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JEFFERSON COUNTY HUMAN SERVICES DEPARTMENT
Serving the Residents of Jefferson County
1541 Annex Rd, Jefferson, WI 53549-9803
Ph: 920-674-3105 Fax: 920-674-6113

May, 2015

Dear County Board Chair,
Members of the Jefferson County Board of Supervisors,
Members of the Jefferson County Human Services Board,
Jefferson County citizens,
And other interested parties,

RE: Letter from the Director

It is my pleasure to submit to you the Jefferson County Human Services Department annual report. In the past year, each of our divisions served our citizens in a variety of ways and surpassed team goals. Please note (see chart on page 5) that each team in each Division has set at least one key outcome indicator for 2015. We take pride in striving to meet these outcomes and conducting continuous quality improvement, while responding to the needs of our citizens.

In 2015 our Divisions will:

- Our Administrative Services Division will provide support, maintenance, and fiscal oversight to the Department.
- The Aging and Disability Resource Division will provide services seamlessly to the elderly and persons with disabilities through the Aging & Disability Resource Center, Adult Protective Services, Benefit Specialist, Transportation and Senior Dining programs.
- The Behavioral Health Division will provide education to all stakeholders on mental health, substance use, and the impact of trauma; and provide evidence based treatment programs that are responsive to the needs of our citizens.
- The Child and Family Division will keep families together and assist them to live in their own communities, while assuring the safety, permanence, and well-being of children.
- The Income Maintenance Division will provide and coordinate resources for citizens. This Division, along with the Southern Income Maintenance Consortium, will provide the entry into the Accountable Care market exchanges as well as determining Medicaid eligibility.

I want to whole heartedly thank our County Board Supervisors and the members of our Human Services Board for their ongoing support. I want to recognize all of our dedicated staff, who remain steadfast in delivering highly effective services. Thank you.

Respectfully submitted,

Kathi Cauley
Director
Jefferson County Human Services

Mission Statement

To enhance the quality of life for individuals and families living in Jefferson County by addressing their needs in a respectful manner and enabling 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.

Performance Management Team Key Outcome Indicators For 2015

Program Title	Program Description	Mandates and/or References	Key Outcome Indicator
Administration Fiscal	Accurately complete all county, state, and federal reports and billing	State and Federal budget acts Numerous Compliance laws All Medicaid and Medicare requirements	100% compliance with reporting requirements as denoted on work chart
Administration Maintenance	Maintain buildings and grounds while planning for future	46	100% of capital projects completed on time and within budget
Administration Support Staff	Support all agency staff and maintain all records	46	Maintain excellent customer service as indicated by our internal customer satisfaction survey.
Adult Protective Services and Elder Abuse	Vulnerable adults, aged 18+ are aware of and have access to Adult Protective Services 24/7.	46.283, 46.90, 51, and 55	100% of referrals are responded to within the time frames contained in the statute; and case notation and legal time frames are met in 100% of cases referred
Aging Disability & Resource Center	Seniors and persons with disabilities get accurate, unbiased information, assistance or access to publicly funded long term care when calling the ADRC.	46.283, DHS 10	100% of ADRC customers surveyed indicate that they would refer the ADRC to someone else.
Elder Benefit Specialist	Assist elders in understanding and accessing benefits	46.81, Older American's Act	During the 12 months in 2015, the benefit specialist programs will continue to serve all of the individuals requesting help without subjecting them to a waiting list.

Program Title	Program Description	Mandates and/or References	Key Outcome Indicator
Senior Dining Program	Serve and deliver, without interruption, well-balanced meals to seniors who request them in our service area, with attention to those who have the greatest economic or social need)	Older American's Act (OAA)	100% of seniors completing satisfaction surveys report that they are not experiencing hunger or food insecurity.
Transportation	Seniors and persons with disabilities receive rides to medical care and appointments with the department.	85.21	100% of ride requests are safely met.
Dementia Care Specialist (DCS)	Provides education & training to organizations wishing to become "dementia capable."	46.283, DHS 10	By 12/31/2015, information about DCS services and available supports will be provided to all county departments
Mental Health Outpatient Clinic	Provide mental health counseling	51 AR 35	PQH 9 and BAM scores will improve by 2%
Comprehensive Community Services	Recovery based community, mental health, and substance abuse services	Supports 51 services AR 36	72% of all treatment plan goals are met
Community Support Program	Integrated services for people with severe and persistent mental illness	51 AR 63	72% of all treatment plan goals are met
Emergency Mental Health	24/7 mobile response to all crisis call	51	Giving consideration to lethality and acuity, maintain diversion rate to least restrictive setting
Community Recovery Services	Residential services for people with mental health and substance abuse	51	100% compliance with CRS rules
Intake	Provides a single access point for all child, juvenile and family service needs.	48, 938	100% of all State and Federal timelines will be met
Children in Need of Protective Services	Monitor safety, well-being, and permanence for all children found to be in need of protection or services by the courts.	48	All new out-of-home placements will be formally screened for permanency options within 90 days of case assignment to ongoing staff.
Juvenile Justice Integrated Services	Provide evidence based treatment and supervision to all court ordered youth.	938	95% of children on formal supervision will remain in the community through the use of community based safety plans and treatment

Program Title	Program Description	Mandates and/or References	Key Outcome Indicator
Birth to Three	Supporting Families in promoting the growth and development of their children.	46 and 51 AR 910	The Birth to Three Program will be issued a notification of 100% compliance with the Federally Compliancy Indicators by DHS based on the annual data review.
Busy Bee Pre-School	Supporting Families in promoting the growth and development of their children.	46 and 51 AR 910	Busy Bees Pre-School will maintain a 4-star rating from the YoungStar Program.
Children Long Term Support/CST	Multi-disciplinary approach to building community based MA funded programing for youth.	46	90% of all children will remain in their home with the use of CLTS and CST services
Independent Living	Enhancing daily living skills for youth in placement to transition to adulthood successfully.	48	90% of IL youth and young adults who have aged out of care will enroll in the military, work program or secondary education program.
Medical Assistance and Market Place exchanges	Facilitates access for those who are eligible	46, 49 and PPACA	Meet mandated performance standards
Foodshare-Food Stamps	Facilitates access for those who are eligible	46 and 49	Meet mandated performance standards
Child Care	Facilitates access for those who are eligible	46 and 49	Meet mandated performance standards
Energy Assistance	Facilitates access for those who are eligible	46 and 49	Meet mandated performance standards

**HUMAN SERVICES BOARD OF DIRECTORS
2014 – 2015**

Jim Mode, *Chair*

Richard Jones, *Vice Chair*

John McKenzie, *Secretary*

Russell Kutz

Julie Merritt

Augie Tietz

James Schultz

**AGING AND DISABILITY RESOURCE
CENTER ADVISORY COMMITTEE**

Earlene Ronk, Chair
Carol Battenberg
Ellen Haines
Dan Krause
Jim Mode
Georganne Mortenson
Carolyn Niebler
Darlene Schaefer
Connie Stengel
Sue Torum, Staff
Sharon Olson, Staff

NUTRITION PROJECT COUNCIL

Marcia Bare
Janet Gerbig
Holly Ingersoll
Rita Kannenberg
Barbara Natrop
Emily Pantely
Judy Pinnow

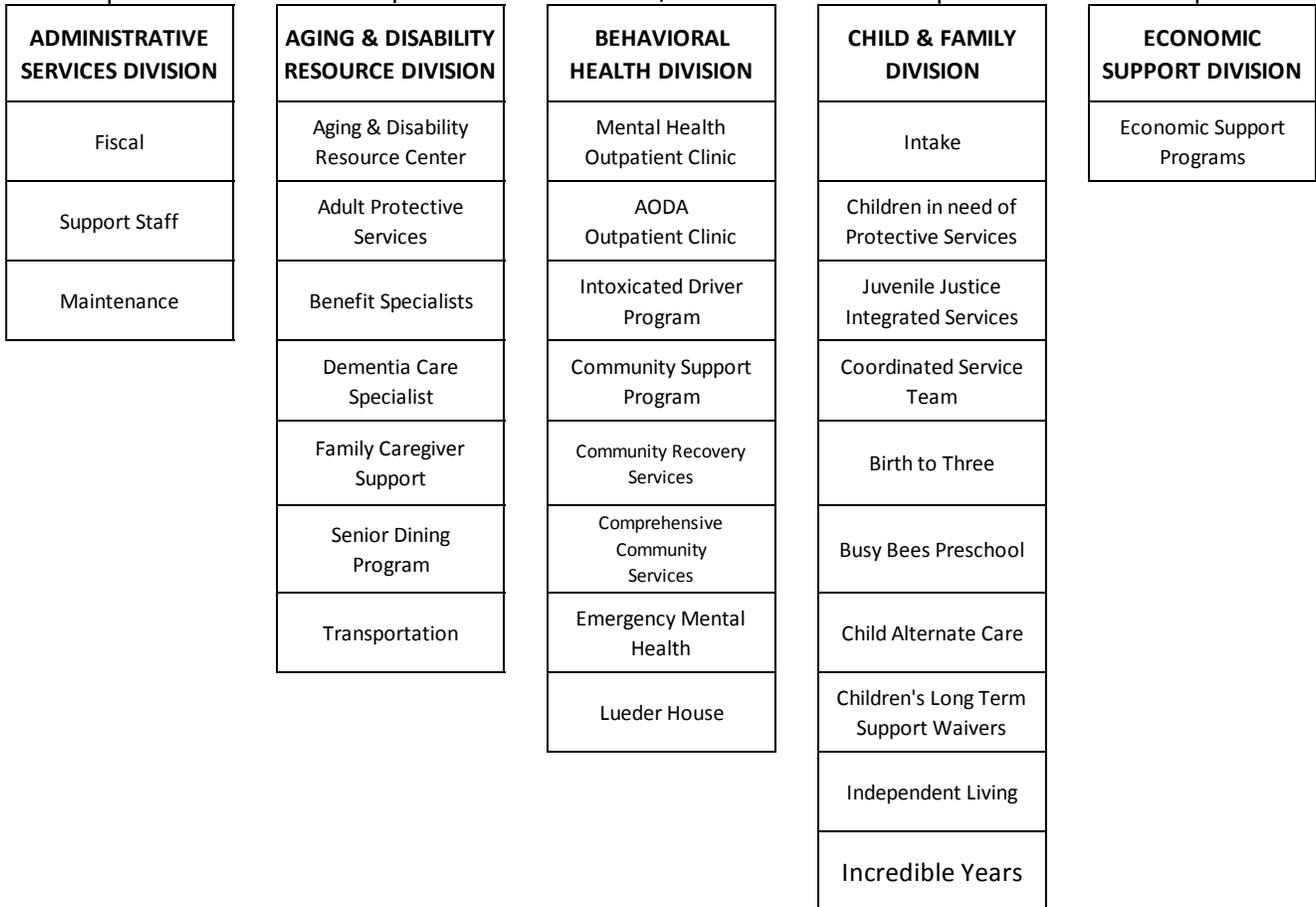
**JEFFERSON COUNTY HUMAN SERVICES DEPARTMENT
ORGANIZATIONAL CHART**

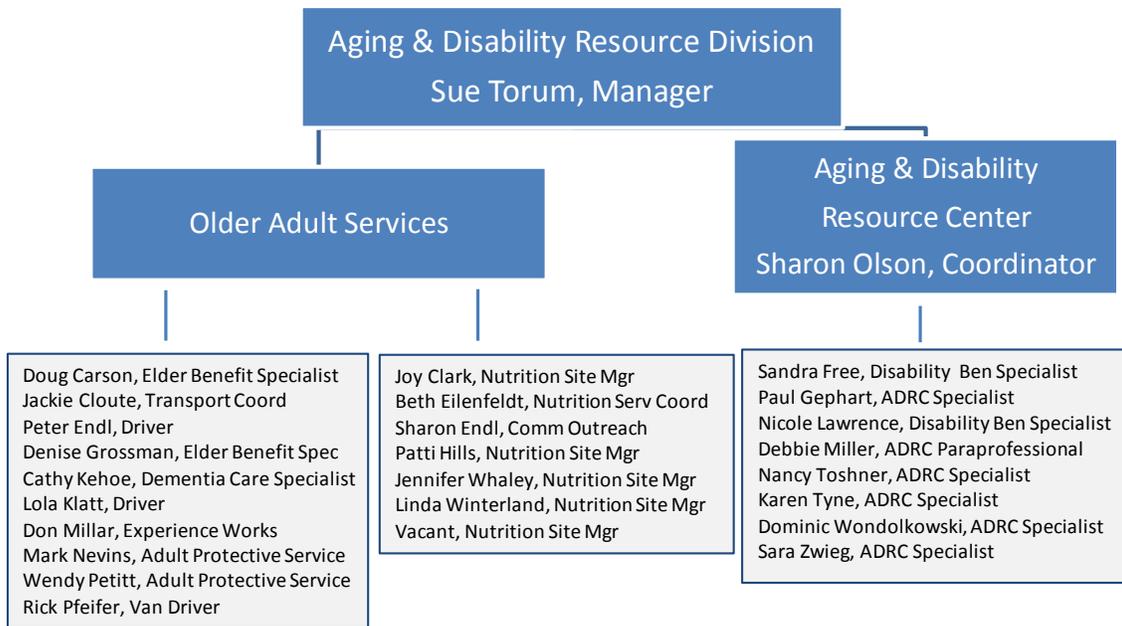
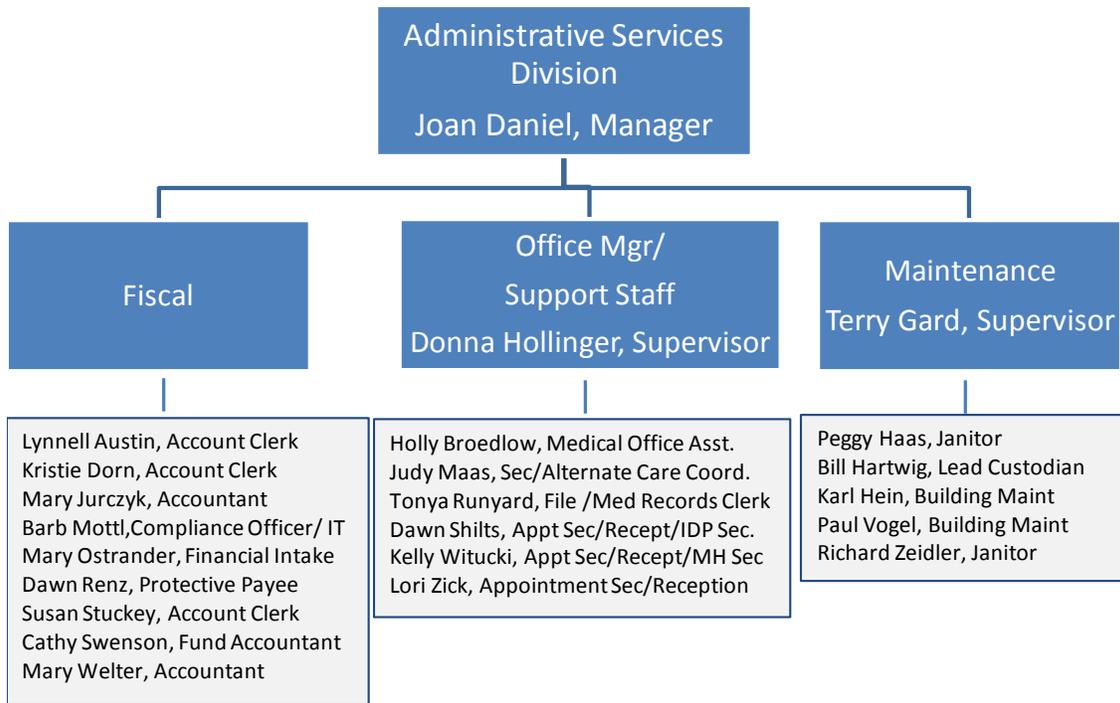
JEFFERSON COUNTY BOARD OF SUPERVISORS

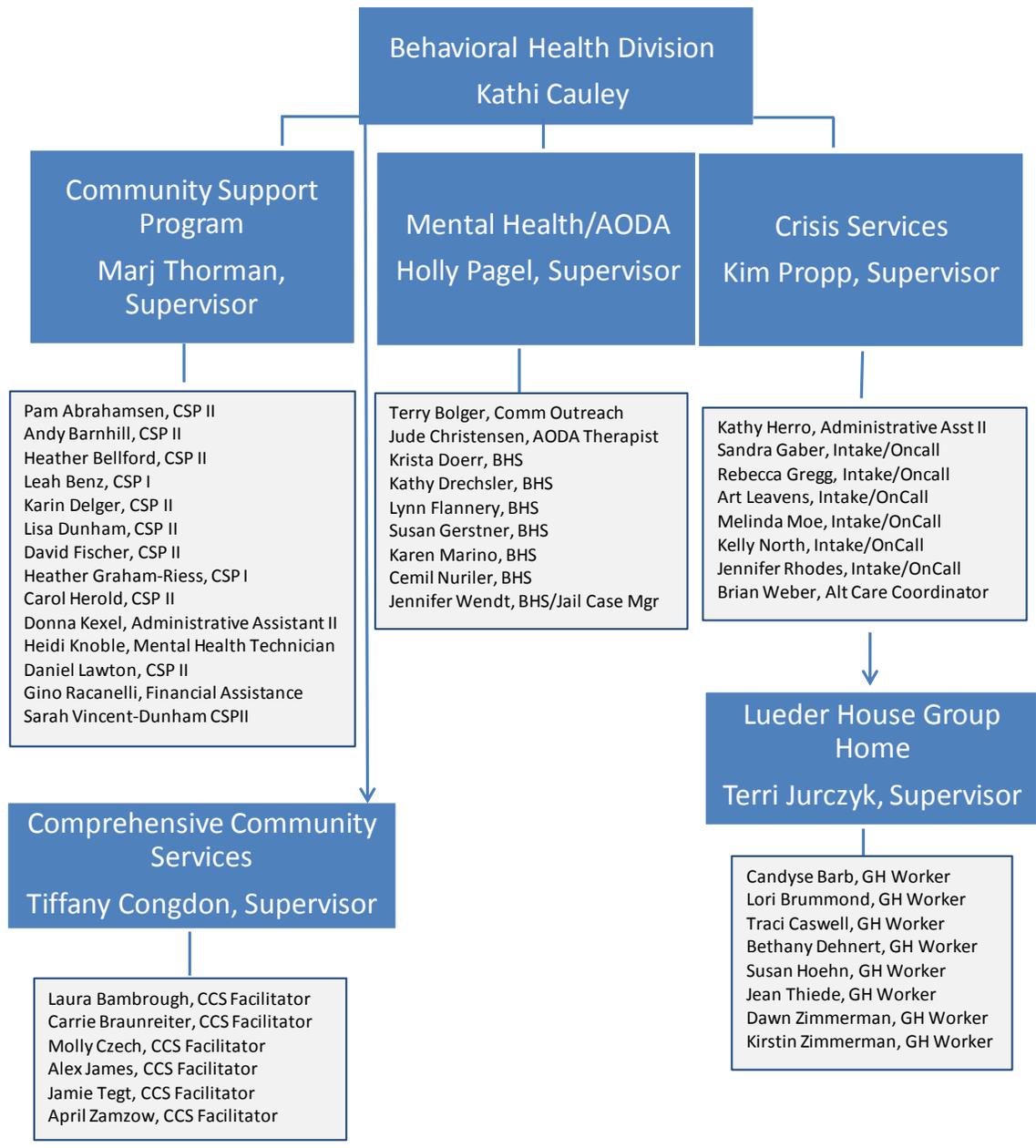
HUMAN SERVICES BOARD

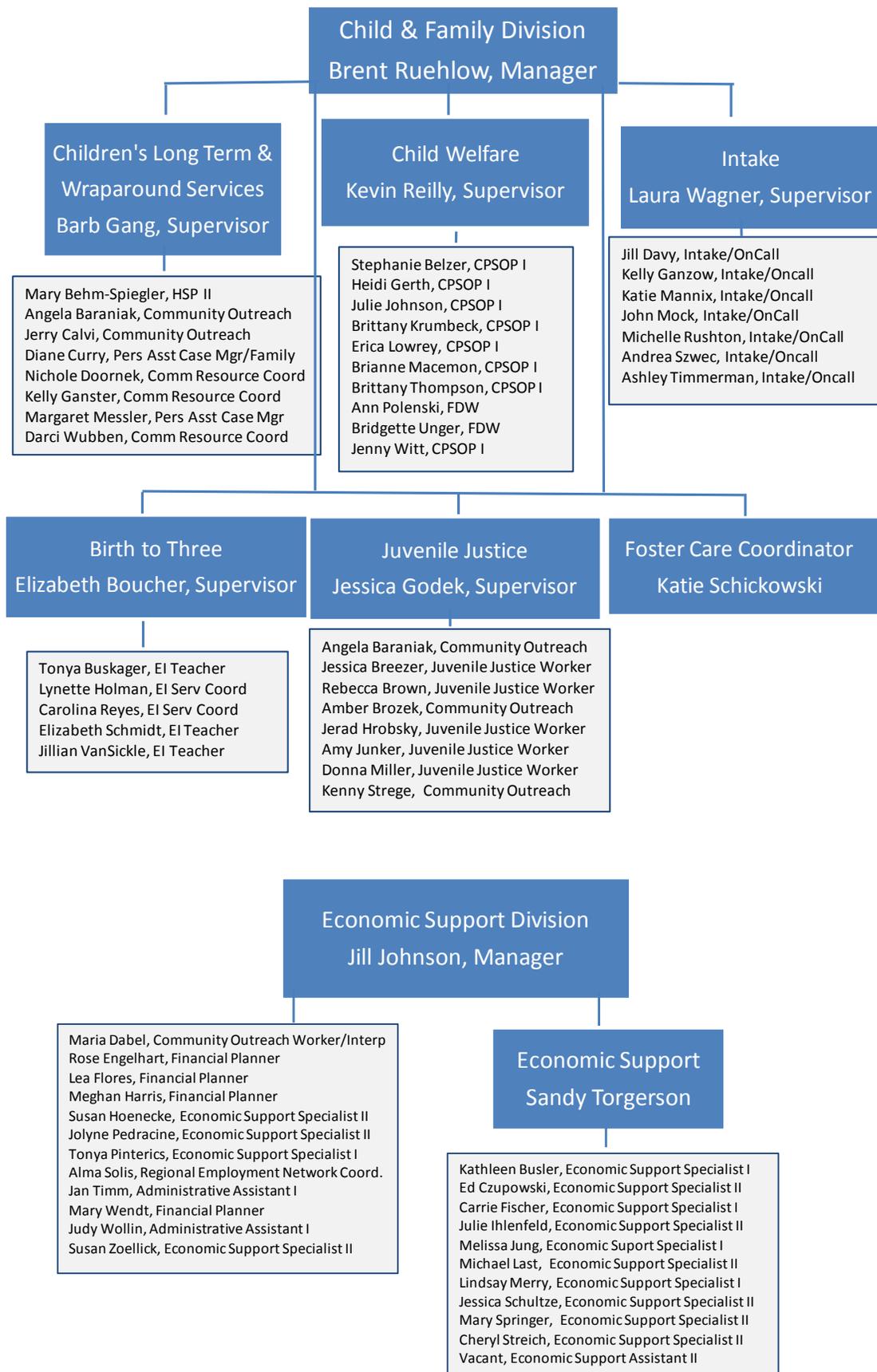
COUNTY ADMINISTRATOR

HUMAN SERVICES DIRECTOR









ADMINISTRATION SERVICES DIVISION

~Providing support, maintenance, and fiscal oversight to the Department~

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

The **Fiscal team** consists of nine full time employees, 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 **Maintenance team** consists of a supervisor, four full time employees and two part time employees. They ensure that the vehicles, buildings and grounds are in working order.

The **Support Staff team** consists of an Office Manager/Supervisor, six full time employees, and two part time staff who are employed through Experience Works. They ensure that phones are answered, appointments are scheduled, records are maintained and filed, and all other support duties are completed.

FISCAL

~Ensuring fiscal responsibility to the citizens of Jefferson County~

Fiscal Statement Summary December Final, 2014 (Unaudited)

We had a positive fund balance of \$931,091 at the end of the year. There were \$242,229 in prepaid assets on our balance sheet for 2015 expenditures. Operations had a favorable balance of \$266,655 for 2014. Our non-lapsing request of \$675,832 was approved. A balance of \$255,259 was returned to the County General Fund.

Major Classifications that impacted the favorable 2014 balance:

Summary of Variances:

Federal/State & Operating Revenue: Overall Revenues were unfavorable by \$698,931. The Children Long Term Services (CLTS) funds received an additional contract in 2014. This contract was for 2014/2015 to provide services to children on the program's wait list. The revenue for this contract was booked in 2014 even though the contract is over two years. Since the process of assessing and getting state approval for children takes time; not all of these funds were earned in 2014 and associated expenses were not incurred. For 2014 revenue for CLTS revenue was under budget by \$610,452.

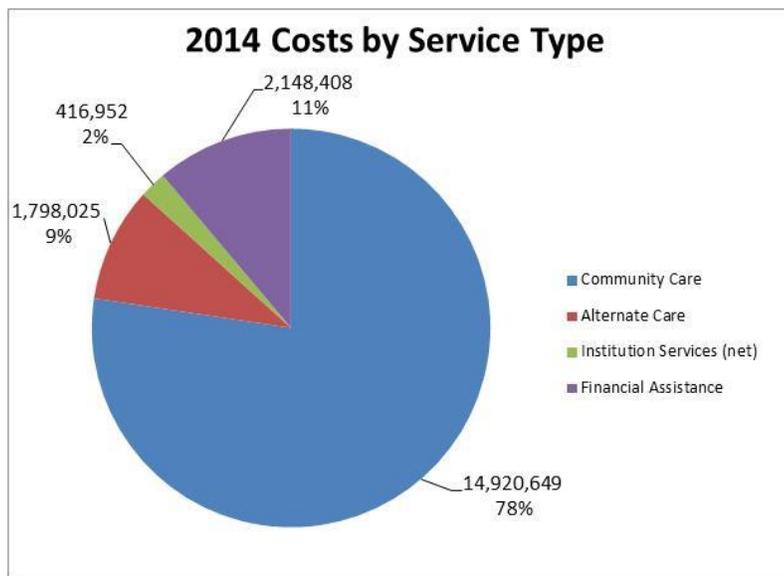
Expenditures: Overall Expenditures were favorable by \$1,449,773. Due to the new contract for CLTS funds that were received and booked in the budget, the associated expenditures were not incurred in 2014. This amounted to \$787,049 underspent for the CLSTS program.

Children’s Alternate Care: The children’s alternate care program budget totaled \$2,225,029. A budget transfer was made of \$238,743 during the year to the capital account for the purchase of the ECHO software system leaving a remaining budget of \$1,986,286. Expenditures for this program were budgeted based on 2013 trends which amounted to an average cost per month of \$211,169 with waiver alternate care expenditures. The average cost per month for 2014 was \$149,434. The 2014 actual expenditures came in at \$1,798,025 with shelter care leaving a favorable balance of \$188,261.

Hospital/Detox: The Hospital/Detox 2014 budget was \$917,466. The actual expenditures were \$415,826 leaving a positive balance of \$501,640. This is primarily due to 2013 revenue collected in 2014 by the Winnebago/Mendota state hospitals. This revenue is booked on a cash basis per the state requirements due to the uncertainty of the amount that will be collected from insurance.

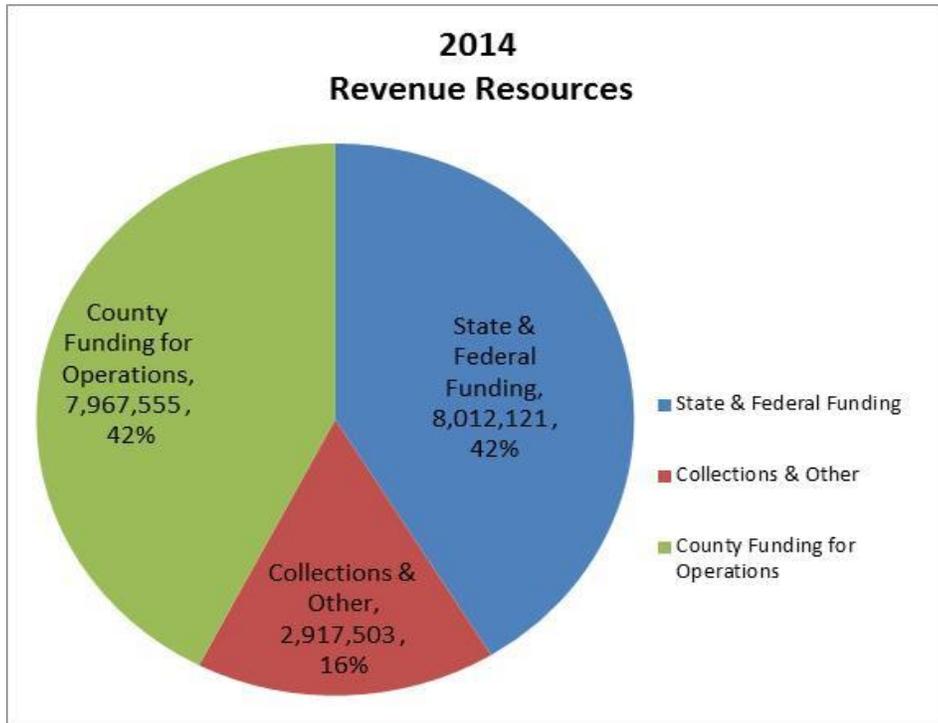
	Original Budget	Actual	Variance
Revenue	475,000	768,600	293,600
Expenditures	1,392,466	1,184,426	208,040
Net	917,466	415,826	501,640

Capital Outlay: The capital was increased for the Echo Software System. This project will be finalized in 2015; the non- lapsing request is 230,418.34 and the pre-paid portion is \$58,850.84 totaling \$289,269.18. This carry forward to 2015 was approved by the Board.

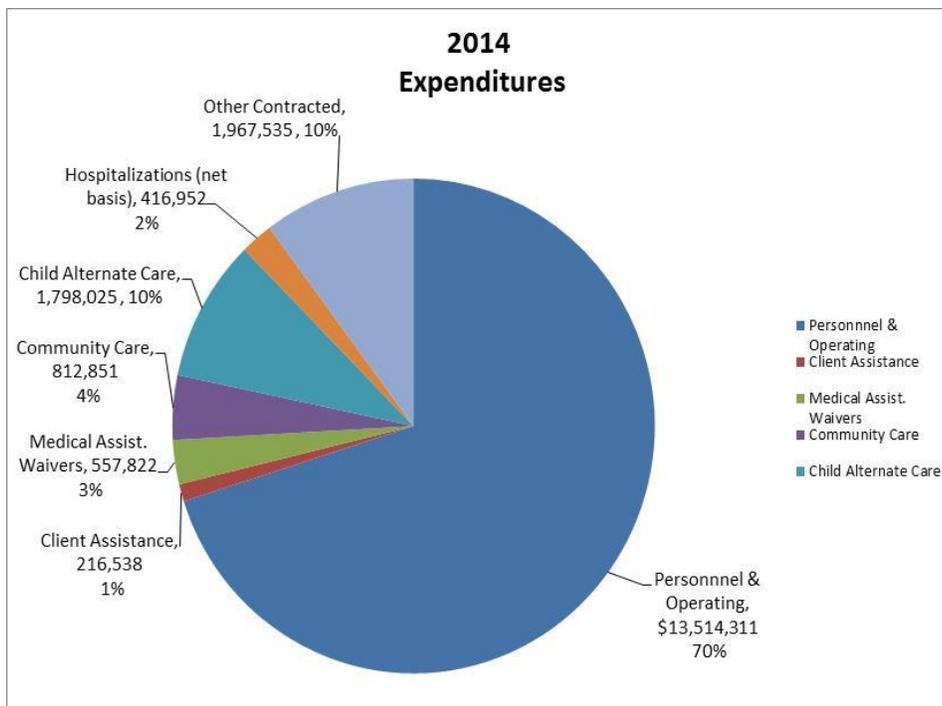


In 2014 actual costs increased in expenditures by \$386,854 from 2013 this is a 2% increase for the department. Alternate Care decreased by 2% from 2013 and Financial Assistance (Economic Support) activities increased by 2%. Community Care increased by 4% from 2013.

In the chart below, Consortium Economic Support and Waiver TPA are reclassified as state payment. This does not include Depreciation/County/Indirect costs reportable to state but not on Human Services ledgers (County levy).



The chart below does not include depreciation or County indirect costs. These costs are reportable to the state but are recorded on the county ledgers. Depreciation totaled \$202,910 in 2014. County indirect charges in 2014 were \$478,201. The hospitalizations cost is reported on net basis (revenue offset expenditures)



FINANCIAL REPORTS

The Financial Reports that follows summarizes Department resources and expenditures by source, target group, and service. Data is presented in numeric and pie chart formats. Total resources for 2014, including County tax levy, were \$19,550,689 plus forward of Non Lapsing Funds carried forward from 2013 in the amount of \$664,436. Providing a total revenue amount of \$20,215,125. Total expenditures amounted to \$19,284,034.

2014 Resources & Expenditures (unaudited)

RESOURCES:	2013 ACTUAL	2014 ACTUAL	2014 BUDGET	2014 VARIANCE
State & Federal Funding	\$ 8,012,121	8,068,013	\$ 8,645,572	577,558
Collections & Other	2,917,505	3,180,548	3,595,521	414,973
County Funding for Operations	8,032,843	8,302,128	8,302,128	0
Total Resources	\$ 18,962,469	\$ 19,550,689	\$ 20,543,221	992,531

EXPENDITURES:	2013 ACTUAL	2014 ACTUAL	2014 BUDGET	2014 VARIANCE
Personnel & Operating	\$ 12,469,150	\$ 13,514,311	\$ 14,050,874	536,563
Client Assistance	202,366	216,538	251,406	34,868
Medical Assist. Waivers	643,916	557,822	1,344,871	787,049
Community Care	646,213	812,851	627,789	-185,062
Child Alternate Care	2,099,713	1,798,025	1,986,286	188,261
Hospitalizations (net balance)	1,068,988	416,952	917,466	500,514
Other Contracted	1,766,835	1,967,535	1,848,716	-118,819
Total Expenditures	\$ 18,897,181	\$ 19,284,034	\$ 21,027,408	1,743,373

SUMMARY	2013 BALANCE	2014 BALANCE	2014 PERCENT of BUDGET
Surplus from operations	\$ 65,288	\$ 266,655	1.30%
2013 Carry Forward	\$ 599,147	\$ 664,436	
Total Net Surplus	\$ 644,435	\$ 931,091	4.43%

2014 resulted in a net surplus of \$931,091 4.43% of total budget, We have requested \$675,832 for Non-Lapsing funds to be carried forward toward the 2015 budget. The remaining balance of \$255,259 was returned to the general fund.

