the same meaning as the other scales.

The means from 2011 continue to show positive results. These results continue to indicate that consumers feel empowered by CSP staff and person centered planning occurs. Further, consumers report liking the approach of staff and find that the barriers to seeking services they need are minimized.

The results were consistent with the results that we collected in 2010.

**Goals for 2012**

1. Implement Collaborative Documentation across the team.
2. Run the NIATx process and implement projects throughout the year.
3. Train the team in CBT and implement this in appropriate treatment plans.
4. Have a conversation with all consumers in treatment plan meeting about health goals and track completion rate of these goals for the year; and facilitate follow-up with primary care provider.
5. Participate in the UW-NAMI Tobacco Cessation research project.
6. Develop a medication recording system for CSP.
7. Increase our use of peer support.
8. Continue to monitor and improve the quality of our services through tracking outcomes in the CSP database, through the ROSI survey and through standardized rating measures.
9. Continue to implement and monitor the fidelity of the evidence based practices and begin using rating scales to measure the effectiveness of treatment.
10. Implement standardized rating and tracking on consumer outcomes.

## **COMPREHENSIVE COMMUNITY SERVICES PROGRAM (CCS)**

*~ CCS services reduce the effects of an individual's mental health and/or substance use disorders; assist people in living the best possible life, and help participants on their journey towards recovery ~*

The Jefferson County Comprehensive Community Services Program (CCS) completed its fifth full year. First certified in February 2006, Jefferson County's CCS program was granted a two-year license in March 2007. This license was renewed on February 20, 2009 and again in February 2011 for two years.

### **Program Description**

CCS is a voluntary, recovery-based program that serves children (0-18), adults (18-62) and senior citizens (63-100) with serious mental health and/or substance abuse disorders. As stated on the State's Bureau of Mental Health Prevention, Treatment and Recovery website, CCS services "reduce the effects of an individual's mental health and/or substance use disorders; assist people in living the best possible life, and help participants on their journey towards recovery."

CCS offer an array of psychosocial rehabilitative services which are tailored to individual consumers. These services include: assessment; recovery planning; service facilitation; communication and interpersonal skill training; community skills development and enhancement; diagnostic evaluations and specialized assessments; employment related skills training; physical health and monitoring; psycho education; psychosocial rehabilitative residential supports; psychotherapy; recovery education and illness management; and additional individualized psychosocial rehabilitative services deemed necessary.

### **General data**

69 consumers ranging in age from 7 to 64 received services. This is comparable to 2010 when we served 71 consumers. Throughout 2011, 18 new consumers were admitted and 23 consumers were discharged. Of the consumers admitted to the program, 14 were children and 4 were adults. Of the consumers discharged, 15 were children and 8 were adults. Consumers had diagnoses of: schizophrenia, schizoaffective disorder, bipolar, major depression, borderline personality disorder, post-traumatic stress disorder, various anxiety disorders, and substance use disorders.

The CCS staff consists of a Psychiatrist/Medical Director and a CCS Service Director. As of January 2012, there are 5 full time CCS Service Facilitators, and a full time job developer.

### **Consumer Satisfaction**

The CCS program conducted a Recovery Oriented System Indicators (ROSI) consumer survey to measure the consumer satisfaction of our program and how recovery oriented we are. We had 9 adult respondents this year. Below is the means and percentages table which breaks the survey down into the following categories: overall mean, person centered, barriers, empowerment, employment, staff approach, and basic needs. The barriers and staff approach categories are negatively phrased and a lower number in these areas shows the program and staff is doing well in these areas. These two areas remain below a mean score of 2. The highest scoring area continues to be person centered category. This is a decrease from last year as it was rated at 100%. We have had staff turnover this year and have 3 new CCS service facilitators. We will work in this next year to train them in person centered planning and recovery principals in order to bring these scores up. We will continue to work on our Supported Employment services and ensure all of the consumers who want to work have the opportunity to work with our job developer and to obtain a competitive job that meets their strengths and talents.

## Means and Percentages for ROSI Consumer Survey Scales

	ROSI overall mean	Scale 1 person centered	Scale 2 Barriers	Scale 3 Empowerment	Scale 4 Employment	Scale 5 staff approach	Scale 6 Basic needs
Average for all consumers	3.3	3.8	1.7	3.3	2.4	1.4	2.8
% with mostly recovery oriented experience	77.8%	88.9%	66.7%	77.8%	20.0%	77.8%	62.5%
% with mixed experience	22.2%	11.1%	33.3%	22.2%	40.0%	22.2%	12.5%
% with less recovery oriented exp	0.0%	0.0%	0.0%	0.0%	40.0%	0.0%	25.0%

### **Monetary benefits**

The CCS program was reimbursed \$327,671.08 from Medicaid for services provided to consumers.

### **Children**

The CCS program served 33 children, ages 7 to 17; of these children, 20 were males and 13 were females. Twenty-four of the children resided at home all year or with a relative, two moved from out of home back home or to a relative's home, four lived in a group home, one lived in a foster home, one lived in a treatment foster home, and one child was placed in a residential treatment facility.

Five children had a mental health commitment order, with two children being able to end their order. Three young adults were employed.

14 children were admitted to CCS and 14 were discharged. Of the fourteen discharged, four children moved out of county, four children chose to withdraw from the program, and five children met their discharge criteria, and one child was transferred to the CSP program for more intensive services.

Of the 33 children that CCS served throughout 2011, 5 of them were admitted for psychiatric hospitalizations. Three of the children had voluntary admissions; two of the children had just one involuntary admission. The voluntary hospitalization days totaled 38 which are down from 62 days in 2010. The involuntary admissions to an institute such as Winnebago Mental Health Institute totaled 16 days compared to 50 days in 2010.

### **Adults**

In 2011, the CCS program provided services for 36 adults aged 18-63. Of these adults, 9 were males and 27 were females. Twenty-seven people lived in their own apartment/home, four people resided in a group home, and two people resided in an adult family home. One person moved from a group home to their own apartment and two people moved from a supported apartment into their own apartment. Three adults had a guardianship with one being dropped during the year. Of the three adults under a guardianship, one also had mental health commitment orders. Four individuals had mental health commitment orders with one individual not having his order continued.

In 2011, four adults were admitted to CCS and eight were discharged. Of the people discharged, two individuals were transferred to the outpatient clinic for services, one person transferred to the Community Support Program (CSP) due to increased symptomology and the need for additional services. Two individuals moved out of state and three individuals moved out of the county.

Between 5 adults: 75 hospital, 20 Mendota/Winnebago/IMD and 196 Lueder Haus/crisis stabilization bed days were used. One adult accounted for the IMD days, six for voluntary hospitalizations, and seven for crisis stabilization days. Two consumers accounted for 156 of the 176 days for crisis stabilization.

### **Elderly**

In 2011, the CCS program did not serve anyone who was considered elderly.

### **Recovery Plans**

Consumer recovery plans are reviewed every six months. Thirty one consumers participated in the CCS program long enough to have two plans in 2011. Overall, 61% of their objectives were met. Eighteen consumers were able to meet 100% of their goals on at least one treatment plan. The children met 54% of their goals. The adults met 64% of their goals. We continued to use person centered planning when doing recovery plans. This approach to conducting the meeting and writing the plans has had a positive response from consumers, family members, contracted providers, and natural supports.

### **Additional service providers**

In 2011, the CCS program contracted with ten providers.

- Four agencies provided contracted therapy services. These agencies provided a mix of in-home and agency individual and/or family therapy.
- CCS had one contracted psycho-social rehabilitation worker. The rehabilitation worker served as extra support for children and was especially helpful to children in foster care.
- Three peer support specialists assisted the CCS program last year. These trained peers provided support and advocacy for persons in their journey of recovery.
- Two individuals were contracted to provide therapy/service facilitation services.

As therapists, psycho-social rehabilitation workers and peer support specialists employ psychosocial rehabilitation practices; their services were billable to Medical Assistance through the CCS program.

### **2011 Evidenced Base Practices**

CCS worked in partnership with the CSP to offer the following evidenced based practice groups; Managing Life and Supported Employment. The Seeking Safety group was offered to women and teens. The women's group was facilitated by a CCS service facilitator and a female peer support specialist.

Fidelity scales were completed for each of the evidence practices for 2011. A fidelity scale indicates how accurately you adhere to the true model. Consumer interviews were not conducted in completing these scales and that will be addressed in 2012. We did review charts, discussed with the person providing the treatment and with the program supervisor and division manager.

- A woman's seeking safety group was offered in September 2011 and is continuing in 2012. Pre and Post measures are being utilized along with a fidelity measure to monitor adherence to the model. Currently eight women from the CCS program are involved in this group. The group is facilitated by a CCS service facilitator and a female peer support specialist. This is an integrative treatment approach for PTSD and substance abuse. This group provides tools and techniques to teach "safe coping skills".

- A seeking safety group for teen girls started in November 2011 and continues into 2012. There are two teens from the CCS group involved. This group is facilitated in partnership with the Juvenile Justice team.
- A DBT group was co-facilitated with the CSP program. It began in 11/2010 and ended 8/2011. This teaches consumers skills in Mindfulness, Interpersonal Effectiveness, Emotion Regulation, and Distress Tolerance. Six CCS consumers participated in the group.
- Supported Employment Fidelity score: 92  
Our CSP and CCS team has one employment specialist, who is fully integrated into the mental health treatment of consumers. The employment specialist does have a small caseload size, and is a generalist, completing all phases of vocational services. Employment searches occur in an individualized manner with a permanent, competitive job being the goal. A rapid job search is conducted. Supports follow the person and occur in the community. The vocational specialist now spends the majority of his time providing vocational supports. This person does not have a case management caseload.

In 2011, there continued to be an individual dedicated to providing vocational services to CSP and CCS consumers. This program followed the evidenced-based model for supported employment developed by Dartmouth College.

Consumers receiving vocational support learned job skills to obtain and keep employment. They learned these skills through individual sessions and through experience with employers. Supports were offered to the employer as well to maintain the job once the consumer began working.

CCS currently has four individuals working, three enrolled and attending technical college, and two individuals looking for employment.

### **CCS COORDINATING COMMITTEE**

The CCS Coordinating Committee is currently comprised of consumers, family members, and staff. The committee meets quarterly and continues to focus on recruitment and retention of members.

The CCS Coordinating Committee is submitting the following recommendations for the CCS program in 2012.

- Establish a CCS Coordinating Committee Board in the New Year and have the board make a one year commitment.
- Start support groups for consumers and parents in the CCS Program that will be overseen by the CCS Service Facilitators.
- Review the CCS policies at every CCS Coordinating Committee meeting.
- Offer a male Seeking Safety group.
- Provide opportunities for kids to socially integrate in normalized activities.
- Provide education on navigating the various systems.
- Refer CCS parents to Incredible Years program.
- Offer a consumer psycho education group.

- Offer a 20s social skills and healthy boundaries group called surviving your 20s.
- Offer a teen's social skills and healthy boundaries group called surviving your teen years.
- Offer a support group to parents.
- Redo the CCS Brochure to make it more eye-appealing and have it available in the community.

### **Review of 2011 Program Goals**

- Maintaining the fiscal responsibility
  - Increase the EMH billing within the CCS program.  
*CCS went from billing 7% EMH in 2010 to an increase of 12% billed to EMH in 2011.*
  - Keeping billable hours at 82% each week.  
*The staff average for billable time in 2011 was 75% compared to 74% in 2010. One staff person had an average of 81% billing for the year. We will continue to work on getting billable time to the 82% mark. The average percent of client time for the staff in 2011 was 85%.*
- Increase the staff knowledge of AODA and Treatment options through training and education.  
*Staff learned more about different treatment options available specifically in regards to adolescents, was further educated on the specific AODA diagnosis and how to provide education of these to consumers and families. A staff person attended training on motivational interviewing.*
- Increase and retain membership on the coordinating committee.  
*We have increased membership of family members. We continue to try to increase membership with outreach and education.*
- Implementing CRS services along with CCS services to decrease the number of out of home placements for children.  
*We began to use this in 2011 and were able to provide enough supports to bring an adolescent girl home from residential treatment in April. Due to the definition of CRS changing in 2012 we will not be able to use this service for children 14 and under. We also have decided not to use CRS combined with CCS as both can offer the same services to consumers.*
- Continue to implement trauma informed care.  
*The CCS team and our agency as a whole is very invested in being trauma informed. It will be important for the new CCS staff to be trained and knowledgeable in trauma informed care.*
- Increase fidelity of the supported employment program.  
*We were able to increase the fidelity of the supported employment program. In 2010 our fidelity score was 87 and 2011 it was 92.*
- Increase DVR and CRS services for consumers involved with supported employment.  
*In 2011 our grant for supported employment ended. Anyone who was interested in employment was referred to DVR, and CRS plans were done for all consumers who qualified.*

### **CCS Program Goals for 2012**

- The CCS policies and procedures will be reviewed and updated by December 2012 with the input of the CCS coordinating committee.
- Review and update training protocol and procedures for new staff by August 2012.
- Start each Monday staff meeting with 10 minutes of wellness to decrease staff stress by May 2012.

- Develop a list of providers in our area that have expertise in trauma and attachment that would partner with CCS to provide the children in the program therapy by July 2012.
- Increase the number of certified peer specialists that work with the CCS program by August 2012.
- Assess, track and integrate physical health measures while facilitating follow-up with primary care provider.
- Implement use of standardized rating and tracking of outcomes.
- Form a change team and initiate change project using the NIATx model.

### **CCS Training Goals for 2012**

- Complete staff training for Cognitive Behavioral training by December 2012.
- Compassion fatigue/vicarious trauma training for all CCS staff by December 2012.
- Applied Suicide Intervention Skills training for staff by June 1, 2012.
- Attachment and trauma training in children for all CCS staff by April 20, 2012.

## **EMERGENCY MENTAL HEALTH**

*~ Individuals receive crisis assessments, response planning, linkage and follow up, and crisis stabilization services~*

Our Emergency Mental Health (EMH) crisis intervention services were certified under HFS 34 in October of 2007. In May of 2010, as part of the outpatient mental clinic certification, we received certification for two more years. In becoming certified, the Department did not have to add any new services or new staff. The Department organized procedures, formalized policies, developed billing systems and trained staff across the entire agency. We continue to revise and update these policies and procedures.

In 2011 we again saw an unprecedented need for our Emergency Mental Health services. The number of crisis contacts increased from 995 in 2008 to 3582 in 2009 to 5114 in 2010 to 5636 in 2011. These people received crisis assessments, response planning, linkage and follow up, and crisis stabilization services. Of the crisis assessments completed, 225 were in response to suicide calls. Most of these callers were able to be assisted in the community with services from our clinic staff, which include psychiatry, medication, counseling, and support from friends and family. The remaining crisis calls resulted in 124 emergency detentions. This number includes 12 people who are not residents of our county and venue was transferred. We have begun to work with other counties who have people placed in group homes and other facilities in our county to either do the Emergency Detention or if they are currently under an order to return the person to more restrictive which saves us time and money. We have also requested releases of information so we can have access to the person's crisis plan and be able to better assist them during their crisis.

Even though the number of calls continues to increase each year, we continue to divert people away from state hospitals. This occurs because Human Service intake workers complete a Crisis Assessment and make the decision about the need for an emergency detention. It is helpful because we have mental health professionals and a psychiatrist who are able to see people with acute symptoms on the same day and then follow them closely.

In 2011, the third full year of certified Emergency Mental Health services, we billed \$189,491 to Medicaid for our services and received payment of \$119,525.

We budgeted \$781,718 for hospitalizations and spent \$625,297, which resulted in a savings of \$156,421. This savings is due to the staff diverting people from the institutes, using general hospitals whenever possible for an emergency detention, and applying for presumptive MA for those who do not have insurance.

Lastly, 118 people were served by the Lueder Haus, our crisis stabilization facility. We were also able to bill \$308,364 to Medicaid for our crisis stabilization services and received payment of \$110,639.

### EMH Data

	2008	2009	2010	2011
<b>EMH calls</b>	995	3582	5114	5636
<b>ED's</b>	114	107	106	124
<b>Suicide calls</b>	323	248	184	224

### CONSUMER SATISFACTION

The EMH program conducted a Recovery Oriented System Indicators (ROSI) consumer survey to measure the consumer satisfaction of our program and how recovery oriented we are. We had 28 adult respondents this year. Below is the means and percentages table which breaks the survey down into the following categories: overall mean, person centered, barriers, empowerment, employment, staff approach, and basic needs. The barriers and staff approach categories are negatively phrased and a lower number in these areas shows the program and staff are doing well in these areas.

#### Means and Percentages for ROSI Consumer Survey Scales

	ROSI overall mean	Scale 1 person centered	Scale 2 Barriers	Scale 3 Empowerment	Scale 4 Employment	Scale 5 staff approach	Scale 6 Basic needs
Average for all consumers	3.3	3.6	2.1	3.4	3.5	1.8	2.8
% with mostly recovery oriented experience	77.8%	84.6%	33.3%	81.5%	73.1%	72.0%	66.7%
% with mixed experience	18.5%	11.5%	66.7%	18.5%	19.2%	8.0%	14.8%
% with less recovery oriented exp	3.7%	3.8%	0.0%	0.0%	7.7%	20.0%	18.5%

## **REVIEW OF GOALS FOR 2011**

1. Reorganize the supervision of crisis services under one supervisor.

*In April 2011 the current Emergency Mental Health Supervisor took over and crisis services for adults and children have been streamlined.*

2. Participate in the Children's Crisis Network to reduce emergency detentions and hospitalizations for children.

*The current supervisor is involved with the Children's Crisis Network, attending meetings, and working with them to cultivate more stabilization beds in the area. In 2012 we are inviting the leaders for the Crisis Network to Jefferson County for a meeting with the children's program supervisors and key staff to discuss how we can increase the use of the network and to continue discussions on stabilization options for children in the area.*

3. Successfully participate in the state sponsored NIATx cohort group to reduce hospital admissions.

*We are currently participating in the NIATx cohort and are planning change projects for 2012.*

## **PROGRAM GOALS FOR 2012**

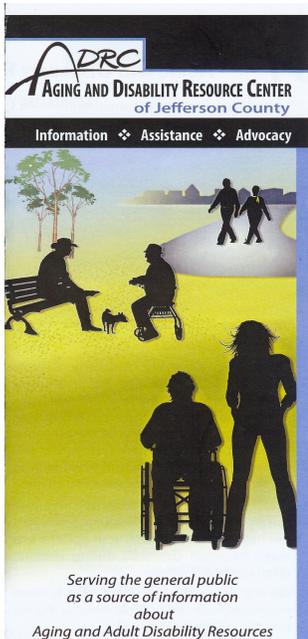
1. Reduce the number of Emergency Detentions of out of county residents placed in group homes in our county by 25%.
2. Send out a survey each month to receive feedback on services and how they are delivered to consumers. Each year send the ROSI survey to receive more comprehensive feedback in order to create our goals for the following year.
3. Send out the ROSI survey to persons who have been admitted to the Lueder Haus for crisis stabilization services. This data will help us to improve upon the services we are already offering.
4. By June 2012 implement collaborative documentation with all emergency mental health staff.
5. Meet with the Patient Care Coordinators at Fort Atkinson Hospital quarterly to review services we have provided to people when in the emergency room to determine what is working and what can be improved. Implement documentation for Fort Atkinson emergency room when assessments are facilitated there by our intake workers by May 1, 2012.
6. Implement and complete one NIATX change project by October 2012.

## **EMH TRAINING GOALS FOR 2012**

1. All new EMH staff will attend the Applied Suicide Intervention Skills Training on May 30 & 31.
2. Staff will attend the attachment and trauma training on April 18, 2012.
3. EMH staff will be trained in Stepwise Interviewing Techniques by December 2012.
4. EMH 101 training will be offered in June and December 2012 for all new staff.

## AGING & DISABILITY RESOURCE DIVISION

~Providing services seamlessly to the elderly and persons with disabilities~



The Aging & Disability Resources Division of Jefferson County Human Services encompasses many programs and funding streams. The division has two distinct units, which provide services seamlessly to the elderly and persons with disabilities.

The Aging & Disability Resource Center, or ADRC, is 100% funded by state general purpose revenue and federal Medicaid dollars. Federal dollars are earned based on staff

activities. The ADRC is required to earn 25% of its support from the federal government in order to meet its budget. The ADRC has consistently earned 40% since opening in 2008 and one new staff member was hired in 2012.

The Aging Programs are funded with federal and state dollars, county tax levy and private donations. Federal funding comes from the Older American's Act, or OAA. The mission of the OAA is to help older people maintain maximum independence in their homes and communities and to promote a continuum of care for the most vulnerable older adults. Counties are required to use funding in several different categories, including advocacy, access, benefits counseling, caregiver support, nutrition services and evidenced based prevention programming.

Since the ADRC opened in July of 2008, the costs associated with operating the Elderly Benefit Specialist Program have shifted from the OAA budget into the ADRC budget. This has dramatically reduced the county tax levy in the Division's budget from \$128,328 in 2009 to \$62,783 in 2011.

## AGING & DISABILITY RESOURCE CENTER

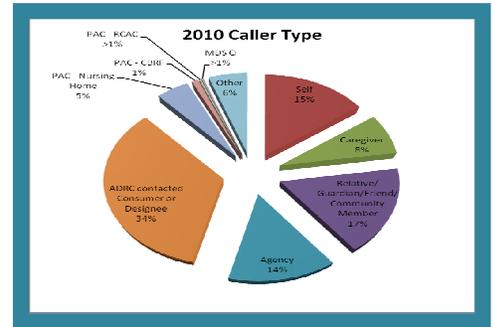
Aging and Disability Resource Centers (ADRCs) offer the general public a single entry point of access for information and assistance on issues affecting older people and people with disabilities, regardless of their income. Individuals, family members, friends or professionals working with issues related to aging, physical disabilities, or developmental disabilities can receive information specifically tailored to each person's situation.

ADRCs are also places where people are offered options counseling to maximize their personal resources and to access Wisconsin's publicly funded long term care programs, including Family Care and Partnership and the Self-Directed Supports Waiver Program called IRIS, *Include, Respect – I Self Direct*.

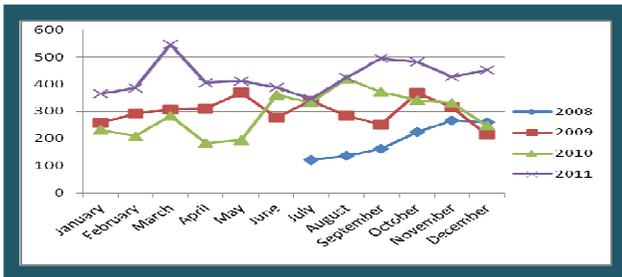
In 2011, the ADRC recorded 5,126 contacts in SAMS IR, which is the database used for collecting data on all ADRC activities. Our statistics show that 68% of known contacts were on behalf people 60+; 32% were made on behalf of people between the ages of 18-59 and less than 1% were regarding children under the age of 18. The primary reason that people contacted the ADRC was for information related to public benefits (3,715 contacts).

### Contacts July 2008 thru December 2011

A contact represents individual one-on-one interactions that have occurred between ADRC staff and a person who contacts the ADRC. A contact may occur in person, including home visits and walk-ins, over the telephone, via email or thru other written correspondence. An individual may contact the ADRC multiple times; each interaction is counted as a contact. Included in the number of contacts are follow-up calls made by ADRC staff members to ensure that customers have received any mailed information and to check in to see if they need any other assistance. According to the Wisconsin Department of Health Services 2011 Summary Report, follow-up contacts have a strong impact on every measure of customer satisfaction.



The ADRC continues to receive a high volume of calls from people who are interested in publicly funded long term care, and ADRC staff completed 374 long term care functional screens in 2011. Screens are offered to anyone who requests one and the results establish functional eligibility for managed care or IRIS.

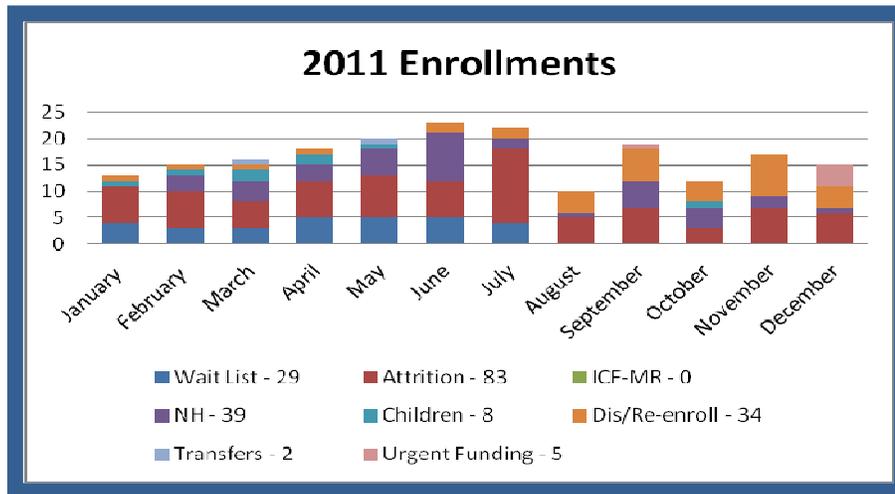


**Waiting List Enrollments:** The 2011 Enrollment Chart shows the number of individuals served in 2011. On July 1, 2011, the State budget capped enrollments into managed care and IRIS. From that point forward, consumers were served via attrition, or if they met the criteria for urgent funding. In 2011, 112 consumers were enrolled from wait list, and an additional 5 consumers were enrolled using urgent funding.