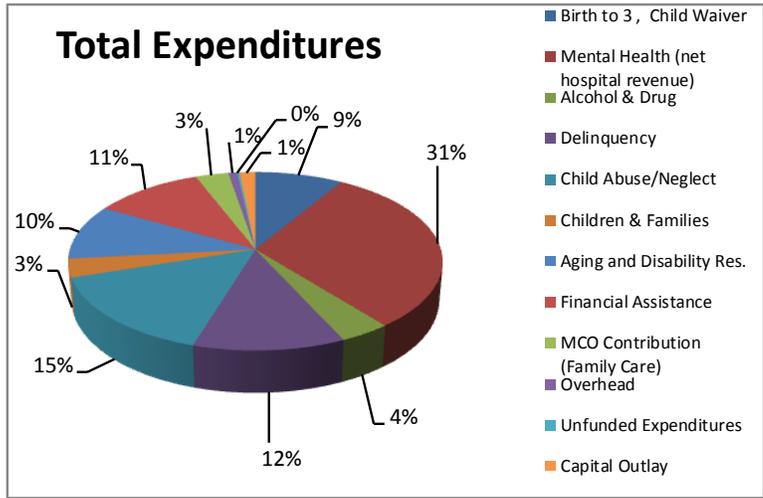
Depreciation	202,727
County Indirect Cost	478,201
	680,928

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

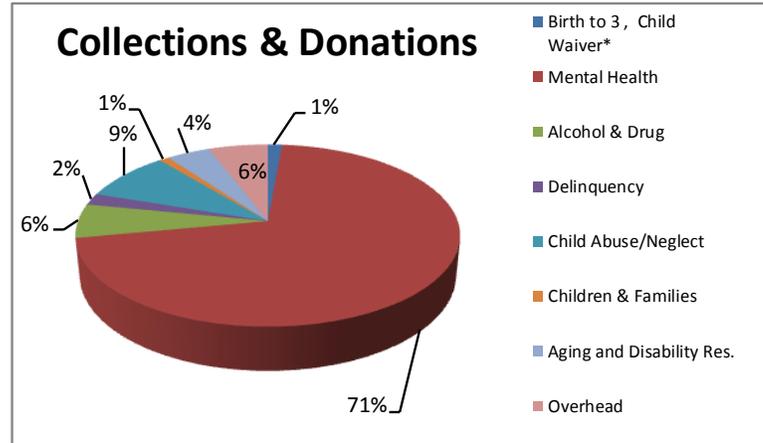
2014 Costs by Target Group

(does not include Depreciation & County Indirect Cost in pie chart)

Total Expenditures	
Birth to 3 , Child Waiver	1,661,253
Mental Health (net hospital revenue)	5,902,710
Alcohol & Drug	754,447
Delinquency	2,236,092
Child Abuse/Neglect	2,941,433
Children & Families	641,902
Aging and Disability Res.	1,923,006
Financial Assistance	2,085,226
MCO Contribution (Family Care)	625,097
Overhead	165,962
Unfunded Expenditures	47,207
Capital Outlay	296,967
TOTAL	19,281,302

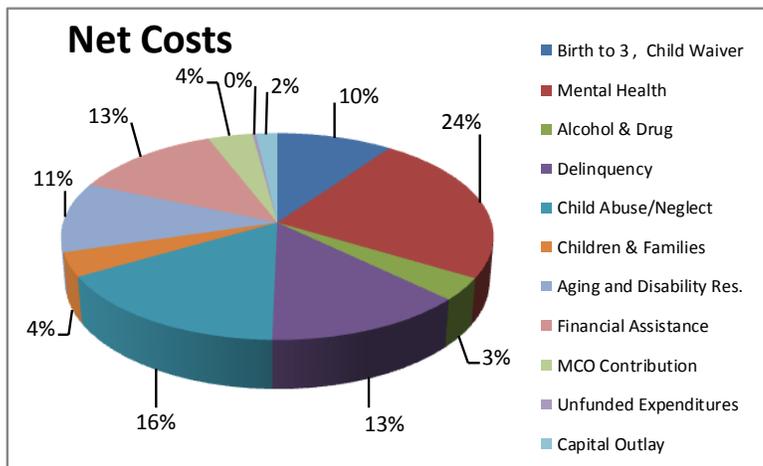


Collections & Donations	
Birth to 3 , Child Waiver*	39,743
Mental Health	2,013,074
Alcohol & Drug	172,718
Delinquency	58,608
Child Abuse/Neglect	250,792
Children & Families	27,701
Aging and Disability Res.	121,155
Overhead	165,962
TOTAL	2,849,753



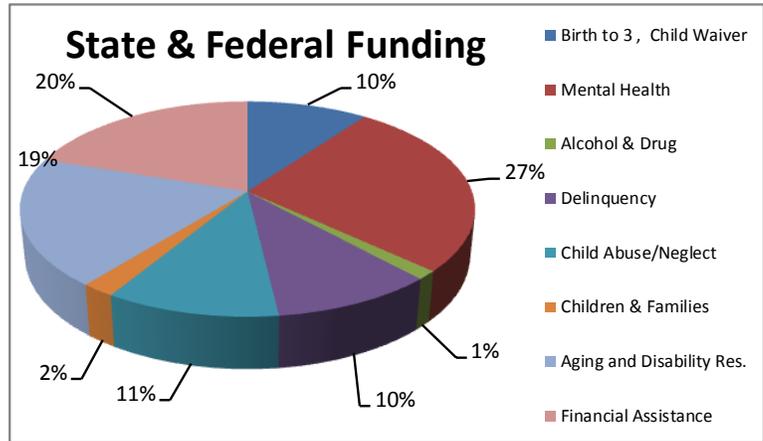
Reclassified Consortium Economic Support and Waiver TPA as State Payment
Hospital Collections are reported on net in expenditures

Net Costs	
Birth to 3 , Child Waiver	1,621,510
Mental Health	3,889,636
Alcohol & Drug	581,729
Delinquency	2,177,484
Child Abuse/Neglect	2,690,641
Children & Families	614,201
Aging and Disability Res.	1,801,851
Financial Assistance	2,085,226
MCO Contribution	625,097
Unfunded Expenditures	47,207
Capital Outlay	296,967
TOTAL	16,431,549

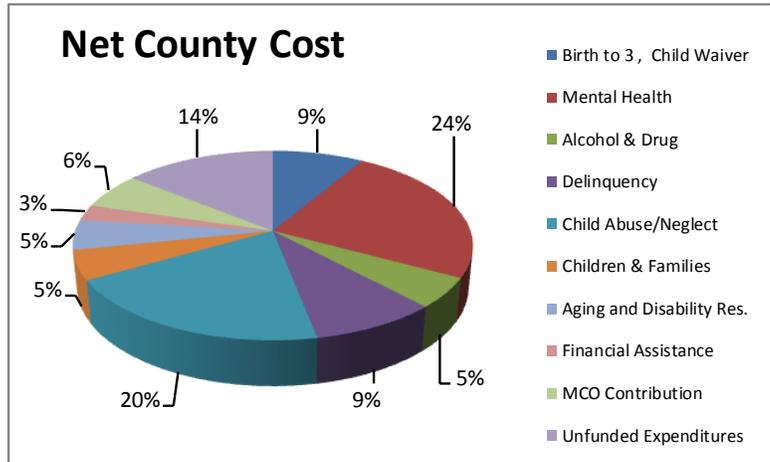


State & Federal Funding	
Birth to 3 , Child Waiver	840,751
Mental Health	2,243,893
Alcohol & Drug	109,299
Delinquency	834,717
Child Abuse/Neglect	892,800
Children & Families	172,534
Aging and Disability Res.	1,617,085
Financial Assistance	1,661,947
TOTAL	8,373,026

Reclassified Consortium Economic Support and Waiver TPA as State Payment



Net County Cost	
Birth to 3 , Child Waiver	780,759
Mental Health	1,645,743
Alcohol & Drug	472,430
Delinquency	1,342,767
Child Abuse/Neglect	1,797,841
Children & Families	441,667
Aging and Disability Res.	184,766
Financial Assistance	423,279
MCO Contribution	625,097
Unfunded Expenditures	47,207
Capital Outlay	273,917
Tax Levy for Operations	8,035,473



NOTE Calculation of Levy	
Note Budget Tax Levy	8,302,128
Less: Net Positive Balance from operations	266,655
Tax Levy from Operations	8,035,473
Net Positive Balance from operations	266,655
Reserve from Balance sheet for Non-Lapsing 2013 Non Lapsing Request approved to be carried forward to 2014	664,436
Tax levy from Operations	931,091
Depreciation	202,910
County Indirect Cost	478,201
Total Tax Levy	8,716,584

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

6 Year Comparison of Mileage and Vehicle Expenses						
	2009 Base Year	2010	2011	2012	2013	2014
Total Mileage	\$269,112	180,174	155,922	160,553	153,189	129,802
Gas/Diesel	\$16,464	20,604	32,298	41,206	46,078	52,607
Non Capial Auto	\$8	9,001	13,007	9,509	19,018	2,009
Sale Squad Vehicles	\$0	0	-1,495	-1,988	-400	-2,003
Vehicle Parts % Repairs	\$5,837	11,413	16,910	17,954	24,033	18,334
Total Expense	\$291,421	\$221,192	\$216,642	\$227,234	\$241,918	200,749
Savings Compared to Base Year		70,229	74,779	64,187	49,504	90,672
Average Savings last 6 years						69,874

Over the last 6 years, we have endeavored to review all department systems for cost savings and efficiencies. The vehicle expense chart above is one example. In 2009 we paid 291,421 to staff for mileage. Over the last five years, we have added additional vehicles and have seen an average saving of approximately \$69,874 per year, even with additional vehicle expenses. The chart above summarizes this data with 2009 being the base year.

DONATIONS AND GRANTS 2014		
DONATIONS	Amount	Program
County City Credit Union	\$ 75.00	Child Abuse Prevention
Kwik Trip	\$ 200.00	Child Abuse Prevention
Culver's	\$ 225.00	Child Abuse Prevention
Dean Buchholz	\$ 30.00	Ready Kids for School
Anthony Wedl	\$ 75.00	Ready Kids for School
Memorial for Phyllis Krueger	\$ 95.00	Mental Health
Anonymous	\$ 50.00	Elderly Benefit Spec
Total Donations	\$ 750.00	
GRANTS	Amount	Program
United Way of Jefferson & Walworth Counties	\$ 500.00	Incredible Years
United Way of Jefferson & Walworth Counties	\$ 500.00	Incredible Years
Knights of Columbus - Intellectually Disabled	\$ 739.00	Birth to Three
Total Grants	\$ 1,739.00	
Total Donations & Grants	\$ 2,489.00	

Donations received in 2014 is a decrease of \$6,386 from 2013

MANAGEMENT OVERHEAD COST COMPARISON – SEVEN YEARS

MANAGEMENT	2008	2009	2010	2011	2012	2013	2014	2008	2009	2010	2011	2012	2013	2014
Expenditure														
Wages - Regular	557,597	517,376	396,555	461,965	499,950	482,243	427,216	100%	92.79%	71.12%	82.85%	89.66%	86.49%	76.62%
Wages-Overtime	5,980	0	0	905	0	0	0	100%	0.00%	0.00%	15.13%	0.00%	0.00%	0.00%
Wages-Regular Overtime	357	0	0	0	0	0	0	100%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Wages-Sick Leave	28,440	65,935	24,852	14,836	15,024	16,592	24,473	100%	231.84%	87.38%	52.17%	52.83%	58.34%	86.05%
Wages-Vacation Pay	55,358	71,251	34,431	43,036	44,160	52,324	67,714	100%	128.71%	62.20%	77.74%	79.77%	94.52%	122.32%
Wages-Longevity Pay	3,122	2,866	1,253	1,973	2,424	2,544	3,490	100%	91.78%	40.13%	63.20%	77.64%	81.49%	111.79%
Wages-Holiday Pay	24,839	23,378	20,329	19,202	22,912	23,012	36,635	100%	94.12%	81.84%	77.31%	92.24%	92.64%	147.49%
Wages-Miscellaneous(Comp)	6,494	8,939	17,743	17,536	18,371	14,778	21,723	100%	137.64%	273.22%	270.03%	282.89%	227.56%	334.51%
Wages-Bereavement	764	509	599	1,022	0	462	931	100%	66.66%	78.40%	133.77%	0.00%	60.47%	121.86%
Wages-Death Benefit	1,839	0	0	0	0	0	0	100%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Social Security	52,405	54,208	38,058	42,774	45,427	44,537	43,919	100%	103.44%	72.62%	81.62%	86.68%	84.99%	83.81%
Retirement (Employer)	31,432	28,281	23,005	30,341	35,801	39,506	40,692	100%	89.98%	73.19%	96.53%	113.90%	125.69%	129.46%
Retirement (Employee)	40,958	37,015	29,664	21,012	-7	0	0	100%	90.37%	72.43%	51.30%	-0.02%	0.00%	0.00%
Health Insurance	221,462	212,410	146,728	142,478	136,585	146,608	162,918	100%	95.91%	66.25%	64.34%	61.67%	66.20%	73.56%
Life Insurance	452	400	276	299	335	347	336	100%	88.43%	61.06%	66.15%	74.12%	76.77%	74.34%
Dental Insurance	10,141	10,046	7,618	9,138	8,960	9,346	9,728	100%	99.06%	75.12%	90.11%	88.35%	92.16%	95.93%
Per Diem	7,480	7,530	6,325	5,720	6,545	6,050	4,950	100%	100.67%	84.56%	76.47%	87.50%	80.88%	66.18%
Advertising	0	303	0	0	47	61	0	100%	0.00%	0.00%	0.00%	100.00%	129.79%	0.00%
Board Member Training	611	465	775	690	509	140	1,348	100%	76.10%	126.84%	112.93%	83.31%	22.91%	220.62%
Registration	1,607	565	874	1,315	2,046	-2,528	8,620	100%	35.16%	54.39%	81.83%	127.32%	8.71%	83.88%
Mileage	4,949	3,887	3,545	3,524	4,520	4,323	4,009	100%	78.55%	71.63%	71.21%	91.33%	-51.08%	174.18%
Misc							-548							
Other Insurance		3,540	2,692		0	0		100%						
MANAGEMENT	1,056,287	1,048,903	755,322	817,766	843,609	840,345	858,154	100%	99.30%	71.51%	77.42%	79.87%	79.56%	81.24%
* Changed methodology for allocating Management in 2014 based on direct charge when work can be identified to program.														
Maintenance Personnel														
Expenditure														
Wages - Regular	227,723	180,279	187,961	197,162	199,615	190,648	187,259	100%	79.17%	82.54%	86.58%	87.66%	83.72%	82.23%
Wages - Overtime						277	1,941	100%	0.00%	0.00%	0.00%	0.00%	100.00%	100.00%
Wages - Other						6,405	6,490	100%	0.00%	0.00%	0.00%	0.00%	100.00%	100.00%
Wages-Sick Leave	9,330	1,718	3,436	2,164	2,544	2,312	2,998	100%	18.41%	36.83%	23.19%	27.27%	24.78%	32.13%
Wages-Vacation Pay	14,139	14,923	14,951	14,095	14,620	16,966	15,671	100%	105.54%	105.74%	99.69%	103.40%	119.99%	110.84%
Wages-Longevity Pay	844	751	786	1,156	1,201	954	1,053	100%	89.01%	93.13%	136.97%	142.30%	113.03%	124.76%
Wages-Holiday Pay	6,874	7,118	8,439	7,119	7,694	7,547	7,468	100%	103.55%	122.77%	103.56%	111.93%	109.79%	108.64%
Wages-Miscellaneous(Comp)	2,287	924	916	1,945	2,217	2,360	2,312	100%	40.41%	40.05%	85.05%	96.94%	103.19%	101.09%
Wages-Bereavement	524	0	542	1,476	0	551	370	100%	0.00%	103.44%	281.68%	0.00%	105.15%	70.61%
Sub total Wages	261,721	205,713	217,031	225,117	227,891	228,020	225,562	100%	78.60%	82.92%	86.01%	87.07%	87.12%	86.18%
Social Security	20,419	16,212	16,680	17,197	17,232	17,271	17,020	100%	79.39%	81.69%	84.22%	84.39%	84.58%	83.35%
Retirement (Employer)	11,240	9,557	10,140	12,155	13,515	15,044	15,665	100%	85.03%	90.21%	108.14%	120.24%	133.84%	139.37%
Retirement (Employee)	14,661	12,524	13,090	8,452	0	0	0	100%	85.42%	89.28%	57.65%	0.00%	0.00%	0.00%
Health Insurance	55,859	62,345	69,751	62,736	43,297	45,340	52,956	100%	111.61%	124.87%	112.31%	77.51%	81.17%	94.80%
Life Insurance	80	123	123	128	130	125	162	100%	153.25%	153.75%	160.00%	162.50%	156.25%	202.50%
Dental Insurance	2,388	2,944	3,431	3,424	3,257	3,633	3,964	100%	123.28%	143.68%	143.38%	136.39%	152.14%	166.00%
Maintenance Personnel Cost	366,368	309,418	330,246	329,209	305,322	309,433	315,329	100%	84.46%	90.14%	89.86%	83.34%	84.46%	86.07%
Overhead														
Unemployment Compensation	(62)	787	22,574	11,537	10,060	-1,137	531	100%	-1269.03%	-36409.68%	-18608.06%	-16225.81%	1833.87%	-856.45%
Workers Compensation	2,356	6,213	29,354	28,635	10,588	315	39,885	100%	263.70%	1245.93%	1215.41%	449.41%	13.37%	1692.91%
Legal	2,271	3,548	3,451	4,705	6,648	4,145	4,226	100%	156.25%	151.96%	207.18%	292.73%	182.52%	186.09%
Accounting & Auditing	10,801	16,349	16,546	17,199	18,566	17,199	19,560	100%	151.37%	153.19%	159.24%	171.89%	159.24%	181.09%
Other Professional Serv	2,400	88	0	0	0	0	0	100%	3.67%	0.00%	0.00%	0.00%	0.00%	0.00%
Computer Support	825	0	5,392	5,311	1,856	1,887	2,790	100%	0.00%	653.58%	643.76%	224.97%	228.73%	338.18%
Clearing House Services				1,844	3,462	2,846	2,698				100.00%	100.00%	100.00%	100.00%
Grounds Keeping Charges	7,138	8,841	10,700	14,994	13,649	18,352	11,791	100%	123.86%	149.90%	210.06%	191.22%	257.10%	165.19%
Purchase Care & Services	0	0	83	0	0	0	10,042	100%		100.00%				
Computer Equipment	46,243	2,834	32,147	46,223	45,831	68,449	25,908	100%	6.13%	69.52%	99.96%	99.11%	148.02%	56.03%
Noncapital Auto	12,000	8	9,001	13,007	9,509	19,018	2,009	100%	0.07%	75.01%	108.39%	79.24%	158.48%	16.74%
Office 2007 Upgrade	33,168	0	0	0	0	0	0	100%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Postage & Box Rent	22,672	29,815	950	21,585	25,563	28,521	26,481	100%	131.51%	4.19%	95.21%	112.75%	125.80%	116.80%
Office Supplies	46,935	41,279	40,517	41,434	43,548	46,592	68,343	100%	87.95%	86.33%	88.28%	92.78%	99.27%	145.61%
Printing & Duplicating	2,413	6,552	6,955	10,429	12,427	11,392	13,998	100%	271.53%	288.23%	432.20%	515.00%	472.11%	580.11%
Small Items Of Equip	2,802	730	139	1,503	8,745	14,693	42,660	100%	26.05%	4.96%	53.64%	312.10%	524.38%	1522.48%
Instructional Material	382	0	89	158	0	0	5,125	100%	0.00%	23.30%	41.36%	0.00%	0.00%	1341.62%
Membership Dues	1,593	1,461	950	1,180	1,585	4,575	1,000	100%	91.71%	59.64%	74.07%	99.50%	287.19%	62.77%
Advertising	12,111	5,269	4,055	7,381	7,476	7,622	7,021	100%	43.51%	33.48%	60.94%	61.73%	62.93%	57.97%
Educational Supplies	935	464	154	0	865	2,126	2,799	100%	49.63%	16.47%	0.00%	92.51%	227.38%	299.36%
Other Operating Expenses	2,585	2,413	20	820	55	110	656	100%	93.35%	0.77%	31.72%	2.13%	4.26%	25.38%
Gasoline, Oil, Fuel	16,257	14,150	18,255	28,759	37,501	40,820	45,712	100%	87.04%	112.29%	176.90%	230.68%	251.09%	281.18%
Water	4,516	4,574	4,618	4,459	4,483	5,422	5,365	100%	101.28%	102.26%	98.74%	99.27%	120.06%	118.80%
Electric	68,905	68,502	75,944	72,773	74,852	75,399	75,664	100%	99.42%	110.22%	105.61%	108.63%	109.42%	109.81%
Sewer	4,104	4,202	4,335	4,331	4,467	4,917	5,272	100%	102.39%	105.63%	105.53%	108.85%	119.81%	128.46%
Natural Gas	34,402	29,997	25,622	23,532	19,558	22,060	30,098	100%	87.20%	74.48%	68.40%	56.85%	64.12%	87.49%
Telephone & Fax	49,248	44,464	46,147	49,090	50,750	54,105	38,863	100%	90.29%	93.70%	99.68%	103.05%	109.86%	78.91%
Internet	943	1,072	1,391	1,284	1,284	1,284	34	100%	113.68%	147.51%	136.16%	136.37%	136.16%	3.61%
Storm Water Utility	1,630	2,133	2,133	1,509	2,133	2,133	2,133	100%	130.86%	130.86%	92.58%	130.86%	130.86%	130.86%
Wireless Internet														

Review of 2014 Goals:

1. The Key Outcome Indicator for the Fiscal Division was 100% compliance with all county state and federal guidelines:

In 2014 we met all the reporting requirements for the state. This encompasses sending in budgets, actual costs, and program reports into the state as required.

2. Electronic Crisis Intervention Assessment (CIA) Implementation:

The Electronic Intervention Crisis Assessment was automated and implemented in 2014. It provides an electronic system for crisis assessments, response and services linkage, and follow up of notes.

Benefit: Helped in the efficiency of the department.

3. Complete two continuous quality improvement projects using the NIATx model for 2014:

The first NIATx project was to work with the Daily Activity Report (DAR) work-file: This file in the current system is where transactions that don't pass the billing systems requirements are loaded for someone to manually correct transactions. The clean transactions then can be processed through the system. When we started clearing this file we had 805 transactions to review. Currently we have monthly reports that are sent to the program managers to ensure that we address transactions timely that are in the DAR work file. All transactions were cleared for 2014 by February, 2015.

Benefit: This ensures that data for state and annual report are correct and complete and all bills can be processed timely.

The second NIATx project was to improve our collection of co-payments from clients: Working with information services we now have a system to separate out the client charge for co-payments on client invoices and *identify payments made by the client for co-payments.*

Benefit: Invoice to the client is more detailed so they are able to understand the charges to them and proof of compliance with Medicaid and Medicare requirements.

4. PPS System, Opening/Closing/Uploads: We worked with MIS to make the mandated state changes to the PPS system. We met the state deadlines for PPS data to be uploaded into the state system for 2014.

5. Prior Authorizations: We worked with MIS to develop a system to initiate prior authorizations and track when they are for renewal. This did not occur because the department decided to purchase a new Human Service system. What occurred is a selection and evaluation process to select software for the department. The team made the recommendation to purchase ECHO Consulting Services, Inc.

6. Finalize program managers' documentation of contract process: We finalized documentation of process for establishing/updating contracts when there is an out-of-home placement. In addition, the department implemented a rate setting process for out-of-home adult placements.

7. Billing rejects tracking/Follow up on denials: We are tracking this process currently in excel. With the implementation of new software ECHO, this process should be automated.

8. Implementation of new report for reviewing Client's ability to pay on an annual basis: The report to cross reference the financial review with the appointment calendar has been implemented. In addition we

have separated new clients coming in from clients who currently need their annual review. Due to the number of clients, additional staff needed to be reallocated to this insurance billing function.

9. **Timely billing of clinic services with 90 days of date of service:** The outpatient clinic has a 90 day requirement, or they will not pay. We met this goal 98% of the time in 2014. Medicare and Medicaid have one year to process bills for payment. It is essential to process all bills for the previous year by February so that we can book the revenue appropriately for the department. Since we close our ledgers by the 3rd week of February we need to know what our outstanding claims are. An ongoing goal is to process claims timely. All bills were processed by 2/14/2015.
10. **Cross training for job functions and state reporting:** We have crossed trained the major functions for each position. We have job manuals that document the process and steps that need to occur if someone is out for any length of time. In 2014 we had employees that were out on Family Leave and the cross training and manuals that were in place proved to be very helpful. We were able to manage the work.

2015 GOALS:

1. **Key Outcome Indicator: 100% compliance with reporting requirements as denoted on work chart.**
2. **Accurately complete all county, state and federal reports and billing:**
State & Federal budgets require numerous reports for the programs that are provided by the Department. We also must be compliant with all Medicaid and Medicare requirements.
GOAL: 100% compliance with reporting requirements as denoted on work chart for the fiscal department.
3. **Implementation of ECHO System for Fiscal/Support Area:** Manage the fiscal and support functions within ECHO system to ensure bills/appointments.
GOAL: Have timely and accurate bills generated from ECHO per the implementation schedule.
GOAL: Be able to schedule appointments for clients and have case managers understand the ECHO scheduling requirements.
4. **To complete two NIATx Projects in 2015.**
GOAL: Efficiency is important for the administrative area. With limited resources within the department and the installation of ECHO, we will evaluate how work is accomplished. During the installation of ECHO we will look for ways to streamline current jobs. We will identify NIATx projects to ensure that we are measuring productivity both prior and after changes.

MAINTENANCE

~Ensuring that all functions of the buildings and grounds are in safe, working order~

Review of Utility Costs

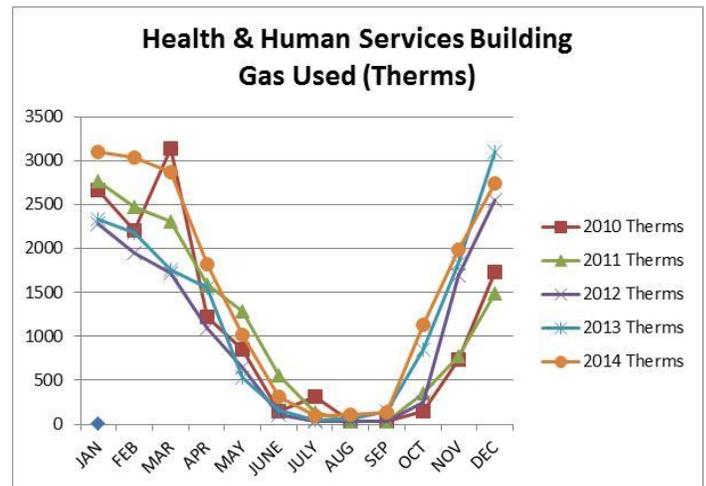
Health/Human, Workforce/UW Extension, Lueder House and Hillside Buildings

We are in our sixth year of tracking utilities for the buildings. Three building upgrades of note for 2014 are the replacement of 5 A/C units located at Hillside. The electric graph reflects a drop in energy consumption for the summer months. Additionally, the Hillside roof replacement with additional insulation resulted in lower thermal usage for the winter months. In November of 2014 all of the parking lot lights were changed from high pressure sodium and mercury vapor to LED resulting in lower electric usage for all of the parking lot lights. The Lueder Haus had a high consumer census during the summer months which resulted in higher electric usage due to increased laundry needs. The Health and Human Services Building has experienced greater use in the last couple of years and utilities reflect higher usage. The Workforce/UW Extension building use remains high but the building utility consumption remains steady due to the energy saving measures put in place during the building construction. The Maintenance staff continues to look for areas of opportunity where we can improve on energy efficiency.

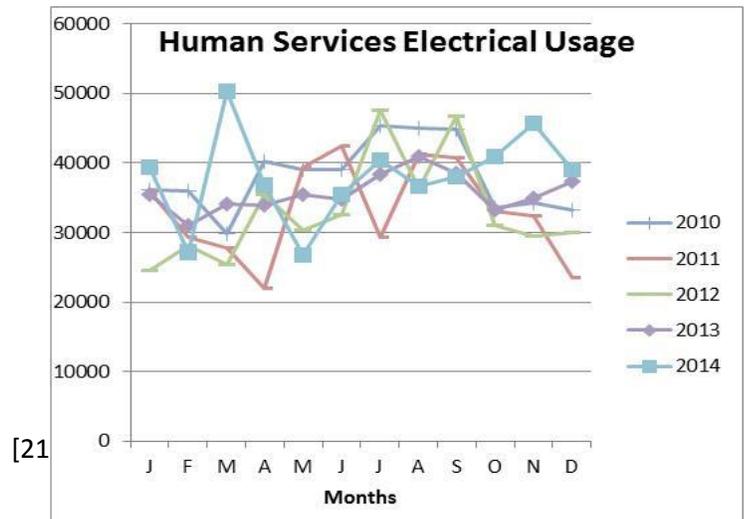
UTILITY USAGE FOR HEALTH & HUMAN SERVICES BUILDINGS

Public usage for the Human Services Building has been on an increase for the last few years. The good news is Gas Therms used are below 2013 consumption yet electric remains higher in the colder months.

Health & Human Service Bldg. Gas Used (Therms)					
Month	2010 Therms	2011 Therms	2012 Therms	2013 Therms	2014 Therms
JAN	2,663	2,772	2,287	2,338	3,102
FEB	2,203	2,476	1,948	2,178	3,039
MAR	3,141	2,311	1,716	1,766	2,872
APR	1,218	1,592	1,099	1,558	1,830
MAY	854	1,283	651	531	1,024
JUNE	153	558	105	165	318
JULY	319	134	37	44	92
AUG	27	27	31	58	103
SEP	27	29	30	146	133
OCT	153	350	254	846	1,136
NOV	742	772	1,699	1,840	1,985
DEC	1,730	1,493	2,550	3,102	2,741



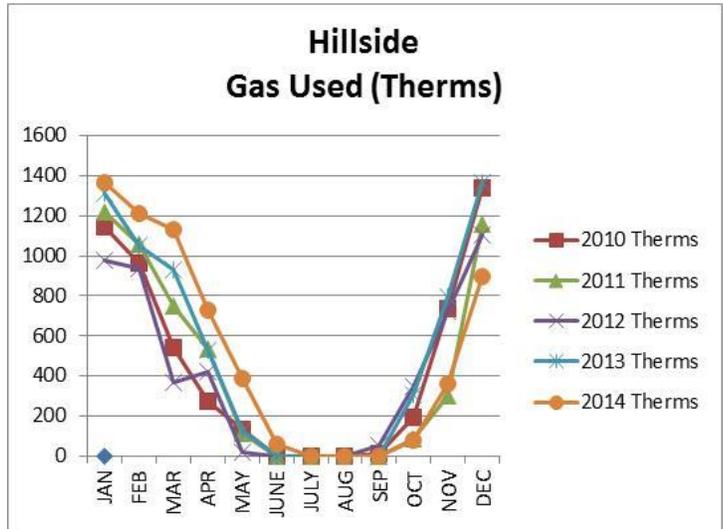
Electric Usage - KWH - Human Services					
	2010	2011	2012	2013	2014
J	36160	36000	24640	35520	39440
F	36000	29360	28160	31120	27120
M	29840	27760	25360	34160	50240
A	40240	22000	35520	33920	36880
M	39040	39440	30320	35440	26720
J	39120	42480	32640	34800	35440
J	45440	29360	47520	38320	40480
A	45040	41280	36400	40880	36720
S	44800	40720	46720	38480	38080
O	33680	33040	31120	33200	40880
N	34320	32400	29440	34880	45680
D	33280	23520	30080	37280	39120



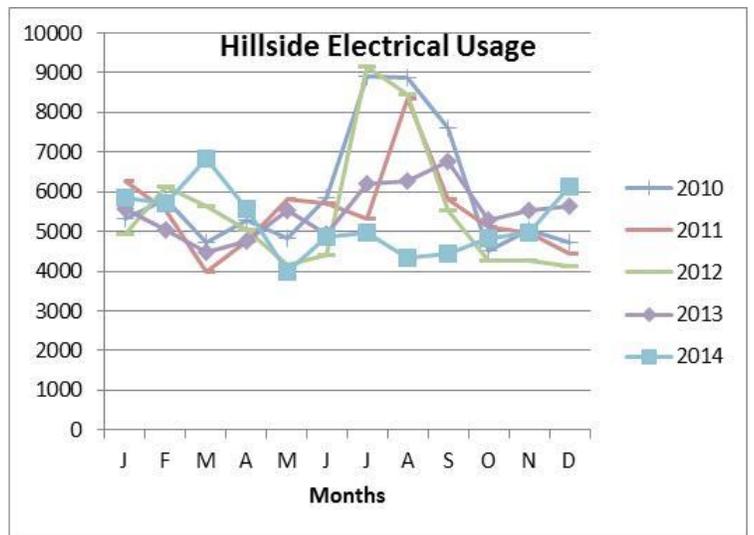
UTILITY USAGE FOR HILLSIDE BUILDING

With the addition of the new roof and added insulation Gas Therms used is at the lowest level in four years. The building retains heat and we have not had ice damming issues at the eaves since this was completed. Electric use remains on the increase in colder months but has declined in the summer; this can be attributed to replacing the 30 year old A/C units with more efficient units. More staff was added to the building and staff is working later into the day as well as weekends.