**ICF MR Relocations:** Options counseling was provided to 1 individual and their legal representatives, who later declined relocation.

**Community Relocations from Nursing Homes:** Individuals residing in a skilled nursing home, who are also on Medicaid, were exempt from waiting list requirements the first half of 2011; from January 1<sup>st</sup> thru June 30<sup>th</sup>, 24 consumers were enrolled. The enrollment cap affected the process for enrolling consumers by placing a requirement that the individual had to reside in an institution for 90 days before being allowed to enroll into a managed care/IRIS program. From July 1<sup>st</sup> to December 31<sup>st</sup>, 2011, 15 consumers were enrolled.

**Children's Waiver Transitions:** The final group of individuals who were exempt from the waiting list are children who are on the Children's Long Term Support Waiver Program (CLTS-W) and who are turning 18 before entitlement. At age 18, these individuals are no longer eligible for children's long term support services because they have the option of enrolling in managed care or IRIS. From January 1 to June 30, 7 consumers were enrolled under these guidelines. Upon the placement of the cap, young adults that were served thru the Children Long Term Support Waiver Program needed to be enrolled before their 22<sup>nd</sup> birthday, and 1 consumer was enrolled from July thru December. A small subset of this group is eligible for the CLTS-W due to a diagnosis of Severe Emotional Disturbance and most often these children will not qualify for the adult programs. In these cases, those individuals can remain on the CLTS-W until age 22.



### Summary of Goals/Strategies for 2011

The ADRC's 2011 goals were centered on Quality Assurance and Customer Satisfaction.

- Satisfaction surveys were distributed on a quarterly basis to facilitate a higher return of the surveys.
- All staff were trained on the NIATx model of process improvement. The NIATx model is customer-centered, outcome focused practice that specializes in continuous improvement. NIATx promotes systems change and innovation with a focus on four ADRC aims: Reduce customer wait time, increase utility of referrals, increase new ADRC customers and increase customer's ability to be healthy at home. The NIATx projects will help the ADRC improve customer satisfaction in the areas of Empowerment and Follow-up. Our first NIATx project is now part of the training demonstration offered to ADRC staff throughout the state.
- Assist Guide was launched thru the ADRC website database.
- Ongoing training has been offered to Aging & Disability Specialists to help them remain up-to-date with program/resource changes so that information is relevant to the caller.
- Marketing of ADRC plan consisted of dividing the county by quadrants, and each I & A staff provided outreach material and presentations to community partners.

### Goals/Strategies for 2012

In December 2011, it was announced that the enrollment caps under Senate Bill 380 were to be lifted and this change went into effect on April 3. The plan is to offer options and enrollment counseling to the 189 consumers who are on the wait list in an efficient and timely fashion. Jefferson County is now an entitlement county for publicly funded long term care programs.

- The ADRC will work with DHS on the Long Term Care Sustainability Plan.
- I & A Staff have been trained and certified to provide an evidenced based prevention program/ community education class called *Living Well with Chronic Conditions*. The classes will run for 6 weeks and be offered within the community.
- Continue NIATx model of process improvement to improve customer satisfaction.
- Plan is to continue to improve on brochures and handouts to provide useful information and resourceful guides

# AGING PROGRAMS

## **Advocacy**

The Older American's Act (OAA) is the foundation of the Aging Network and its central tenet is advocacy. The OAA provides the framework under which the ADRC Advisory Committee operates and involves committee members in advocacy activities including:

1. Assisting in the development of better public policy
2. Ensuring that the Aging & Disability Resource Division is accountable to citizens
3. Giving a voice to (misrepresented or underrepresented) citizen interests
4. Mobilizing citizens to participate in the public policy process
5. Supporting the development of a culture of tolerance, equality and acceptance of people with disabilities and the elderly.

## **Goals for 2012**

- Actively engage citizens in the Environmental Scan that is a required component of the 2013-2015 Aging Unit Planning Process.
- Reach out to organizations and hold focus groups to discuss relevant issues, such as transportation, service, financial or housing needs.
- Offer a Senior Statesmanship Program to educate seniors about effective advocacy strategies.

## **Jefferson County Senior Dining Program**

### **Fellowship, Food Fun**

Jefferson County's Senior Dining Program served 692 unduplicated individuals via the Senior Dining Program for a total of 31,893 meals in 2012. This represents a 15% decrease from the previous year. The congregate sites served 14,686 meals, and 17,207 home deliveries were made. Statistical analysis shows that this trend has occurred during six of the last seven years. Due to declining numbers, the Waterloo congregate dining site was closed. The home delivered program continues to operate locally through a contract between this department and City of Waterloo. The program is administered by staff at the Karl Junginger Library.

Of the 692 individuals registered for meals, 240 females and 89 males are living alone, in poverty and have high nutritional risk scores. This represents 48% of the program's demographic. The home delivered meal assessor provides participants with medication management strategies, nutrition education and nutrition counseling. These services are critical in helping people manage chronic conditions so that they can remain in their own homes. According to the Government Accounting Board, several studies reveal that 1 in 5 older patients is prescribed what is considered to be a harmful medication; and another study suggests that roughly two-thirds of prescriptions are either 1) not needed, 2) unnecessarily unsafe (a safer alternative is available), or 3) the dose is too high.

According to the American Dietetic Association, 87% of older adults have one or more of the most common chronic diseases, including hypertension, diabetes and coronary heart disease, all of which are preventable or treatable in part by access to appropriate nutrition services

**FACT:** The cost of one day in a hospital roughly equals the cost of one year of OAA Nutrition program meals. One month in a nursing home equals that of providing mid-day meals five days a week for about seven years.

*American Dietetic Association*

## **Summary of Goals/Strategies for 2011**

On January 1<sup>st</sup>, Hoffman House began its catering operations in Jefferson County. Response to the new menus, which follow the **2010 Dietary Guidelines for American's** (*required*), was varied.

We met our goal to send out satisfaction surveys in early spring, which allowed us to respond to our customer's complaints early on. Some people were very satisfied with the changes, while others were clearly not and that was the most vocal group. Nutrition Program staff responded to the concerns immediately and did a variety of things to implement change, including 1) having an in-person meeting with site participants, the caterer and his cook; 2) sharing all surveys with the caterer, including participant comments from daily worksheets; 3) compiling statistical information about site participation from the previous year, per site, to examine trends; 4) communicating with the Aging & Disability Resource Center Advisory Committee, Human Services and County Board about constituent concerns, including our response and action plans; and 5) following up with a letter to all meal participants informing them that we heard their concerns and were responding.

## **Goals/Strategies for 2012**

Continue to promote the health benefits of 2010 Dietary Guidelines for American's to help people understand and accept the menu changes and a healthier lifestyle.

- Distribute satisfaction surveys again in the spring to gather participant feedback.
- Engage in discussions with GWAAR (Greater WI Agency on Aging Resources) and the Department of Health Services about "modernizing" the Senior Dining Program to ensure that it is meeting people's wants and needs. The program will celebrate its 40<sup>th</sup> year in 2012 and federal guidelines have changed very little since inception.
- Encourage participants to attend a Chronic Disease Self Management Program as provided by Aging & Disability Resource Specialists.

## **Transportation Services**

Jefferson County provides transportation services to the elderly and persons with disabilities via volunteer drivers and one paid van driver. Services are funded via the s85.21 Specialized Transportation Program, Family Care, Partnership, county tax levy, and passenger co-payments. Persons seeking access to medical care are given priority services, as well as those needing help in meeting their nutritional needs.

Jefferson County provides the following services:

1. Elderly Services Van: Provides transportation on a fixed route basis to elderly and disabled individuals for grocery and other shopping trips. In 2011, 3058 one-way trips were provided. Passengers are asked for a \$1.00 co-payment per one-way trip.
2. Taxi Program Subsidy: Provides a user-side subsidy for taxi services provided to elderly who use the taxi in order to attend a Senior Dining Program in Fort Atkinson, Jefferson and Lake Mills. In 2011, 826 one-way trips were subsidized at .75 per trip.
3. Driver-Escort Program (volunteer drivers): Provides door-to-door transportation to elderly and disabled individuals for medical appointments when they have no other transportation options. In 2011, volunteer drivers provided 5,790 one-way rides. Passengers are asked for a \$1.00 co-payment per in-county trip and a \$5.00 co-payment per out-of-county trip.

### **Summary of Goals/Strategies for 2011**

The goal to improve coordination between transportation providers was not met because counties are caught between disconnected federal and state policies. While the Federal Government mandates that publicly funded transportation providers & stakeholders must coordinate with each other, the State of WI has contracted with a company called Logisticare to provide non-emergency medical transportation that is covered by Medicaid. This reduced the counties passenger manifest by nearly 50%, so the divide widens, rather than becoming narrower.

The goal to explore grant opportunities to fund a Mobility Manager to study the county's transportation system was met. After receiving the necessary support from the Aging & Disability Resources Advisory Committee, the Community Action Coalition wrote the grant, but unfortunately, it did not get approved.

### **Goals/Strategies for 2012**

- Conduct an in-depth analysis of the department's transportation program to improve access and increase efficiencies.
- Collaborate with the Community Action Coalition and others to write another grant for a Mobility Manager.
- Convene a Coordinated Planning Meeting.
- Develop an outreach plan to identify isolated seniors who need transportation services.
- Increase van ridership by 25%.

### **Benefit Specialists**

**Elderly Benefit Specialist:** The Jefferson County Elderly Benefit Specialist program reported 1796 contacts, serving 730 unduplicated clients during the 12 month period which ended Sept. 30, 2011, resulting in \$1,861,090 in financial monetary impact. Those numbers are largely due to the EBS availability to meet with clients at monthly outreach sites (satellite offices) established at all the community centers, congregate meal sites, HUD housing complexes, and other public venues. Even seniors who typically would not visit the ADRC find other opportunities to access the services of the EBS program.

Special efforts were made in 2011 to reinforce partnerships with other organizations that share an objective to improve the lives of seniors. (ie; Conexiones Latinas, Parish Nurse Network, Rainbow Hospice, Community Care Alliance Organization, local community health fairs, Second Harvest, Wisconsin Aging Network and others).

The program continues to nurture its infant SHIP volunteer base and recruited 3 additional volunteers to work with 2 returning volunteers, primarily for Medicare Part D outreach. The higher contact numbers reported in this time period are directly related to the additional enrollment workshops during Medicare's Annual Election Period (AEP) that were captured with the help of new SHIP volunteers. In addition to those AEP workshops, the EBS(s) host 6 ABCs of Medicare "classes" at the ADRC. These classes include a computer demonstration that teaches participants how to access valuable online tools at a secure Medicare website.

The EBS program did receive MIPPA (Medicare Improvement for Patients and Providers Act) grants and tracked those activities as required. 683 contacts were recorded for persons who self reported as low income. Although the MIPPA funds will be exhausted in 2012, the EBS mission and priority target group shall remain those clients who have lower incomes and the most vulnerable seniors.

This year, the EBS program trumped up efforts to provide services to elderly Hispanic Jefferson County residents. The Elderly Benefit Specialist completed an 8 week continuing education course in Spanish in order to improve communication with non English speaking seniors. In 2011, EBS participated in CMS Medicare 101 in Español Webinar and subsequently recruited a volunteer who did distribute Latino outreach brochures (Red Tape Cutters in Español) to three businesses with high numbers of non-English speaking employees.

By participating in bi-monthly meetings of the Conexiones Latinas Advisory Board, the EBS was able to further network with other organizations who share a mission to inform and educate the Hispanic community regarding services and resources in not only Jefferson County, but also Walworth, Rock and Dodge County. As a result, EBS in some of those other counties may also contribute to the Hispanic newsletter that is distributed quarterly to various points throughout those counties. The goal was to introduce the Elderly Benefit Specialist and SHIP program in communities that don't necessarily come to local congregate meal sites or visit the senior centers where typically the EBS provides such outreach.

An outcome of the effort in Jefferson County was the referral of nine cases (for non-English speaking elderly) in 2011. To aid in proficiency, the Elderly Benefit Specialist has resumed conversational Spanish lessons and continues to participate with the Advisory Board meetings of Conexiones Latinas. In addition, this EBS will target two local Mexican tiendas (grocery stores) in Jefferson County each quarter to distribute their newsletter that is printed in Español and that includes information regarding public benefits and safety net programs. The objective is to become identifiable with the local merchants who have connections with the Hispanic community and increase the number of senior clients who are non-English speaking by 10% in 2012.