Hillside Gas Used (Therms)					
Month	2010 Therms	2011 Therms	2012 Therms	2013 Therms	2014 Therms
JAN	1,145	1,217	977	1,315	1,368
FEB	966	1,055	939	1,048	1,211
MAR	542	751	365	932	1,131
APR	275	535	420	531	730
MAY	132	115	17	123	386
JUNE	-	-	-	-	61
JULY	-	-	-	-	-
AUG	-	-	-	-	-
SEP	13	-	51	-	-
OCT	196	84	345	305	76
NOV	735	298	722	799	362
DEC	1,340	1,158	1,105	1,368	894



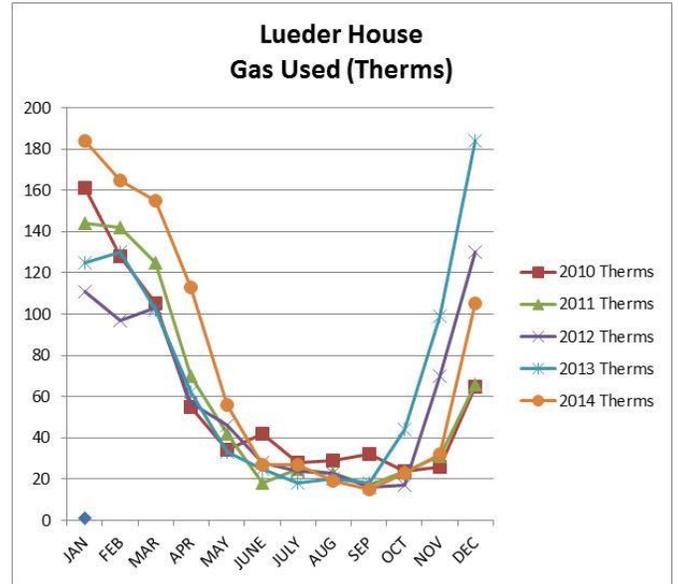
Electric Usage KW Hours - Hillside					
	2010	2011	2012	2013	2014
J	5320	6280	4920	5560	5840
F	5800	5520	6120	5040	5720
M	4720	4000	5640	4480	6840
A	5280	4760	5040	4760	5560
M	4840	5800	4160	5520	4000
J	5840	5720	4400	4920	4880
J	8920	5320	9160	6200	4960
A	8880	8360	8440	6280	4320
S	7600	5800	5520	6760	4440
O	4520	5100	4280	5280	4840
N	5040	4960	4280	5520	4960
D	4720	4440	4120	5640	6120



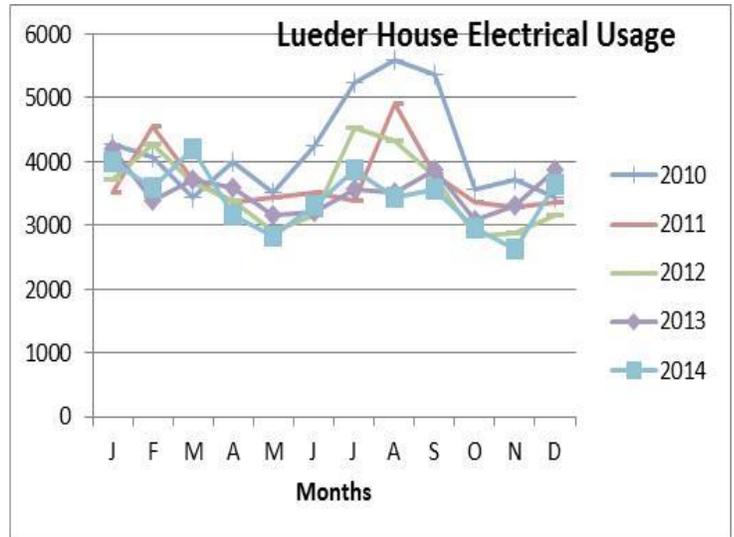
UTILITY USAGE FOR LUEDER HOUSE

Last year Gas Therms used was lower than use in 2012 and 2013. Electric use was trending higher in the summer due to census and increased changeover although still remains in the average range based on past graphs.

Lueder House Gas Used (Therms)					
Month	2010 Therms	2011 Therms	2012 Therms	2013 Therms	2014 Therms
JAN	161	144	111	125	184
FEB	128	142	97	130	165
MAR	105	125	103	102	155
APR	55	70	57	62	113
MAY	34	42	46	33	56
JUNE	42	18	28	25	27
JULY	28	25	24	18	27
AUG	29	23	23	20	19
SEP	32	17	16	18	15
OCT	24	24	17	44	23
NOV	26	31	70	99	32
DEC	65	66	130	184	105



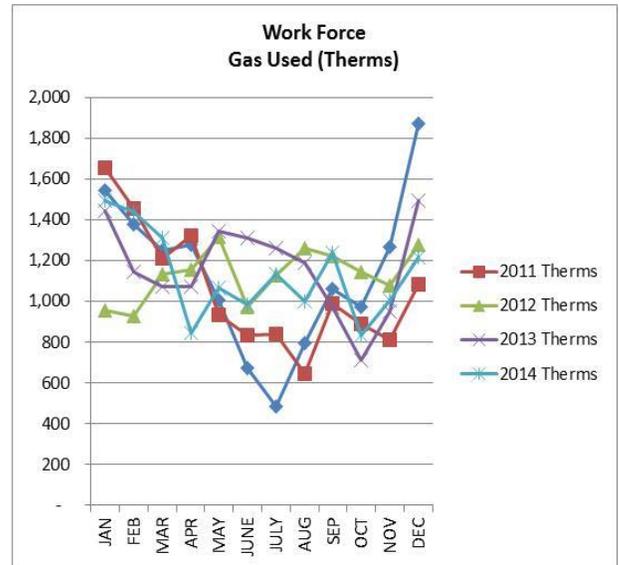
Electric Usage - Lueder House					
	2010	2011	2012	2013	2014
J	4280	3520	3720	4200	4000
F	4080	4560	4280	3400	3600
M	3440	3720	3680	3720	4200
A	4000	3360	3400	3600	3160
M	3520	3440	2920	3160	2840
J	4240	3520	3160	3200	3320
J	5240	3400	4520	3560	3880
A	5600	4920	4320	3520	3440
S	5360	3800	3760	3880	3560
O	3560	3360	2840	3080	2960
N	3720	3280	2880	3320	2640
D	3440	3360	3160	3880	3640



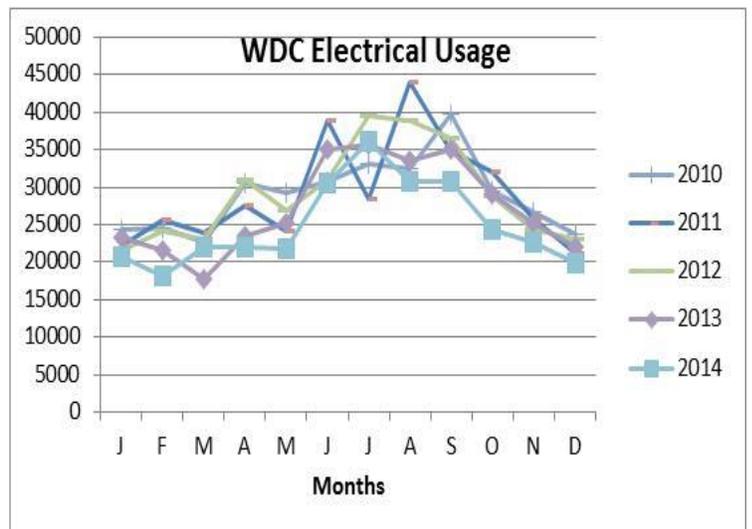
UTILITY USAGE FOR WORKFORCE DEVELOPMENT CENTER

Public use remains high but the Gas Therms used continues to chart lower than 2012 and 2013. Electric use has trended lower than the last four years. This building with the entire efficacy's added during construction draws lower amp use than the other building based on square footage.

Work Force Gas Used (Therms)					
Month	2010 Therms	2011 Therms	2012 Therms	2013 Therms	2014 Therms
JAN	1,542	1,657	958	1,442	1,493
FEB	1,378	1,454	928	1,145	1,437
MAR	1,252	1,209	1,134	1,073	1,311
APR	1,279	1,322	1,158	1,071	843
MAY	1,008	936	1,319	1,345	1,065
JUNE	671	833	972	1,310	982
JULY	484	839	1,127	1,263	1,131
AUG	794	646	1,262	1,191	1,003
SEP	1,060	989	1,224	972	1,241
OCT	973	889	1,146	712	834
NOV	1,266	811	1,080	952	1,008
DEC	1,874	1,086	1,278	1,493	1,215



Electric Usage - KWHours - WDC					
	2010	2011	2012	2013	2014
J	24320	22160	21600	23360	20720
F	24560	25600	24240	21680	18240
M	22720	23920	23120	17760	22080
A	30560	27600	31040	23520	21920
M	29360	24240	26880	25280	21840
J	30800	38800	30880	35120	30560
J	33200	28320	39600	35760	36160
A	32480	44080	38880	33600	30720
S	39760	34800	36640	35120	30720
O	29520	32000	28800	28960	24400
N	26800	25840	24320	25120	22560
D	23680	21200	23040	22080	19760



BUILDINGS, EQUIPMENT, AND PHYSICAL PLANT

Hillside House 1938

Head Start renovation 1987
Electrical upgrade early 1990's
Replaced boiler 2010
Added entry door access control 2013
Replaced roof, added insulation 2013
Replaced office lighting to T8 2013
Replaced 7 A/C units with air handlers 2014
Replaced sidewalks 2014
Replaced two entry doors 2014
Replaced sewer line in floor 2014
Upgrade to Tridium System 2014
Painting 2014

Health/Human Building 1980 portion

Remodeled basement 1989
Replaced roof membrane/gutters 2003
Replaced rooftop HVAC unit 2007
Replaced four rooftop unit heaters 2009
Remodel TPR room 2010
Added door access control 2013
Replaced flooring 2013
Remodel Viewing room 2013
Replaced office lighting with T8 2013
Remodeled three work regions 2014
Added BR Glass at main reception 2014
Replaced two entry doors 2014
Upgrade to Tridium System 2014
Replaced sidewalks 2014
Added LED lighting 2014
Replaced vestibule unit heater 2014

Health/Human Building 1995 portion

Installed Back-up generator 2008
Replaced flooring in Health lab and exam rooms 2008
Remodeled Intake area 2010
Seal coat re-stripe parking lot 2010
Added access control 2013
Replaced A/C coil and compressor 2013
Replaced three boilers with some DD Control 2013
Remodeled Health Department conf room 2013
Replaced damaged heating coil 2014
Added BR Glass at ADRC and Health Reception 2014
Upgrade to Tridium System 2014
Added LED lighting 2014

WDC/UWX Building 1999

Installed backup generator 2005
Remodeled call center 2013
Repaired A/C coil 2014
Replaced flooring 2014
Added LED lighting 2014

Lueder Haus/CSP 1996

Remodeled/Added CSP offices 2004 - 2010
Replaced A/C condensing unit 2012
Added LED outside lighting 2013
Modified deck 2013
Painting 2013
Replaced all flooring 2014

Review of 2014 Goals: All goals were meet.

1. **Key Outcome Indicator:** 100% of capital projects completed on time and within budget was met.
2. Replaced deteriorated sewer lateral located in Hillside Building.
3. Replaced flooring located at WDC/UW Extension Building.
4. All parking lots lights changed out from High Pressure Sodium and Mercury Vapor to energy efficient LED.
5. Six new copier/printers were networked.
6. Eleven office suites were installed.
7. Staff painted multiple offices and public areas.

8. Fleet vehicles were maintained.

2015 GOALS for MAINTENANCE

1. **Key Outcome Indicator: 100% of capital projects completed on time and within budget.**
2. Request proposals to install a whole house back-up generator for Lueder Haus.
3. Request proposals to install BR Glass for the reception area located in the lower level of the Health Department.
4. Continue to build onto the Tridium Automation system for all of the HVAC mechanicals.
5. Complete Hillside office remodeling project.
6. Continue to maintain all buildings and fleet vehicles in optimum condition.

SUPPORT STAFF

~Assisting staff and customers to ensure a seamless delivery of services~

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 charts and client paperwork, typing and 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 internal and external customers.

Review of 2014 Goals:

1. **Complete a NIATx project.** We completed a project that helped reduce the number of locations where filing can be found.
2. **Write up policy and procedure for filing from opening through purging, scanning, and retention.** This was discussed and due to the new electronic health record system, it was determined that we would not scan documents. We do have a retention and purging policy.
3. **Work towards scanning more closed documents – continue to clean up closed file room.** As noted above, it was determined not to scan documents until the electronic health record system is in place.
4. **Train team on the Alternate Care Review process regarding recent changes.** This was accomplished.

5. **Conduct a refresher training for staff in customer service skills.** This was accomplished.
6. **Train staff to increase knowledge in Excel.** This was accomplished.

2015 GOALS:

1. **Key Outcome Indicator: Maintain excellent customer service as indicated by an internal customer satisfaction survey.**
2. Support all agency staff and maintain all records according to mandate 46 via internal customer survey NIATx project.
3. Ensure that all support staff can locate important documents while working at the front desk via a NIATx project.
4. Become proficient in the ECHO, electronic health record system.
5. Become proficient in the DrFirst program and have the ability to assist the Dr and Nurse Practitioner.
6. Purge old microfilm.
7. Complete the re-sorting of charts.
8. Continue process for auditing chart files to monitor that filing is complete and filed correctly.

AGING & DISABILITY RESOURCE DIVISION

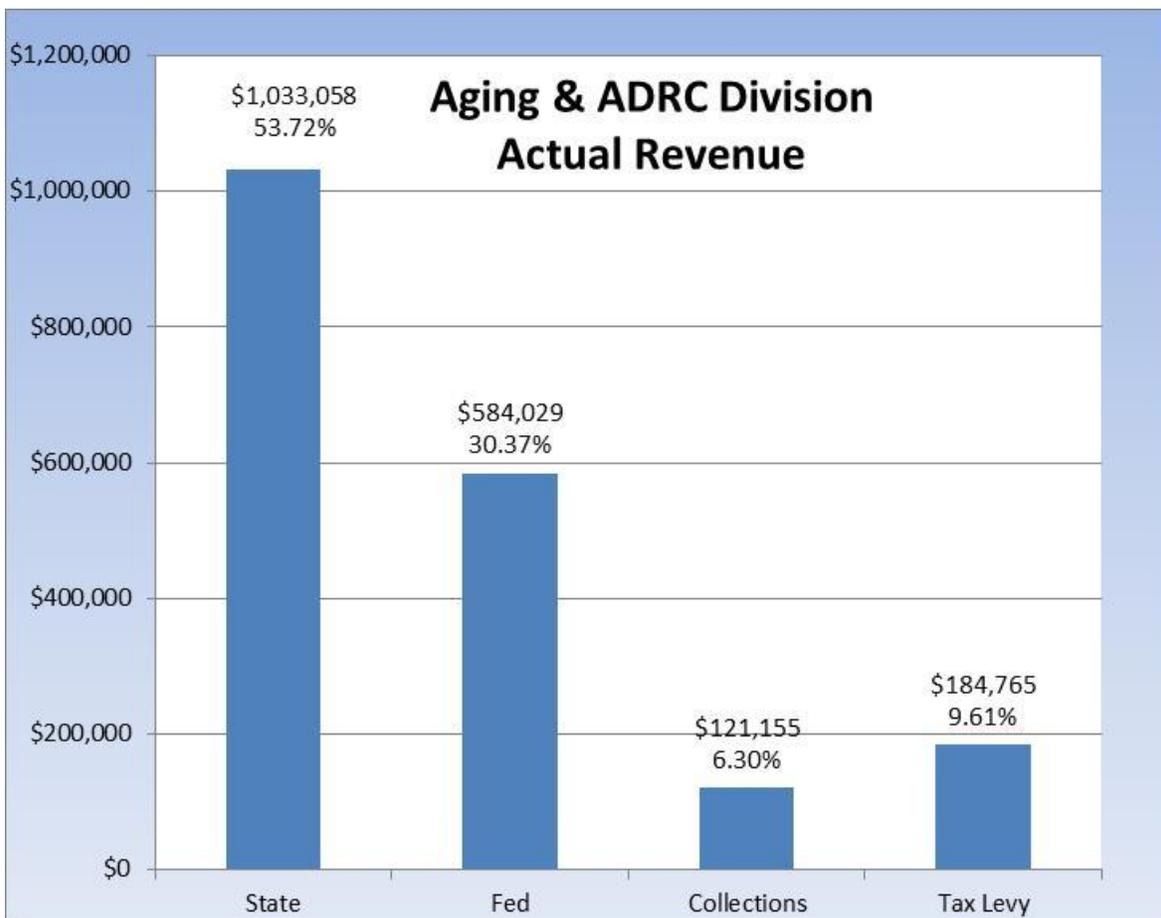
~Providing services seamlessly to the elderly and persons with disabilities~

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 28.6% of its support from the federal government in order to meet its operating

budget. The ADRC has consistently averaged 40%+.

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 OAA Reauthorization Act of 2015 would reauthorize programs through 2018 and includes provisions that aim to protect vulnerable adults by strengthening the long term care ombudsman program and existing elder abuse screening and prevention efforts.



AGING & DISABILITY RESOURCE DIVISION TEAMS

Aging & Disability Resource Center

Adult Protective Services

Benefit Specialist

Senior Dining Program

Transportation

AGING AND DISABILITY RESOURCE CENTER

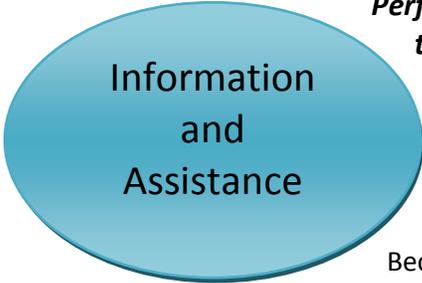
~Providing information and assistance or services for older adults and persons with physical or developmental disabilities and their families~

Aging and Disability Resource Centers (ADRCs) are welcoming and accessible places where older people and people with disabilities can obtain information, advice, and help in locating services or apply for benefits. They provide a central source of reliable and objective information about a broad range of programs and services and help people understand and evaluate the various options available to them. By helping people find resources and make informed decisions about long-term care, ADRCs help people conserve their personal resources, maintain self-sufficiency and delay or prevent the need for potentially expensive long-term care. ADRCs serve as the single access point for publicly funded long-term care, providing eligibility determination and enrollment counseling for the state's managed long-term care and self-directed supports waivers.

ADRC services are available to older people and adults with disabilities regardless of income and regardless of whether the person is eligible for publicly funded long-term care. ADRC services are also available to families, friends, caregivers, physicians, hospital discharge planners, and others who work with or care about older people or people with disabilities.

The ADRC is funded by the Department of Health Services utilizing a cost model that includes the elements that are used in calculating the cost of operating an ADRC serving 1% of the state population over age 18. (In Jefferson County, there is a total estimated 18+ population of 60,153 or 1.4244% which equals \$686,513 of total funds.) Federal revenue included in the budget request is based on an assumption that approximately 28.6% of reported activities will qualify for the federal administrative match rate. Amounts are separated between state and federal funding. Federal amounts are an estimate of what will be generated by 100% time reporting, based on current experience. The DHS base contract is \$500,000 with an estimate of an additional 40% from federal match funds due to 100% time reporting. The ADRC of Jefferson County is fully funded by the State contract and federal match funds.

The Department of Health Services is purchasing a set of resource center services that are intended to be consistently available to citizens throughout the State. The requirements of this contract define a "franchise model" for Aging and Disability Resource Centers. The "Scope of Services" describes the services to be provided by and the organizational and procedural expectations for all Aging and Disability Resource Centers (ADRCs). Our four largest service areas are Information and assistance, options counseling, enrollments and marketing. Performance goals are identified for each topic included in the "Scope of Services."



Information
and
Assistance

Performance Goal - People receive information and assistance to get what they need.

Information and assistance is a professional service which involves: listening to the inquirer, assessing his or her needs, helping the inquirer to connect with services or gain information to meet the identified needs and following up with the inquirer or service provider to determine whether the needs were met.

Because people may not know to ask for a specific service by name, it is important that the Resource Specialist have the time to establish a personal rapport, understand the individual’s concerns and be able to offer potential resources and solutions. Within the cost model the assumption is that the number of contacts for information and assistance per 1% of the population is 3,188. Our goal, as Jefferson County’s target population is 1.4 would be 4,463 contacts in a calendar year. In 2014, the ADRC of Jefferson County had 5,265 contacts with consumers, averaging about 438 contacts per month.

Breakdown of Contacts per Month 2014

No. of contacts	Month	No. of working days	Average per day
558	January	22	25
417	February	20	28
472	March	21	20
402	April	22	18
395	May	22	18
407	June	21	19
442	July	23	19
436	August	21	21
396	September	22	18
499	October	23	22
383	November	18	21
458	December	20	23

The majority of activities reported for Jefferson County, 99%, fell under Information and Assistance. Follow-up is the second most frequent service provided to ADRC customers. The ADRC budget is formulated on 186 contacts requiring follow up per 1% of the population/ 1.4% = ~260. In Jefferson County, there were 704 contacts resulting from follow up activities. Follow-up includes finding out how the person is doing, asking whether the help they received was right for them, and if other connections or referrals are needed. Activity reporting helps ADRC’s capture the extent of federal match funds to which they are assisting individuals in more than 14 “Scope of Service” areas.



Options
Counseling

Performance Goal – People have the information they need to make informed choices about long term care.

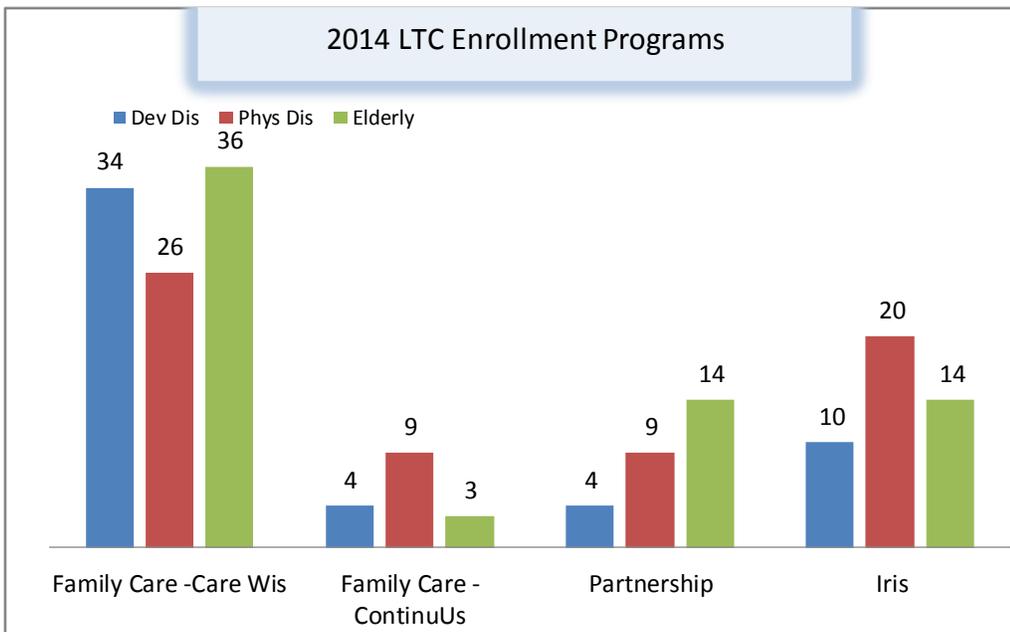
A person-centered, decision support service that empowers older adults, adults with disabilities and their families/caregivers to make informed decisions about current or future long –term care choices. In 2012 and 2013, the staff of the ADRC staff were trained in Motivational Interviewing and Options Counseling Standards as part of a NIATX project. The ADRC Surveys in 2013 and 2014 were given or sent only to consumers who the staff provided options and enrollment counseling.

Overall, our results were favorable, as customer perceptions of the ADRC representative that worked with them went from 84.5% in satisfaction to 91.5%. In 2014, our overall customer satisfaction percentage increased to 93.79% and our consumer recommendation that they would recommend the ADRC to someone else went from 92.7% in 1992 to 100% in 2014.

Long Term Care Options Counseling

Performance Goal - People are able to make informed decisions regarding enrollment in publicly funded long-term care programs and experience a timely, accurate, and streamlined process for eligibility determination and enrollment.

Long term care options counseling is an extension of the information and assistance process in which staff help people to understand the various long term care options available to them. The staff of the ADRC provides a Long Term Care Functional Screen assessment to assist consumers in evaluating and weighing their long term care service options. The ADRC cost model budget establishes that at a 1% population, the ADRC should be averaging 144 functional screens a year. Jefferson County’s population at 1.4 results in 201 Long Term Care screens. In 2014, the ADRC assessed 219 consumers. If the results find that the consumer is functionally eligible for the program, the staff will assist the consumer with the Medicaid application. Upon approval of Medicaid, the enrollment program is then chosen by the consumer as well as their preferred start date. In Jefferson County there are two managed care organizations (MCO): Care Wisconsin who provides the Family Care Program as well as the Partnership Program and the other MCO is ContinuUs which provides the Family Care Program. Consumers also have another long term care option to choose from.



IRIS, Include Respect, I Self-direct, is a Waiver program that is available for consumers to manage their Long Term Care budget and direct their care. The ADRC provides enrollment counseling for individuals to choose which program is best able to meet the consumers’ needs. In 2014, the ADRC enrolled 183 individuals into publicly funded long

term care, Family Care (112), Partnership (27) and IRIS (44) (Include Respect, I Self-direct) programs.

Provide Assistance with Resident Institutional Relocations

Performance Goal - People have the information and assistance they need to make informed decisions regarding moving to or relocating from a nursing home or assisted living facility.

Out of the 183 enrollments, 19 individuals were enrolled via ICF- MR/Nursing Home relocations. The average cost of a nursing home in 2014 was \$7,354 a month or \$88,250 per year, by enrolling individuals into a lower cost community setting results in huge savings in tax dollars, and at the same time, provides individuals with choice and independence.

Service: Transitional Services for Students and Youth

Performance Goal - Young adults with disabilities experience seamless transition and entry into the adult long-term care system.

The ADRC assists youth (17.6 to 25 years) in transitioning from high school into the adult services system. Of the 25 youth that the ADRC provided options counseling, 7 were enrolled into the publicly funded long term care programs. The ADRC staff are able to meet with students and their families when the consumer is 17 years, 6 months of age by attending their IEP Meeting, Interdisciplinary Education Plan. Some students are already receiving services thru the Children's Long Term Support Waiver programs, so staff are able to help consumers transition into the Adult programs without a disruption of services.



Performance Goal - People know about and use the services of the Aging and Disability Resource Center.

In 2014, the ADRC provided 24 activities of marketing and outreach. ADRC Staff also attended the various Farmer's Markets through-out the county and had an impressive response by the number of people gathering information about our services. Staff presented at various locations through-out the county in which they provided information on Assistive Technology at a local Senior apartment building to meeting with medical staff at clinics and emergency room personal as well as presenting on ADRC Resources to support groups and community organizations. This year the ADRC took over the distributions of the Senior Farmer's Market Vouchers and was able to distribute all of the 201 vouchers given to Jefferson County.

Review of 2014 Goals:

1. **The Key Outcome Indicator for 2014 was for customers to express a high level of satisfaction with provided services.** According to the top three survey indicators, the ADRC scored as follows: 97% satisfied under the follow up category; 84.38% satisfied with the overall usefulness of the help received; 100% would recommend the ADRC to another person.
2. The ADRC has been facilitating a Care Transition Workgroup with local health care community partners. The goal is to work on a plan to reduce readmissions to the hospital which occur within 30 days of discharge.
 - ❖ Working as a community team to create educational material that staff in nursing homes, assisted living homes as well as individuals and caregivers to avoid a readmission to a hospital setting.
3. The ADRC of Jefferson County applied for and received approval to administer the Senior Farmers' Market Nutrition Program (SFMNP) for Jefferson County.

- ❖ We distributed 201 Senior vouchers with application and allocation of the checks. With that, the Farmer's Market Benefit guide was created to provide information to the individuals of resources and benefits they may be eligible for.
4. The ADRC continues to work on Aiming for Excellence NIATx Projects:
 - ❖ In 2014, we worked on a project to enhance a consumer's telephone experience. Our present system will allow a consumer to reach the call center by dialing 8 during a voicemail mail message. The previous phone tree restricted a person from transferring to another staff and consumers needed to redial the ADRC number.
 5. Increase number of customer satisfaction surveys thru mailings and via website.
 - ❖ In 2014, we focused our efforts getting Satisfaction surveys to consumers who staff provided Options and enrollment counseling. Staff would give the satisfaction survey to consumers after their home visit or upon sending along with a copy of their enrollment form. Unfortunately, the number of returns is less than what we desired, but overall the responses have been positive.
 - To maintain sustainability with our knowledge and customer responses, we will continue with present practice.
 6. Increase promoting health and wellness via educational programs such as Living Well with Chronic Conditions, fall prevention, and providing memory assessments and screening.
 - ❖ The ADRC held two Living Well Classes in 2014 which met our goal. One session was held in Watertown, the northern part of the county and the other in Jefferson, on the southern end.
 - Our goal is to continue to provide Living Well Classes in 2015.
 7. Improving brochures and handouts has been an ongoing goal. The ADRC worked on two ADRC Services and Benefit Guides. The SFMNP Guide was created to give more information on the Senior Farmer Market Program and was very well liked, that an ADRC services and Benefit Guide was created that can be updated and handed out year round. We will continue to improve our brochures for resources.

2015 GOALS:

1. **Key Outcome Indicator: 100% of ADRC customers surveyed indicate that they would refer the ADRC to someone else.**
2. The ADRC has been facilitating a Care Transition Workgroup with local health care community partners. The goal is to work on a plan to reduce readmissions to the hospital which occur within 30 days of discharge. The ADRC will continue with this goal for 2015.
 - We will be presenting the material and project scope in May 2015 to community assisted living partners to see if they will utilize the materials.
3. The ADRC of Jefferson County will continue to administer the Senior Farmers' Market Nutrition Program (SFMNP) for Jefferson County.
 - In 2015, our goal is to increase the number of seniors to utilize their vouchers. The 2014 check redemption rate for Jefferson County was 76%. This means that out of the \$5,025 in checks that were distributed, \$1,204 was not utilized. We can offer solutions to increase the redemption rate.
4. The ADRC continues to work on Aiming for Excellence Projects (NIATx):
 - ❖ In 2014, we worked on a project to Increase staff knowledge of cultural diversity and then to market services to ethnic populations.

- In 2015, we will work on updating our resource brochure information by translating our written material into Spanish. Our first priority is for Youth with Special Needs.
- In 2015 we will also translate our ADRC poster into Spanish and distribute it throughout the county to create awareness of the ADRC services.

5. Continue to promote the ADRC and raise awareness of programs and issues relating to aging and maintaining independence for people with a disability.

6. The ADRC will improve our brochures and handout materials by having agency created material translated into Spanish such as the Benefit Guide and SFMP Guide.

Disability Benefit Specialist Program

During 2014, the Disability Benefit Specialists (DBS) provided information and application assistance for 215 consumers who requested help with a variety of issues ranging from health insurance, food supply, housing availability to Social Security income. The DBS assisted with issues in 332 individual cases. Each case represented an individual with a disability, who was between the ages of 18- 59 years old, living in Jefferson County. The reported value of gained benefits impacting Jefferson County was over 1,607,700 dollars. The DBS also provided 128 responses to information only calls, that consumers were assisted without the need of opening a case.

In 2014, a targeted effort was made to expand outreach efforts to the Spanish-speaking population in the county. The Disability Benefit Specialist Program provided Spanish language program brochures to area agencies. Spanish and English brochures were provided at community Farmer's Markets throughout the county.

2015 GOALS:

In 2015, the DBS Program will work with Disability Rights Wisconsin MIPPA outreach efforts to increase participation in Medicare savings programs in Jefferson County.

AGING PROGRAMS

~Providing services for the elderly and persons with disabilities of Jefferson County~

Advocacy

The Older American's Act (OAA) is the foundation of the WI 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:

GOAL: Ongoing

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; and
5. Supporting the development of a culture of tolerance, equality and acceptance of people with disabilities and the elderly.

Alzheimer's Family Caregiver Support Program

The Alzheimer's Family and Caregiver Support Program (AFCSP) was created by the Wisconsin legislature in 1985 in response to the stress and service needs of families caring at home for someone with irreversible dementia. To be eligible, a person must have a diagnosis of Alzheimer's disease or a related disorder, and be financially eligible. A maximum benefit of \$4,000 per family, per calendar year is available. The county's total allocation is \$19,009.

Review of 2014 Goals: All goals have been met.

1. To increase a family's ability to keep those diagnosed with dementia at home. By the end of 2014, 5 eligible families will be provided with up to \$4,000 to help cover the cost of needed goods and services. 75% of the families served will report no changes in living arrangement.
2. 100% of families served will be offered Dementia Care Specialist Services.

2015 GOALS:

1. 100% of families being served will be offered the *Memory Care Connections Program* through the Dementia Care Specialist.

Dementia Care Specialist

In 2010, the Alzheimer's Association reported 1,576 persons in Jefferson County had Alzheimer's disease or another dementia and in 2030 they project that number to increase to 2,438, which is a 55% increase. Also in 2010, 453 persons aged 65+ that had been diagnosed with AD were living alone in Jefferson County. It is estimated that 75% of those diagnosed live alone.

Jefferson County has employed a Dementia Care Specialist since 1/2/13. Funding for the position comes from state GPR dollars and federal Medicaid matching funds. The 2015-2017 budget continues funding for these services.

Review of 2014 Goals: All goals have been met.

1. Facilitated a 2nd summit to report on task group activities;
2. Provided education and support to peers in the ADRC to encourage excellence in dementia care;
3. Trained the ADRC and 6 businesses on becoming part of the Dementia Friendly Community;
4. Collaborated with the Dodge County Dementia Alliance to expand the project in Watertown;
5. Increased opportunities for people with dementia to remain in their own homes through 1:1 case consultations;
6. Increased position from part-time to full-time.

2015 GOALS:

1. **Key Outcome Indicator: By December 31, 2015, information about DCS services and available supports will be provided to all county departments.**
2. "Dementia Friends" will be trained to help train business wanting to become Dementia Friendly.
3. Organize 1 local conference in 2015 to raise awareness about dementia in the local community.
4. Provide 1 In-Service to the staff at Fort Atkinson Hospital in conjunction with the Alzheimer's Association.
5. Present at the May annual Alzheimer's Conference on work being done by the Person Center Dementia Care Mentors Alliance in Jefferson County.

Senior Dining Program

The Elderly Nutrition Program, enacted by Congress in 1972, provides grants to support nutrition services to older people throughout the country and is intended to improve the dietary intakes of participants and to offer participants opportunities to form new friendships and to create informal support networks. The legislative intent is to make community-based services available to older adults who may be at risk of losing their independence.

In 2014 the program received \$212,675 in state/federal funds; \$99,711 in program income (includes \$5,996 in 2013 carry-over) and \$22,946 in county tax levy, which is the required match.

The purpose of the elderly nutrition program is:

- To reduce hunger and food insecurity;
- To promote socialization of older individuals; and
- To promote the health and well-being of older individuals by assisting such individuals to gain access to nutrition and other disease prevention and health promotion services designed to delay the onset of adverse health conditions resulting from poor nutritional health or sedentary behavior.

Review of 2014 Goals: Goals to increase participation by 5% were met; Wii Bowling is on hold.

1. **The Key Outcome Indicator was that seniors were provided with a healthy meal and had the opportunity to maintain contact with others.** In 2014, meals were served at 7 congregate locations across the county; delivered meals were available to six communities. 100% of the sites remained open and no-one was subject to a waiting list for meals.
2. To increase congregate participation in Fort Atkinson and Palmyra by 5%.
3. To offer Wii Bowling at the Palmyra Site to encourage attendance.

2015 GOALS:

1. **Key Outcome Indicator: 100% of seniors completing satisfaction surveys report that they are not experiencing hunger or food insecurity.**
2. 100% of meals delivered will be at the proper temperatures.

3. 100% of meals served and delivered will be recorded in SAMS within 30 days of the serving month.
4. The catering contract will contain the business' Continuity of Operations plan.
5. 100% of site manager absences will be covered.

Transportation Services

Jefferson County provides transportation services to the elderly and persons with disabilities through the s85.21 Specialized Transportation Program. Persons seeking access to medical care are given priority services, as well as those needing help in meeting their nutritional needs. Two additional part-time drivers were hired and two additional vehicles were purchased in 2014.

The WI Department of Transportation is the major source of funding for these services. The 2014 allocation was \$181,805; the county provided \$50,414.93 in tax levy (the required county match was \$36,361) and passenger revenue was \$27,381. Total expenditures were \$237,127.

Review of 2014 Goals: The first goal is ongoing and with the exception of ridership the remaining goals were met. Ridership went down after discontinuing the grocery shopping van. Conversely, rides for agency consumers who were in inpatient settings greatly increased.

1. **The Key Outcome Indicator was to ensure that seniors and persons with disabilities had transportation to medical appointments.** Rides are prioritized in this area and 100% of ride requests to medical appointments were met.
2. Continue exploring ways to implement the CTAA Workgroup Recommendations, including:
 - ✓ Simplified dispatch or development of a regional dispatch center;
 - ✓ Procurement of software, services, and equipment for one-click/one-call center
 - ✓ Interagency agreements for mobility management services (provider referrals and brokerage)
 - ✓ Commitment of 85.21 funding to support service in rural towns
3. Increase ridership by alternatively scheduling three part-time drivers and volunteers to cover the need.
4. Purchase two new vehicles to use in the transportation pool;
5. Reallocate costs realized via attrition to vehicle purchases and contract with the Taxi Cab Company for intracounty transportation.
6. Explore expansion into 2015.

2015 GOALS:

1. **Key Outcome Indicator: 100% of ride requests are safely met.**
2. Continue exploring ways to implement the CTAA Workgroup Recommendations, including:
 - ✓ Simplified dispatch or development of a regional dispatch center;
 - ✓ Procurement of software, services, and equipment for one-click/one-call center
 - ✓ Interagency agreements for mobility management services (provider referrals and brokerage)
 - ✓ Commitment of 85.21 funding to support service in rural towns.

- ✓ Explore State Urban Mass Transit Operating Assistance program (codified in Wisconsin State Statute 85.20) to seek operating cost assistance for public transportation services, i.e. bus, shared-ride taxicab, rail or other conveyance either publicly or privately owned.

3. Attend all county transportation meetings.

Elder Benefit Specialist

Funded by the federal Older Americans Act and the State of Wisconsin, Elderly Benefit Specialists work in each of the 72 counties and every tribal aging unit in Wisconsin. Benefit specialists provide accurate and current information on benefits, alternative actions to secure benefits or appeal denials of benefits, advocate on elders' behalf with other parties, and explain what legal action or other possible solution is required.

Between 01/01/2014 and 12/31/2014, the Elder Benefit Specialist program served 841 clients and reported 1730 total contacts. The results of the services provided through this program are beneficial to the senior clients, the local community, and also the State of Wisconsin. In 2014, the economic outcomes of the EBS cases tracked a whopping \$2,047,539 federal dollars compared to \$167,617 state dollars and \$173,448 in "other" dollars for a grand total of \$2,388,604 of monetary impact for Jefferson County seniors.

The EBS is an active member of the Board of Directors for the Conexiones Latinas group which meets 8 times throughout the year to examine outreach strategies for reaching non-English speaking populations on a variety of issues. The EBS places emphasis on services or programs that may benefit the elderly in this group. Six of the 23 Hispanic seniors that the EBS served in 2014 were new individuals to the program. Most of these new clients were referred by a friend or relative who had worked with the EBS on prior issues.

In 2014, we worked to strengthen and streamline volunteer assistance for the State Health Insurance Program (SHIP) services that EBS are expected to provide. Jefferson County was one of 3 counties piloting a "Seniors Out Speaking" volunteer program, coordinated by the EBS. The success of this model has resulted in support of the Area Agency on Aging and the volunteer program will now be offered in other areas of the state. In 2014 EBS recruited 1 new SHIP volunteers to work with the SOS and another to provide Medicare Part D assistance during the Annual Enrollment Period. We hope to continue to grow the volunteer base at a manageable pace in 2015.

The strain of meeting an increased demand for Medicare counseling (to seniors who are turning age 65) was addressed by increasing the frequency of the popular ABCs of Medicare workshops. Beginning in March 2014, monthly ABCs of Medicare workshops were added to EBS calendar and evaluations have been consistently positive.

Review of 2014 Goals: All goals have been met

1. **The Key Outcome Indicator was that seniors have access to all benefits they are entitled too.** 100% of the people asking for services through the program were served.
2. Continued to build on success of Second Harvest Foodshare Outreach project by providing continued FS outreach via Press Releases, MOWs inserts, and WFAW Morning Magazine radio call-in.
3. Grew the SOS Volunteer base by "promoting" one of the SOS Leadership Team to serve as SOS coordinator/captain. Thus, some of the administrative monitoring will be delegated to the Leadership Team and this ownership should encourage more efforts to land outreach sites to present the monthly Medicare Minutes.

4. Doubled the number of ABCs of Medicare workshops from 6 to 12 per year, including specific instructions on the online computer tool.

2015 GOALS:

1. **Key Outcome Indicator:** During the 12 months in 2015, the benefit specialist programs will continue to serve all of the individuals requesting help without subjecting them to a waiting list.

2. **Special State/Federal Consideration for 2014/2015** A priority for the EBS will be providing education and outreach to seniors, providers, and state and federal legislators, summarizing how proposed changes related to Aging And Disability programs could affect seniors in Jefferson County and Wisconsin. (i.e.: Provide factual data that supports the merits of the State SeniorCare prescription program, and how it coordinates with other insurances.)

Family Caregiver Support Program

The National Family Caregiver Support Program provides 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. This program's budget is \$38,109. The federal government covers \$28,582 with the county matching the difference.

Review of 2014 Goals: This goal was not met.

1. The Caregiver Coalition will devote its effort to public information. Members will jointly work on a quarterly newsletter that promotes health, wellness and available services.

2015 GOALS:

1. A network of providers serving care recipients and care givers will be developed to address caregiver issues and needs.

2. A Grandparent Support Group will be established for grandparents living with and raising their grandchildren.

3. Outreach efforts will include the development and distribution of a manual that explains the difference and similarities between the National Family Caregiver Support (NFCSP) and Alzheimer's Family Caregiver Support Program's (AFCSP).

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 and individuals with disabilities are met, especially those with cognitive impairments when substantial risk is evident. Several different statutes establish the counties responsibilities in responding to these situations. The Human Services Department is the designated "lead agency" for receiving and responding to allegations of abuse or neglect.

APS services are mandated by state statute and are severely underfunded. The 2014 expenditures totaled \$207,823. State funds totaled \$91,856 (includes an additional award of \$10,004 in 2014) and county tax levy totaled \$115,967.

Highlights from 2014

- 112 reports of abuse/neglect were received
 - 31 on Adults-at-Risk Age 18-59
 - 33% of reports were regarding self-neglect
 - 20% of reports were neglect by others

- 17% of reports were physical abuse
 - 52% of reports were substantiated
- 81 on Elder Adults-at-Risk Age 60
 - 36% of reports were regarding self-neglect
 - 18% of reports were regarding financial exploitation
 - 15% of reports were emotional abuse
 - 10% of reports were regarding neglect by others
 - 49% of reports were substantiated
- In the majority of cases referred the abuse/neglect occurred where people live
- Persons with Alzheimer's disease or a related dementia are in a high risk group
- 190 Annual Review of Protective Placements or WATTS reviews
- 55 Petitions for Guardianship
- 16 Petitions for Protective Placements

Review of 2014 Goals: The goals were met.

1. **The Key Outcome Indicator for 2014 was to ensure that vulnerable adults receive supportive services in the least restrictive environment consistent with their values and they were free of neglect and abuse.** The indicator was met. 100% of referrals received when people were at "significant risk of harm" were responded to within time limits and services or alternate living arrangements were made after assessing needs and preferences.
2. Provided training with Corporation Counsel, Register-in-Probate and Clerk of Courts for new volunteer guardians
3. Marketed Elder Abuse I-Team services to community organizations

2015 GOALS:

1. **Key Outcome Indicator: 100% of referrals are responded to within the time frames contained in the statute; and case notation and legal time frames are met in 100% of cases referred.**
2. Maintain 100% compliance with established court time frames.
3. Respond to abuse/neglect referrals within 24 hours of the call.
 - Complete NIATx project to measure adherence.
4. When implemented, use ECHO software to document case notes/activities 100% of the time.

BEHAVIORAL HEALTH DIVISION

Purpose Statement: Promote prevention and recovery

~To provide education to all stakeholders regarding mental health, substance use, and the impact of trauma; and provide evidence based treatment programs that are trauma informed and responsive to the needs of our citizens~

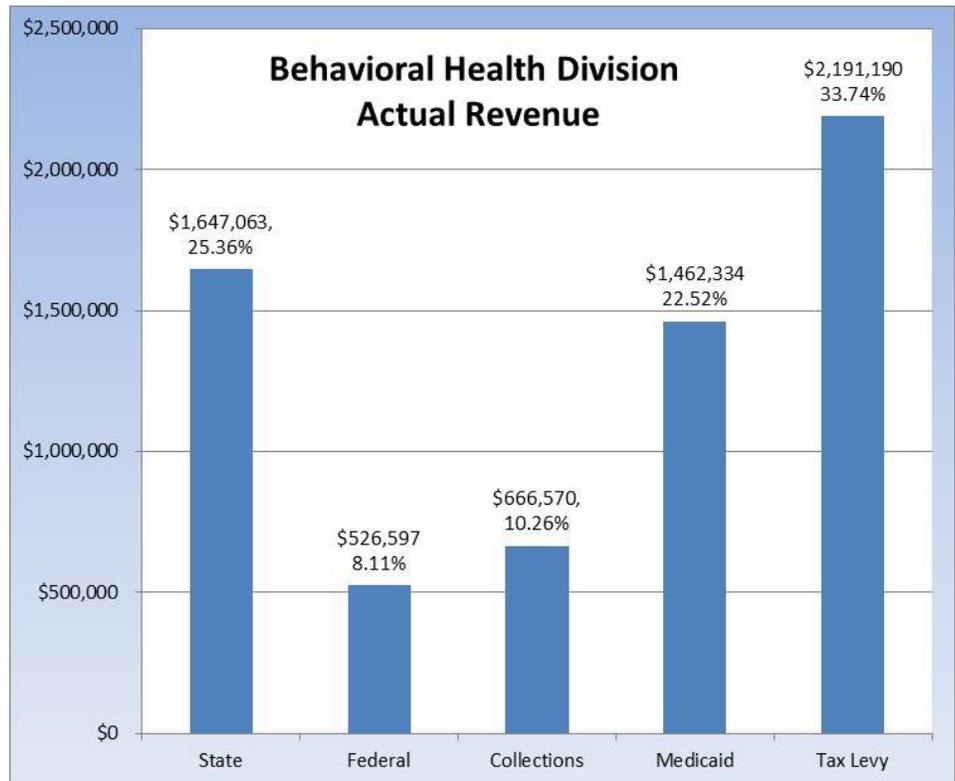
The Behavioral Health Division of Jefferson County Human Services has developed comprehensive programs that promote individual recovery and offer evidence based treatment options. We offer an integrated, county staffed, service delivery system. County provided programs include the Mental Health and AODA outpatient clinics, Intoxicated Driver Program, Comprehensive Community Services Program, (CCS), Community Support Program, (CSP), and Crisis/Emergency Mental Health Services. As part of crisis services, we operate the Lueder House, a state licensed eight bed community based residential facility for adults with mental illness who need crisis stabilization services.

Our Medical Director is a licensed adult and child psychiatrist. He is on site daily and available 24/7. He oversees all treatment programs and authorizes all necessary services. We also have 44 full time employees.

The Behavioral Health Division also contracts for evaluations, residential and inpatient services, specialized treatment services, and certified peer support. Providers then receive training about recovery, treatment, service plans, and billing. Service contracts with providers set forth our expectations.

We are steadfast in responding to the needs of citizens. Most recently, we have identified two significant trends. We have continued to see an increase in the number of citizens struggling with opiate addictions. Secondly, we have seen an increase in the number of children struggling with complex mental health issues. We have expanded programs to address both these issues and they are described in the following team reports.

The Division’s revenue comes from County, State, and Federal funds as reflected in the graph below.



BEHAVIORAL HEALTH DIVISION TEAMS

Mental Health and Alcohol & Other Drug Abuse Clinics

Intoxicated Driver Program

Community Support Program

Community Recovery Services

Comprehensive Community Services

Emergency Mental Health (Crisis)

MENTAL HEALTH AND ALCOHOL AND DRUG OUTPATIENT CLINICS 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 team strives to provide person centered and recovery focused services, and is committed to delivering evidence based practices. Over the last year, we again experienced an increase in the need for services to treat opiate addiction.

The Mental Health, and Alcohol and Other Drug Abuse (AODA) Outpatient Clinics serve primarily adult Jefferson County residents with mental health and substance abuse concerns. In 2014 there were 206 new consumers entered into to the Mental Health clinic and 211 new consumers entered into the AODA clinic for substance abuse treatment. As the chart below indicates, the clinic provided Mental Health services to 661 individuals and Substance Abuse services to 327 individuals.

NUMBER OF CLINIC CONSUMERS

	2008	2009	2010	2011	2012	2013	2014
MH Clinic	294	332	478	541	615	690	661
AODA Clinic	246	207	217	225	288	334	327
Totals	540	539	695	766	903	1,024	988

The **key outcome indicator** of our work is to reduce the presenting symptoms and problematic behaviors in the consumers we see in the clinics. In the mental health outpatient clinic, most consumers requesting services are depressed. With each consumer we track his or her symptoms of depressions with the Patient Health Questionnaire (PHQ-9). The **key outcome indicator** is a reduction in this score. In the AODA clinic, we use the Brief Addiction Monitor (BAM) to measure substance abuse behaviors. The key objective is to reduce consumers' BAM score. In 2014, PHQ-9 scores reduced by 5%. For 2015, further reduction by 2% in scores of both measures is the key outcome indicator.

Participants of the program are assessed for strengths and needs; the principles of hope and empowerment are integrated into clinic services. 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 manner; decreasing the disruption of the individual's life while still providing support for recovery services.

The clinic staff consists of a Medical Director/Psychiatrist, seven full-time staff with masters' degrees in Social Work, Counseling or Psychology, one of whom works part-time in the county jail, as well as a Community Outreach Worker.

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 services to an average of 233 people per given month in 2014, approximately 18 of those individuals were ordered under WI § 51.45. In addition to those individuals who received treatment through the clinic, staff persons are also responsible for supervising the commitment period of all individuals on a Chapter 51 commitment and ensuring that the individual is following through with the treatment recommendations regardless of where treatment occurs.

Public Intoxication Data for Jefferson County

Under Wisconsin statutes (51.45), a person incapacitated by alcohol can be placed under protective custody by a law enforcement officer and taken to an approved detoxification facility. Prior to discharge, the individual is informed of the benefits of further diagnosis and appropriate voluntary treatment. Upon discharge from such facility, our department is then responsible for arranging transportation for these people, 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, department staff meet with the individual face to face to complete an assessment and the appropriate referral is made; which can be an emergency detention, voluntary hospitalization, residential treatment, intensive outpatient, or outpatient services to include individual and possibly group therapy.

Detoxification Data	2010	2011	2012	2013	2014
Admissions	101	122	67	89	75
Individuals	75	91	54	67	58
Individuals with multiple admissions	8	16	5	12	14
Days	113.6	119.64	74	114	109
County Expenditures	\$44,778	\$58,291	\$28,642	\$47,742	\$48,500

In reviewing individuals with multiple detoxifications admissions; 8 of the 14, participated in some level of substance abuse treatment.

INTOXICATED DRIVER PROGRAM

Counties are mandated to provide an Intoxicated Driver Program (IDP) (HFS62). Each county is responsible for establishing and providing substance use assessments of drivers who have received an operating while intoxicated (OWI) conviction. The assessment can be ordered by the court or the Department of Transportation. The IDP assessor completes an assessment using the Wisconsin Assessment of the Impaired Drive tool (WAID). A driver safety plan is developed based on the results of the assessment. A person can be sent for either education if a substance use disorder is not found, or treatment if a substance use 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 being revoked or in some cases, 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 2014, the IDP program completed 315 assessments and driver safety plans. This was a 7% decrease from 2013. Of those 315 assessments in 2014, 179 were first time offenders. This number accounts for 57% of the assessments. 61 were second time offenders, 41 had three lifetime OWI’s, 17 had four lifetime OWI’s, and 17 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. 128 offenders were referred to Group Dynamics or to Multiple Offender Program. A total of 186 individuals were referred to outpatient substance abuse treatment.

Number Operating While Intoxicated Offenses

	2014
1st Offense	179
2nd Offense	61
3rd Offense	41
4th Offense	17
5th Offense or more	17
Total	315

Consumer Satisfaction

In 2014, the clinic administered a consumer satisfaction survey. The questionnaire consists of 12 questions in the yes/no format that ask consumers if they are satisfied with the appointment process, checking in, their initial appointment and ongoing treatment. The last two questions are open ended and ask the consumer what they like most about our services and what suggestions they have on how services can be improved. 42 surveys were completed. Of these completed surveys, there were 2 consumers that answered no when asked if they were seen within 10 minutes of their scheduled appointment time. For suggestions on improving services, the primary area of concern was wait time for seeing the doctor. One consumer asked for a reminder of his/her upcoming appointment. In 2015, consumers will be receiving reminder postcards for their upcoming appointment.

When asked what they like most about our services. Consumers stated:

"I like that when I come here, I feel like my therapist will help me discover what the underlying issues are and how to accept and change them."

"That I accepted as who I am."

"Everyone here is very friendly and very helpful."

"It's not far from my home. I have numbers available to me if needed. I can talk about anything."

"Availability of appointments in the late afternoon."

"My therapist and doctor are far the best around."

"Therapist is knowledgeable and caring. She tailored her approach to best suit my needs."

Review of 2014 Goals:

1. Commencing in early 2014, the clinic staff participated in cognitive behavior therapy training that included reviewing and discussing Judith Beck's text "Cognitive Behavior Therapy: Basics and Beyond." Staff presented and lead discussions with their peers and presented case examples.
 - a. Staff persons are using Cognitive Behavior Therapy in treatment plans for depression and anxiety.
 - b. Patient Health Questionnaires are reviewed every three to six months during the clinical review and treatment planning process
2. Throughout 2014, the clinic staff participated in an agency wide training on **Motivational Interviewing**.
 - a. All staff persons are utilizing Motivational Interviewing and this is discussed in clinical staffing's and weekly supervision. Supervision of individual sessions will commence in 2015.
 - b. Patient Health Questionnaires are reviewed every three months during the clinical review process.
3. Throughout 2014, clinic staff continued **to gain knowledge on heroin** and how to best meet clients' complex needs by reviewing literature, participating in trainings, ongoing clinical staffing's, weekly clinical supervision with the Clinic Supervisor and Medical Director, as well as by attending state conferences.
 - a. Clinic Supervisor participated in a grand rounds approach with other teams and administration to identify what is working and what the needs are.
 - b. Clinic staff continued to administer the Opiate (Narcotics/Heroin) Use Questionnaire to help best meet the needs of the clients and illicit feedback in group and individual treatment sessions.
4. In 2014, clinic staff continued to examine ways to increase efficiency. Changes were made to the referral process and how clients are contacted for their initial appointment, there was an increase in the amount of emergency assessment appointments available for clients, and a database email system was created notifying staff of upcoming deadlines.
5. In 2014, 20% of the Substance Abuse Prevention and Treatment Block Grant monies shall be designated towards prevention efforts.
 - a. In May of 2014, Jefferson County Human Services will co-sponsor an educational heroin summit.
 - b. The Clinic Supervisor will continue to participate in the ATODA School Council.
 - c. Clinic staff were trained in motivational interviewing.
6. In 2014, the Mental Health and AODA clinics will develop an advisory group.
 - a. The group will consist of clinic consumers and staff.
 - b. The council will examine policies, discuss and review what helped and also discuss and review what was not helpful.

7. In 2014, clinic staff captured consumer characteristic needs, service utilization and outcomes and report the data to the State of Wisconsin via the Program Participation System (PPS).
8. Throughout 2014, the clinic continued to participate in the Strengthening Treatment Access and Retention-Quality Improvement (STAR-QI) NIATx project with the Department of Health Services. The focus area was clinical outcome tracking on both the Patient Health Questionnaire (PHQ-9) and Brief Addiction Monitor (BAM) assessment tools. These assessments are administered to consumers every 3 months when the treatment plan is reviewed during the clinical review process.
 - a. A random sample of Patient Health Questionnaire scores improved by at least 5% on mental health clients in 2014, hence showing a reduction in symptoms of depression.
 - b. A random sample of Brief Addiction Monitor protective factor scores increased by 5% on AODA clients in 2014 showing a reduction in substance use.

Evidenced Based Practices for 2014

1. **Motivational Interviewing**-- Motivational Interviewing (MI) is a goal-directed, client-centered counseling style for eliciting behavioral change by helping clients to explore and resolve ambivalence. The operational assumption in MI is that ambivalent attitudes or lack of resolve is the primary obstacle to behavioral change, so that the examination and resolution of ambivalence becomes its key goal. (<http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=346>). The clinic is utilizing this therapy protocol in both group and individual sessions. Clinic staff received intensive motivational interviewing training by MINT trainers throughout 2014 and will continue with training throughout 2015.
2. **Medication assisted treatment** for opioid addiction via the use of Buprenorphine, Vivitrol and Naltrexone. (<http://www.ncbi.nlm.nih.gov/books/NBK64164/>). In 2014, the clinic ran four different treatment groups, specific for clients prescribed Buprenorphine. 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>). The clinic completed one round of group therapy utilizing the Seeking Safety material in 2014.
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>). All clinic staff persons were trained in cognitive behavior therapy and CBT is used in both group and individual sessions. The Outpatient Clinic staff reviewed and discussed Judith Beck's text "Cognitive Behavior Therapy: Basics and Beyond" in 2014.

2015 GOALS:

1. **Key Outcome Indicator: Patient Health Questionnaire-9 and Brief Addiction Monitor scores will improve by 2%.**
2. The outpatient clinic will continue to track clinical outcomes by collecting client data via the Patient Health Questionnaire (PHQ-9) and Brief Addiction Monitor (BAM) assessment tools. These tools will be administered during clients first sessions and throughout treatment a minimum of every 6 months. This tracking, reviewing

and discussing clinical outcomes will provide feedback about client progress during treatment and routinely and formally monitoring treatment responses. The goal for 2015 is to decrease PHQ scores by 2% and to increase BAM protective factors by 2%. This data will be collected via a random sample of client scores.

- a. **Patient Health Questionnaire (PHQ-9)**: The PHQ-9 is a multipurpose tool utilized for screening, diagnosing monitoring and measuring the severity of depression. It rates the frequency of symptoms which factors into the scoring severity index. Question 9 of the tool screens for the presence and duration of suicidal ideation. A non-scored follow up question assigns weight to the degree to which symptoms of depression have affected the client's level of functioning.
- b. **Brief Addiction Monitor (BAM)**: The Brief Addiction Monitor is a 17-item monitoring tool that covers important substance use related behaviors to support measurement-based care and outcomes assessment. Of the 17 questions, 4 are specific to alcohol or drug use. The remaining questions address aspects related to substance use, recovery, and treatment that include a number of life areas considered important for a multidimensional assessment of substance abusing clients and include interpersonal relationships, psychological/medical problems, and finances. The BAM measures three summary factors: Recovery Protection, Physical and Psychological Problems, and Substance Use and Risk.

3. Review, discuss and implement the Diagnostic and Statistical Manual-5—the Clinic Supervisor, Medical Director and clinical staff persons will review and discuss “DSM-5 Made Easy” ultimately implementing the DSM-5 by October 1st, 2015. Weekly training sessions will commence in May of 2015 that will allow for presentation of material, clinical case presentations and roundtable discussion of the DSM-5.

4. Continue Motivational Interviewing Training throughout 2015—Clinic staff will continue to be trained in motivational interviewing skills. The Clinic Supervisor will monitor skills via individual supervision, clinical staffing's and observation of individual and group therapy sessions.

5. The clinic will begin transitioning to ECHO electronic health record system in September of 2015. The Clinic Supervisor will participate in weekly meetings to prepare for implementation and trainings will occur with staff beginning in early 2015 with additional trainings occurring prior to implementation.

6. Clinic staff will participate in annual compliance training. Compliance will be discussed in clinical staffing's and weekly supervision.

7. All clinic staff will participate in substance abuse training to address the increase in opiate addicted clients treated by the outpatient clinic.

8. Clinic staff will continue to utilize cognitive behavior therapy in treating clients, building on skills by discussing in clinical staffing's and weekly supervision.

COMMUNITY SUPPORT PROGRAM

~Advancing mental health services for people with severe and persistent mental illness~

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 2014 and was recertified for two years at that time. It will again be audited in May of 2016.

In its fifteenth year of operation the Jefferson County Community Support Program provided services to 164 consumers ranging in age from 9 to 74. These consumers had mental health diagnoses such as schizophrenia, schizoaffective disorder, bipolar, major depression and various anxiety disorders. In 2014, 18 consumers were admitted and 27 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 2014, the CSP staff consisted of a CSP Director/Clinical Coordinator; psychiatrist/medical director; program assistant; two full time mental health technicians both of whom were also peer support specialists; 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. The ACT model is considered an evidenced based practice for individuals with a severe and persistent mental illness and is now used on a nationwide and international basis. 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 CSPs 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 leads 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.

The fidelity scale rating to the ACT model increased in the past year from a rating of 114 to 118. Fidelity is rated on a five point scale, with five meaning full fidelity. We rated 1 in two areas this year related to staffing patterns. Full fidelity involves having two nurses per one hundred consumers and a full time vocational specialist. We only have six hours of nursing time to provide for the needs of one hundred sixty four consumers over the year. There is also only very limited access to a vocational specialist at this time. There are no plans to address this currently. The second area involves the number of consumers we have attending monthly treatment groups for dual diagnosis. While we see an increase in substance abuse issues for the consumers we are currently serving, many of these individuals prefer not to engage in group treatment. The team continues to use Motivational Interviewing to enhance engagement and motivation when working with people dually diagnosed with substance abuse issues. In other areas, the team scored in a three to five range. This indicates very good fidelity to the model. The fidelity score improved this year due to the increased community contacts, face to face time, and greater adherence to the model.

Jefferson County's CSP also provides consumers the evidence based practices of Illness Management and Recovery, Integrated Dual Diagnosis groups for those with substance abuse issues, Supportive Employment, Seeking Safety, Cognitive Behavior Therapy, Coping CAT and Dialectical Behavioral Therapy. Consumers also

are encouraged to complete Wellness Recovery Action Plans that specify what is helpful for the person in a crisis situation and function similar to a psychiatric directive.

Close attention was again paid to tracking outcomes in the consumer database to monitor for outcome measures. In 2014, fifty two emergency room visits were tracked for CSP consumers. This averages .31 visits per consumer in the CSP in 2014, down from .52 ER visits per consumer last year.

Eighteen Community Support Program consumers again accounted for 23 tracked hospital stays in 2014 the same as admissions for 2013. This accounted for 225 hospital days for the year. Twenty four consumers accounted for 46 tracked admissions to the Lueder Haus in 2014. We continue to make greater use of the Lueder Haus as we continue to focus on providing support in the least restrictive setting, moving away from the hospital.

In 2014, the key outcome indicator was the percent of treatment plan goals met by each consumer. The CSP consumers met 68.1% of their treatment goals that were identified in their individualized recovery plans. In 2013, 61% of identified goals were met. This will be the key outcome indicator in 2015.

This data will continue to be reviewed and tracked in 2015, with an emphasis on reducing the utilization of the emergency rooms, hospitals, and Lueder Haus while increasing the percentage of recovery 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. Thirty eight consumers completed this survey down from fifty eight last year. 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	3.4	1.8	3.2	2.9	1.5	3.2
% w/ Mostly Recovery-Oriented Experience	71.4%	75%	48.6%	75%	54.2%	78.8%	74.3%
% w/ Mixed Experience	25.7%	22.2%	43.2%	25%	23.1%	15.2%	20%
% w/ Less Recovery-Oriented Experience	2.9%	2.8%	8.1%	0%	12.5%	6.1%	5.7%

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 means from 2014 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 score for employment is lower and that likely results from fewer services available in this area.

The results were consistent with the results that we collected in 2013.

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 2014 include:

1. Four consumers, who were on Chapter 51 orders, successfully completed his or her court requirements.
2. One consumer resumed managing her own money as his skills were enhanced and the protective payeeship was dismissed.
3. Twenty four percent of the adult consumers worked in a job of their choosing.
4. Twenty six consumers served the community through volunteer work through such places as Fort Atkinson Memorial Hospital, St. Vincent's, nursing homes, Food pantry, CSP consumer council, Horizons, and Twice as Nice.
5. Three consumers pursued educational goals. One of the consumers attended UW Whitewater. One consumer began classes at MATC. One attended Edgewood College in Madison.
6. Two consumers moved out of adult placements and into their own apartments.
7. Nine goals were met from last year's report. These will be reviewed below in detail.

Review of 2014 Goals:

In the year 2014, the CSP chose as its key outcome indicator to focus on increasing the percentage of treatment plan objectives met for the consumers in their recovery plans. It was felt that focusing on this indicator would assist both in increasing the effectiveness of the staff in working with consumers as well as the consumer's satisfaction with services and progress in recovery as they are achieving the things they have identified as important. For the 2014 year, the CSP key outcome indicator was to increase the percent of treatment plan objectives accomplished to 70%. The overall percentage of treatment plan objectives accomplished in 2014 was 68%. All CSP staff attended the Motivational Interviewing training and have been applying their skills when working with consumers. All staff have been utilizing Cognitive behavioral therapy skills as well to assist treating individuals with an array of diagnosis. The CSP team will continue to strive to increase the percent of recovery plan objectives accomplished to 72% for 2015.

There were ten program goals established for 2014.

Goal number one for 2014 was: Present the annual report to the consumers in some forum.The annual report from 2013 was presented to the consumers who attended the recovery day in November.

Goal number two for 2014 was: Train all staff in motivational interviewing and actively implement the skills in treatment sessions with consumers to improve their ability to achieve their goals.

Training days were held several times throughout 2014 in Motivational Interviewing. Following the trainings, each staff was asked to tape record an actual session using the skills for feedback on their adherence to the model by the professional trainers. Staff began including motivational interviewing interventions in their recovery plans following the trainings. Supervision sessions also addressed the use of motivational interviewing skills in sessions. Each staff was also asked to include a performance goal for next year's evaluation in their annual performance review.

Goal number three for 2014 was: Provide staff with additional training in trauma informed care.

In 2014, Staff attended a variety of trainings and conferences including The Mental Health and Substance Abuse Conference, The Midwest Conference on Childhood Abuse, and The Crisis Conference where trauma informed care was addressed. Staff working with children attended the Midwest Conference on Childhood Abuse to learn additional information in this area.

Goal number four for 2014 was: Review the ACE study from Wisconsin with all staff in a team meeting.

This goal was not met.

Goal number five for 2014 was: Implement two NIATX projects in 2014.

This goal was met and will be addressed more fully in sections eight and nine of the report.

Goal number six for 2014 was: Look at ways to improve participation in consumer council and review their place in the program.

This goal was met as two new staff members became involved in consumer council and again worked to increase participation among the consumers in the planning of fund raisers and events for the Community Support Program. A peer support mentor also became involved and worked to actively assist consumers in running more of the events.

Goal number seven for 2014 was: Provide two recovery focused events for the consumers in 2014.

This goal was met as the second annual recovery day event was held. A luncheon was provided by CSP consumer council and several individuals volunteered to share their personal recovery stories with the people that attended. There was positive feedback surrounding this event as it gave consumer's an opportunity to focus on his or her success over the past year. Many other events were held such as a garage sale and brat fundraiser, a Scoopie night in Fort Atkinson to raise money for activities, and trips to the zoo, pumpkin patch, and the Ducks in Wisconsin Dells.

Goal number eight for 2014 was: Implement a formal mechanism to systematically review each consumer's services to promote the maximum recovery focused services targeting barriers to increased independence in the community and addressing those barriers in services.

This became the CSP's first NIATx project of the year. The caseload of each case manager was reviewed to identify the need for CSP services with the CSP supervisor to identify areas that could be built on to increase independence and the use of natural supports and reduce reliance on professional services. Long term care needs for activities of daily living were addressed through available Care Wisconsin services to free up more

time for identified mental health services of incoming more acute consumers. This will be done periodically each six months.

Goal number nine for 2014 was: Review with each CSP consumer service needs to identify individuals who could do well with less intensive services and who are interested in graduating from the CSP as they move forward in their recovery journey.

This goal was met as the second NIATX project of the year. Consumers were identified within the program that had moved forward in their recoveries and were utilizing few CSP supports. Discussions were held with these consumers to ascertain their interest in graduating from CSP services and moving to less intensive supports either within the agency or in the community. Twenty six consumers were discharged this year, almost three times the number discharged in 2013. This allowed the case managers in the CSP to admit individuals on the waiting list for services and for the team to be able to admit as consumers were identified with the need for intensive CSP services and who were determined to be eligible for the program.

Goal number ten, the Key Outcome Indicator for 2014 was: Raise the rate of completion of treatment plan objectives from the 61% in 2013 to 70%.

This goal was partially met as the treatment plan completion rate was raised to 68.1% for the year, an increase of 7%.