### **All 2011 goals and strategies were met.**

#### **Goals/Strategies for 2012**

- Participate in a workgroup of stakeholders from GWAAR, DHS, and other EBS, with the goal of expanding the EBS volunteer base for Medicare and LEP outreach
- Coordinate a new group of volunteers for Peer Presentations (seniors speak out) who will provide short presentations called Medicare Minutes.
- Continue to provide excellent and credible service throughout the transition of the legal services provider for the EBS program.

#### **Disability Benefit Specialist**

The Disability Benefit Specialist (DBS) works with people with disabilities who are 18-59 years old, assisting them in applying for Medicaid, Social Security Disability or appealing a benefit denial. From 1/1/11-12/31/2011, the DBS worked on 263 new cases. The individuals served identified themselves as having a physical disability (46%); mental health issue (26%) or developmental disability (12%). The majority of people served were between the ages of 40-59 years old. The monetary impact in terms of benefits for customers totaled \$1,734,387!

#### **Goals/Strategies for 2012**

- Provide training for DBS of the NIATx Model for process improvement.
- Increase number of Benefit Check-ups for consumers.

#### **Family Caregiver Support Programs**

The department currently coordinates caregiver services and benefits under the following two programs: 1) National Family Caregiver Support Program; and 2) Alzheimer's Family Caregiver Support Program. These programs are intended to provide caregivers with information about available services; assistance in gaining access to services; individual counseling, support groups and training; respite care to give them a break from providing care and supplemental services to compliment care.

In 2011, twenty-two caregivers were provided funding under the National Family Caregiver Support Program which covered 775 hours of service. Caregivers often work with private providers, i.e. friends and neighbors whom they trust, at a reduced rate, so they are able to stretch their \$500 budget. The average cost of hourly respite services was \$14.20. This is approximately 40% less than the cost of agency provided services.

### **Summary of Goals/Strategies for 2011**

2011 was a record year for accomplishing goals in this area. The Greater WI Agency on Aging Resources granted the county \$1,250 to establish a Caregiver Coalition. Coalition members worked together to develop a Caregiver Resource Guide. The funding allowed us to print 1,700 copies of the directory which will be widely distributed across the county. This will go a long way in helping us meet our mission to educate communities and caregivers.

### **Goals/Strategies for 2012**

- Develop marketing strategies about the benefits of joining the coalition
- Work on developing a Caregiver Fair
- Collaborate with other professional organizations to offer a variety of educational programs for caregivers
- Work with caregivers to establish a “peer supports” network
- Distribute Caregiver Resource Manuals

### **Adult Protective Services (APS) & Abuse/Neglect of Vulnerable Adults & Elders**

The APS unit is responsible for ensuring that the health and safety needs of the elderly or individuals with disabilities are met, especially when they are in situations where there is cognitive impairment and substantial risk is evident. Several different statutes cover the counties responsibilities in responding to these situations, and the Human Services Department is the designated “lead agency” for receiving and responding to allegations of abuse or neglect.

**In 2011, this unit completed the following:**

- 198 Annual Review of Protective Placements or WATTS reviews
- 72 Elder Abuse Investigations (60+)
  - 42.4% Self-Neglect
  - 22.7% Financial Exploitation
  - 13.6% Emotional Abuse
  - 21.3% Other
- 26 Vulnerable Adult Investigations (18-59 years)
  - 26.9% Self Neglect
  - 23.1% Physical Abuse
  - 15.4% Sexual Abuse
  - 7.7% Emotional Abuse
  - 27.9% Other
- 37 Petitions for Guardianship

### **Summary of Goals/Strategies for 2011**

The goal to develop a financial abuse prevention program is ongoing. There are many tool kits available to use when doing presentations and staff who work in this area are always willing to talk to groups who are interested in this topic.

The goal to distribute a quarterly newsletter has not been met, and it is also ongoing. The Division Manager provided a presentation on APS and abuse/neglect issues at the Crisis Intervention Training that the department provided to law enforcement in 2011. This provided us with an excellent opportunity to network and educate officers as to how the department can help them do their jobs and why it is important to involve APS workers when responding to abuse/neglect calls about elders and other vulnerable adults.

All of the goals regarding the department's policies and procedures related to county sponsored guardianships have been met: Non-emergency County provided guardianship services have been eliminated to the fullest extent possible; the APS unit continues to recommend discontinuing court orders for placement on a case-by-case basis and the fee collection process has been successfully updated.

### **Goals/Strategies for 2012**

- Host a Volunteer Guardian Recruitment training/event;
- Work with the Probate Office to develop practices that ensure that guardians understand their reporting responsibilities to avoid unnecessary court hearings.
- Work with *Your Friends in Action* to recruit volunteers who are committed to helping vulnerable adults who are at the high risk for abuse/neglect.

## ADMINISTRATIVE SERVICES DIVISION

*~ Providing the support, maintenance, fiscal duties and oversight for the department to complete the necessary work~*

The administrative Services Division provides the support, maintenance, fiscal duties and oversight for the department. To complete the necessary work, there are three sections overseen by a division manager.

The fiscal team consists of eight full time employees, one part time employee, and one volunteer. They ensure that all accounting, billing for client insurance, protective payee payments, client financial ability to pay reviews, data tasks, and all financial reports are accomplished for the department.

The Support Staff team consists of an Office Manager/Supervisor and six full time employees. They ensure that appointments are scheduled, phones are answered, records are maintained and filed and all other support duties are completed.

Lastly, the Our Maintenance team consists of a supervisor, three full time employees and one part time employee. They ensure that the buildings and grounds are in working order.

## FISCAL

### **REVIEW of 2011**

#### **Protective Payee:**

As of January 2011 the protective payee check clearing process and deposit of Social Security, SSI, and SSI was downloaded from the bank site and posted automatically into the protective payee system. This saved us thousand of entries a month into the protective payee system. For 2011 Protective Payee served 284 clients of which 198 Care WI clients were being served. In 2010 Protective Payee Program served 287 clients. The data base was updated in 2011 to track Care WI Client information.

At the end of 2011, tracking client information on a monthly basis was being recorded. For the month of December, 2011; staff responded to 767 calls from Protective Payee clients. Budgets were reviewed with 49 clients, and 34 clients were met to review money problems. Bank reconciliation was completed. Twenty- five Social Security Reviews were also completed. Over 557 payments to vendors were issued in the month of December.

We initiated a process for clients on the protective payee system. Clients are only able to retain \$100 in a separate account. This helps us identify if the client is reaching their \$2,000 asset limit to be eligible for Medical Assistance because all excess funds above the \$100 are now with our department. We can now monitor the client balance to ensure they don't lose their SSI benefits or Medicaid benefits.

#### **Comprehensive Billing System:**

We worked with the MIS Department to define what is needed for a comprehensive billing system. Currently MIS is at the programming stage in the development of a new system. In January of 2011, all paper insurance claims were discontinued and services were billed electronically through the clearing house. This saved staff time in reviewing claims sent out and the cost for submitting claims. Using the clearinghouse also saved programming time since we are now able to adjust claims by building payer rules within the clearinghouse system to modify claims as needed.

Fiscal staff worked with MIS to integrate Targeted Case Management into the billing system. Programming has been done and implementation of electronic billing for targeted case management will be started in 2012.

### **Uniform Fee System Review:**

We worked with the MIS Department to develop a report to notify fiscal staff when clients need to be reassessed for their annual financial review for services to comply with the Uniform Fee System. This was implemented in 2011. In addition, we worked with MIS to have the client financial information printed when they are coming in for an appointment so that if there are changes in any of their personal information or insurance, we can update this information in a timely manner.

### **Children Long Term Services (CLTS) Waivers:**

In August of 2011 the state switched the CLTS Program invoices to be paid by Wisconsin Physician Service (WPS). Within this system, electronic authorizations are sent to WPS and, based on the approved authorization from the department; payments by WPS will be made to the provider when they invoice WPS. Fiscal and program staff worked with the MIS Department to define the requirements of the system. Fiscal staff reconciled WPS payments and finalized the year end reports to the state.

### **Employee Reimbursement for Travel/Training Expenditures:**

The vouchers for employee travel/training were being submitted on paper (excel spreadsheet) and then rekeyed into JD Edwards by fiscal staff for reimbursing staff. We worked with MIS to define the process and in 2012 implemented the new payment process. The new system allows the worker to go to the Jefferson County Employee Web page and key the information in and submit the request electronically to their supervisor for approval. Once fiscal staff reviews all request to insure county policies are being met, we then upload the information automatically for payment. This eliminated the double keying and streamlined the process for obtaining supervisor approval.

### **Payroll Time Sheets for Administrative & Aging & Disability Resources Center (ADRC) Staff:**

The employee time sheets for administrative department in 2011 were still being done in excel and then rekeyed into the payroll system. We worked with the MIS to define requirements and programming was done to have the employee directly key information and submit payroll time to supervisor for approval. Once fiscal staff reviews payroll for accuracy, this information is uploaded into the payroll system for payment. This eliminated the double keying and streamlined the process for obtaining supervisor approval.

### **Goals for 2012**

- Automate payroll time sheets for Workforce Development staff due to tracking additional information required by the state contract.
- Implement continuous quality improvement NIATx projects.
- Complete mandated HSRS changeover. This will require working with MIS to upload information from HSD systems to the state. Analysis, definition, and implementation from fiscal staff will be required to meet this state requirement. This will save time of re-keying information.
- Develop and implement financial reporting for the Economic Support Division to the consortium.
- Work with MIS to automate uploading journal entries instead of rekeying into JD Edward System.
- Work with managers/supervisors on including performance outcomes to include in the 2013 provider contracts.

## **SUPPORT STAFF**

The Support Staff is a vital team within the department working diligently behind the scenes. We help external customers by making appointments and providing information. It is imperative that our team is knowledgeable about all county resources so that we can direct customers to the proper agencies, such as local food pantries or PADA. We also process requests for the release of medical records which requires staff to understand the many statutes covered under HIPAA, Mental Health, AODA, and Child Welfare.

We assist internal customers by maintaining client paperwork & charts, typing & processing reports, making appointments and helping with special projects. Having excellent communication skills are critical for our staff due to the constant changes throughout any given day. All staff are also crossed trained and able to backup each other to ensure a seamless delivery of services to both these internal and external customers.

### **2011 Review**

- One staff was promoted from Support Staff to Medical Office Assistant, directly assisting our clinic psychiatrist.
- Were able to incorporate two part time staff into 1 full time staff, bringing a more cohesive flow to the job.
- Staff went to Walworth County Human Services and spoke with an experienced Medical Records clerk. We gleaned vital information from their agency regarding the release of medical records.
- Began billing clients for their portion of services, which has increased revenue for the Department.
- Worked with the fiscal team to revamp the vouchering system. This translates into a reduced staff load and an increase in revenue.
- Were fortunate to have two individuals help us into 2012 from agencies that place people on job sites to learn new skills. This training is to help them re-enter the workplace. One individual was from the *Transitional Works Program* and the other was from *Experience Works*. Both were paid positions through these agencies. Not only did these individuals assist the team with much needed help, but they also learned important job and interactive skills.
- Provided training to staff on HIPAA, which presented an opportunity for teams to evaluate current law & team processes.

### **2012 Goals**

- Develop an informational PowerPoint presentation to play on the lobby TV. This will help educate visitors about the many programs and policies that Human Services as well as other county departments have.
- Work on a NIATx Quality Improvement initiative on the "Release of Information," which should provide process improvements.

## **MAINTENANCE**

In the last few years a number of improvements have been made at the Health/Human Services Buildings and more are planned for 2012.

In 2010 we replaced sidewalk at Hillside Building and Health Department entrances. Also in 2010 we replaced four roof-top furnaces on the Human Services Building that were original equipment in 1980.

In 2011 we began a program to phase in replacement of flooring in the four buildings. We budgeted \$10,000 and started replacing carpet and VCT in the higher usage areas. Also in 2011 we replaced a boiler in the Hillside Building that had a bad heat exchanger. Additionally, we budgeted \$30,000 for energy upgrades. The

lighting in the Health/Human buildings has upgraded from T12 lamps to High Performance T8 fixtures. We are currently working on the same upgrade for Hillside and Lueder Haus. In 2011 we budgeted for and completed parking lot seal coat and re-striping.

In 2012 we plan to add a sidewalk and hand rail at CSP to allow a safer means to walk down the hill for staff and consumers. Also we have budgeted another \$10,000 for flooring upgrades. The flooring is on order and will be scheduled for installation in the coming weeks. Additionally, we plan to replace cooling coils on a condensing unit that has a slow leak.

## FINANCIAL REPORTS

The Financial Reports that follows summarize Department resources and expenditures by source and type, by target group, and by service type. Data is presented in numeric and pie chart formats. Total resources for 2011, including County tax levy, were \$19,291,771 Total expenditures were \$18,274,200.