2015 GOALS:

- 1. Key Outcome Indicator: 72% of all treatment plan goals are met.**
2. Meet key indicator outcome by increasing the successful completion of treatment plan objectives from 68% to 72%.
3. Train all staff in Echo and implement the new electronic documentation system.
4. Train all new staff in motivational interviewing and monthly practice motivational interviewing skills in a team meeting.
5. Participate in the trauma informed care grant and further train staff in this area and implement into clinical work.
6. Implement a weekly clinical training team meeting for CSP staff to further expand evidence based practices in CSP.
7. Implement two NIATX projects in 2015.
8. Expand the opportunities for peer support services in CSP.
9. Explore and implement more evidence based practices to the children in CSP services.

COMMUNITY RECOVERY SERVICES

~Providing qualifying consumers with services to move forward in their recovery goals~

Community Recovery Services provide qualifying consumers with services to move forward in their recovery goals. Services that can be provided are peer support, employment services and community living supportive services. The program is funded through Medicaid. In 2014, nine consumers were served in the program. There were two admissions and two discharges. All nine consumers received community living supportive services. All of the consumers received supports in adult county residential placements. The two consumers who were discharged were able to move to their own independent apartments and were discharged from the CRS program to only CSP supports. Although the program remains small in size, we have seen impressive outcome measures in the past several years for individuals returning to live more independently in the community.

In 2014, the program focused on quality assurance and monitoring in regards to the recovery notes provided by the CLSS supports. This included multiple trainings of programs and direct service providers in the note format and proper provision and documentation of CRS services. Quality was monitored and frequent contacts were made with providers to resolve problems. A financial and clinical audit of the program was conducted in fall of 2014 with 100% compliance with state requirements.

A ROSI survey was implemented this year with the following results. Two of the ten consumers responded to the survey. A more detailed explanation of the ROSI survey can be found in the CSP section of this annual report.

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	2.9	3.4	1.8	3.3	1.5	1.9	2.8
% w/ Mostly Recovery-Oriented Experience	50%	100%	50%	100.0%	50%	50%	50%
% w/ Mixed Experience	50%	0%	50%	0%	50%	50%	50%
% w/ Less Recovery-Oriented Experience	0.0%	0.0%	0.0%	0.0%	33.3%	0.0%	0.0%

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 respondents agreed that they felt empowered by the program services and liked the staff approach. They continue to experience barriers in meeting basic needs. The just as in the CSP Rosi, the consumers identify a need for better employment services. The CRS team will focus next year on obtaining a larger sample size of participants completing the ROSI survey to obtain additional input into how the program is meeting the consumer's needs.

In 2014, options for expanding the program will be explored and a continued focus will be made on ensuring the quality of provider services and documentation while maintaining compliance with the state regulations.

COMPREHENSIVE COMMUNITY SERVICES PROGRAM (CCS)

~Providing qualifying consumers with services to move forward in their recovery goals~

The Jefferson County Comprehensive Community Services Program (CCS) completed its seventh full year. First certified in February 2006, Jefferson County's CCS program was granted a two-year license in March 2007. This license has been renewed every two years, most recently March 2014.

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 offers an array of psychosocial rehabilitative services which are tailored to each individual consumer. These services include: Screening and assessment; service planning; service facilitation; diagnostic evaluations; medication management; physical health monitoring; peer support; individual skill development and enhancement; employment related skills training; individual and/or family psychoeducation; wellness management and recovery/recovery support services; psychotherapy; substance abuse treatment; and non-traditional or other approved psychosocial rehabilitative services deemed as necessary.

Key Outcome Indicators

For the 2014 year, the CCS goal was to increase the percent of recovery plan objectives accomplished to 70%. The overall percentage of recovery plan objectives accomplished in 2014 was 62%. Sixty-eight percent of the objectives for children were accomplished and fifty-eight percent of objectives were met by adults in the program. All CCS staff have attended the Motivational Interviewing training and have been applying their skills when working with consumers. All staff have been utilizing Cognitive behavioral therapy skills as well to assist treating individuals with an array of diagnosis. Throughout the 2014 year, the CCS had three long time staff leave the agency, thus three new staff were hired. The CCS also received an additional position in 2014 and this position was also filled. The CCS team will continue to strive to increase the percent of recovery plan objectives accomplished to 70% for 2015.

General data

During 2014, 86 consumers ranging in age from 5 to 71 received services. This is consistent with number of people served in 2013. Throughout 2014, 29 new consumers were admitted and 24 consumers were discharged. Of the consumers admitted to the program, 16 were children and 13 were adults. Of the consumers discharged, 13 were children and 11 were adults. Of the 24 consumers who were discharged, 3 moved from our geographic service area, 9 recovered to the extent that CCS level of services were no longer needed, 2 consumers needed services beyond what CCS could offer, 7 consumers decided to withdraw from services, 2 were incarcerated and 1 passed away. Consumers had diagnoses of: schizophrenia, schizoaffective disorder, bipolar disorder, major depression, borderline personality disorder, post-traumatic stress disorder, various anxiety disorders, reactive attachment disorder, attention deficit hyperactivity disorder, obsessive compulsive disorder, conduct disorder and substance use disorders.

The CCS staff consists of a Psychiatrist and a CCS Service Director. As of January 2014 there are 6 full time CCS Service Facilitators, and a full time job developer/psychosocial rehabilitation provider.

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. This year’s ROSI showed a difference in all categories except the barrier and staff approach category which did not really show any change. The overall mean of the empowerment, barriers, staff approach and employment categories increased positively. The categories of person centered and basic needs decreased in percentages. Even though these categories decreased at least 66.7% of people feel they had a mostly recovery oriented experience. Last Year's ROSI showed a 66.7% in mostly recovery oriented experience for the category of empowerment. This category increased to 100% for 2014. Last year's ROSI showed a 100% in mostly recovery oriented experience for the category of person centered. A theory as to why this percentage has decreased to 77.8% is the result of three long term staff leaving the agency in 2014. A focus for the program is to train the newly hired CCS staff in person centered planning, treatment and recovery oriented approaches with consumers. This year CCS utilized a contracted job developer trained in IPS to assist consumers in their pursuit of obtaining employment. This worker maintains strict fidelity to the evidenced based model and has been trained in the Dartmouth IPS model.

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	1.8	3.6	3.3	1.3	2.9
% with mostly recovery oriented experience	77.8%	77.8%	50.0%	100.0%	66.7%	87.5%	75.0%
% with mixed experience	22.2%	22.2%	50.0%	0.0%	33.3%	12.5%	12.5%
% with less recovery oriented exp	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	12.5%

Monetary benefits

In 2014 the CCS program was reimbursed \$404,828.47 from Medicaid for services provided to consumers. This is an increase of \$12,208.75 from 2013. This will continue to be a focus of our program in the next year to assure we are recouping the maximum amount of funds possible. We are focusing on compliance, collaborative documentation, and increasing our network of community providers. Some of the challenges of this year for the CCS team were the loss of three long time CCS staff, two of which left within one month of each other and needing to replace those positions. This involved recruiting, interviewing and training new staff. During this time two consumers decided to discharge from the program as they were near or to their

discharge goal and did not want to start with a new service facilitator. New consumers were not signed in as quickly due to the caseloads of the remaining service facilitators and taking on extra consumers until the vacant positions were filled.

Children

In 2014, the CCS program served 47 children, ages 5 to 17; of these children, 29 were males and 18 were females. Sixteen children were admitted to CCS and 13 were discharged. Of the thirteen discharged, 2 children moved out of county, 4 children chose to withdraw from the program, 6 children met their discharge criteria, and one child needed a higher level of treatment. Thirty-seven of the children resided at home all year or with a relative, one moved from out-of-home back home or to a relative's home, three lived in a group home, four lived in a foster home/treatment foster home, and four children lived in a group home part of the year and a foster/treatment foster home part of the year.

During 2014, 6 children had a mental health commitment order. Two of the children were able to end their mental health commitment order. In regards to Child Protective Services (CPS) orders, one of the children's families began a CPS order; 9 were currently on an order, one order ended, and one child's family moved out of county. Juvenile Justice Orders consisted of 10 adolescents having already been on an order, 3 adolescents beginning an order, and 6 of the adolescents being able to end their order. Of the 3 adolescents beginning their orders in 2014, one of the adolescents was a new admission to CCS. Three adolescents were on a Deferred Prosecution agreement (DPA).

There were 18 children/adolescents with police contacts with a total of 54 police contacts. Six children/adolescents had 4 or more police contacts during the year, with one adolescent having a total of 10 police contacts for the year. Three of the adolescents spent time during the year in shelter or secure. There was a total of 3 days in Secure for one of the adolescents and a total of 117 days in Shelter for two adolescents.

Of the 39 children in CCS, 8 children attended school partial days due to behavior and mental health issues. Of the 8 that attended partial days, 3 were able to go back to school for full days in 2014. Four children participated in an alternative school program throughout 2014. Five of the adolescents received suspension s from school during the 2014 year.

There were 11 children admitted for psychiatric hospitalizations. Six of the children had voluntary admissions, 6 of the children had involuntary admissions. The voluntary hospitalization days totaled 33. The involuntary admissions to Winnebago Mental Health Institute totaled 196 days. There were 6 emergency room visits.

Adults

In 2014, the CCS program provided services for 39 adults aged 18-71. Of these adults, 6 were males and 33 were females. Thirty-eight consumers lived in their own apartment/home and one person resided in a supervised apartment. Two individuals had mental health commitment orders.

In 2014, 13 adults were admitted to CCS and 11 were discharged. Of the people discharged, 1 person was transferred to the Community Support Program (CSP) due to increased symptomology and the need for additional services. One individual moved out of county, 3 individuals did not engage in services, and 3 individuals were discharged for successfully meeting discharge criteria.

One adult had voluntary psychiatric admissions; one adult had voluntary and involuntary admissions. The voluntary admission days totaled 12 days. The involuntary admissions totaled 1 day. Four of the adults in CCS utilized our crisis stabilization facility. The days for the crisis stabilization services totaled 23. There were also

10 ER visits between 7 adults. Two adults were hospitalized for surgeries, including a liver transplant and kidney failure.

Elderly

The CCS program served two consumers who were considered elderly.

Recovery Plans

Consumer recovery plans are reviewed every six months. Thirty-six consumers participated in the CCS program long enough to have two plans in 2014. Overall, 62% of their objectives were met. Twenty consumers were able to meet 100% of their objectives on at least one treatment plan. Six consumers were able to complete 100% of the objectives for the year. The children met 68% of their objectives. Eight children were not able to meet any objectives during a 6 month period. Of the eight, five were on delinquency orders, four only had one plan for the year and two were in out-of-home placements. The adults met 58% of their objectives. Seven adults were able to complete 100% of their objectives for a six month period. Two adults were able to complete 100% of the objectives for the entire year. 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. Consumers have reported feeling in charge of their services and being able to direct the team in their needs. Family members and providers feel that they can easily read and understand the plan. Family members and other natural supports feel more connected as they are written into the plan providing services to the person. The plans also inform the consumer of the services they are to receive. This increases accountability since everyone on the team knows his or her responsibility in assisting the consumer in building recovery.

Additional service providers

The CCS program contracted with eleven providers.

- Five individuals provided contracted therapy services. These individuals provided a mix of in-home and agency individual and/or family therapy.
- Four certified peer specialists assisted the CCS program last year. These trained peers provided support and advocacy for persons in their journey of recovery.
- One individual provided in-home services to assist consumers with mental health and substance use concerns.
- This year CCS utilized a contracted job developer trained in IPS to assist consumers in their pursuit of obtaining employment. This worker maintains strict fidelity to the evidenced based model and has been trained in the Dartmouth IPS model.
- The CCS team trained ABA of Wisconsin providers to assist youth and adolescents in their recovery. We plan to utilize these services in 2015.

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

2014 Evidence Based Practices

CCS provided the following evidenced based practice groups; Seeking Safety group and Managing Life group (Dialectical Behavior Therapy). The Managing Life group was co-facilitated with a clinic therapist and with a certified peer specialist. Individually, people were offered Psycho-education, Illness Management and Recovery, Cognitive Behavior Therapy (CBT), Dialectical Behavior Therapy (DBT), Motivational Interviewing (MI), Coping Cat and Supported Employment.

CCS Coordinating Committee

The CCS Coordinating Committee is currently comprised of consumers, staff, parents and individuals from the community. The committee meets quarterly at Human Services for at least one hour. The committee continues to focus on recruitment and retention of members and reviewing policy and procedures of the CCS program.

The CCS Coordinating Committee submitted the following recommendations for the CCS program in 2015:

- A support group on sexual abuse/PTSD (**CCS currently facilitates a Seeking Safety Group to address PTSD**).
- A group that includes adult males (not necessarily just for males). (**The CCS plans to utilize a contracted provider to facilitate a group for men and women to assist with their recovery goals**).
- An emotion-regulation group for children/adolescents. (**The CCS plans to facilitate an aggression replacement training (ART) group for males and females for either children or adolescents in the summer and/or fall of 2015**).
- A group on protective behaviors for children. (**CCS plans to utilize the ART skillstreaming curriculum for teaching pro-social skills/increase protective behaviors in children/adolescents. This will be done in a group setting and individually**).
- A flyer to be sent out every three months for CCS consumers and supports.
- A fundraising event to raise money for the CCS program.

Review of 2014 Goals:

1. Regionalize CCS with Rock and Walworth counties by July 2014 or as the State allows. **This took place in August 2014 and the JRW Regional CCS has created regional policy and procedures.**
This will involve:
 - Sharing specific services and procedures
 - Developing governance understandings
 - Completing required paperwork and approvals from DHS
 - Hiring additional staff
 - Serving more consumers
2. Increase the number of CCS providers for children and adults by December 31, 2014 who are trained in needed evidence based treatment protocols. **CCS added four new providers who have training in evidence based treatment.**
3. Increase the role of peer specialists by educating all new consumers on what a peer specialist is and how they can help them in their recovery by December 31, 2014. **The CCS service facilitators/team and peer support specialists assisted with educating new consumers on these services and how it can benefit their recovery.**
4. Ensuring compliance in Medicaid billing requirements and documentation by reviewing notes every two weeks, discussing documentation weekly during clinical supervision, continuing collaborative documentation, training new staff regarding proper documentation and weekly chart audits by December 31, 2014. **The above will continue to be a practice for the 2015 year as well.**
5. Present Annual report to the CCS coordinating committee by July 31, 2014. **This was accomplished and will take place again this summer for the new annual report.**
6. Complete at least one continuous quality improvement project using the NIATx model. **The CCS started a QI NIATx project to focus on increasing the key outcome indicator by utilizing the newly developed note template in the electronic system to increase the percentage of consumers objectives met by 4%.**
7. Continue to track outcomes for children and in 2015 use the data from 2013 and 2014 to establish services for 2015.

At each CCS team meeting we discuss and track this information. For 2015, we developed an improved tracking system along with an internal procedure to ensure the data is collected properly. Each year we will be able to compare the data that has been collected to see where we are making progress and what we need to change in order to see progress. We will continue to track outcomes in these areas and we will continue to compare the outcomes from previous years to see where we need to implement or improve services.

Review of Training Goals for 2014

1. **Key Outcome Indicator:** Throughout 2014, the CCS staff will participate in agency wide training on Motivational Interviewing. **(All CCS staff attended this training. Staff utilizes these skills in their daily work and skills are reviewed during weekly supervision as well).**
 - a. All staff then will use motivational interviewing skills when appropriate. This will be tracked by an increase in consumers engaging in treatment, and increasing the percentage of objectives met to 70%. **(62% of objectives were met for the 2014 year. Children met 68% of their objectives for the year and adults met 58% of their objectives).**
2. Commencing in early 2014, the CCS staff will apply their Cognitive Behavior Therapy training.
 - a. All staff will then use Cognitive Behavior Therapy in all treatment plans for depression and anxiety **(All staff have been utilizing CBT in their recovery plans throughout 2014).**
 - b. PHQ 9 results will be compared to pre and post implementation **(Fifteen consumers completed 2 PHQ 9. Seven consumers' symptoms improved; six consumers' symptoms increased; one consumer's symptoms did not change at all and the last consumer did not report any symptoms either time. Nine consumers only had one PHQ 9 for the year and three consumers did not have a PHQ 9 distributed).**
3. Implement DSM V by October 1, 2014. **(It was decided by our agency that we will begin to utilize the DSM V when the ICD 10 goes into effect on October 1, 2015).**
4. Attend training on the DSM V and begin using by October 1, 2014. **(One staff was trained on using the DSM V in 2014. Due to staff turnover the CCS team will participate in an inner-agency training prior to implementing the use of the DSM V and ICD 10 on 10-1-2015).**

PROGRAM GOALS FOR 2015

1. **Key Outcome Indicator:** **72% of all treatment plan goals are met**
2. Increase number of CCS providers for children/adolescents who are trained in Trauma Focused Cognitive Behavioral Therapy (TF-CBT) by December 31, 2015.
3. Decide on an assessment tool for children and adolescents to track at the time of admission and at the time of every recovery plan review. CCS will begin to implement this by May 1, 2015.
4. Begin a group for children and/or adolescents using the Aggression Replacement Training (ART) model by June 2015.

5. Increase the number of peer specialists providing services to CCS children/adolescents and adults by December 31, 2015.
6. Ensuring compliance in Medicaid billing requirements and documentation by reviewing notes every two weeks, discussing documentation weekly during clinical supervision, continuing collaborative documentation, training new staff in regards to proper documentation, and weekly chart audits by December 31, 2015.
7. Present the annual report to the CCS coordinating Committee by October 31, 2015.
8. Complete at least one continuous quality improvement project using the NIATx model.
9. Continue to track outcomes for children and in 2015 use the data from 2013 and 2014 to establish services for 2016.
10. Develop Project YES services for youth and young adults aged 16-25 who are at risk of or have a mental illness and/or substance use disorder into the CCS service array to assist with a healthy transition into adulthood.

TRAINING GOALS FOR 2015

1. **Key Outcome Indicator:** Beginning in April of 2015, three CCS staff will participate in evidence based Trauma Focused Cognitive Behavioral Therapy training/learning collaborative focused on treating children ages 3-18.
 - o These three staff will utilize the TF-CBT model of treatment when appropriate for specific consumers who have been exposed to or experienced trauma. This will be tracked by an increase in consumers engaging in treatment, and increasing the percentage of objectives met to 70%.
2. Beginning in 2015, the CCS staff will apply their Motivational Interviewing skills and Cognitive Behavior therapy skills in all sessions.
3. Implement DSM V by October 1, 2015.
4. Attend training on the DSM V and begin using by October 1, 2015.
5. All staff will be trained in using the new EMR (ECHO) by September 1, 2015.

EMERGENCY MENTAL HEALTH

Our Emergency Mental Health (EMH) crisis intervention services were certified under HFS 34 in October of 2007. 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.

Our Intake/Crisis staff operate 24/7 on site, including weekends and holidays. Potential Emergency Detentions are assessed by County staff using an immediate response system who consult with our psychiatrist. Depending upon acuity of presenting issues, including safety, and lethality determinations are made for

immediate intervention including inpatient hospitalization, group home or other crisis stabilization placement. St. Mary's and UW in Madison, Rogers in Oconomowoc, and St. Agnes and Fond du Lac HCC in Fond du Lac are the primary facilities used for Emergency Detentions. Winnebago Mental Health Institute is used as our last option for an emergency detention. Non-crisis community requests or referrals for services are also managed by our staff, who assess immediate and longer term needs with consumers, and then connect them to the needed services by written and oral discussion with the appropriate manager and staff. The Intake staff have immediate and open access to the Medical Director as well as to managers as needed.

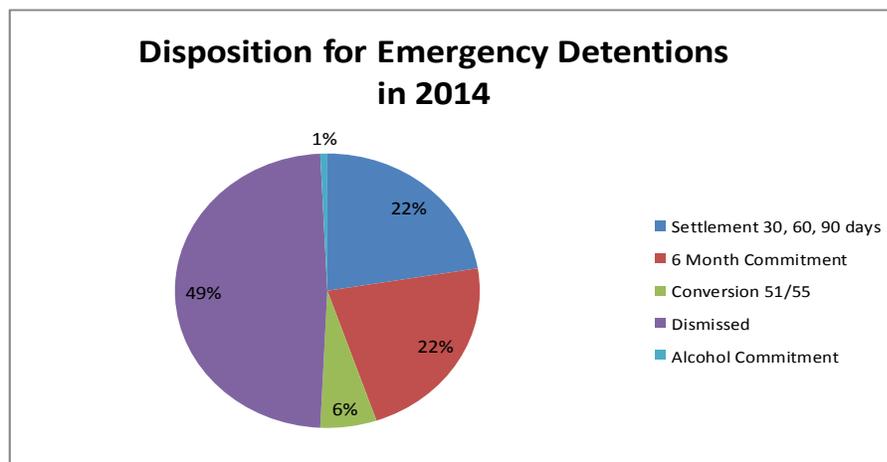
CONSUMER SATISFACTION

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 14 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.

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	3.4	3.6	1.6	3.6	2.6	1.1	2.7
% w/ Mostly Recovery-Oriented Experience	83.3%	84.6%	78.6%	92.9%	42.9%	92.3%	63.6%
% w/ Mixed Experience	16.7%	15.4%	21.4%	7.1%	28.6%	7.7%	9.1%
% w/ Less Recovery-Oriented Experience	0.0%	0.0%	0.0%	0.0%	28.6%	0.0%	27.3%

In 2014 we had 6,375 EMH/Suicide contacts. These people received crisis assessments, response planning, linkage and follow up, and crisis stabilization services. Of these contacts 319 emergency detention assessments were completed, 142 people were emergently detained and 177 were diverted. Of the individuals who were emergently detained, 7 of them were emergently detained in another county with venue transferred to us, 21 of them were out of county residents, 12 of those who were out of county residents were placed in a group home, and 12 people were emergently detained from the Jefferson County Jail. Of the 142 people only 33 people were currently receiving services through our human services department.



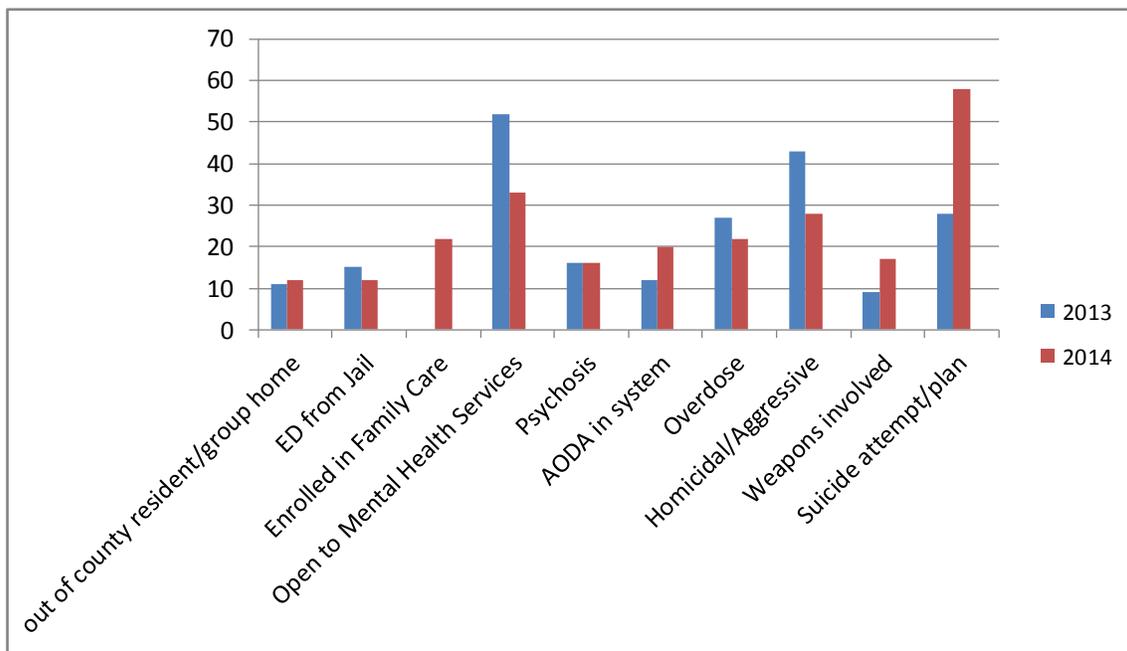
KEY OUTCOME INDICATOR

Our key outcome indicator, a measure of how we are doing our work, is our diversion rate, i.e. the number of times we are able to find a disposition that is not emergency detention. We adhere to the statute of least restrictive setting for each person and we want each person to have the best possible outcome. To do this, we consider a number of factors: we complete a standardized suicide assessment, we consider lethality, means, opportunity, age, gender, access, and past history. When possible we will divert the person to a setting that is not locked facility.

The key outcome indicator for 2014 was to maintain the diversion rate of 2013. The table below shows the comparison between the years for emergency detentions, diversions, percent diverted and percent emergently detained.

Year	2013	2014
Total # Assessments	311	319
Total # Emergency Detentions	154	142
Total # Diversions	157	177
Percentage of Diversions	50.4%	55.4%
Percentage of Emergency Detentions	49.5%	44.5%

Due to increasing numbers of suicide assessments and emergency detentions we tracked reasons why people were placed under an emergency detention and if they were in services at the county, residents of another county, in family care, and placed in group homes. The chart below shows the comparison from 2013 to 2014.



The Lueder house, our crisis stabilization facility, is an 8 bed class A CBRF (community based residential facility). In 2014, there were 103 admissions at the Lueder house. The average length of stay for consumers was 16 days.

In the sixth full year of certified Emergency Mental Health services, we billed \$88,618.25 to Medicaid for our services and received payment of \$46,494.78.

Lastly, 58 people were served by the Lueder Haus, our crisis stabilization facility. We were also able to bill \$317,585.77 to Medicaid for our crisis stabilization services and received payment of \$98,865.98.

YOUTH CRISIS SERVICES

In 2014 we recognized the need to find more options for youth in crisis. We assembled an internal team and identified a number of interventions that were needed. The internal team consisted of all the Behavioral Health Supervisors, the Director, the Child and Family Manager, and the Child and Family Supervisors.

The needed interventions we identified were:

1. We need a crisis stabilization facility and in home crisis services
2. We need to identify high risk youth in the community
3. We need review crisis contacts of those youth not E.D'd
4. We need review the crisis contacts of those youth who were E.D'd.
5. We will analyze the findings of the above 2 items.
6. We need to review and improve Crisis Plans
7. We need more community clinicians who offer evidence based treatment services for youth.
8. We need other inpatient psychiatric hospital options for youth.
9. All stakeholders need more awareness of trauma, the impact of trauma, and more clinicians trained to treat trauma in youth.

We have taken the following actions to develop the needed interventions:

1. Our internal team meets monthly, to review data, and situations we have encountered.
2. We will provide training for foster parents and other vendors to provide crisis stabilization in a foster home and in the homes of youth.
3. We revamped our Crisis Plan and trained all staff in how to do a more detailed version.
4. We ask our community partners about who are potential high risk youth.
5. We hired a Youth Therapist in our Mental Health Outpatient Clinic area.
6. We have contracted with additional hospitals for inpatient psychiatric services.
7. We have contract for additional outpatient therapy services.
8. We are participating in the Department of Child and Family Trauma Informed Care and in the Department of Health Services Project Yes grants.
9. We added two positions in our Comprehensive Community Services program and are serving more youth.
10. We are serving more youth in our Community Services Program.
11. We are offering Seeking Safety group treatment for adolescents.
12. We are exploring offering Aggression Replacement Therapy in a school next fall.
13. We have two NIATx projects underway regarding the use of our Emergency Mental Health communication and following up at the time of discharge from a hospital.

We are pleased to report that the number emergency detentions of youth declined in 2014 to 18 from 33 in 2013.

Review of 2014 Goals:

1. **Key Outcome Indicator: maintain current emergency detention diversion percentage, whenever possible, by continuing to review and improve voluntary options.**
We were able to increase our diversion rates by 5%. In 2015 we would like to keep this as a key indicator as we continue to explore and improve upon voluntary options for treatment.

2. **By December 31, 2014 EMH supervisor will have met with area mental health providers to discuss services offered and to develop a better relationship with them and the EMH program.** *This goal was not fully met. We feel it is important to continue to develop and maintain good working relationships. There were meetings with police departments and the hospitals but not area mental health providers.*
3. **Implement electronic health records by July 1, 2014.**
We were able to implement electronic health records on June 16, 2014.
4. **Meet with essential personnel from the nursing homes in Jefferson County and ADRC manager to discuss changes in chapter 55 and to work with them on meeting the growing need for the elderly with mental health diagnosis by December 31, 2014.**
The ADRC Division manager and the EMH supervisor continue to meet in regards to developing resources and meeting the growing need of the elderly. In 2015 there will be a panel presentation coordinated by the ADRC and EMH and will be provided to staff at Fort Atkinson hospital for them to understand the needs. Especially the needs of people diagnosed with dementia.
5. **Complete training in emergency mental health for the certified peer specialists and have them bill for the services they are providing at the Lueder House by June 1, 2014.**
The peer specialists were provided training in EMH in 2014. They provided services at the Lueder House.
6. **Complete one walk through and continuous quality improvement project using the NIATx model at the Lueder House by October 1, 2014.**
A walk through was conducted at the Lueder House. The project that came about as a result of the walk through was to change the intake process. The location/privacy of the process, the paperwork, and developing the stabilization plan all changed as a result of this project. The intake packet is more condensed and less overwhelming. The staff understand the person should be taken to a room where others are not present when conducting the intake process, and finally the staff have been trained in developing stabilization plans for person entering the Lueder House. This resulted in the staff having more of a stake in the plan and assisting the person in executing the techniques in the plan. In the past when the case manager wrote them and put in what the stabilization staff were to do there was less involvement by the crisis staff. This then results in more communication between staff and consumers and more investment on the stabilization staffs part in helping the consumers recover.
7. **Increase certified peer specialist services at the Lueder House by June 1, 2014.**
In 2014 we had two groups at the Lueder House that were run by peer specialists. We also had a peer specialist available to assist consumers who were looking for employment or a place to live. The peer specialists met with consumers who were new to services at Jefferson County or who were new to the county in general to talk with them about what services and resources are available.
8. **Develop a children's crisis stabilization home in the area as an alternative to hospitalization and as a resource when there are no beds available for a voluntary hospitalization by December 31, 2014.**
We currently have two foster homes in the county who are willing to provide children's crisis stabilization services. We have a work group that meets monthly to further develop stabilization options outside of the home and also within the child's home. Lastly, we are part of a children's crisis stabilization grant with other counties to help develop these services and to provide training to those who are providing the services.
9. **Explore ways to increase revenue, including reviewing what staff are in the referral and follow up areas.**
After the transition to the new electronic health records it was easier to see where we were missing opportunities for billing. We were able to view the number of crisis plans and to see who was having

frequent contact and needed a crisis plan. We were also able to link notes and make them billable that workers thought were unbillable but really billable. All of these things will increase revenue in 2015.

- 10. Find a provider who is able to provide crisis stabilization services for children in their home and initiate use.** *This is a goal we are currently working on. We have identified potential providers and are working on providing training and meeting with them to work out the details.*
- 11. Explore options of where we can capture revenue that we are currently not using by June 1, 2014.** *As stated before we were able to pinpoint these areas once our electronic records went live. Because that did not occur until June 16, 2014 we were delayed in meeting this goal.*

EMH TRAINING GOALS FOR 2014

- 1. Train all staff to use electronic health records by July 1, 2014.**
All staff that provide EMH were trained in the electronic health records. In December we provided another training to staff in the Children's and Family Division as we felt there was billing they could be doing that we were not recouping.
- 2. Offer EMH 101 training to all new staff and to specific vendors, in particular those who could provide one to one crisis stabilization for children in the child's home.** *This was done with a foster home and with Juvenile Justice staff. We will be providing another training in 2015 to capture more providers.*

2015 GOALS:

- 1. Key Outcome Indicator: Giving consideration to lethality and acuity, maintain diversion rate to least restrictive setting rate.**
- 2.** Maintain current emergency detention diversion percentage, whenever possible, by continuing to review and improve voluntary options.
- 3.** Implement and go live with the ECHO electronic health records system by September 1, 2015.
- 4.** Apply to the Zero Suicide Academy by March 6, 2015. If accepted the team will attend the academy in April and then spend the year implementing the project.
- 5.** Complete a Niatx project involving the behavioral health division. This project will focus on follow up with persons when they are discharged from a hospital. This will be completed by September 1, 2015. This will facilitate us reviewing and reducing our readmission rate.
- 6.** Implement the use of the Columbia Suicide Assessment and the Columbia Risk assessment tools by July 1, 2015.
- 7.** Implement the use of crisis stabilization criteria form. Dr. Haggart will fill this out each time he meets with consumers at the Lueder House to ensure they still meet stabilization criteria. If they do not they will be put on placement status and subject to a daily charge for staying at the Lueder House. This will be implemented by April 30, 2015.
- 8.** Continue to develop further stabilization options for adult and children.
- 9.** Develop further contracts with hospitals to be providers when an emergency detention is necessary.

EMH Training Goals for 2015

- 1.** Train EMH staff in the Columbia suicide rating scale and the Columbia suicide risk assessment.
- 2.** Attend the Zero Suicide Academy.
- 3.** Train in-home and foster homes to provide crisis stabilization for children.

CHILD & FAMILY DIVISION

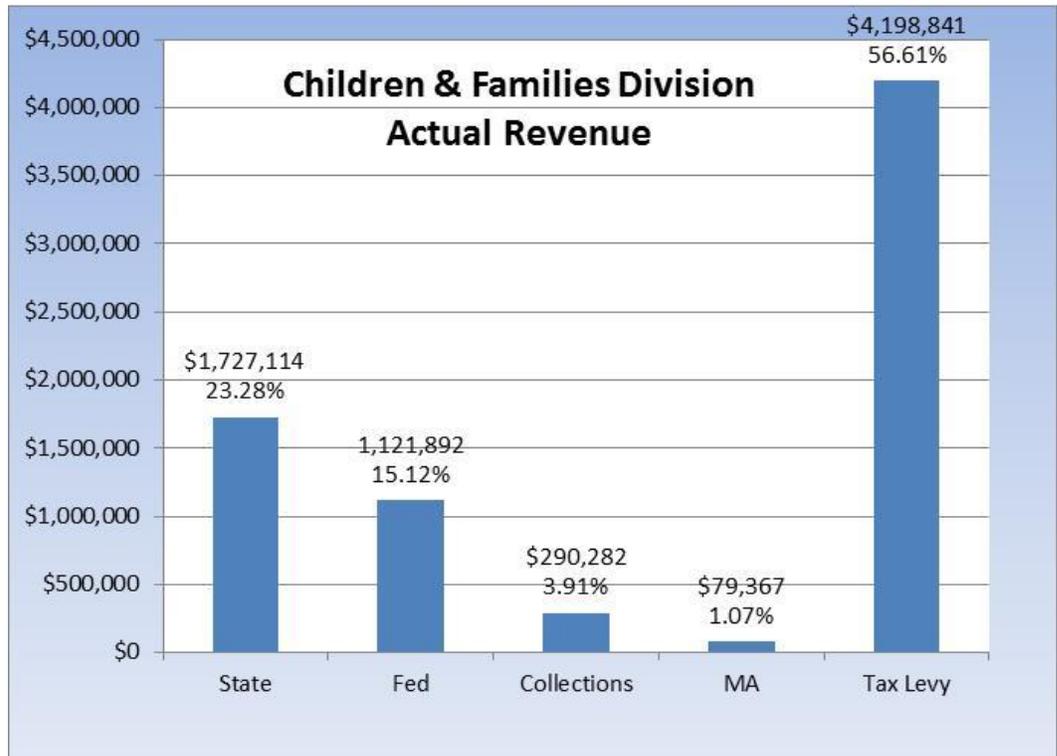
~ Keeping families together and assisting them to live in their own communities ~

The Child and Family Division of Jefferson County Human Services is designed to provide interventions and services from birth to adulthood, and at times beyond. These treatment based services and interventions come in a variety of forms provided by the following teams; Juvenile Court Intake, Access, Initial Assessment, Early Intervention, the Busy Bee Pre-school, Child Protective Services, Juvenile Justice, Coordinated Service Teams, Children’s Long Term Support, Child Alternate Care, and Independent Living. These diverse teams that make up our Child and Family Division serve the residents of Jefferson County through a variety of multi-faceted programs. The long term goal across the division is to partner with the family to develop a comprehensive client centered treatment plan that provides coaching and service provision for long term independent success. The primary focus of this division is to provide safety, permanence, and well-being across the continuum from birth to the age of majority.

A core belief of our Division is that children have the right to live in a safe environment with appropriate intervention and services to assist them until our interventions are no longer needed. In 2014 the Child and Family Division continued efforts aimed at children with complex alcohol and drug

issues along with severe mental health needs. To deal with these complex multifaceted issues the Division continues to partake in a variety of opportunities provided by DCF and DHS. Through the successful application and awarding process, the division continued the long tradition of successful partnerships with the state in the form of the Post Reunification Services Program, Family Find Initiative, Citizen Review Panel Designation, Primary Coach to Teaming Model, Children’s Long Term Support and Coordinated Service Team Expansion. One of our staff members was awarded the 2014 Secretary’s Caring For Kids Award from the Secretary of Children and Families at DCF.

The Child and Family Division revenue comes from County tax levy, State and Federal funds as denoted in the following graph. The most significant expenses for the Division are customarily alternate cares costs, staff wages and benefits.



For 2014 the Division established overarching goals for the Division as well as key outcome indicators for each team. The overarching goals for the Division were as follows:

- Safety, permanence, and well-being for all children referred to the Department
- Develop prevention and treatment programs for the emerging issues impacting children and families

The **key outcome indicators** included meeting state and federal indicators, timelines, key staffing

procedures, hospitalization prevention, team composition, community placement preservation, and secondary education attendance.

The Division continues to provide best practice and evidenced based practices across all teams to build on the pre-existing strengths, while addressing 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.

CHILD & FAMILY DIVISION TEAMS

Access and Initial Assessment

Intake

Child in Need of Protective Services

Juvenile Justice Integrated Services

Restorative Justice Programs

Coordinated Service Team

Birth to Three

Busy Bees Preschool

Child Alternate Care

Children's Long Term Support Waiver Program

Independent Living

Incredible Years

INTAKE

~Our mission is to collaborate with families in order to meet their needs, while ensuring the safety of our children, youth and community as a whole~

The Intake Unit is the access point for interventions and services for children, youth, and families in Jefferson County. These interventions and services include receiving and screening access reports regarding child welfare and juvenile justice, conducting Child Welfare Assessments, conducting Child Protective Services Initial Assessments, as well as processing Truancy and Juvenile Justice Referrals. Our mission is to collaborate with families in order to meet their needs, while ensuring the safety of our children, youth, and the community as a whole. Since 2012, the Intake Unit has been a part of various initiatives that have refined our skillset in working with families; these include:

- Alternative Response
- In-Home Safety Services Initiative
- Family Find and Engagement
- Team Based Practice
- Motivational Interviewing

Alternative Response

As noted in prior Annual Reports, in 2012 Jefferson County was selected to be part of Phase 3 of the Alternative Response pilot in Wisconsin. The purpose of CPS intervention has always been to ensure child safety while partnering with families to meet their needs, but unlike a traditional Initial Assessment, the Alternative Response approach focuses on engagement, teaming, and connecting families with both formal and informal services up front. While traditional Initial Assessments (investigations) are warranted in high-risk child abuse and neglect cases, research has shown that Alternative Response is a more appropriate and successful practice in low to moderate-risk child abuse and neglect cases. Because we have always strived to engage families, the transition to the Alternative Response approach was seamless. In 2014 we requested onsite technical support in order to enhance our practice and acquire additional skills. The Initial Assessment Workers proficiency in conducting Alternative Response Initial Assessments continues to evolve and they have found this approach in working with families to be more meaningful. Approximately 63% of the Initial Assessments conducted in 2013 were Alternative Response and approximately 69% were conducted in 2014. Because of the successes we have had with the Alternative Response approach, the Department of Children and Families asked Jefferson County to provide a case presentation at the 2014 Annual Alternative Response Statewide Meeting.

In-Home Safety Services Initiative

In 2012, Jefferson County began working with Rock and Green Counties under a consortium after being awarded an In-Home Safety Services Initiative Grant by the Department of Children and Families. Under this consortium we team with Orion Family Services, Inc. to create and implement in-home safety plans that control danger threats, thereby keeping children safely in their homes. Components of the In-home Safety Services Initiative continue to include concentrated safety monitoring through home visits and phone calls, a 24/7 crisis response hotline, volunteers and informal supports to families, and connection to resources. In 2013, Jefferson County referred 7 families for in-home safety services in which out-of-home placements for 15 children were prevented. These children were able to be safely maintained in their natural home environments. Not only does research indicate that children fare better when maintained in their homes, but the County saved over \$96,000 in alternative care costs in 2013. In 2014, we referred 9 families for in-home safety services in which out-of-home placements for 16 children were prevented and \$81,000 was saved in alternate care costs. We are committed to maintaining children in their homes whenever possible which

supports our culture of working with families here in Jefferson County. Our Initial Assessment Workers are true advocates of the In-Home Safety Services Initiative and have been leaders in formulating feasible and sustainable Safety Plans that allow for children to be safely maintained in their homes. The Department of Children and Families has recognized this and asked Jefferson County to provide a case presentation at the 2014 Annual In-Home Safety Services Initiative Statewide Meeting.

Family Find and Engagement

As indicated, our goal is to always maintain children and youth in their homes whenever possible but there are times when children and youth must be placed outside of their homes due to safety concerns. When this occurs the goal is always to preserve relationships and place children and youth with relatives or other natural family supports. To support our efforts, staff within the Child and Family Division began training in Family Find and Engagement in 2014. The Family Find and Engagement model offers methods and strategies to locate and engage relatives of children currently living in out-of-home care. Over a period of several months, the staff was trained to apply various tools and strategies in their practice. The training and coaching spanned several months and consisted of several components in which staff learned various tools and strategies to implement in their practice. Staff has found that these tools and strategies are not only essential with out-of-home cases, but are also valuable when working with any family. Outcomes from using the Family Find and Engagement model include increased reunification rates, improved wellbeing and placement stability, decreased re-entry rates, and a strong sense of connectedness for children.

Team Based Practice

To complement the tools and strategies developed through Family Find and Engagement, staff from the Child and Family Division also received comprehensive training in Team Based Practice. Team Based Practice, also known as Family Teaming, is a process by which families work with staff to form teams of formal and informal supports that will come together to achieve safety, permanence, and lasting change through identifying the strengths and needs of families. Through collaborative teaming, professionals and natural supports come together to prevent crises, thereby reducing potential out-of-home placements and hospitalizations when situations begin to escalate.

Motivational Interviewing

Also in 2014, the Intake Unit embarked on an agency wide training initiative in Motivational Interviewing. Motivational interviewing is a form of collaborative conversation for strengthening a person's own motivation and commitment to change. It is a person-centered technique of addressing ambivalence about change by focusing on how a person talks about change. It is designed to strengthen an individual's motivation and progress toward a specific goal by eliciting and exploring the person's own reasons for change. All staff took part in classroom training along with individualized coaching sessions that provided feedback on taped sessions with clients. Motivational Interviewing complements our other tools and methods of practice. (What we have learned through our extensive training is that Motivational Interviewing is not only fundamental to our work with families, but is also overarching and seamless with the other concepts and approaches we have learned through all of our initiatives.) We are energized by this and continue gaining proficiency in Motivational Interviewing through use of the tools and skills acquired.

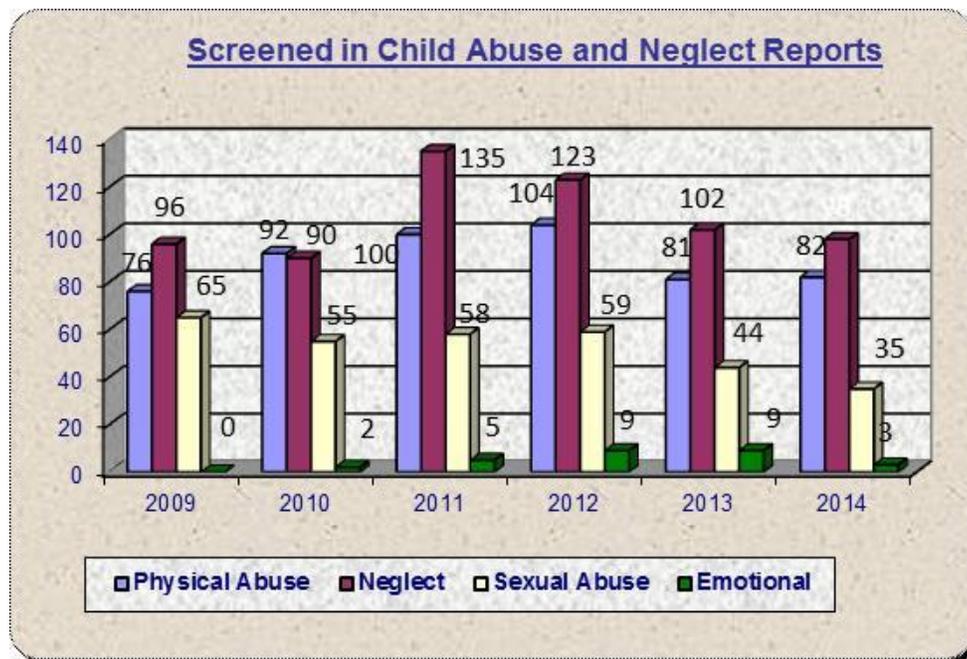
REVIEW OF CPS AND JUVENILE JUSTICE DATA:

All of our initiatives support the work we do with children, youth, and families by partnering with them to meet their underlying needs, with the goal always being to keep families safely intact when possible. Of the 218 Initial Assessments conducted in 2014, only 10% required removal of children from their homes due to maltreatment or safety threats that couldn't be sufficiently controlled within the home. Of that 10%, the majority resulted in safe placements with natural family supports, such as relatives, neighbors, and family friends. Likewise, in the 273 juvenile referrals processed in 2014, only 3% required removal of juveniles from their homes due to victim or community safety concerns that couldn't be adequately controlled within the

home environment. This data is noteworthy and will be gathered in the coming years as it's hoped that the tools and skills acquired through all of our initiatives will directly impact alternate care placements for children and juveniles.

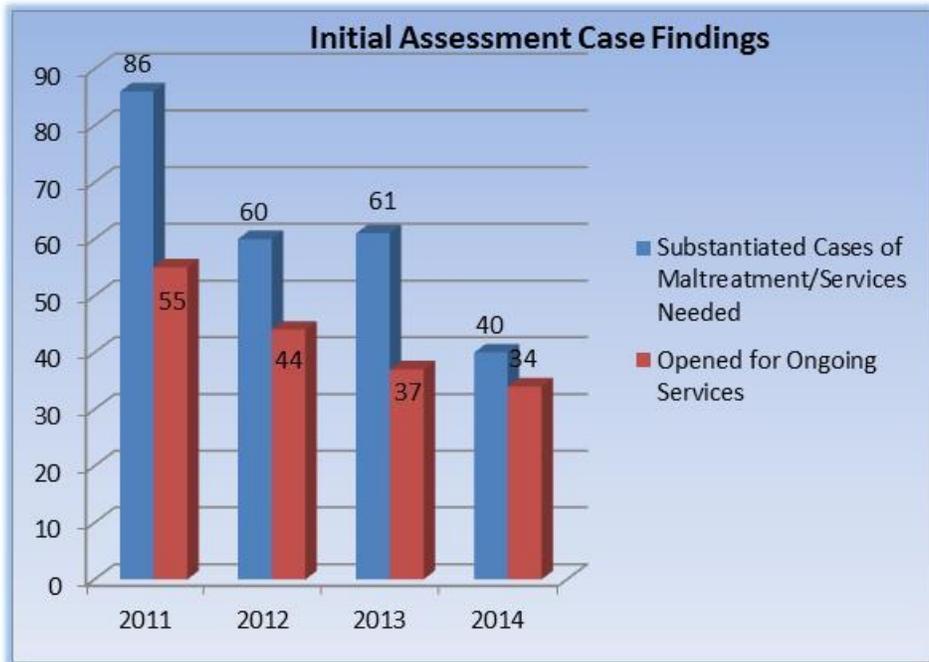
As illustrated on the graph below, the number of reports for investigation between 2009 and 2011 steadily increased, but have continued to decline by 23% since 2012. Neglect remains the most investigated type of child maltreatment in Jefferson County with allegations involving alcohol and drug abuse by parents being the most commonly identified concern. When maltreatment of a child has occurred or a safety threat to a child has been identified during the Initial Assessment process, it is likely that the family will be referred for ongoing services within our Agency. Such ongoing services can be in the form of a six-month Informal Disposition Agreement in which the family agrees to receiving services on a voluntary level, or a formal CHIPS Court Order in which the family is ordered by the Juvenile Court to receive services through our Agency. A case involving a family can involve more than one child.

Screened In Child Abuse and Neglect Reports	2009	2010	2011	2012	2013	2014
Physical Abuse	76	92	100	104	81	82
Neglect	96	90	135	123	102	98
Sexual Abuse	65	55	58	59	44	35
Emotional	0	2	5	9	9	3
TOTALS	237	239	298	295	236	218



As illustrated on the graph on the following page, there were 86 substantiated cases of maltreatment in 2011 with 55 of those being opened for ongoing services within our Agency. In 2012, there were 60 substantiated cases of maltreatment with 44 of those cases being opened for ongoing services. In 2013 we implemented and continue to use the Alternate Response approach. In 2013, 20 Alternate Response cases were identified as services needed in lieu of a maltreatment findings and 41 were substantiated cases of maltreatment. Of the 61 cases, 37 were referred for ongoing services within our agency. In 2014 there were 16 Alternate Response

cases identified as services needed and 24 substantiated maltreatment cases. Of the 40 cases, 34 were referred for ongoing services within our agency. The Initial Assessments that were substantiated or found to be Services Needed that were not opened for ongoing services within our Agency would be due to the families' demonstrated protective capacities, so ongoing CPS services and intervention would not be required. This data shows that cases opened for ongoing services within our Agency have steadily decreased in the past four years. We believe that this is because of the comprehensive work the Initial Assessment Workers are performing in which they are engaging families, identifying their needs, utilizing natural supports, and "frontloading" services as a means to avoid formal or ongoing involvement with our Agency.



The Intake Unit is also responsible for processing Juvenile Justice and Truancy Referrals. These referrals are generated by local law enforcement and schools. Processing these referrals generally includes meeting with the juvenile and 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 Delinquency Risk Assessment Tool aids the Intake Worker in determining the juvenile's risk to reoffend. 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 Consent Decree, or filing of a Delinquency Petition which initiates formal court action. The Juvenile Court Intake Workers are very thoughtful in determining disposition of each referral they process. They consider the strengths and underlying needs of each juvenile, as well as their prior history and risk to reoffend. (Rather than being strictly punitive, our focus is on restorative justice, all while striving to maintain juveniles safely in their communities when possible. Should a juvenile be placed on a Deferred Prosecution Agreement, Consent Decree, or a formal Court Order, the case is then transitioned to the Juvenile Justice Ongoing Team.

As illustrated on the graphs below, the number of JIPS and Delinquency adjudications decreased by 34% from 2011 to 2014 and the number of juvenile offenses referred by Law Enforcement also decreased between 2011 and 2014 by 18%. The graph of intake referrals by age indicates an increase in 17 year olds in 2014. A juvenile is only adjudicated JIPS or Delinquent if placed on a formal court order. As noted above, we focus on restorative justice and we feel that we are able to accomplish this in many cases through Deferred Prosecution

Agreements and Consent Decrees rather than through formal court intervention. While there is no formal data regarding this, it could be suggested that one reason the number of referrals has decreased over the years is because our Agency's services and interventions have reduced recidivism.

POLICE REFERRALS for JUVENILE OFFENSES

1 and 5 Year Comparisons

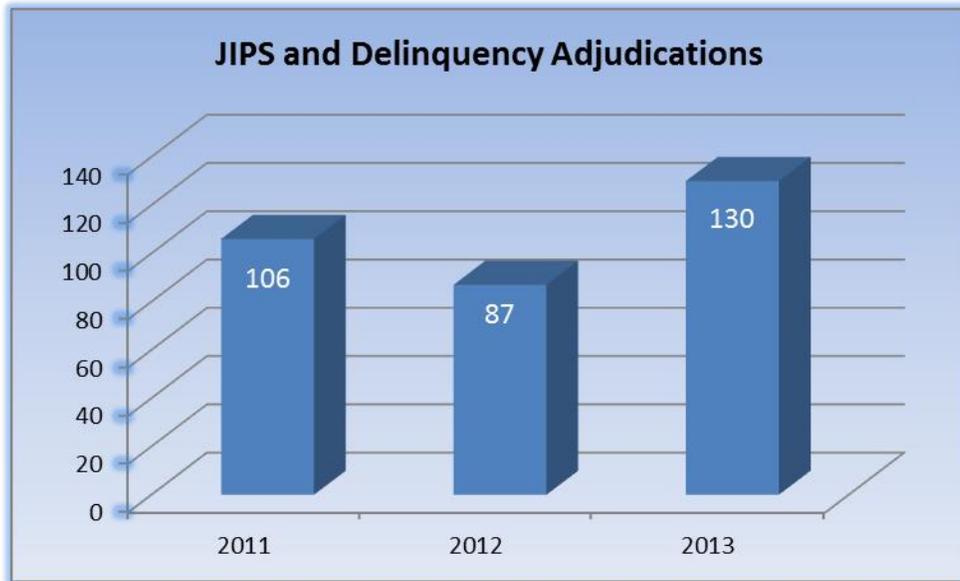
OFFENSES (2010-2014)	2014	2013	1 Year (2013-2014) Increase/Decrease	2014	2010	5 Years (2010-2014) Increase/Decrease
Alcohol/Tobacco	2	1	1	2	1	1
Arson	1	1	0	1	0	1
Battery	40	50	(10)	40	33	7
Burglary/Robbery	7	33	(26)	7	35	(28)
Burning Materials/Fireworks/Explosives	0	1	(1)	0	3	(3)
Contempt of Court/Violation of Court Orders	5	2	3	5	6	(1)
Crimes Against Children/Other	3	10	(7)	3	24	(21)
Criminal Damage to Property	30	56	(26)	30	42	(12)
Criminal Trespass	5	9	(4)	5	8	(3)
Disorderly Conduct	124	175	(51)	124	133	(9)
Drug Related	35	39	(4)	35	55	(20)
Fleeing/Escape	2	0	2	2	9	(7)
Forgery	0	0	0	0	0	0
Intimidation/Harrassment	0	3	(3)	0	0	0
Obstructing/Resisting Arrest	17	14	3	17	25	(8)
OWVWOC/Other Vehicle	5	2	3	5	15	(10)
Receiving Stolen Property	2	3	(1)	2	3	(1)
Reckless Endangerment	3	1	2	3	0	3
Sex Offense	25	42	(17)	25	44	(19)
Theft	45	52	(7)	45	49	(4)
Truancy	30	33	(3)	30	37	(7)
Weapon Related	12	8	4	12	4	8
TOTALS	393	535	(142)	393	526	(133)

2014 MULTIPLE JUVENILE REFERRALS BY AGE

		Age <11	Age 11-12	Age 13-14	Age 15	Age 16	Age 17+	Total Juveniles Referred	% of Total
R e f e r r a l s	1	15	13	32	16	15	7	98	57%
	2-3	4	5	17	3	15	1	45	31%
	4-5	1	3	2	2	1	0	9	4%
	6-8	0	1	4	2	1	0	8	4%
	9+	0	0	7	1	0	0	8	4%
Total Juveniles with Multiple Referrals per Age		20	22	62	24	32	8	168	100%

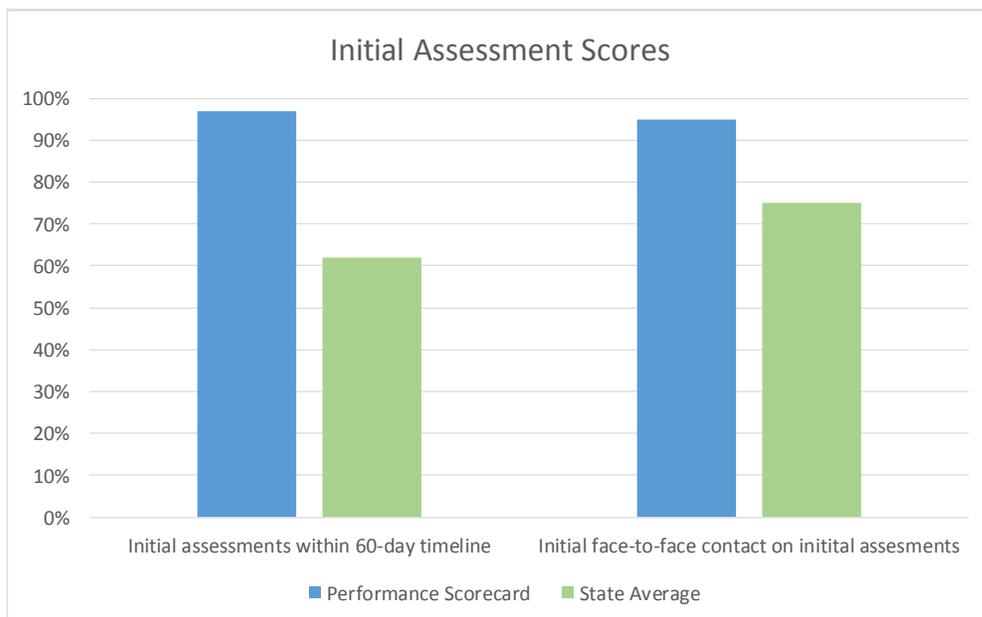
2010-2014 Juvenile Intake by Age

	Age <11	Age 11-12	Age 13-14	Age 15	Age 16	Age 17+	Total Youth
2014	20	22	62	24	32	8	168
2013	19	28	74	43	43	2	209
2012	11	33	62	39	38	4	187
2011	14	45	70	56	49	5	239
2010	13	42	61	50	57	2	225



Lastly, the Intake Unit takes great pride in working with families to meet their needs while carrying out best practices and being in compliance with State and Federal Standards and timelines. According to DCF reporting, the Intake Unit completed 207 Initial Assessments in 2014. Our performance scorecard for completing Initial Assessments within the mandated 60 day timeline was 97%, whereas the State average was 62%. The Intake Unit's performance scorecard for successfully completing initial face-to-face contact on Initial Assessments within the screened in response time was 95%, whereas the State average was 75%. Data compiled internally indicates that approximately 90% of Juvenile and Truancy Referrals were processed accordingly within the mandated 40 day timeline.

Requirement	Performance	
	Scorecard	State Average
Initial assessments within 60-day timeline	97%	62%
Initial face-to-face contact on initial assesments	95%	75%



Review of 2014 Goals:

- 1. The Key Outcome Indicator for 2014 was to meet 100% of mandated timelines.** According to DCF reporting, the Intake Unit completed 207 Initial Assessments in 2014. Our performance scorecard for completing Initial Assessments within the mandated 60 day timeline was 97%, whereas the State average was 62%. The Intake Unit's performance scorecard for successfully completing initial face-to-face contact on Initial Assessments within the screened in response time was 95%, whereas the State average was 75%. Data compiled internally indicates that approximately 90% of Juvenile and Truancy Referrals were processed accordingly within the mandated 40 day timeline.
- 2. Engage absent parents within the first 30 days.** Absent parents have an important impact on the dynamics of the family and may play a role in ameliorating the circumstances that led to the Department's involvement with the child or juvenile. While it is best practice and a State Standard to engage absent parents when the Department is involved with a child or juvenile, a goal for 2014 will be to actively engage absent parents sooner in the life of a case. The goal will be to engage absent parents within the first 30 days of the Initial Assessment process and within 15 days of a Juvenile Referral Intake Inquiry. *This goal was accomplished. While contact with absent parents may not have always been achieved, data gathered internally from a pulled sample of cases indicates that contact with absent parents was attempted within the desired timelines. The tools and skills learned through such initiatives as Family Find, Alternative Response, and Team Based Practice have supported this objective.*
- 3. Continue our Citizen Review Panel.** Because we are in the beginning stages of developing our Citizen Review Panel, a goal for 2014 will be to confirm the Panel's members, define our Panel's goals and objectives, as well as complete the statewide improvement project. *This goal was accomplished. To date, our Panel is comprised of approximately 12 members; however, it's anticipated that our membership will continue to expand as one of our goals and objectives is to recruit members who are Jefferson County citizens without any direct professional relationship with our Agency. The statewide improvement project continues to be underway and the Jefferson County Citizen Review Panel is supporting the completion of this.*
- 4. Continue to maintain compliance with all CPS and Juvenile Justice State and Federal Standards and timelines.** *This goal was accomplished. According to DCF reporting, the Intake Unit completed 207 Initial Assessments in 2014. Our performance scorecard for completing Initial Assessments within the mandated 60 day timeline was 97%, whereas the State average was 62%. The Intake Unit's performance scorecard for successfully completing initial face-to-face contact on Initial Assessments within the screened in response time was 95%, whereas the State average was 75%. Data compiled internally indicates that approximately 90% of Juvenile and Truancy Referrals were processed accordingly within the mandated 40 day timeline.*
- 5. Provide more outreach to schools in order to strengthen collaboration with one another.** This will be accomplished through more involvement on school-related committees, as well as conducting more informational in-services to school staff and students, specifically at the onset of the academic year. *This goal was accomplished. The Intake Unit staff have continued conducting various Mandated Reporter Trainings at the request of our community partners and have met with schools and law enforcement to discuss the Delinquency and Truancy referral processes. At the onset of the 2014-2015 academic year, the Intake Unit reached out to each school district in Jefferson County, welcoming the opportunity to meet in order to discuss such topics as Mandated Reporting, the role of Child Protective Services, and the Juvenile Court Intake process.*

6. Continue developing and strengthening our relationships with community partners. This will be accomplished through distribution of the newly developed Jefferson County Community Resource Guide with our community partners, as well as through informal in-services with one another in order to have a better understanding of the services and resources each other can provide. *Through the process of trying to develop a Jefferson County Community Resource Guide it became apparent that resources and services within the community can change so quickly so the Guide was essentially outdated before it could ever be distributed, and it would prove difficult to update the Guide on a continual basis. While this Guide did not come to fruition as hoped, there are numerous websites and other material readily accessible to the community regarding the many services and resources available in Jefferson County. As noted above, the Intake Unit staff have continued conducting various Mandated Reporter Trainings at the request of our community partners and have met with schools and law enforcement to discuss the Delinquency and Truancy referral processes. The Intake Unit also continues to be part of the Child Death Review Team, the Sexual Assault Response Team, the Domestic Violence Case Review Team, and our Citizen Review Panel.*
7. Continue utilization of informal supports, as well as Orion Family Services via the In-Home Safety Services Grant or their contracted services, on cases where safety threats have been identified, thereby preventing out-of-home placements on children and juveniles. *This goal was accomplished. In 2014, the In-Home Safety Services Grant and Orion Family Services were used with 9 families, which included 16 children. These services safely maintained these 16 children within their homes and avoided alternative care costs of \$81,000. Additionally, the use of informal supports, such as relatives and family friends have been used when Protective and Safety Planning is necessary, thereby preventing the need for children to be formally placed outside of their homes.*
8. Increase knowledge and application of Motivational Interviewing as evidenced by ongoing participation in the Agency wide Motivational Interviewing training initiative. *This goal was accomplished. All of the Intake Unit staff participated in the Motivational Interviewing training initiative, which included a series of onsite trainings. In addition to this, all staff members conducted two audio recorded samples of using Motivational Interviewing, which were then submitted to the trainers for coaching calls so that our skills could be rated and constructive feedback could be provided. In efforts to keep Motivational Interviewing at the forefront of our practice, the Intake Unit has conducted transfer of learning activities, as well as shared each other's experiences in using these tools and skills.*

2015 GOALS:

1. **Key Outcome Indicator: Meet all State and Federal timelines 100% of the time.**
2. Continue to build upon what we have learned through our training initiatives in Motivational Interviewing, Alternative Response, Family Find, and Team Based Practice. This will be accomplished through implementation of the tools and skills in our daily practice, as well as by incorporating the concepts and language in our documentation and reports.
3. Restructure the Juvenile Court Intake form used when processing juvenile referrals so that it incorporates the tools and skills acquired through Motivational Interviewing as this will allow for more comprehensive and insightful information gathering.
4. Restructure the recommendations we propose in Juvenile Court Orders so that they are client centered, behaviorally focused, and address the underlying needs of each individual juvenile.

5. Continue to provide outreach and intervention to schools and other community partners. This will be accomplished through collaboration with School Liaison Officers and other school personnel on Delinquency and Truancy related matters, as well as through continuing to conduct informational in-services to schools and other community partners on children, youth, and family related issues.
6. Elicit more information from families regarding their informal supports so that these informal supports can be utilized in situations where safety threats have been identified, thereby preventing out-of-home placements for children and juveniles.
7. Provide each child that is placed in alternate care with a “Comfort Bag” as to support a feeling and sense of comfort for them.
8. Increase knowledge and application of Trauma Informed Care as evidenced by ongoing participation in the Wisconsin Trauma Project.

CHILDREN IN NEED OF PROTECTION AND SERVICES (CHIPS)

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

MISSION STATEMENT: *Innovatively creating and utilizing evidence based programs, initiatives, and practice standards as a means of achieving safe and timely permanence for the children of Jefferson County.*

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

large number of reports are also received from court disposition. schools, police departments, physicians and other

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. 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 and Services (CHIPS) team becomes involved via formal case transfer. In 2014, the CHIPS and Intake teams continued to refine the case transfer policy as a means of clearly defining worker roles, decreasing safety concerns, and following DCF standards. Another important change in practice in 2014 was to involve the CHIPS Team assigned Case Manager at the onset of Temporary Physical Custody Orders, prior to any pending Circuit Court disposition.

The Children in Need of Protection and Services (CHIPS) Team is comprised of a supervisor, eight ongoing Case Managers and two Family Development Workers. 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 treatment plan for the child(ren) and parents is developed. Each case is unique with 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), the 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, schools, and private child placing agencies (CPA).

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. 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, Ch. 54 Guardianship, and Termination of Parental Rights and Adoption.

In 2014, the Jefferson County Human Services Child Protective Services Unit continued their membership in a consortium with Green and Rock counties aimed at improving child safety through the production of Standards based Safety Planning. The IHSS (In-Home Safety Standards) consortium meets quarterly to review existing In-Home Safety Plans. This standards based, peer review process allows for a structured environment to present, review, and refine existing Safety Plans. The goal of this process is identify safety threats and create safety control based tenets as opposed to treatment based tenets. In preparation for taking part in this consortium, all members of the team completed either Safety Foundations or Safety Booster training. Case Managers and Supervisors attended every quarterly meeting in 2014 as well as the statewide meeting hosted by DCF.

In 2014, the CHIPS Team continued to take part in the Permanency Roundtable series. A Permanency Roundtable (PRT) is a process designed to facilitate the permanency planning process by identifying realistic solutions to permanency obstacles for children. The PRT protocol invites key players such as State Permanency Consultants, Policy Experts, External Consultants, trained Facilitators, Case Managers, and the Team Supervisor to take part in a formalized, prescribed case consultation process. The process is initiated by a formal case presentation by the assigned case manager. The team is then allowed to ask questions of the case manager and supervisor as a means of clarification. This is followed by a brainstorming session whereby any and all ideas are welcomed. The case manager is then allowed to choose new avenues to explore in terms of achieving permanency for the cases being reviewed. Finally, the permanency outcomes for all of the children are rated on a continuum from poor, uncertain, fair, good, very good to permanency achieved. In 2014, the Team hosted five days of Permanency Roundtables consultations. These consultations involved 15 cases where the Permanency for 21 children was discussed. As a result of these consultations, the Permanency rating for 13 of 21 children improved or stayed the same. More importantly, nine cases involving 16 children were slated to be reviewed during the five rounds and these cases improved to a rating of good or the children reached Permanency prior to the actual scheduling of the next round.

In 2014, the CHIPS Team continued to utilize the Subsidized Guardianship program as highlighted in 2011 Wisconsin Act 181: Best Outcomes for Children. The implementation of the Subsidized Guardianship program is now more clearly defined in the Child Protective Services Ongoing Standards. In 2014 the CHIPS team successfully petitioned the Jefferson County Circuit Courts on behalf of one more child. Also, in terms of the use of Guardianship, the CHIPS collaborated closely with the Jefferson County District Attorney's Office and the Courts to help seven children find permanency with relatives under more traditional Ch. 48 Guardianship proceedings. The choice of and use of certain types of Guardianships to help children achieve permanency is

largely dependent upon the types of benefits the child and Guardian may receive following the Court's granting of the Guardianship. The CHIPS Team strives to use the most appropriate form of Guardianship on every case where Guardianship is the identified permanency goal.

In 2014, when fully staffed, the eight ongoing Case Managers carried an average of 9.8 cases or about 1.5 less cases per worker than in 2013. The average caseload for the year included responsibility for an average of 6.5 children placed in home which is down slightly from 2013 and can be viewed as a very positive trend towards lower overall case numbers. Ongoing Case Managers closed the year averaging 9.2 children placed outside the home which is down 2.4 children from 2013. This is a significant reduction directly attributable to enhanced Safety Planning, trial reunifications, increased collaboration with legal partners, Alternative Response, and bi-weekly permanency tracking for all out-of-home cases. These raw numbers are very meaningful in terms of overall case counts however they reveal very little about case activities as they relate to initiatives, assessments, case planning, document production, and engaging families.