### 2011 Resources & Expenditures

(unaudited)

RESOURCES:	2010 ACTUAL	2011 ACTUAL	2011 BUDGET	2011 VARIANCE
State & Federal Funding	\$ 8,210,334	\$ 8,097,644	\$ 8,079,027	\$ 18,617
Collections & Other	2,905,075	3,218,772	3,093,463	125,309
County Funding for Operations	7,780,565	7,975,355	7,975,355	0
<b>Total Resources</b>	<b>\$ 18,895,974</b>	<b>\$ 19,291,771</b>	<b>\$ 19,147,845</b>	<b>\$ 143,926</b>

EXPENDITURES:	2010 ACTUAL	2011 ACTUAL	2011 BUDGET	2011 VARIANCE
Personnel & Operating	\$11,820,734	\$ 11,671,595	\$ 12,521,758	\$ 850,163
Client Assistance	472,401	565,131	418,514	(146,617)
Medical Assist. Waivers	718,876	803,371	608,085	(195,286)
Community Care	782,576	695,579	715,578	19,999
Child Alternate Care	1,969,916	1,492,351	1,736,320	243,969
Hospitalizations	602,220	684,571	880,718	196,147
Other Contracted	2,416,259	2,361,602	2,266,873	(94,729)
<b>Total Expenditures</b>	<b>\$ 18,782,982</b>	<b>\$ 18,274,200</b>	<b>\$ 19,147,846</b>	<b>\$ 873,646</b>

SUMMARY	2010 BALANCE	2011 BALANCE	2011 PERCENT of BUDGET
Net Surplus	112,992	1,017,571	5.31%
(Without Personnel Variance)		532,322	2.78%

**2011 operations resulted in a net surplus of \$1,017,571 ( 5.57% of total budget ), which \$884,017 was lapsed into the County General Fund; Non Lapsing Request for 2012- 389,480 was approved).**

\$	255,927	Beginning fund balance, 1/1/11
\$	(884,018)	Transfer back to General Fund per Fund Balance Policy
\$	<u>1,017,571</u>	Current departmental surplus (deficit)
\$	<b>389,480</b>	<b>Ending fund balance, 12/31/11</b>
\$	-	Variance

## Financial Statement Summary December Final, 2011

A surplus of \$1,017,572 from operations. We asked for Carryover of \$389,444.17 which has been approved by the full board.

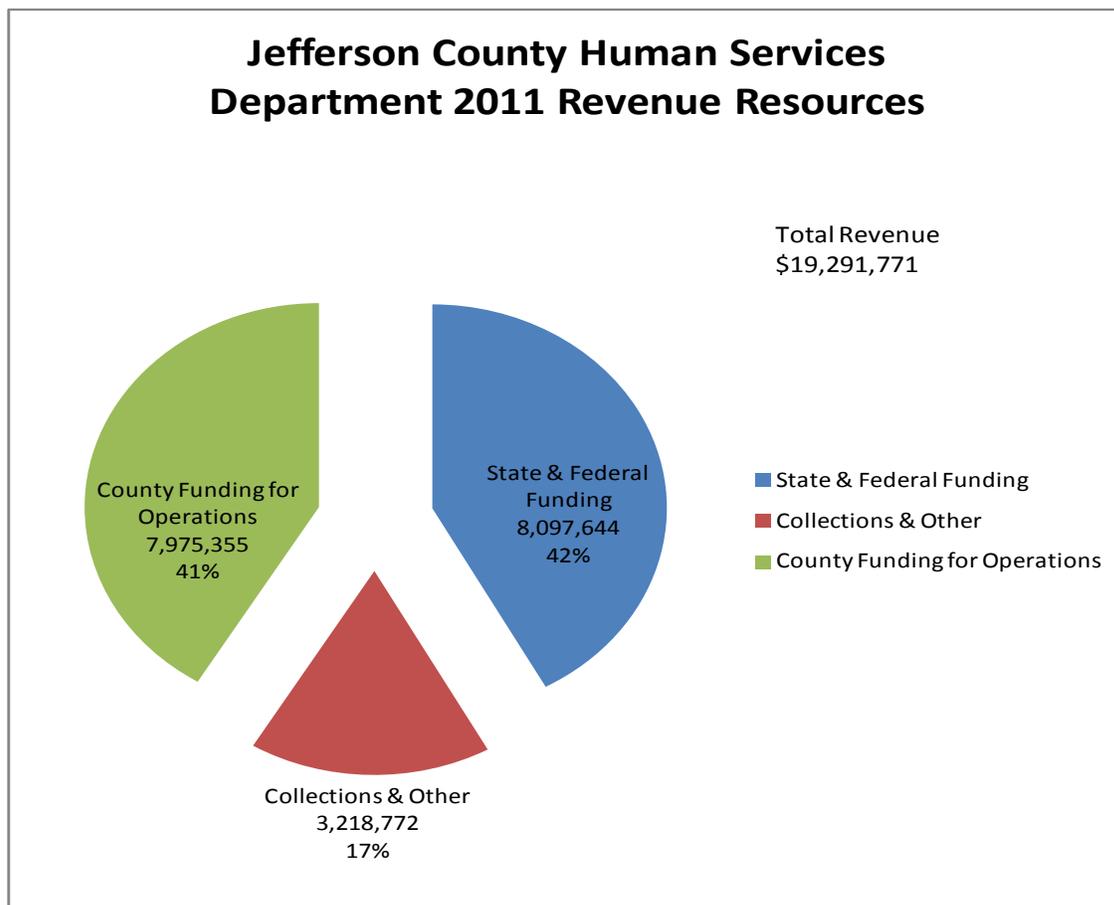
### Summary of the variances:

Overall Revenues are favorable by \$143,926  
Expenditures were under budget by \$873,646  
Net Savings \$ 1,017,772

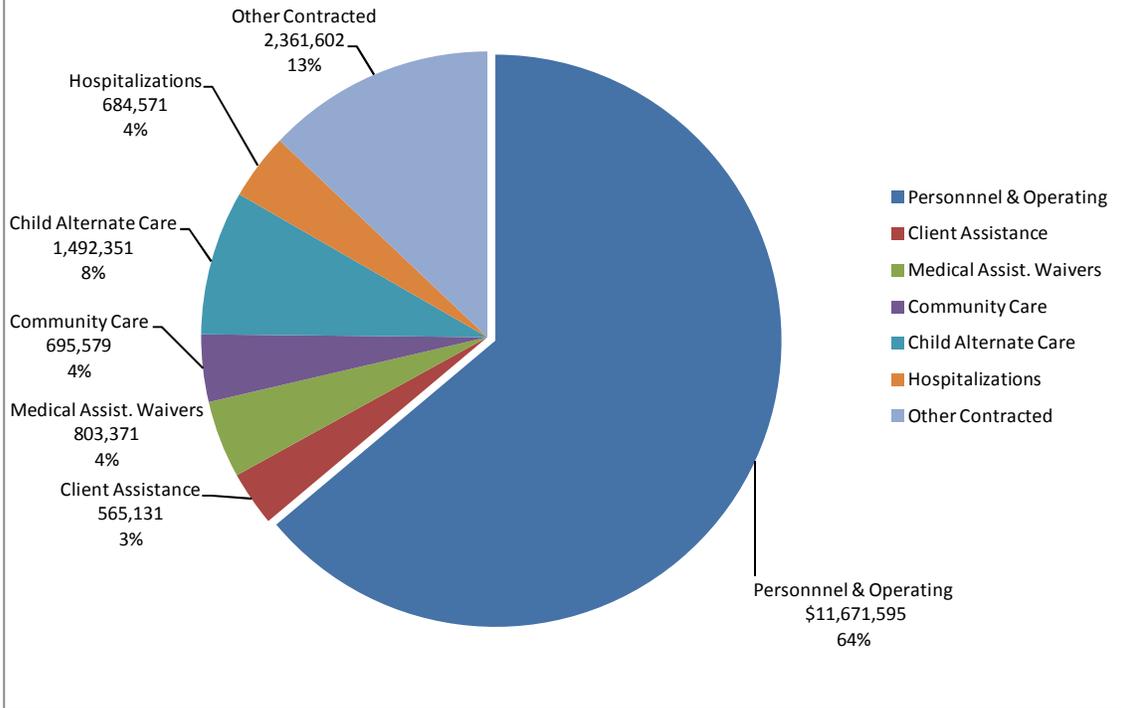
### Four Major Classifications impacting the favorable Balance

Personnel Cost: \$485,249 Savings (Health Insurance - \$260,824; Retirement- \$187,280)  
Child Care Alternate Care: \$243,969 Savings  
Hospitals: \$196,147 Savings  
Dr. Haggart: \$88,512

**Note:** Since 2009 annual savings for staff travel expenditures is \$74,779 due to switching to cars that use propane and using county vehicles when possible.



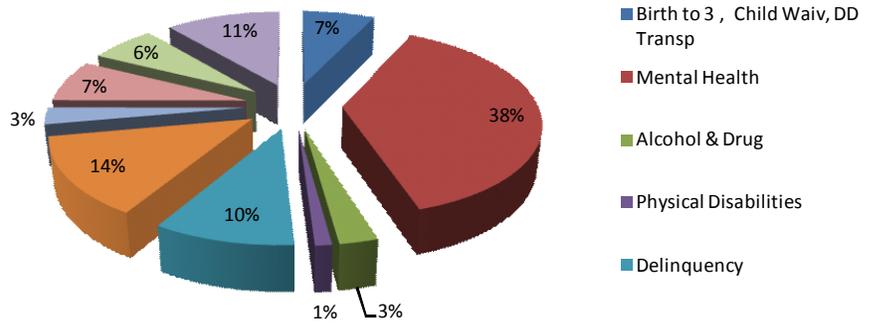
### Jefferson County Human Services Department 2011 Expenditures



## 2011 Costs by Target Group

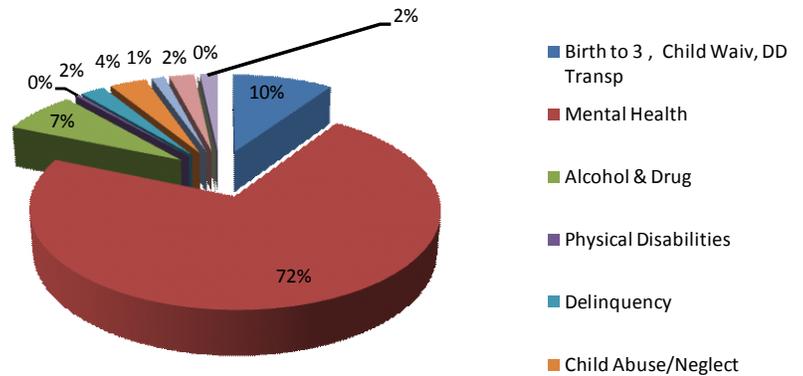
### Total Expenditures

Birth to 3 , Child Waiv, DD Transp	1,327,989
Mental Health	7,150,191
Alcohol & Drug	497,185
Physical Disabilities	215,692
Delinquency	1,809,043
Child Abuse/Neglect	2,534,423
Children & Families	547,591
Elderly	1,372,373
MCO Contribution	1,209,192
Financial Assistance	2,098,945
<b>TOTAL</b>	<b>18,762,624</b>



### Collections & Donations

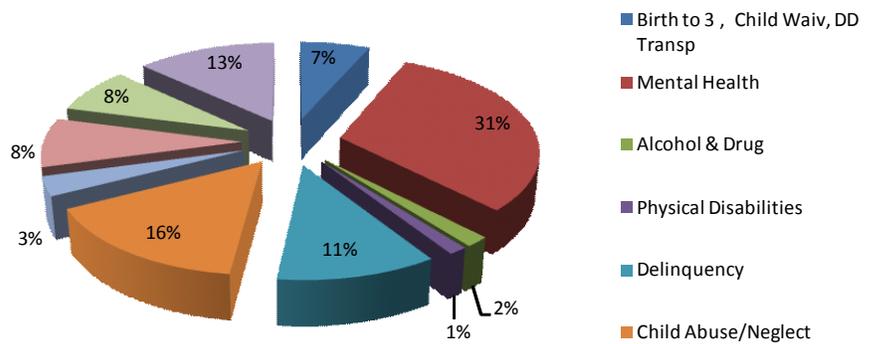
Birth to 3 , Child Waiv, DD Transp	305,421
Mental Health	2,306,146
Alcohol & Drug	230,001
Physical Disabilities	11,295
Delinquency	74,288
Child Abuse/Neglect	111,927
Children & Families	39,739
Elderly	76,536
MCO Contribution	0
Financial Assistance	54,965
<b>TOTAL</b>	<b>3,210,318</b>



Note: Switched to WPS payments versus state paying for services provided by Jefferson County HSD.

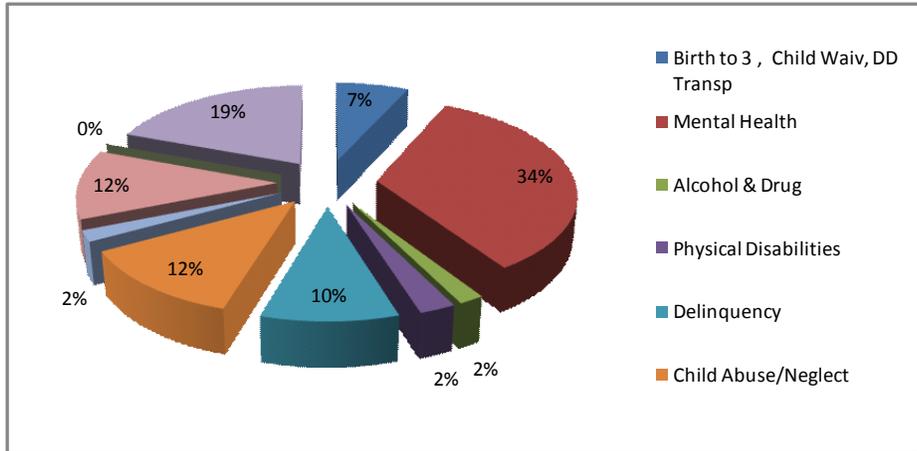
### Net Costs

Birth to 3 , Child Waiv, DD Transp	1,022,568
Mental Health	4,844,044
Alcohol & Drug	267,184
Physical Disabilities	204,397
Delinquency	1,734,755
Child Abuse/Neglect	2,422,496
Children & Families	507,852
Elderly	1,295,837
MCO Contribution	1,209,192
Financial Assistance	2,043,980
<b>TOTAL</b>	<b>15,552,306</b>



**State & Federal Funding**

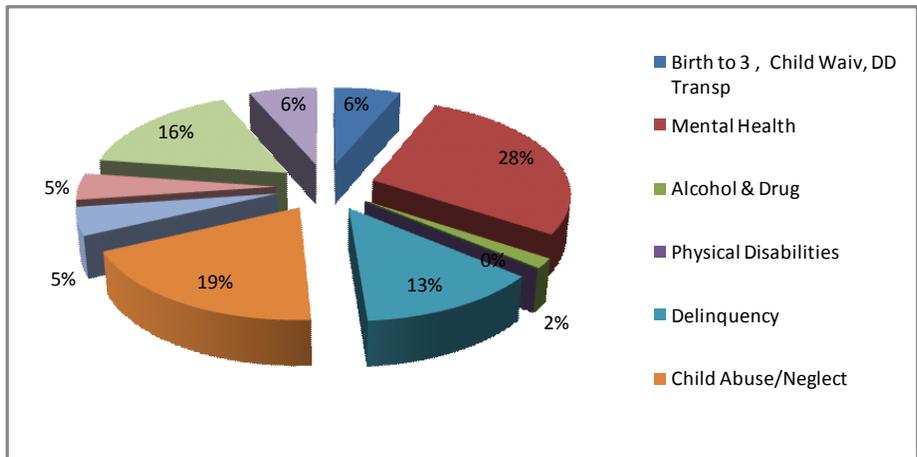
Birth to 3 , Child Waiv, DD Transp	553,436
Mental Health	2,749,520
Alcohol & Drug	143,457
Physical Disabilities	204,397
Delinquency	773,255
Child Abuse/Neglect	1,003,232
Children & Families	152,167
Elderly	953,905
MCO Contribution	0
Financial Assistance	1,564,275
<b>TOTAL</b>	<b>8,097,644</b>



Note: Funding for Waiver changed from state to WPS - classified as collections

**Net County Cost**

Birth to 3 , Child Waiv, DD Transp	469,132
Mental Health	2,094,524
Alcohol & Drug	123,727
Physical Disabilities	0
Delinquency	961,500
Child Abuse/Neglect	1,419,264
Children & Families	355,685
Elderly	341,932
MCO Contribution	1,209,192
Financial Assistance	479,705
<b>TOTAL</b>	<b>7,454,662</b>



**NOTE Calculation of Levy**

Note Budget Tax Levy	7,975,355
General Fund & Non Lapsing	-1,017,571
Depreciation	162,309
County Indirect Cost	334,569
<b>Tax levy</b>	<b>7,454,662</b>

Depreciation/County/ Indirect Costs reportable to state but not on Human Services Ledgers.

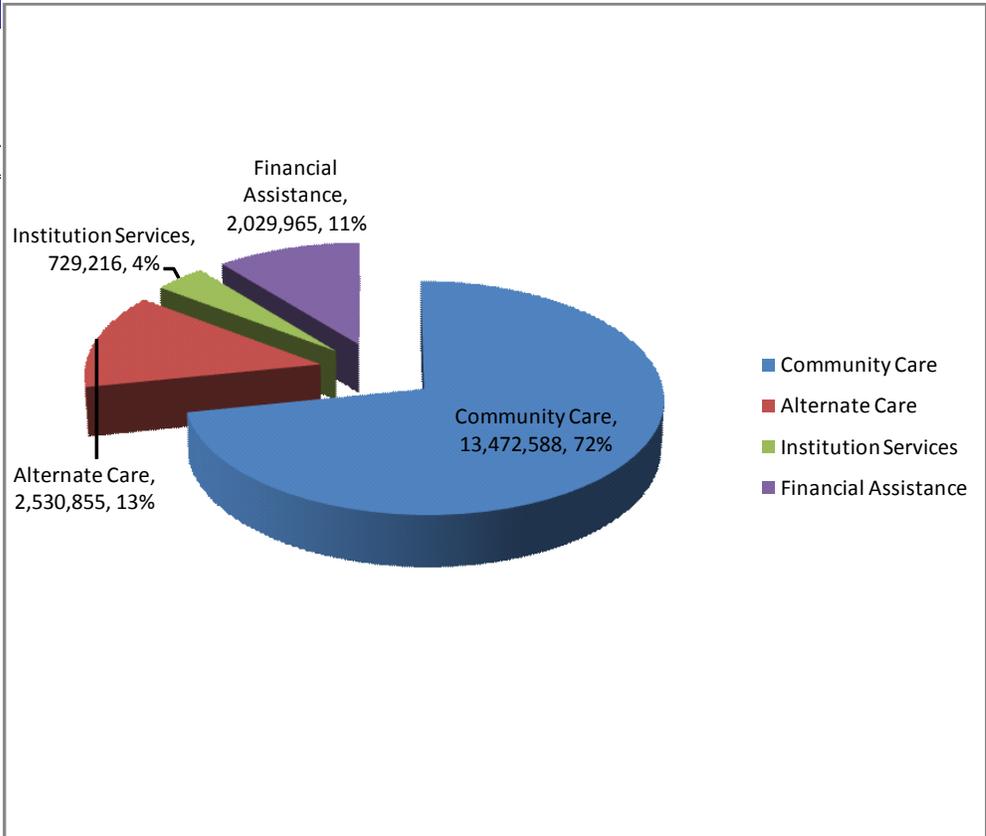
NOTE: ADRC Services & Transportation are allocated this year to Disability Groups Served

The graph below indicates the following:

- Community Care includes all Behavioral Health and Family Resource Services.
- Alternate Care includes all costs for Children and Adults.
- Institution Services includes all inpatient services for children and adults, and juvenile corrections.
- Financial Assistance includes all of Income Maintenance costs.

## 2011 Costs by Service Type

Total Expenditures	
Community Care	13,472,588
Alternate Care	2,530,855
Institution Services	729,216
Financial Assistance	2,029,965
<b>TOTAL</b>	<b>18,762,624</b>



**Four Year Comparison**

<b>MANAGEMENT</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
	Base Year							
<b>Expenditure</b>								
Wages - Regular	557,597	517,376	396,555	461,965	100%	92.79%	71.12%	82.85%
Wages-Overtime	5,980	0	0	905	0.00%	0.00%	0.00%	15.13%
Wages-Regular Overtime	357	0	0	0	100%	0.00%	0.00%	0.00%
Wages-Sick Leave	28,440	65,935	24,852	14,836	100%	231.84%	87.38%	52.17%
Wages-Vacation Pay	55,358	71,251	34,431	43,036	100%	128.71%	62.20%	77.74%
Wages-Longevity Pay	3,122	2,866	1,253	1,973	100%	91.78%	40.13%	63.20%
Wages-Holiday Pay	24,839	23,378	20,329	19,202	100%	94.12%	81.84%	77.31%
Wages-Miscellaneous(Comp)	6,494	8,939	17,743	17,536	100%	137.64%	273.22%	270.03%
Wages-Bereavement	764	509	599	1,022	100%	66.66%	78.40%	133.77%
Wages-Death Benefit	1,839	0	0	0	100%	0.00%	0.00%	0.00%
Social Security	52,405	54,208	38,058	42,774	100%	103.44%	72.62%	81.62%
Retirement (Employer)	31,432	28,281	23,005	30,341	100%	89.98%	73.19%	96.53%
Retirement (Employee)	40,958	37,015	29,664	21,012	100%	90.37%	72.43%	51.30%
Health Insurance	221,462	212,410	146,728	142,478	100%	95.91%	66.25%	64.34%
Life Insurance	452	400	276	299	100%	88.43%	61.06%	66.15%
Dental Insurance	10,141	10,046	7,618	9,138	100%	99.06%	75.12%	90.11%
Per Diem	7,480	7,530	6,325	5,720	100%	100.67%	84.56%	76.47%
Advertising	0	303	0	0	100%			
Board Member Training	611	465	775	690	100%	76.10%	126.84%	112.93%
Registration	1,607	565	874	1,315	100%	35.16%	54.39%	81.83%
Mileage	4,949	3,887	3,545	3,524	100%	78.55%	71.63%	71.21%
Other Insurance		3,540	2,692		100%			
<b>MANAGEMENT</b>	<b>1,056,287</b>	<b>1,048,903</b>	<b>755,322</b>	<b>817,766</b>	<b>100%</b>	<b>99.30%</b>	<b>71.51%</b>	<b>77.42%</b>
<b>Maintenance Personnel</b>								
<b>Expenditure</b>								
Wages - Regular	227,723	180,279	187,961	197,162	100%	79.17%	82.54%	86.58%
Wages-Sick Leave	9,330	1,718	3,436	2,164	100%	18.41%	36.83%	23.19%
Wages-Vacation Pay	14,139	14,923	14,951	14,095	100%	105.54%	105.74%	99.69%
Wages-Longevity Pay	844	751	786	1,156	100%	89.01%	93.13%	136.97%
Wages-Holiday Pay	6,874	7,118	8,439	7,119	100%	103.55%	122.77%	103.56%
Wages-Miscellaneous(Comp)	2,287	924	916	1,945	100%	40.41%	40.05%	85.05%
Wages-Bereavement	524	0	542	1,476	100%	0.00%	103.44%	281.68%
<b>Sub total Wages</b>	<b>261,721</b>	<b>205,713</b>	<b>217,031</b>	<b>225,117</b>	<b>100%</b>	<b>78.60%</b>	<b>82.92%</b>	<b>86.01%</b>
Social Security	20,419	16,212	16,680	17,197	100%	79.39%	81.69%	84.22%
Retirement (Employer)	11,240	9,557	10,140	12,155	100%	85.03%	90.21%	108.14%
Retirement (Employee)	14,661	12,524	13,090	8,452	100%	85.42%	89.28%	57.65%
Health Insurance	55,859	62,345	69,751	62,736	100%	111.61%	124.87%	112.31%
Life Insurance	80	123	123	128	100%	153.25%	153.75%	160.00%
Dental Insurance	2,388	2,944	3,431	3,424	100%	123.28%	143.68%	143.38%
<b>Maintenance Personnel Cost</b>	<b>366,368</b>	<b>309,418</b>	<b>330,246</b>	<b>329,209</b>	<b>100%</b>	<b>84.46%</b>	<b>90.14%</b>	<b>89.86%</b>
<b>Overhead</b>								
Unemployment Compensation	(62)	787	22,574	11,537	100%	-1269.03%	-36409.68%	-18608.06%
Workers Compensation	2,356	6,213	29,354	28,635	100%	263.70%	1245.93%	1215.41%
Legal	2,271	3,548	3,451	4,705	100%	156.25%	151.96%	207.18%
Accounting & Auditing	10,801	16,349	16,546	17,199	100%	151.37%	153.19%	159.24%
Other Professional Serv	2,400	88	0	0	100%	3.67%	0.00%	0.00%
Computer Support	825	0	5,392	5,311	100%	0.00%	653.58%	643.76%
Clearing House Services				1,844				100.00%
Grounds Keeping Charges	7,138	8,841	10,700	14,994	100%	123.86%	149.90%	210.06%
Purchase Care & Services	0	0	83		100%			
Computer Equipment	46,243	2,834	32,147	46,223	100%	6.13%	69.52%	99.96%
Noncapital Auto	12,000	8	9,001	13,007	100%	0.07%	75.01%	108.39%
Office 2007 Upgrade	33,168	0	0	0	100%	0.00%	0.00%	0.00%
Postage & Box Rent	22,672	29,815	950	21,585	100%	131.51%	4.19%	95.21%
Office Supplies	46,935	41,279	40,517	41,434	100%	87.95%	86.33%	88.28%
Printing & Duplicating	2,413	6,552	6,955	10,429	100%	271.53%	288.23%	432.20%
Small Items Of Equip	2,802	730	139	1,503	100%	26.05%	4.96%	53.64%
Instructional Material	382	0	89	158	100%	0.00%	23.30%	41.36%
Membership Dues	1,593	1,461	950	1,180	100%	91.71%	59.64%	74.07%
Advertising	12,111	5,269	4,055	7,381	100%	43.51%	33.48%	60.94%
Educational Supplies	935	464	154	0	100%	49.63%	16.47%	0.00%
Other Operating Expenses	2,585	2,413	20	820	100%	93.35%	0.77%	31.72%
Gasoline, Oil, Fuel	16,257	14,150	18,255	28,759	100%	87.04%	112.29%	176.90%
Water	4,516	4,574	4,618	4,459	100%	101.28%	102.26%	98.74%
Electric	68,905	68,502	75,944	72,773	100%	99.42%	110.22%	105.61%
Sewer	4,104	4,202	4,335	4,331	100%	102.39%	105.63%	105.53%
Natural Gas	34,402	29,997	25,622	23,532	100%	87.20%	74.48%	68.40%
Telephone & Fax	49,248	44,464	46,147	49,090	100%	90.29%	93.70%	99.68%
Internet	943	1,072	1,391	1,284	100%	113.68%	147.51%	136.16%
Storm Water Utility	1,630	2,133	2,133	1,509	100%	130.86%	130.86%	92.58%
Wireless Internet				6,204				100.00%
Maintain Machinery & Equip	43,637	34,414	26,958	36,042	100%	78.86%	61.78%	82.60%
Ground & Ground Improvement	360	211	9,226	12,490	100%	58.61%	2562.78%	3469.44%
Bldg Repair & Maint			1,440	1,440	100%			
Refuse Collection			3,568	3,795	100%			
Household & Janitorial Supp	17,040	14,689	14,105	17,459	100%	86.20%	82.78%	102.46%
Other Supplies			277					
Vehicle Parts & Repairs	7,074	5,837	11,413	16,910	100%	82.51%	161.34%	239.04%
Repair & Maintenance	25,305	22,338	18,797	28,897	100%	88.28%	74.28%	114.19%
Green Initiatives				23,721				100.00%
Data Processing Inter-D	186,370	300,578	224,152	276,266	100%	161.28%	120.27%	148.24%
I.P. Telephony	23,456	74,748	24,358	19,069	100%	318.67%	103.85%	81.30%
Duplicating Allocation		8,818	6,595	4,654				
Other Insurance	85,900	9,071	8,631	46,541	100%	10.56%	10.05%	54.18%
Prior Year Expenditures	0	(4,390)	0	-207	100%			
Miscellaneous Expenditures	320	2,000	1		100%	625.00%	0.31%	0.00%
MIS Direct Charges			3,491		100%			
<b>Overhead Expenditure Total</b>	<b>779,035</b>	<b>764,060</b>	<b>714,257</b>	<b>907,240</b>	<b>100%</b>	<b>98.08%</b>	<b>91.68%</b>	<b>116.46%</b>