At the start of 2014, there were 90 open cases and at the close of 2014 there were 78 open cases or a reduction of 14%. With regard to out-of-home care, the CHIPS Team was responsible for 93 children placed in out-of-home care at the start of 2014 and 73 children placed in out of-home-care at the end of the year or a reduction of 22%. The CHIPS Team oversaw 60 children subject to in-home orders at the start of 2014 and there were 52 children subject to in-home orders at the close of the year or a reduction of 14%. These numbers clearly demonstrate that fewer children were being subjected to the trauma associated with placement outside their home.

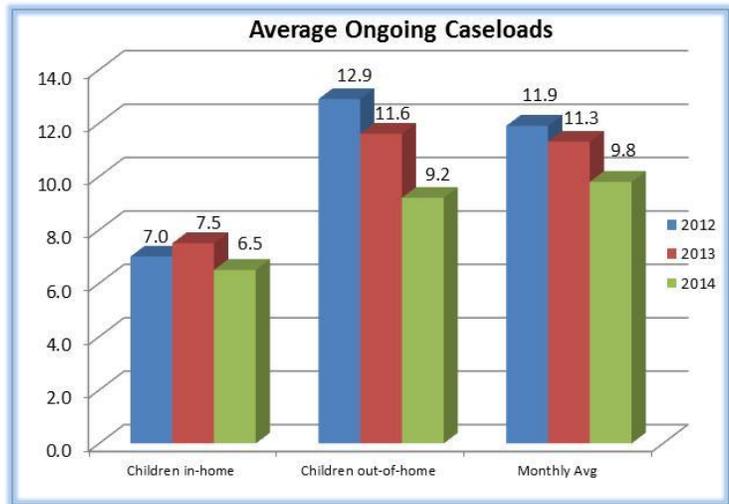
Over the course of 2014, 26 new cases were generated from intake. These cases involved 39 children who were able to remain in the home of a parent or guardian. In addition, these new cases involved 22 children placed outside the home of a parent or guardian. Three case participants gave birth to another child during the course existing orders in 2014 and one of these children was able to be reunified with her birthmother shortly after the court process commenced. The other two children born during the course of existing orders are part of larger sibling groups and they remained in out-of-home care at the close of the year. Three children on existing in-home orders had to be placed in out-of-home care during the course of the year due to safety concerns. The fact that so few children had to be removed from their home during the course of existing orders is a testament to the safety planning and engagement skills of the CHIPS Team.

The generation of these new cases was offset by the closure of 37 cases. Safe case closure can be the result of reunification and up to 12 months of careful case monitoring. Case closure can also be the result of other forms of permanence being achieved such as Termination of Parental Rights, various forms of Guardianship, OPPLA (age out in care), transfer to adult services, and the closure of an in-home case without further service needs or safety related concerns. Twenty six or 70% of the 37 safe case closures were closed due to the safe expiration of the circuit court order. These cases involved children never placed outside the home or children previously outside the home but safely reunified with one or both parents. The remaining 11 safe case closures were the result of administrative closings following Termination of Parental Rights, Guardianship, or OPPLA.

In 2014, the CHIPS Team helped 46 children find permanency. Fourteen children were the subject of Termination of Parental Rights proceedings including a sibling group of five. All were successfully adopted or were in the process of being adopted at the start of 2015. Seventeen children were reunited with one or both biological parents after having previously been placed outside the home. Of these 17 children reunified with one or both parents, one child unfortunately re-entered care due to new allegations of neglect. Eight children found permanency with relatives via Guardianship in accordance with their court approved Permanency Plans and one of these Guardianships was part of the Subsidized Guardianship initiative. Seven children found Permanency via (OPPLA) meaning they turned 18 while still placed in care. Three of these children had significant disabilities and the CHIPS Team worked with internal and external service providers to provide a smooth transition to adult services. Two of these children chose to leave care prior to graduation from high

school and live with extended family. The last two of these children to find Permanency under this designation unfortunately chose to leave care prior to graduation.

As we look forward to 2015, the CHIPS Team will continue to adapt our practice in accordance with recent initiatives and trainings. All members of the Team completed an agency wide initiative and training series focused on Motivational Interviewing (MI). Motivational Interviewing is a collaborative, person centered form of guiding to elicit and strengthen motivation to make meaningful change. The fidelity of this collaborative form of communication is important to the Team as we move forward in 2015 and we plan to use transfer of learning exercises during Team meetings and to make M.I. a focus on every case during worker supervision.



Motivational Interviewing dovetails very well with our two other training series the team completed in 2014 and were a direct response to the 2013 Quality Service Review (QSR). In May of 2013, the Jefferson County Human Services Child Protective Services Unit was subject to Department of Children and Families Quality Service Review (QSR). Members of the Continuous Quality Improvement section (CQI) visited Jefferson County for one week in May to review 11 cases currently being managed by the Ongoing Case Management Team. Wisconsin's Continuous Quality Improvement (CQI) section, in partnership with tribal and county child welfare systems, provides a quality service review process that assists agencies to understand how their practice is working to ensure child safety, permanence and well-being. The QSR protocol is closely aligned with the Wisconsin Practice Model which defines how the Wisconsin Public Child Welfare System engages children, youth, families and the community in developing and delivering needed services that meet the unique needs of those serviced by child welfare and private agencies. The goal of the QSR process is to enhance Social Work practice, inform policy, and determine needed changes to training and technical support.

Overall, the QSR rated our practice as quite good with all cases reviewed earning a satisfactory rating in terms of safety, well-being, and permanence. However, case reviewers noted areas of challenge for our unit including Team formation and Family Teaming. As a result, the CHIPS Team took part in two additional intensive training series in 2014 as a means of directly addressing these areas of challenge.

All members of the CHIPS Team completed an intensive training called Family Find. This training was provided in conjunction with the Wisconsin Department of Children and Families (DCF) and the National Institute for Permanent Family Connectedness. The CHIPS Team completed a six part training over the course of six months that included six full days of training in both Jefferson and Madison. These training sessions were accompanied by scheduled call-ins, coaching sessions, individual coaching sessions, and regular trainer feedback. The Family Finding model offers methods and strategies to locate and engage relatives of children currently living in out-of-home care. The goal of Family Finding is to connect each child with a family, so that every child may benefit from the lifelong connections that only a family provides. Members of the CHIPS Team learned to use tools such as mobility mapping, connectedness mapping, family search engines, engagement, and Family Team meeting models. This model has become part of our practice in a very short amount of time and the continued fidelity of this model will be a focus as we look forward to 2015.

The second training series we sought out in 2014 was Team Based Practice. The entire CHIPS Team enrolled in and completed this three day on-site training in collaboration with the Southern Child Welfare Training Partnership, our designated DCF based training partnership. Family Teaming is a process by which families, as planners and decision makers, work with the agency to gather together a team of formal and informal resources. Once assembled, this team helps to identify strengths and needs and they participate in case planning. Team Based Practice values dictate that people are capable of change, and that most are able to find the solutions within themselves and that a family is more invested in a case plan where they are full partners in the decision making process.

The combination of Motivational Interviewing, Family Find, and Team Based Practice integrate well because all three share common values. All three of these training series are designed to recognize, encourage, and promote change in individual case participants. These changes can be centered around substance abuse, protective capacities, employment, housing, or any other change or life improvement the case participant wishes to make. Additionally, all three of these training series empower families to be more involved in the decision making process. Finally, as we move in to 2015, the CHIPS Team will work to maintain the fidelity of these recent trainings and initiatives through transfer of learning activities, objective analysis of exercise successes and failures, as well as through weekly worker supervision.

Review of 2014 Goals:

1. Children in Need of Protective Services Key Outcome Indicator was to assure that 70% of all new placements are reviewed in a Permanency Roundtable or Permanency Snapshot model. In 2014, the unit received 28 new out of home placements. Of these, 4 children's cases were formally screened through the Permanency Roundtable model. In February of 2014, The State of Wisconsin DCF changed guidelines for all future PRT's stating that children must be in out of home care for at least fifteen months before this screening model could be used. As a result, the remaining 24 children's cases were formally screened for permanency through the use of Permanency Snapshots, Family Team Meetings, and formal staffings with The Jefferson County District Attorney's Office and Guardian Ad Litem staff. In summary, 100% of all cases were formally screened for permanency, some on multiple occasions via multiple methods.

2. In accordance with the 2013 QSR Review, all members of the CHIPS ongoing case management team complete a Family Teaming training in conjunction with the Southern Partnership. This goal can be measured via certificate of course completion and through regularly scheduled Family Teaming meetings on cases. *This goal has been accomplished. The entire ongoing case management team completed a three day Family Teaming training on December 1-3, 2014.*

3. As part of our ongoing commitment to the Permanency Roundtable model, that all children placed outside the home for a period of time of greater than 15 months without an OPPLA designation be subject to a Permanency Roundtable consultation. This goal can be measured through SACWIS case query. *This goal has been accomplished. All cases eligible for Permanency Table Consultation were scheduled in 2014. The ongoing case management team hosted five rounds of PRT's involving 21 children.*

4. As part of our continued effort to implement proper in-home Safety Plans, continue to collaborate with the IHSS (In-Home Safety Services) consortium on a regular quarterly basis with case presentations delivered at each consortium meeting. Have every agency created Safety Plan be subject to peer review. This goal can be measured via attendance at consortium meetings and through routine supervision and Safety Plan approval in SACWIS. *This goal has been accomplished. In 2014, the ongoing case management team made use of the Safety Plan peer review model whenever possible. These plans were reviewed for safety controls as opposed to service allocation by peers, supervisors, the division manager, and both internal and external service providers whenever possible during regular staffings and at case transfer from the intake department. Members of the*

ongoing case management team attended every IHSS consortium meeting and took part in case presentations for consortium review.

5. As part of our continuing effort to take part in State DCF pilot projects, collaborate with State of Wisconsin DCF officials to qualify four children for the PS (Post Reunification) program. This goal can be measured via SACWIS query. *This goal was partially accomplished. The ongoing case management team worked closely with DCF to qualify two cases for the Post Reunification Grant. Due to the RPM score JCHSD only had two families that qualified and were prepared for a return home in 2014.*

6. As a means of enhancing team competence and engagement skills, all members of the CHIPS ongoing case management team will attend and complete an advanced Motivational Interviewing (MI) training. This goal can be measured via certificate of completion and ongoing participation in the agency wide initiative. *This goal has been accomplished. All members of the ongoing case management team attended an advanced Motivational Interviewing training throughout the course of 2014.*

7. As part of our efforts to adhere to the Ongoing Case Management Standards and Permanency Roundtable guidelines, complete a full disclosure meeting with parents/caretakers not more than 60 days post disposition on all new cases. This can be measured via SACWIS case note query. *This goal has been accomplished. This goal proved very difficult to achieve in 2014. A meeting template was created using existing DCF resources regarding parental rights and responsibilities when a child is placed in out-of-home care. However, many cases were subject to dispositional hearings delayed by as many as five months and several cases had associated pending criminal charges which caused some case participants to decline to meet with staff to discuss permanency or rights and responsibilities. In the end, this goal and meeting exercise proved valuable on seven new cases.*

8. As part of our continuing efforts to enhance performance in circuit court, have every member of the CHIPS ongoing case management team complete a court preparation and testimony training in conjunction with the Southern Partnership. This can be measured via certificate of completion and feedback during District attorney and Judge's roundtable meetings. *This goal has been accomplished.* All members of the ongoing case management team were able to complete this training. Attendance of this training was based on training availability through the Southern Partnership.

2015 GOALS:

1. Key Outcome Indicator: All new out of home placements will be formally screened for permanency options within 90 days of case assignment to ongoing staff.

2. The CHIPS ongoing case management team will update all applicable Policy and Procedure to digital format by 12/31/2015. This can be measured via completion and posting of the on-line manual.

3. In order to comply with DCF Ongoing Standards, the CHIPS ongoing case management team will develop and institute a system whereby all Case Plans are drafted, reviewed, and approved within the 60 day timeline set by DCF. This can be measured via institution of the system and through regular review during worker supervision and Team meetings.

4. Each case manager will accomplish a Family Team Meeting in accordance with the Oct. 7-10, 2014 Family Teaming training. This goal can be measured via verification of scheduled and completed Family Team Meetings.

5. As a means of maintaining the fidelity of the Family Find training series, each case manager will complete an element of Family find such as Seneca Search, Connectedness Mapping, or Mobility Mapping. Each case

manager will present their completed element to the Team via transfer of learning. This goal can be measured via completion during Team meetings.

6. Each CHIPS ongoing case manager will complete Trauma Informed Care training in 2015. This can be measured via certificate of completion.

7. In order to comply with federal and agency benchmarks, all out-of-home care face to face case notes will be entered within 24 business hours. This can be measured via the development and institution of an internal tracking system.

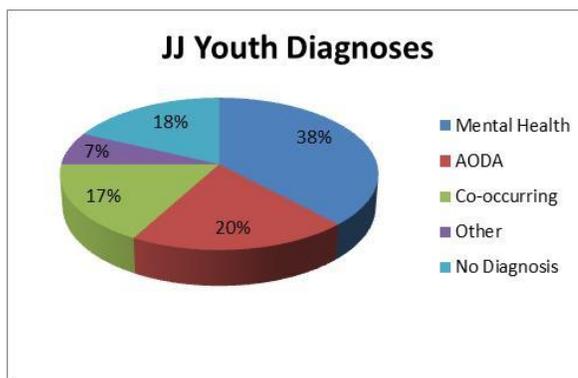
JUVENILE JUSTICE INTEGRATED SERVICES

~Understanding that our youth come to us with deep pain, and looking at both the strengths and needs that each one of our kids has, hoping that they will feel encouraged and supported to achieve success~

The Juvenile Justice Integrated Services Team provides ongoing case management for youth on Juvenile Delinquency orders, Juvenile in Need of Protection or Services (JIPS) orders, Consent Decrees, Chapter 51 Orders, Deferred Prosecution Agreements, as well as voluntary cases. The Juvenile Justice Team recognizes the dignity of each and every youth. Being at the forefront of the statewide trend to go away from the punitive, “mini adult” probation model, the Jefferson County Juvenile Justice Team values:

- Engagement of youth and families
- Trauma-Informed care
- Goal-driven targeted case management
- Treatment focused service delivery
- Development of natural strengths and supports to enhance the positive, pro-social qualities of our youth
- Trained and committed juvenile justice professionals and community partners
- Community safety
- Utilization of effective evidence-based strategies and promising practices
- Fair and equitable treatment of youth and families
- Continuum of services based on assessment of youth risk and needs
- Prevention of youth involvement in the juvenile justice system
- Joining with other systems, including but not limited to child welfare, education, and mental health, to develop a team approach to serving youth.

Our team strives to meet the unique needs of youth while assuring a safer society. To be effective in preventing juvenile delinquency and future criminal behavior, we identify risk factors early on, including 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. The Juvenile Justice team is comprised of the Division Manager, Juvenile Justice Supervisor, six Case Managers and two Intensive Community Outreach Workers.

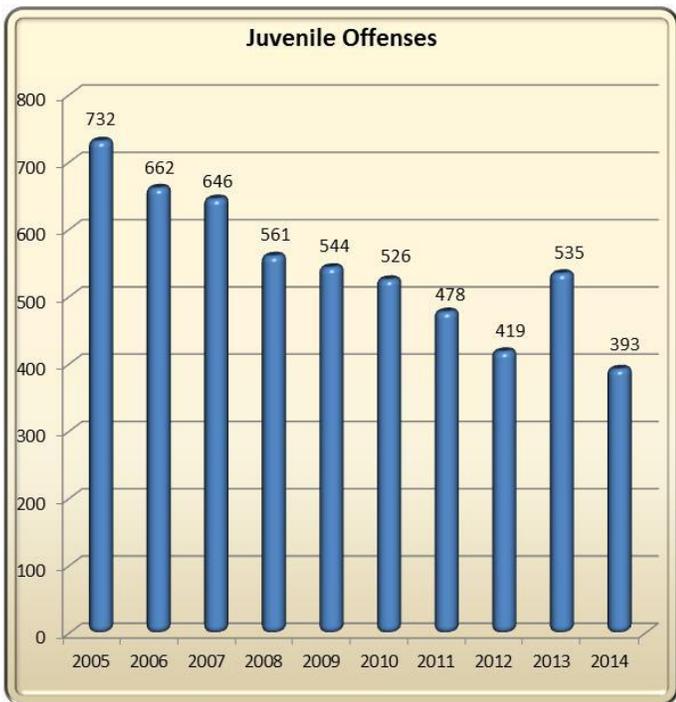


The youth served by the Jefferson County Juvenile Justice Team come with multiple strengths and needs. Many of the youth that are in the Juvenile justice system of Jefferson County have been diagnosed with mental health disorders. Several carry trauma with them, which can lead to emotion dysregulation, alcohol and/or drug use, poor impulse control, poor social skills and antisocial behaviors. In 2014, the number of youth with diagnosed mental health disorders, youth with alcohol and/or drug issues and youth who experienced co-occurring mental health and AODA concerns was notable.

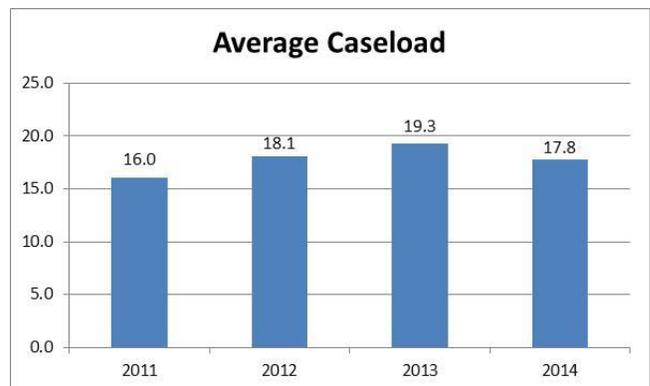
As reflected in the chart below, nearly all crimes of greatest concern decreased in 2014 from the previous year. The hope is that, due to the contracts with specialized AODA counseling created in 2013 and continued in 2014, that these crimes will continue to decrease over the next year. Also, it is noted that weapons referenced in “weapons related crimes” does not necessarily mean deadly weapons, such as guns, knives, etc. Weapons can be any object used to threaten harm to another individual.

JUVENILE CRIMES OF GREATEST CONCERN 2010-2014

OFFENSES	2010	2011	2012	2013	2014
Arson	0	0	1	1	1
Battery	33	31	35	50	40
Burglary	35	43	18	33	7
Crimes Against Children/Other	24	12	7	10	3
Drug Related	55	44	54	39	35
OMVWOC/Other Vehicle	15	5	10	2	5
Sex Offense	44	42	21	42	25
Truancy	37	31	24	33	30
Weapon Related	4	12	6	8	12
TOTALS	247	220	176	218	158



As reflected in these charts, juvenile offenses in Jefferson County decreased to the lowest number that we have seen in many years. This follows the statewide trend of juvenile offenses decreasing across the State of Wisconsin. In addition, the Juvenile Justice team has put a lot of effort into increasing our community based services over the last two years, and these efforts appear to be paying off in the number of overall referrals we are seeing and caseload size reduced by 1.5 youth.



The Intensive Supervision Program (ISP) was statutorily designed to provide a heightened level of monitoring and swift consequences to high risk level youth who are struggling with following the guidelines of traditional juvenile supervision. The Jefferson County ISP has redesigned itself in many ways over the last couple of years to focus on what we have learned works best for the youth we serve. To address the need for community safety while helping youth to grow as individuals and community members, daily face-to-face contacts (Sunday through Saturday) are made to enforce conditions of the court order, enforce house rules, monitor school attendance and academic performance, monitor community service, restitution, electronic monitoring and employment. Intensive Juvenile Community Outreach Workers (ISP Workers) work with youth on coping skills and crisis management and partner with the parent and ongoing case manager to assist the youth in developing pro-social skills and competencies. To bridge the gap between needed services and unidentified service providers, these workers have been trained in and directly provide some of our evidenced-based programming. This includes programming for serious/chronic offenders such as the "Aggression Replacement Training" group for juveniles with anger management issues, "Wellness Recovery Action Planning" for youth with mental health diagnoses or mood instability, and the "Juvenile Cognitive Intervention Program" for juveniles who struggle with repeated offenses and criminal thinking. We also offer "Incredible Years" parenting class for teenage parents and parents of adolescents. ISP/JCOW workers teach youth meaningful skills to help them to navigate their worlds better. To name just a few examples, ISP/JCOW workers spent valuable time with youth teaching them numerous social skills, developing and utilizing their talents, coping techniques, how to manage anger more appropriately, how to ask permission, how to be respectful, how to apply for jobs, how to stretch their money and keep a budget, organization techniques and how to keep up with homework. This work seems to help kids make positive improvements in their lives and lead happier, healthier lives. In 2014, 30 individuals received the services of the ISP/JCOW program; 90% of those youth remained in their homes. Additionally, 85% of youth completed their community service hours during this reporting period, many receiving assistance from their ISP/JCOW worker to find creative community service opportunities that matched their strengths. One hundred percent of youth who received ISP/JCOW programming in 2014, and who owed restitution, received some assistance with job education and/or searches.

Intensive Supervision/Juvenile Community Outreach Workers have a smaller caseload so they can devote a great deal of time to the youth they serve. The ongoing case managers carry larger caseloads, though the average caseload did decrease a bit in 2014. This is reflected below.

CREATIVE RESOURCES

The Juvenile Justice Team continued to see an increase in juveniles with significant challenges, specifically, youth who struggle with symptoms related to mental health diagnoses, Alcohol and Drug Abuse (AODA) or both. These problems have typically been perplexing for parents, school professionals and case managers to address, as outside resources can be limited in smaller communities. In addition to the general lack of specialized providers, many of the youth we identified with these needs had barriers that prevented them from obtaining the proper services. The Juvenile Justice team responded to these needs in 2013 by contracting with carefully sought out, highly qualified providers. Throughout 2014, two contracted providers, Connections Counseling and Resonating Change, continued to offer counseling services in the Jefferson County Human Services buildings that address AODA and/or mental health concerns. Additionally, Lutheran Social Services' Functional Family Therapy Program continued to offer evidenced based family therapy in the home. These contracts have filled a large service gap and have been invaluable to the youth who utilize this programming.

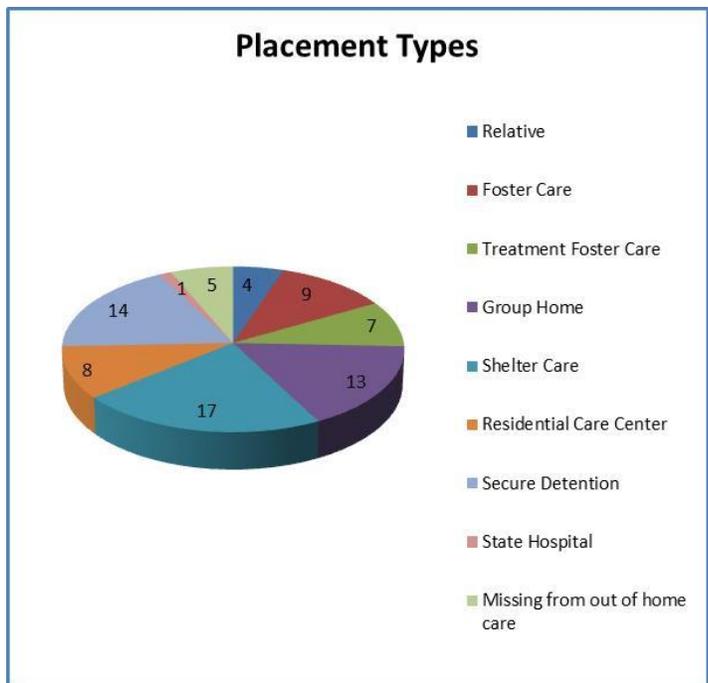
Our team was very fortunate to add the "STOP" program from Community Care Programs to the in-house service array in 2014. This program provides specialized treatment for adolescent sexual offenders, and works closely with the youth and their family to ensure a safe home and community environment.

In 2014, 15 individuals participated in the services of Resonating Change, and 14 individuals participated in the services of Connections Counseling. Additionally, five youth received STOP therapy held here at Jefferson County and 29 total families, including 19 Juvenile Justice referrals, three Intake referrals, one CPS referral and five CST referrals, received Functional Family Therapy in their homes. The Juvenile Justice Team also increased the utilization of some additional in-home services, such as Orion Family Services and Anu Family Services, that offer added supervision and monitoring services outside of work hours, including crisis intervention, parenting support and even homework assistance for youth struggling with school and truancy issues.

We believe that the services mentioned above, in conjunction with solid case management, have helped to maintain the in-home placements of 39 youth in 2014. Out of the youth who did ultimately experience an out-of-home placement, 98% were community placements. Out-of-home placements are costly and we are confident that these contracts and services have had positive cost saving measures for the county.

When placements are necessary to address community safety and treatment for the juvenile, our team strives to keep our youth in the least restrictive environment, preferably a family setting, if possible. The total number of juveniles who experienced some type of out-of-home placement in 2014 was 26, with a total of 78 placements, some short term in a secure, non-secure or hospital setting to address safety concerns. Forty five percent of our total out-of-home placements were in community settings. This speaks to the high level of needs that these youth had at the time of placement and the demand for specialized treatment providers to address some very difficult, and in some cases, dangerous behaviors.

The chart to the right reflects the total placements, and it is noted that some of these youth experienced multiple placements as they stepped down from a more restrictive placement or were moved to a higher level of care. Our team also strives to address the needs of our juveniles while protecting the community in the least restrictive placement setting to minimize and prevent further trauma. At times, this takes a great deal of planning and coordinating additional services to support placement providers in accommodating the needs of these youth and maintaining community placements. Our efforts were successful in 2014, as we had only one semi-correctional setting placement and no straight correctional placements.



In addition to the use of new and existing resources, we continue to offer in-house services as well, such as Aggression Replacement Training groups for juveniles who need to learn additional anger management tools, Prime for Life AODA education classes and Juvenile Cognitive Intervention Program; all evidenced based models. 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, and these interventions help us to make that possible.

FAMILY FIND

The Juvenile Justice Team, along with the CPS and Intake Teams, were very fortunate to participate in the DCF sponsored Family Find Initiative in 2014. Family Find is a model that offers methods of strategies to locate and engage relatives of children currently living in out-of-home care. The goal of Family Find is to connect each

child with a family, whether biologically related or not, and identify and build meaningful connections for children who are placed in out-of-home care. These teams participated in a number of trainings and coaching sessions to learn how to deliver this service model, which includes meeting with the child to determine relatives in that person's life and who he or she feels is important. Based on early exercises with the child and parents or caregivers, a team is created to develop a plan to identify 40 connections in the child's life. In the end, the child's permanency team creates a minimum of three options for building connections and permanency and develops one plan for achieving it. It has been extremely successful for identifying permanency options for children in care who otherwise would have aged out of the system, as well as for building relationships with absent parents or relatives whom the child may rely on for years to come. The Juvenile Justice Team uses the Family Find model on youth who are at risk of being placed out of the home as well, and this has led to an increase in natural supports for the family to maintain placement of their child. When placement does become necessary, more relative options are available from the start.

TARGETED CASE MANAGEMENT

The Juvenile Justice Team has been providing targeted case management, both as a billing source and for overall best practice, for approximately five years. Targeted case management includes a comprehensive assessment of the juvenile and his/her family. During the assessment, the case manager looks at several different life domains, including trauma, life satisfaction, strengths, mental health, family functioning and others. A goal driven case plan is created with the youth and family to determine what the case manager will assist with and what services need to be put in place. The plan is reviewed regularly with the youth and family, and a new plan with new goals is completed every six months. In addition to the treatment benefits of this practice model, \$88,837.25 was billed out in 2014, and the Juvenile Justice Team was able to recoup \$24,760.66 for the County.

Review of 2014 Goals:

1. The Key Outcome Indicator in 2014 was that 95% of children on supervision will remain in the community through the use of community based safety plans and treatment. According to data obtained from the state reporting database, the team exceeded this goal with an average of 97% of youth being placed in a community setting in 2014.

2. To carry on the value of providing services supported by research, we will continue to provide evidence-based service delivery, including, but not limited to, Motivational Interviewing, Juvenile Cognitive Intervention Program (JCIP), Aggression Replacement Training (ART), Incredible Years, PRIME for Life and Wellness Recovery Action Planning (WRAP) for youth who battle mental illness. This will be evidenced in 2014 by our team offering four ART groups, two JCIP groups, two Prime for Life groups, and a minimum of one WRAP group. Additionally, staff members who have not been trained in Incredible Years curriculum will participate in this if it is brought to the agency. *This goal has been partially accomplished. Three ART groups were completed, and nine youth received individualized assistance (instead of group) completing WRAP plans. One JCIP group was completed and another started – unfortunately the second group disbanded due to numbers and individual curriculum was offered to these juveniles through case manager instruction or through individual therapy. Unfortunately, the Prime for Life requires one to two fully trained/certified facilitators, and the team didn't have the resources to provide any of these groups in 2014. Instead, the case managers worked closely with our contracted AODA providers to present the information to the individuals who needed it. Lastly, no formal Incredible Years trainings were offered in 2014, and therefore no new workers were trained. There is still a need for this, and in 2015 the plan is to have untrained workers co-facilitate with a trained teacher; thus, becoming trained in the process.*

3. To enhance our knowledge, skills and practice in the areas that are most pertinent to our juveniles and families, all members of the Juvenile Justice Team will participate in advanced Motivational Interviewing training. Additionally, staff members who were not previously trained in Incredible Years Parenting curriculum will complete this if offered through the agency. Lastly, the team will increase their expertise in the area of juveniles who exhibit risky behaviors by seeking out and attending a training that includes information on the harm reduction model. *This goal has been accomplished. All members of the Juvenile Justice team completed intensive training in Motivational Interviewing (MI) and follow up coaching by an MI expert. The team also participates in MI exercises during team meetings and has ongoing conversations regarding how to continue to improve the skills we've developed. The team will continue to focus on MI in 2015, receiving additional training and coaching and maintaining ongoing conversations to keep it at the forefront of our minds. The team did receive information on harm reduction in different ways. The Juvenile Justice Supervisor participated in a workgroup sponsored by the Department of Justice and obtained information on the harm reduction model as it relates to drug use and brought that information back to the team. An article was also forwarded onto the team and discussed during one of our meetings.*

4. Maintain fiscal, TCM billing and JCHSD policy regarding timely documentation by carefully checking the format when entering progress notes, making sure entries are made within the time limits, and correcting necessary case notes within 24-business hours. *This goal has been accomplished. Due to the various implemented NIATX improvements needed in 2015: The yearly average for billing compliance was 82%.*

5. To increase community awareness regarding the need for positive roles models and Jefferson County foster parents for at risk youth, the Juvenile Justice team will collaborate with the Independent Living and Alternate Care teams and utilize our youth in foster care to plan an event that helps promote this need. *Goal in progress. We have had discussions with the alternate care coordinator about this idea and somehow moving forward with it in 2015. Due to a number of factors, including a consistently high number of crisis situations that needed immediate and ongoing attention, the team could not devote a large portion of time to this goal.*

6. To continue our goal of increasing community awareness of the needs of at risk juveniles, build additional community partners, network and learn about additional resources, the team will provide an additional representative to participate in "Jefferson County Connections." *This goal has been accomplished. We have added an additional team member to this committee who is doing an excellent job of networking with community partners.*

7. To increase communication with key community partners, such as school districts and police departments, the team will reach out to those entities to offer presentations that include information about the juvenile justice process, role clarification and services offered through the program. *This goal has been accomplished. The team made a presentation to the Lake Mills Police Department and School District in 2014. In addition, a committee was formed, a project leader was named and committee members are researching and collecting information on evidence based practices and materials from the programs that are currently part of our service array. This information will then be brought back to the larger team to discuss and a presentation format will be developed and implemented.*

2015 GOALS:

1. **Key Outcome Indicator: Ninety five percent of children on formal supervision will remain in the community through the use of community based safety plans and treatment**
2. To increase independent living and self-sufficiency skills in the youth we serve, the team will facilitate an ongoing life skills group, as evidenced by higher scores on post- tests.

3. To increase our resources and continue to make improvements in our program, the team will explore various funding opportunities to finance additional tools to guide our practice.
4. To decrease recidivism, the team will take the necessary steps to update our risk assessment tool.
5. To increase connections, natural supports and permanency options, Juvenile Justice Case Managers will implement the tools learned through Family Find trainings with 100 % of our youth placed in out-of-home care.
6. No less than 80% of youth with a diagnosed mental illness who receive services through the Juvenile Justice program will have a crisis plan.
7. 100% of Juvenile Justice Team members will participate in advanced motivational interviewing training in 2015.
8. To improve processes in identified areas, the Juvenile Justice Team will complete a minimum of two NIATx projects in 2015.

RESTORATIVE JUSTICE PROGRAMS

Opportunities Inc. contracts with Jefferson County Human Services to provide Restorative Justice Program options to youth who have offended to ensure they are positively restored to their communities.

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.

The Jefferson County Teen Court program was established in 1998. In 2014, there were 14 Teen Court participants. Completion statistics are as follows:

	Participants	Percentage
Successful Completion	9	64
Active in the Process	5	36
Unsuccessful Completion	0	0
Chose to Withdraw	0	0

Participants are required to serve on the peers jury for other participants. The jury determines the sentence which may include options such as apology letters, community service, and restitution and various projects or activities. Participant feedback from the Teen Court experience included the following comments.

- “It was a learning experience”
- “I like how we can learn from our mistakes, not just be punished”

- “I personally like how Teen Court works now, you get plenty of time to complete your tasks, and learn things as you go”

Referral sources for this program include Jefferson County Human Services, Police Departments and Municipal Courts.

Cost-benefit analysis reports completed in the past have concluded that the Teen Court Program affords Jefferson County not only financial savings but also great rewards while participating in restorative justice processes. It is also noteworthy to mention that no referrals were made for a repeat offense in 2014.

Community Service

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

The Restorative Justice Program of Jefferson County has been providing service to community supervision to youth since 1997. In 2014, the Restorative Justice Team worked with 101 community service participants. During the year, 61 completed their order with 91% successfully fulfilling expectations by completing their service to community plan.

The Restorative Justice Team takes creative and individualized approach when planning with participants of service to community program, to increase the probability of follow-through. The Restorative Justice Program offered 6 weekly supervised community service sites and 17 community service events throughout the year at a variety of locations across the county. Additionally, Restorative Justice Staff provided assistance in locating and obtaining individualized service to community opportunities for participants.