Moved Utilities for Work Force Building to Income Maintenance for comparison included for this report

# UTILITY USAGE

~Our goal is to reduce energy consumption to the lowest level possible for all buildings~

December 2011 to March 2012 the Midwest experienced the fourth mildest winter on record, thus utility usage was down when compared to 2011. I compared the Therms used in January, February and March 2012 to 2011, Natural Gas was 69% lower on average for all four buildings.

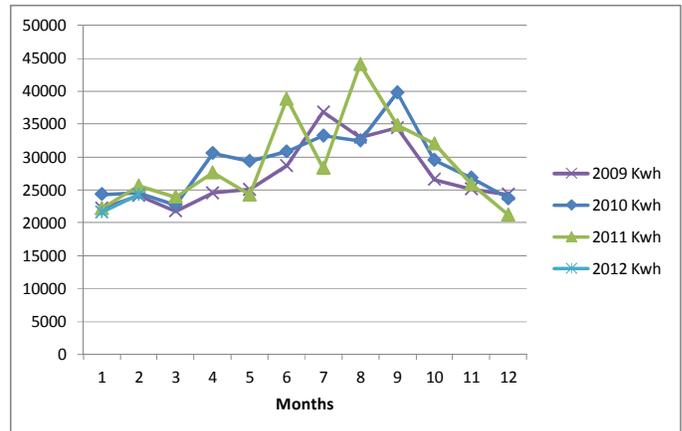
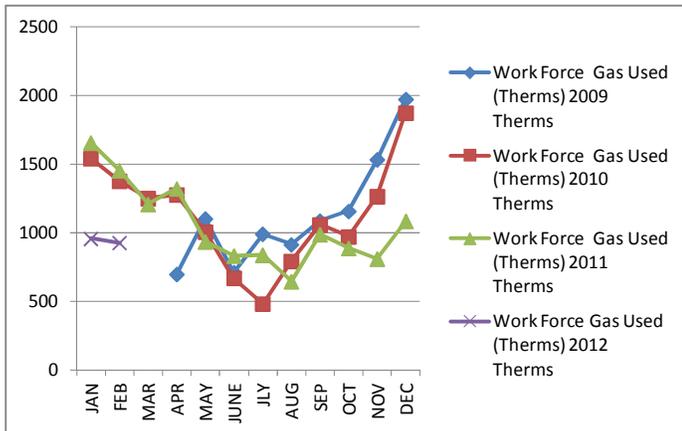
Electric usage was down on average 19.2 % even though the buildings have seen more usage in the last two years. We continue to upgrade lighting and look for more cost effective and innovative ways to conserve energy at the facilities. One area we looked at to save on electric usage was to convert all of the parking lot light fixtures from 200 and 400 Watt High Pressure Sodium bulbs to 100 Watt LED fixtures. We have asked the local utility representative to calculate the cost savings and assist in applying for Focus on Energy grants to offset a portion of the cost. The cost estimate to convert all lamp fixtures at the four buildings is \$28,270. We would like to budget for this upgrade and complete in 2013.

**Work Force Gas Used (Therms)**

Month	2009 Therms	2010 Therms	2011 Therms
JAN		1,542	1,657
FEB		1,378	1,454
MAR		1,252	1,209
APR	699	1,279	1,322
MAY	1,104	1,008	936
JUNE	713	671	833
JLY	992	484	839
AUG	915	794	646
SEP	1,088	1,060	989
OCT	1,158	973	889
NOV	1,535	1,266	811
DEC	1,974	1,874	1,086

**Electric Usage - Workforce Development Building**

	2003 Kwh	2004 Kwh	2005 Kwh	2006 Kwh	2007 Kwh	2008 Kwh	2009 Kwh	2010 Kwh	2011 Kwh
J	14560	16640	16000	17360	21200	22880	22160	24320	22160
F	13760	16240	17680	20640	22960	24640	24080	24560	25600
M	14400	16400	16320	18400	20240	16640	21760	22720	23920
A	16960	19680	21520	24480	20960	20560	24480	30560	27600
M	16480	19040	20320	23680	24080	24320	25040	29360	24240
J	18400	25040	24240	25920	29200	30720	28640	30800	38800
J	23520	23120	30160	32720	28080	25520	36800	33200	28320
A	24880	26160	31920	31360	29840	27520	32960	32480	44080
S	30400	25840	29760	32480	30480	29760	34400	39760	34800
O	14400	22480	24320	23120	28000	27920	26560	29520	32000
N	17920	20560	22720	20160	27360	26560	25120	26800	25840
D	17040	20400	22240	23360	21840	24720	24320	23680	21200

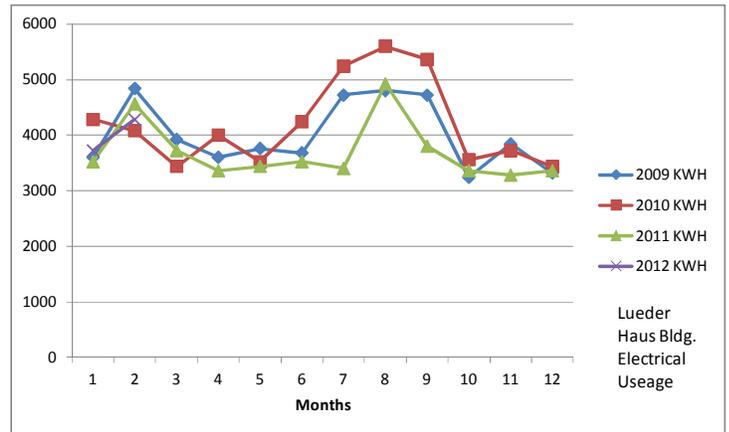
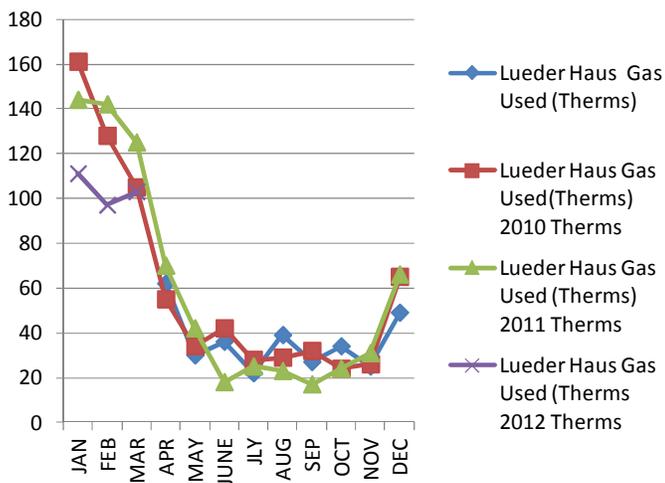


### Lueder Haus Gas Used (Therms)

Month	2009 Therms	2010 Therms	2011 Therms
JAN		161	144
FEB		128	142
MAR		105	125
APR	62	55	70
MAY	30	34	42
JUNE	36	42	18
JLY	22	28	25
AUG	39	29	23
SEP	27	32	17
OCT	34	24	24
NOV	25	26	31
DEC	49	65	66

### Electric Uage - Lueder Haus Bldg.

	2003 KWH	2004 KWH	2005 KWH	2006 KWH	2007 KWH	2008 KWH	2009 KWH	2010 KWH	2011 KWH
J	4000	4080	3920	4080	4160	4400	3600	4280	3520
F	4640	4560	4960	3560	5520	5320	4840	4080	4560
M	4040	3560	3360	4200	4120	3360	3920	3440	3720
A	3640	4120	3840	4040	3680	3720	3600	4000	3360
M	3400	3280	3360	4040	3800	3440	3760	3520	3440
J	3480	3680	4320	4320	5120	4400	3680	4240	3520
J	4360	4920	5800	5040	4760	4560	4720	5240	3400
A	4840	4520	5960	5640	5360	4800	4800	5600	4920
S	4480	4760	5160	5000	5640	4880	4720	5360	3800
O	3720	3880	3960	3960	4520	3680	3240	3560	3360
N	3240	3760	3040	3160	3960	3440	3840	3720	3280
D	3480	4000	4280	4480	4080	4440	3320	3440	3360

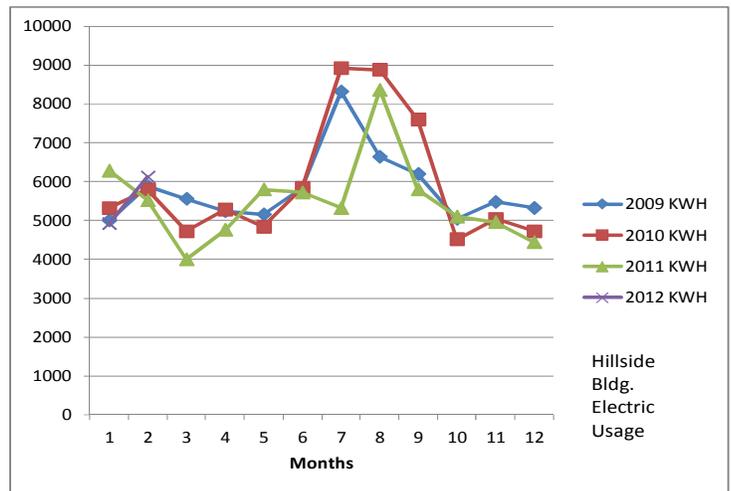
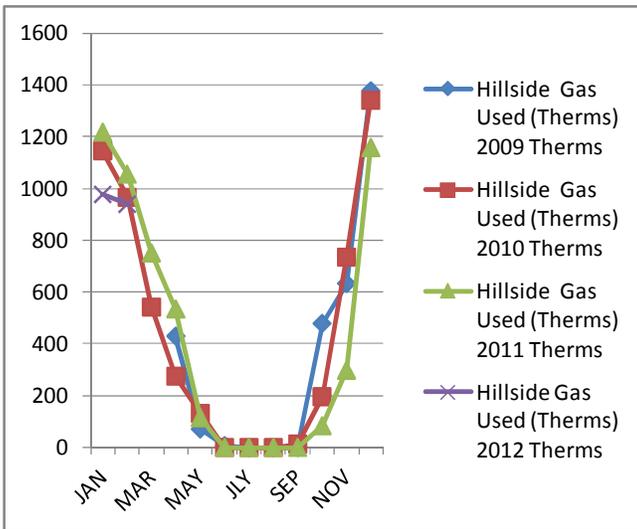


### Hillside Gas Used (Therms)

Month	2009 Therms	2010 Therms	2011 Therms
JAN		1145	1217
FEB		966	1055
MAR		542	751
APR	430	275	535
MAY	71	132	115
JUNE	7	0	0
JLY	0	0	0
AUG	0	0	0
SEP	0	13	0
OCT	479	196	84
NOV	633	735	298
DEC	1377	1340	1158

### Electric Usage - Hillside Bldg.

	2003 KWH	2004 KWH	2005 KWH	2006 KWH	2007 KWH	2008 KWH	2009 KWH	2010 KWH	2011 KWH
J	6640	6080	5440	6320	6120	6640	5000	5320	6280
F	6520	6720	7320	5480	7240	8320	5880	5800	5520
M	5880	5840	6120	6400	5760	5440	5560	4720	4000
A	5960	6680	7280	5680	5280	10480	5240	5280	4760
M	6040	6240	6520	4960	5800	1920	5160	4840	5800
J	5000	5480	7000	6000	7960	7320	5840	5840	5720
J	7680	6840	9680	7520	8640	7120	8320	8920	5320
A	8680	7040	10120	9160	9360	8000	6640	8880	8360
S	8720	6360	7720	7360	8760	7240	6200	7600	5800
O	6320	6680	5960	5800	6560	5880	5040	4520	5100
N	5880	6440	5640	5240	6920	6480	5480	5040	4960
D	5840	6520	6640	6280	6480	6360	5320	4720	4440

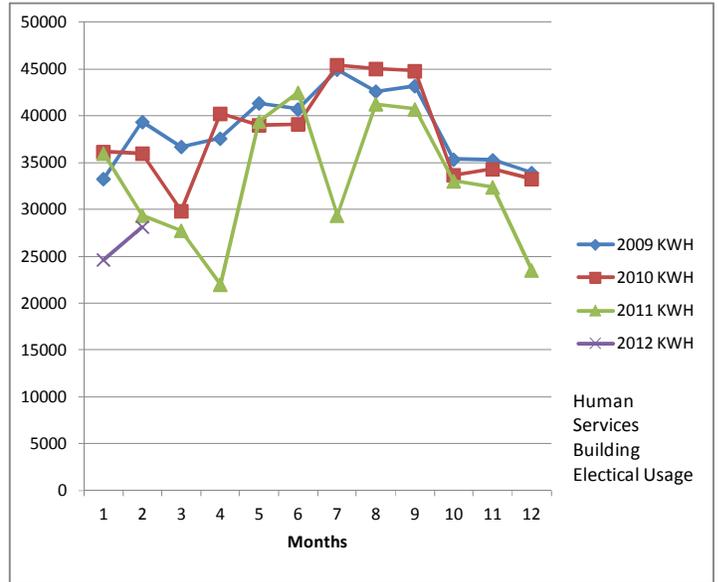
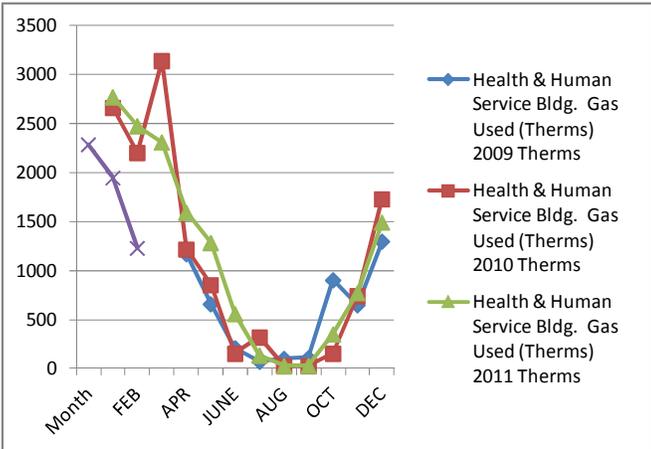


**Health & Human Service Bldg. Gas Used (Therms)**

	2009 Therms	2010 Therms	2011 Therms
Month			
JAN		2663	2772
FEB		2203	2476
MAR		3141	2311
APR	1170	1218	1592
MAY	659	854	1283
JUNE	210	153	558
JLY	72	319	134
AUG	102	27	27
SEP	109	27	29
OCT	903	153	350
NOV	649	742	772
DEC	1298	1730	1493

**Electric Usage - Human Services Building**

	2003 KWH	2004 KWH	2005 KWH	2006 KWH	2007 KWH	2008 KWH	2009 KWH	2010 KWH	2011 KWH
J	39440	41760	40560	43280	43120	41360	33280	36160	36000
F	47680	42960	46240	38720	52160	48080	39360	36000	29360
M	28560	36720	38880	46160	42640	32080	36720	29840	27760
A	39440	44560	44960	42720	40800	38480	37600	40240	22000
M	39680	39280	39040	45200	45040	37200	41360	39040	39440
J	42320	40800	45760	42400	52320	51680	40720	39120	42480
J	50880	52960	50080	49040	48480	41440	44960	45440	29360
A	51760	49600	51920	55840	51200	43440	42640	45040	41280
S	48560	48560	47200	49360	53760	47040	43200	44800	40720
O	45920	40560	41840	44080	43840	43680	35360	33680	33040
N	38080	40480	37680	38080	42960	47920	35280	34320	32400
D	38560	43600	43920	43840	40800	42960	33920	33280	23520



# **MANAGERS and SUPERVISORS**

*(As of May 1, 2012)*

**Director, *Kathi Cauley***

**Medical Director, *Mel Haggart, M.D.***

**Administrative Services Division Manager, *Joan Daniel***

Maintenance, *Terry Gard*

Office Manager & Support Staff, *Donna Hollinger*

**Aging and Disability Resource Division Manager, *Sue Torum***

Aging & Disability Resource Center, *Sharon Olson*

**Behavioral Health Division Manager, *Kathi Cauley***

Community Support Program, *Marj Thorman*

Comprehensive Community Services, *Kim Propp*

Mental Illness/AODA, *Holly Pagel*

Lueder Haus, *Terri Jurczyk*

**Economic Support Division Manager, *Jill Johnson***

W-2 Programs, *Sandy Torgerson*

**Child & Family Division Manager, *Brent Ruehlow***

Intake, *Laura Wagner*

Child Welfare, *Kevin Reilly*

Youth Delinquency, *Jessica Godek*

Early Intervention Program, Busy Bees Preschool, *Diane Bazylewicz*

Wraparound, *Barb Gang*

# TEAMS and STAFF

*As of May 1, 2012*

## **ADMINISTRATION**

Joan Daniel, *Manager*

### **Fiscal**

Lynnell Austin  
Kristie Dorn  
Mary Jurczyk  
Susan Langhoff  
Barb Mottl  
Mary Ostrander  
Dawn Renz  
Darlene Schaefer, *Volunteer*  
Cathy Swenson  
Mary Welter  
Tammy Worzalla

### **Maintenance**

Terry Gard, *Supervisor*  
Karl Hein  
Dennis Miller  
Paul Vogel  
Richard Zeidler

### **Support Staff**

Donna Hollinger, *Supervisor*  
Holly Broedlow  
Judy Maas  
Tonya Schmidt  
Dawn Shilts  
Kelly Witucki  
Lori Zick

## **AGING & DISABILITY**

### **RESOURCE CENTER**

Sue Torum, *Manager*  
Sharon Olson, *Supervisor*  
Doug Carson  
Joy Clark  
Jackie Cloute  
Betty Droster  
Beth Eilenfeldt  
Sharon Endl  
Sandra Free  
Donna Gnabasik  
Denise Grossman  
Patti Hills

Deborah Miller  
Mark Nevins  
Martha Parker  
Wendy Pettit  
Nancy Toshner  
Karen Tyne  
Lynn Walton  
Dominic Wondolkowski  
Sarah Zwieg

## **BEHAVIORAL HEALTH**

Kathi Cauley, *Director*  
Melvin Haggart, *MD*

### **Community Support Program**

Marj Thorman, *Supervisor*  
Laura Bambrough  
Heather Bellford  
Leah Benz  
Tiffany Congdon  
Candice Dienberg  
Lisa Dunham  
David Fischer  
Heather Graham-Riess  
Carol Herold  
Donna Kexel  
Heidi Knoble  
Daniel Lawton  
Karin Pratt  
Gino Racanelli

### **Comprehensive Community Services, Crisis & Lueder Haus**

Kim Propp, *Supervisor*  
Carrie Braunreiter  
Lori Brummond  
Bethany Dehnert  
Heather Dempsey  
Danielle Graham - Heine  
Candyse Hake  
Kathy Herro  
Susan Hoehn  
Terri Jurczyk  
Jessica Knurek  
Tiffeny Koebernick

Art Leavens  
Kelly North  
Jean Thiede  
Kaitlin Tolliver  
Brian Weber

**Mental Health & AODA**

Supervisor – *Holly Pagel*  
Terry Bolger  
Krista Doerr  
Kathy Drechsler  
Lynn Flannery  
Susan Gerstner  
Karen Marino  
Cemil Nuriler  
Dennis Sterwald  
Jennifer Wendt

**ECONOMIC SUPPORT**

Jill Johnson, *Manager*

**Economic Support Services**

Maria Dabel  
Rebecca David  
Kristine DeBlare  
Rose Engelhart  
Lea Flores  
Susan Hoenecke  
Michael Last  
Jan Timm  
Mary Wendt  
Judy (Polly) Wollin  
Susan Zoellick

**W-2**

Sandy Torgerson, *W-2 Supervisor*  
Edward Czupowski  
Julie Gondert  
Julie Ihlenfeld  
Michael Last  
Jessica Schultze  
Mary Springer  
Cheryl Streich

**CHILD & FAMILY**

*Manager – Brent Ruehlow*

**Youth Delinquency**

Jessica Godek, *Coordinator*  
Jessica Breezer  
Jude Christensen

Kelly Conger  
Donna Miller  
Megan Miller  
Elizabeth Stillman  
Linda Terry

**Child Welfare**

Kevin Reilly, *Supervisor*  
Rebecca Arndt  
Dawn Demet  
Heidi Gerth  
Julie Haberkorn  
Amy Junker  
Brittany Miller  
Katie Schickowski  
Jessica Stanek  
Diane Wendorf  
Jenny Witt

**Early Intervention**

Diane Bazylewicz, *Supervisor*  
Karen Brunk  
Tonya Buskager  
Dora Esquivel  
Lynette Holman  
Jillian VanSickle

**Children's Long Term Services & Wraparound**

Barb Gang, *Supervisor*  
Mary Behm-Spiegler  
Julie Butz  
Jerry Calvi  
Diane Curry  
Nichole Doornek  
Darci Frazier  
Kenny Stregre

**Intake**

Laura Wagner, *Supervisor*  
Jill Davy  
Rhea Ellestad  
Sandra Gaber  
Kelly Ganzow  
Rebecca Gregg  
Ashley Kuether  
Katie Mannix  
Melinda Moe  
Andrea Szewc  
April Zamzow

## **INFORMATION & ACKNOWLEDGEMENTS**

If you have any questions regarding anything in this report or you know someone who is in need of our services, please contact us at the following address:

**Jefferson County Human Services Department  
1541 Annex Rd, Jefferson, WI 53549**

Phone Number: 920-674-3105  
Fax Number: 920-674-6113  
TDD Number: 920-674-5011  
Website: [www.co.jefferson.wi.us](http://www.co.jefferson.wi.us)

### **FOR ECONOMIC ASSISTANCE, CONTACT:**

**Workforce Development Center  
874 Collins Rd, Jefferson, WI 53549**

Phone Number: 920-674-7500  
Fax Number: 920-674-7520

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