Some of the opportunities included doing recreational activities with the residents of assisted living facilities, cleaning, or setting-up activities for community organizations like the YMCA of Watertown, Bread and Roses, and Head Start. Community events included the Helenville Dandelion Dash, Fort Atkinson’s Share and Care Fair and the Ready Kids to School program, and Jefferson’s Christmas Neighbors. With the array of options for participants to choose from, 2219 service to community hours were performed.

Youth participants gained a valuable experience and expressed their feelings of completing service to community with comments such as:

- “It’s nice to help out and people appreciate it”
- “Work is a lot harder than you think. But it feels good to help out the community.”
- “It felt good to help others”

Review of 2014 Goals:

- 85% of all Community Service cases closed in 2014 will successfully complete their community service order.
 - Outcome: 91%
- Opportunities, Inc. will develop four additional community service events in 2014.
 - Outcome: 17

Restitution

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

The restitution monitoring component of the Restorative Justice Program has been in place since 1996. In 2014, the Restorative Justice Team assisted 23 participants in meeting their restitution obligations. Fourteen (61%) of the 23 participants of the Restitution program were categorized as ineligible for work, meaning they are 15 years of age or younger. Of the 9 referrals eligible to work, 8 completed services in 2014; 6 successfully paying all restitution owed.

Individualized plans are developed with each participant to emphasize the importance of paying back victims and to ensure victims were fully restored. The Restorative Justice Specialists assist participants in locating jobs; however, with over half of the referrals being ineligible for employment, other creative options were implemented. Such options included completing extra chores at home and shoveling snow and mowing lawns for elderly neighbors. Opportunities, Inc. also provides work options for participants 16 years of age or older.

In 2014, over \$14,000 in restitution was collected and repaid to the victims of crimes in an effort to compensate them for monetary damages.

Review of 2014 Goals:

1. 85% of all Restitution cases eligible for work in 2014 will successfully complete their restitution order making the victim whole.
 - Outcome: 75%
 - Note: 6 of 8 referrals were successful
2. 75% of youth ineligible for work will have family pay toward restitution with youth providing a specific meaningful contribution to reimburse the family.
 - Outcome: 90%
3. Opportunities, Inc. will develop individual job options for 12 youth in 2014.
 - Outcome: Two assisted with job development; 2 job options developed.
 - Note: 9 referrals potentially eligible for this assistance

Educational Program

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 2014, 14 youth were signed up to complete the First Offender Program. Nine youth successfully completed the class (64%).

Review of 2014 Goals:

- 70% of successful participants of the First Offenders program will not re-offend in the following 9 months.
 - Outcome: 100%

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.

Options for incorporating the concepts of the Victim Offender Conferencing program are in three tiers. This 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.

Review of 2014 Goals:

- The Restorative Justice Program will provide at least 6 Victim Offender Mediation and/or apology letter sessions in 2014
 - Outcome: Zero referrals were made to the program in 2014.

COORDINATED SERVICES TEAM/WRAPAROUND

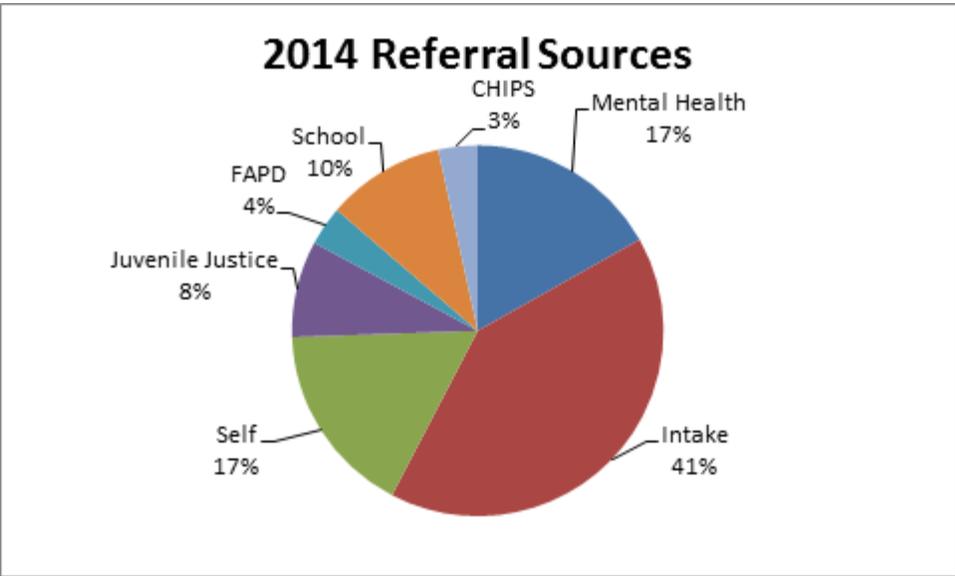
“Keeping children with social, emotional, mental health and cognitive needs in their home”

Program Description and Updates

Coordinated Services Team (CST) is a team approach that works to keep children with multiple needs in their home and community through the creation and maintenance of a comprehensive, coordinated, and community based system of care centered on strengthening the child and family. The children, youth and families who receive CST services are typically involved with two or more child and family serving systems, such as mental health, special education, developmental disabilities, child welfare and juvenile justice. As a result of the CST process, 150 family members (such as siblings, parents, relatives) other than the identified child received support and/or services that they may not have received if the family was not involved in CST.

All CST meetings and services are provided in the community or the family's home. Schools, police departments, provider agencies, county departments, state and federal agencies, local organizations, churches, Judicial System, coordinated service teams throughout the State, White Pines Consulting, UW – Whitewater, all collaborate with the Jefferson County CST program.

The Jefferson County Coordinated Service Team (CST) reported outcome data to the State Division of Mental Health and Substance Abuse Services (DMHSAS) for 35 children in calendar year 2014. These children were 67% male and 33% female; 82% White, 12% Latino, and 6% African-American. Their ages ranged from 5-16, with an average age of 10.5 years old.



Youth were referred from a wide variety of sources indicating a well-established network of providers and agencies that are connected with the CST initiative. Of all the 35 children served in 2014, the referral sources at the time of enrollment are depicted above. While the largest percentages of youth were referred from our Intake Department (41%), 17% were self-referrals, and another 17% were mental health referrals. Included in the mental health category are referrals from the Veteran’s Hospital, Fort Atkinson Police Department, Rogers and Meriter inpatient hospitals and the Fort Atkinson Medical Clinic. The average length of participation in CST for these children was 11.3 months ranging from 5-17 months.

Of the 35 children served in 2014, 15 were also disenrolled in 2014. Outcomes for these 15 children will be presented later in this report. This report compares the living situations, juvenile offenses, school performance and behavior at the time of enrollment to that at the time of disenrollment for those 15 children who were disenrolled.

- **LIVING SITUATIONS: 80% of Youth Maintained with Their Families**

Of the 15 youth disenrolled in 2014, 12 (80%) were maintained with their biological or adoptive parents during their entire period of participation in the CST Initiative. One child was maintained in a group home throughout their participation period, and the other two youth experienced the following changes in their placement from enrollment to disenrollment:

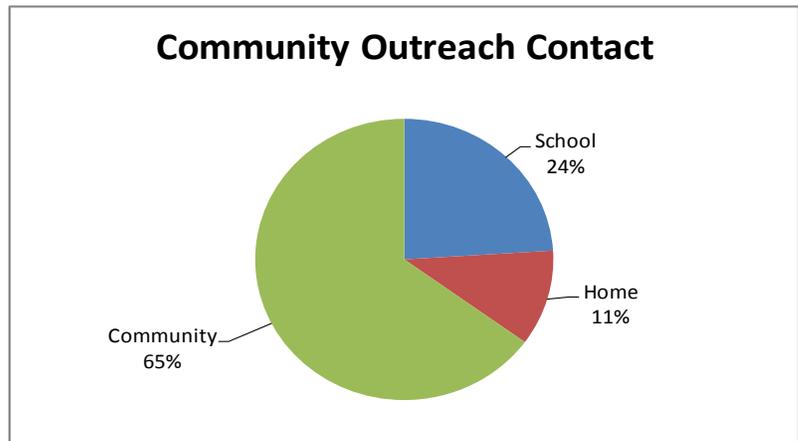


- **JUVENILE OFFENSES: 93% of Youth in CST had no Juvenile Justice System Involvement**

Of the 15 children who were disenrolled in 2014, 14 (93%) committed no offenses in the two months before enrollment or while participating in the CST Initiative. One youth was charged with an unspecified minor assault during his/her participation.

Community Outreach

In 2014 Community Outreach staff completed 166 school contacts, 22 home visits and 445 community integration activities. Community Outreach is a service offered to CST families which provides community integration, home visits, school visits, crisis intervention, development of social skills, employment skills and a short respite for the parent or guardian. Through our involvement, schools have identified a decrease in problematic social behaviors as evidenced by fewer police contacts, reduced referrals to the Jefferson County Human Services Intake Department and the accomplishment of team goals documented on the plan. Documentation supports an improvement in school attendance and academic achievement as well. Schools have pointed out that by having outreach provided in the schools, the previously identified problematic social behavior has decreased as well. The Outreach worker can respond to the school if the child is in crisis, minimizing the need to contact law enforcement. Parents have also expressed improved functioning in the home. Other areas of improvement include an increase in children’s self- care with daily living skills as well as increased social functioning with peers.



• **SCHOOL PERFORMANCE: Young Children show Improvements; Ninth Graders Struggle**

Of the 15 children who were disenrolled in 2014, 11 had complete educational data near the time of their CST disenrollment to allow analysis of their final status and progress in school. Each child’s status and progress at disenrollment is illustrated in the table below. Final academic grades, the number of unexcused absences, and the number of suspensions in their final school period (semester/trimester) at disenrollment are displayed along with an indicator of progress from CST enrollment to disenrollment.

From kindergarten through eighth grade, all children had satisfactory (S) or improved academic grades upon disenrollment. Most of these children did not have any unexcused absences or suspensions in the last period of evaluation. However, all 3 ninth graders were still struggling in these areas at the time of CST disenrollment.

Grade Level at Disenrollment	Academic Grades	Unexcused Absences (#)	Suspensions (#)
Kindergarten	★ S	★ 0	★ 0
First Grade	★ S	★ 0	★ 0
Second Grade	★ S	↑ 2	↑ 0
Third Grade	★ S	★ 0	★ 0
Fourth Grade	★ S	★ 0	↓ 2
Fourth Grade	★ S	★ 0	★ 0
Sixth Grade	★ B	↓ 1	↓ 2
Eighth Grade	↑ C	★ 0	★ 0
Ninth Grade	↓ F	↓ 2	↓ 2
Ninth Grade	↓ F	↓ 4	★ 0
Ninth Grade	↓ D	↓ 4	★ 0

★ = maintenance at positive level; ↑ = positive change; ↓ = negative change

To enhance our delivery of services to families, all staff participated in Motivational Interviewing training, as well as feedback and coaching. After the training staff felt the importance of continuing to enhance their MI skills and we focused on improving a number of internal transfer of learning activities. The CST team felt the need to change our comprehensive assessment from closed questions to open questions as result of the MI training and this change was made. After implementation, staff relayed that they were able to elicit more information from the parent and or child.

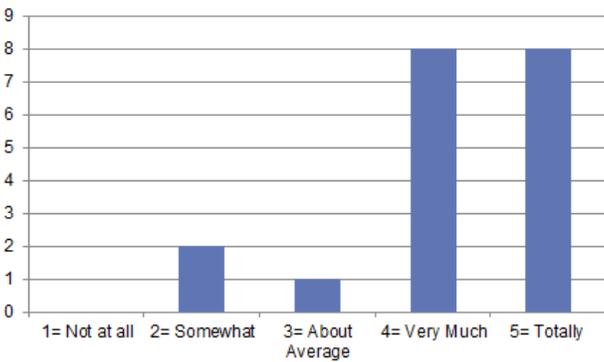
In 2014 the CST team streamlined documents from opening to closing to assure collection of required documentation needed for billing targeted case management. The other intent of this change was made so families can have a positive experience and improved understanding of how the process works and not feel overwhelmed. With streamlining paperwork and with the electronic note system in place, compliance with meeting targeted case management requirements has shown a major increase. In 2014 CST recouped \$32,134 in targeted case management costs as compared to \$27,202 in 2013.

The fidelity of the CST process is measured through Team Effectiveness Surveys. Below are questions from the survey and current CST participant’s responses. Results of the surveys are shared with the coordinating committee on an annual basis for recommendations.



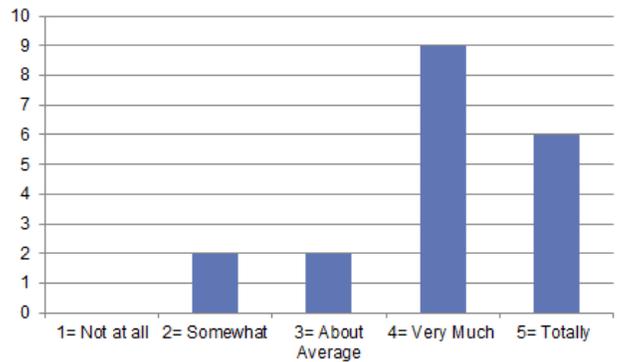
Team Effectiveness:

Are all team members involved in discussion and action?



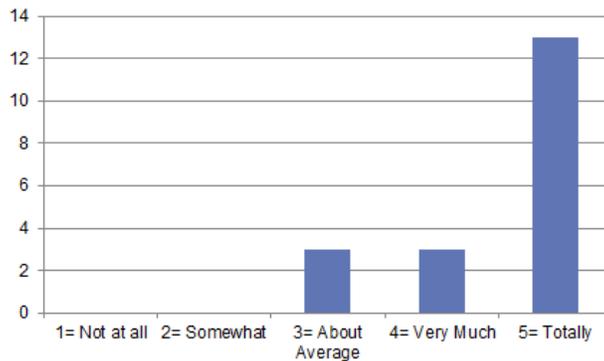
Team Effectiveness:

Is there a high level of trust among team members?



Team Effectiveness:

Do team members listen to and respect differences of opinion?



Testimonials from Team Effectiveness Surveys

- “These regularly scheduled team meetings allowed me to develop a better rapport with the client.”
- “I learned a great deal about the services that are available to families here in Watertown. I had no idea the support that is available for transportation, counseling, family services, etc.”
- “Great to reach a student in need of extra support & supportive relationships to help seek advice to support the student.”
- “It has been very helpful to learn about different resources available for the family. I’ve also felt more involved with the family and supported by others in the community.”
- “I cannot express the amount of support Wraparound provided to this family. Getting a plan together and developing a crisis plan all supported the client.”
- “This team was essential in holding the child and family accountable. The goals and tasks were very specific and measureable.”

Review of 2014 Goals:

1. The Key Outcome Indicator for the Coordinated Services Team (CST) in 2014 was that 90% of all children involved in services would remain in the home. According to the statewide tracking system 97.4% (75 out of 77) of the children served via the CLTS program were able to remain in the home. Additionally, 97.1% (34 out of 35) of the children served via the CST program successfully remained in the home.

2. Increase access and services to 10-12 additional families that are referred and who meet criteria in a timely manner and to eliminate the waiting list by 9/30/14. This will be accomplished by adding a new service coordinator position by applying for the Coordinated Services Team Initiative Statewide Expansion. *This goal has been accomplished. The CST team and supervisor completed the Coordinated Services Team Initiative 2014 Statewide Expansion Application requirements. The application was submitted to the State office by February 14, 2014 and on June 6, 2014 a new Coordinated Services Team facilitator was hired. By year end we were able to eliminate the existing waitlist as referrals can now be assigned to a service coordinator within days of receipt. Enrollment has increased from an average of 22 families to 33 families in the reporting period.*

3. Reinstate Jefferson County’s Coordinated Services Team Coordinating Committee meeting the requirements of Statute 46.56 and the Coordinated Services Team Initiative Statewide Expansion allocation by June 2014 as evidenced by meeting minutes. *This goal has been accomplished. Our interagency agreement for the Coordinating Committee was updated and modified to meet the requirements State Statute 46.56 (initiative to provide coordinated services to children and families). The first coordinating committee meeting was held on Thursday, October 9th and attendance included parents, therapists, school personnel, Jefferson County Human Services staff, Headstart, Community Action Coalition, Family Support Coordinator and a community member from the Watertown community. Committee members reviewed the Coordinated Services Team Initiative Legislative Checklist to assess current program status against the fundamental elements of Wisconsin 46.56.*

4. Develop and implement a service utilization system for data collection showing the cost effectiveness of using coordinated services team initiative as evidenced by the completed monthly service cost sheet for interventions. *This goal has been accomplished. The service utilization data collection spreadsheet was developed and via data collection the below illustrates the cost savings of having a child participate in the Coordinated Services Team Process compared to being placed in a group home, treatment foster home, respite or a hospital setting. Hospital monthly costs are based on seven day admittance.*

Placement	Monthly Cost	Monthly Wraparound Cost	Savings
Group Home	\$6,124.05	\$384.82	\$5,739.23
Treatment Foster Care	\$5,000.00	\$384.82	\$4,615.18
Respite Care	\$1,395.00	\$384.82	\$1,010.18
Hospitalization	\$7746.90	\$384.82	\$7362.08

The above data was collected on a child that receives Coordinated Services coordination through the team process, targeted case management and community outreach.

5. Develop an internal and external training to inform and educate Jefferson County Human Services staff and community partners of the importance of effective communication when overlapping systems meet for united service delivery. *This goal is partially accomplished.* Dan Naylor from White Pines Consulting Service presented training on Collaborative Team Practice in Juvenile Justice. Dan is a Coordinated Services Team (CST) Specialist. In attendance were Juvenile Justice Case Managers, Intake staff and Supervisor, Independent Living Coordinator, Division Manager and CST Project Coordinator. Training material included: Characteristics of Wisconsin Youth in the Juvenile Justice System, Research on Juvenile Justice and the Collaborative Team Approach, Balance Approach to Juvenile Justice, Community Protection, Accountability for Delinquent Acts, Blending a Collaborative System of Care with Court Functions. A satisfaction survey was completed by participants at the end of the training. The CST Coordinating Committee is currently in the process of developing a county-wide training and resource sharing day for 2015.

6. Develop a resource pool of trauma informed care professional that can be called upon as team members to increase optimism for children who have experienced trauma and who are involved in the Coordinated Services Team process. *This goal has been accomplished.* Community members, school personnel, and agencies receive ongoing information from the Wisconsin Trauma Informed Care Listserv dhs-dmhsas-wi-ti-carechampion@lists.wi.gov. Resources are tailored to the needs of the family team. Discussions have been held with the children’s therapist at PADA (People against Domestic Abuse) who has agreed to be a resource for teams. Guides for “What Parents Can Do for their Children Exposed to Violence or Disaster” are available to team members and children and families. We have developed a working relationship with Elizabeth Hudson. Elizabeth is the lead at the Office of Children’s Mental Health, which coordinates and integrates state agencies’ related activities. She attended a CST team meeting educating family members, case managers, service providers and school staff on how trauma affects children in their environments. Dan Naylor presented to the Juvenile Justice Team on how trauma-informed care includes the ability to look at problems and needs and consider if they are a result of past traumatic experiences.

2015 GOALS:

1. **Key Outcome Indicator:** Ninety percent of all children will remain in their home with the use of CLTS and CST services.

2. Through the utilization of the State Legislative checklist, Jefferson County CST will adhere to the statutory provisions established by the Legislature in Wisconsin Statue 46.56 as evidenced by the coordinating committee reviewing the check list. The coordinating committee will identify deficit’s that need to be addressed and develop a plan on meeting the statutory provision contained in the checklist within the 2015 year with 100% completion of the checklist.

3. Provide a county wide training and resource fair to develop a community of practice by bringing family members, school personnel, and providers together to build an understanding regarding preventative services available to families throughout Jefferson County.
4. Re-evaluate the Team Effectiveness, Family Satisfaction and Team Closure surveys by consulting with an outside evaluator to obtain feedback on the validity and effectiveness of the survey, so the CST program can maximize survey results to make needed program changes for improved outcomes.
5. Coordinated Services Team staff will be trained in developing connectedness maps, genograms and mobility maps so family teams can develop a shared understanding of the family dynamics and history as evidenced by completion of the tools as well as completion of the goal identified on the plan of care.



BIRTH TO THREE PROGRAM

~Supporting Families in Promoting the Growth and Development of Their Children~

Mission Statement

The Birth to Three Program is committed to children under the age of three with developmental delays and their families. We value the family's primary relationship with their child and work to enhance the child's development and support the family's knowledge, skills and abilities as they interact with and raise their child.

Since 1979, the Jefferson County Birth to Three Program has been committed to providing services for families with young children who have special needs. Birth to Three services focus on empowering parents to enhance their child's growth and development. Recognizing parents as the primary influence in their child's life, Jefferson County Birth to Three uses the parent coaching approach to support families in understanding their child's development and building their capacity to create meaningful learning experiences as they interact with and raise their child.

The Jefferson County Birth to Three Program continues to integrate best practices in early intervention into programming. In 2014, the Wisconsin Birth to Three Program identified Child Outcomes, the Primary Coach Approach to Teaming (PCATT) and Results Driven Accountability as the focuses for programming. To ensure effective implementation of the Child Outcomes process, Jefferson County sent the six county employees and four of the contracted providers to the Child Outcomes Birth to 6 Professional Development opportunity provided by the state team. Three county employees also attended the follow-up Ongoing Assessment workshop that was also offered.

Professional development activities to enrich the implementation of the PCATT took place throughout the year. Staff participated in state training modules, put into practice elements of the teaming model and began using a daily note outlined to support coaching-based conversations with families. In 2015, the state leaders will continue to focus on improving the fidelity of evidence based practices, such as the PCATT, in Birth to Three programming.

The Federal Government will continue to hold state Birth to Three programs accountable to ensure high quality programming through Results Driven Accountability (RDA). Program data collected through the Program

Participation System (PPS) is tracked in relation to the Federal Birth to Three Indicators. Results are reported annually to the Office of Special Education Programs.



“I loved Birth to Three. They helped me work with my child and she loved when they were here.”—Amanda

Birth to Three Federal Indicators

The Birth to Three Indicators have been identified by the Federal Government as the essential components for implementing high-quality, early intervention programming. The Wisconsin Department of Health Services (DHS) is required to track county data and report state results on each of the indicators to the Office of Special Education Programs.

Indicator 1: Timely Services

Percentage of infants and toddlers with Individualized Family Service Plans (IFSP) who receive services in a timely manner.

Indicator 2: Natural Environments

Documents Wisconsin provider's performance regarding the extent to which services are provided in the home or programs for typically developing children.

Indicator 3: Child Outcomes

Documents how Birth to Three programs are making a positive difference in the lives of children and families in the following areas:

- Positive social-emotional skills including social relationships
- Acquisition and use of knowledge and skills
- Use of appropriate behaviors to meet their needs

Indicator 4: Family Outcomes

Measures the percent of families in the program who report that services have helped:

- The family knows their rights
- The family effectively communicate their child's needs
- The family help their child develop and learn

Indicators 5 and 6: Child Find

Methods and procedures each county uses to identify infants and toddlers potentially eligible for services.

Key Principles

Infants and toddlers learn best through everyday experiences and interactions with familiar people in a familiar context.

All families, with necessary supports and resources, can enhance their children's learning and development.

The primary role of the service provider in early intervention is to work with and support family members and caregivers in children's lives.

The Birth to Three process, from initial contacts through transition, must be dynamic and individualized to reflect the child's and family members' preferences, learning styles and cultural beliefs.

Individual Family Service Plan outcomes must be functional and based on children's and family's needs and family-identified priorities.

The family's priorities, needs and interests are addressed most appropriately by the primary provider who represents and receives team and community support.

Interventions with young children and family members must be based on explicit principles, validated practices, best available research, and relevant laws and regulations.

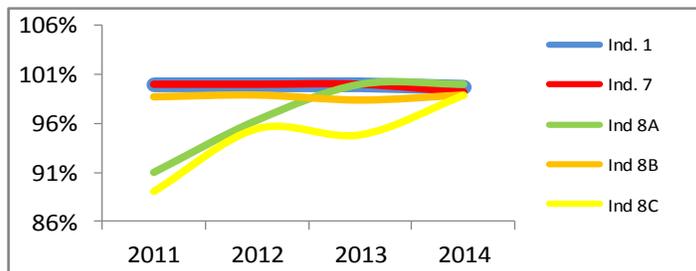
Indicator 7: Timely IFSPs

Percent of eligible infants and toddlers with IFSPs for whom an evaluation, assessment and initial IFSP meeting were conducted in a timely manner.

Indicator 8: Timely Transitions

- **Transition Steps and Services**
Percent of all children who received timely transition planning
- **Notification to Local Education Agency (LEA)**
Percent of all children who received timely transition planning including notification to LEA
- **Transition Conference**
Percent of all children who received timely transition planning including a transition planning conference

Jefferson County Trends in Compliancy



Indicators 1, 7 and 8 are considered compliancy indicators. County providers are held accountable for reaching 100% compliance in all components of each area within the year. Findings of noncompliance results in a written correction plan and ongoing file audits until 100% compliance is reached.

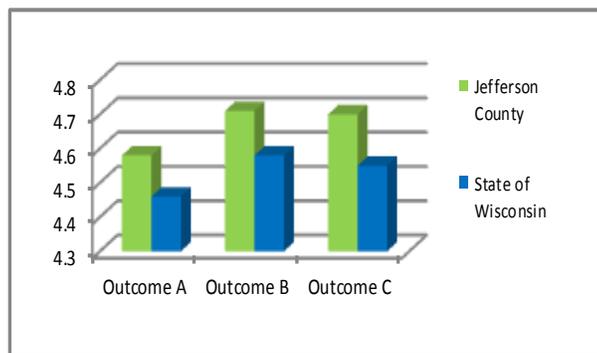
Jefferson County Birth to Three received an initial finding of 100% compliancy by the state in 2014.

 "Thank you all for everything you have done for our family. You have not only helped our little one grow, but all of us!" --Stephanie

Family Outcome Survey Results

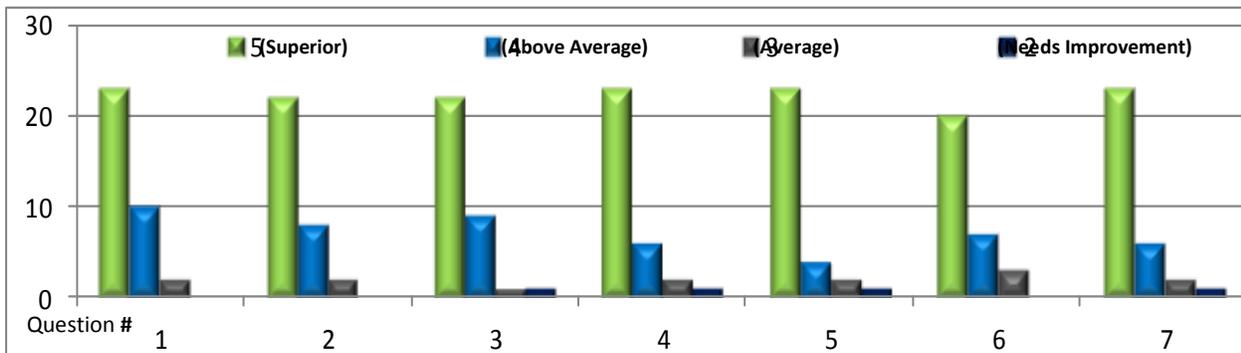
The Wisconsin Birth to Three Program is also required to collect information regarding the effectiveness of programming annually under the Individuals with Disabilities Education Act (IDEA). The Wisconsin Family Outcomes Survey asks families to report on how participating in the local Birth to Three Program helped them in the three federally identified outcome areas.

- Outcome A:** Know their rights
- Outcome B:** Effectively communicate their child’s needs
- Outcome C:** Help their child develop and learn



The Jefferson County Birth to Three Program collects information on the effectiveness of services through the Family Exit Survey. Each family receives a survey at their child’s discharge meeting with a stamped envelope to return at their convenience.

2014 Jefferson County Birth to Three Family Survey Results



1. Our Birth to Three team explained that the program focuses on helping families be able to strengthen their child’s abilities within their everyday routines at home.
2. Our team helped us understand our child’s abilities and development.
3. Our team helped my family develop outcomes (goals) that were important for my child and family to work toward.
4. Birth to Three services have helped us be able to communicate our child’s needs to others.
5. Our Birth to Three Team helped my family through the transition process.
6. Did you receive timely follow-up to questions, concerns or phone calls?
7. Overall, how happy are you with the services and support you received through the Birth to Three Program?

Birth to Three: Making Connections

Connecting through Community Outreach

The Jefferson County Birth to Three Program continually searches for opportunities to identify infants and toddlers potentially eligible for services. By educating community partners, participating in community events and by providing literature to programs and organizations that service the families of Jefferson County, we are ensuring that families with children under the age of three who have developmental delays are able to access our services.

2014 Child Find Activities To Locate Children in need of Birth – 3 Services

Fort Atkinson Child Share and Care Fair
 Watertown Children’s Community Fair
 Johnson Creek Child Safety Fair
 Jefferson Farmer’s Market
 Lake Mills Farmer’s Market
 Ready Kids for School
 Jefferson County Head Start
 -- Family Fun Nights

2014 Outreach Activities

Provided local Medical Providers with information regarding changes in screenings and programming
 Participated in the Incredible Years Program
 Presented information for the Jefferson County Health Department
 Hosted annual Early Childhood Interagency Meetings

Connecting with Families

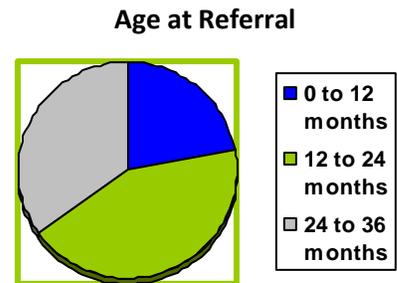
During 2014, the Birth to Three Program was in contact with 420 families in Jefferson County. Some of these families were continuing services previously outlined in Individualized Family Service Plans. Other families had their initial referrals to the program made in 2014.

Trends in Family Contacts			
2011	2012	2013	2014
417	415	391	421

Referral Source	Percentages
Primary Health Care Providers	54%
Parent	23%
Social Services Agency	14%
Hospitals or Specialty Clinics	4%
Other	5%

Anyone who has concerns about the development of a child birth to three years of age living in Jefferson County may contact the program to make a referral. Family members and medical providers are the most common referral sources.

Developmental Concern at time of Referral	
Communication	70%
Cognitive	10%
Fine Motor Concerns	8%
Gross Motor Concerns	22%



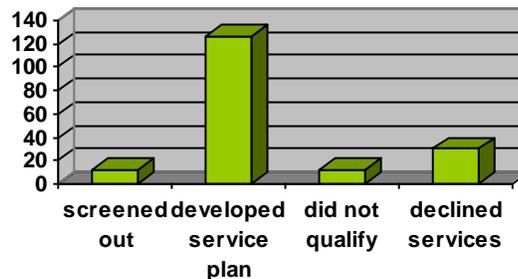
***Referrals can be for multiple areas**

Seventy four percent of families that were referred to the program in 2014 chose to pursue the referral. Families who chose not to pursue the referral were offered resources, developmental information and the opportunity for a follow-up contact.

They worked so well with my child and helped with working on his goals. I couldn't be any happier with the outcome.
 --Alyssa

Outcomes from continuing the referral process vary based on the child's development and the family's interest in participating in programming.

Outcomes of the 181 referrals that were pursued in 2014



To ensure timely services, the Birth to Three process begins with Intake Service Coordinators contacting the family of the referred child to explain what can be expected now that their child has been referred. The Intake Service Coordinator provides an overview of the program, discusses the referral information that was provided and explains the program's mandated timelines and parental rights of the child's legal guardian. The Intake Service Coordinator will schedule a visit to welcome the family to programming, gather information regarding the families understanding and concerns about their child's development and collect needed documentation.

During the initial visit, the Intake Service Coordinator explains the mission of the Birth to Three Program, the process for eligibility, development of services and consents for services and access to insurance. The coordinator collects information about the child and family that ensures the team of professionals working with the family has a comprehensive summary of their strengths, values, supports and the child's medical and developmental history.

Connecting with Children

Birth to Three evaluations provides a global view of a child's development. Through the evaluation process, parents learn about their child's development in the following areas:

- Problem solving (cognitive)
- Understanding and expressing ideas (communication)
- Self-help skills (adaptive)
- Ability to move around their environment (motor)
- Expressing feelings and emotions (social-emotional)

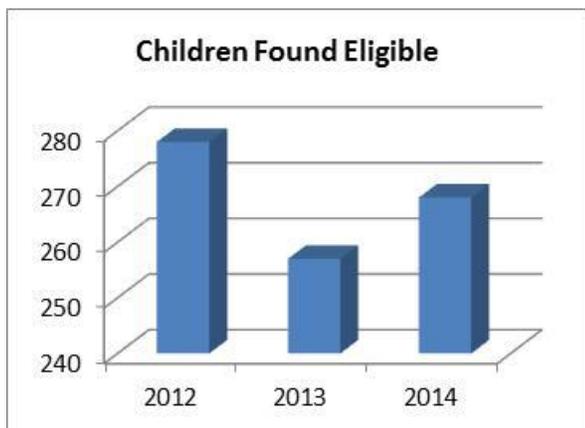
Evaluation information is collected through parent interviews, observations of the child and play-based, standardized evaluation tools. The Early Intervention (EI) Team creates a developmental summary of the child's skills and abilities to share with the family. The summary of the evaluation leads the discussion regarding the child's eligibility for services.

“We were thrilled by the progress our son made in under six months. We couldn't have imagined how far he would come in such a short time.” --Natalie

Connecting Children with Services

Children are determined eligible for Birth to Three services based on one of three possible criteria:

- Demonstrate a significant delay in any area of development
- Demonstrate atypical behaviors that are negatively impacting development
- A diagnosed medical condition that has a high likelihood of resulting in developmental delays



Families of children who are not found eligible for services are offered tools to help them continue monitoring their child's development and information about other community resources. Families are encouraged to contact the program if they are still concerned about their child's development in three months.

Connecting Families with Services

The Birth to Three Team has six staff to facilitate and monitor the implementation of services. Rehab Resources Inc. is contracted by the county to provide therapy services for the program.

Jefferson County Birth to Three Staff
Program Supervisor
Two Intake Service Coordinators
Three Educators/Ongoing Service Coordinators

Rehab Resources Inc. Staff
Owner/Operator
Office Administrator
Three Speech and Language Pathologists
One Occupational Therapist
One Physical Therapist

Each family that has a child who qualifies for Birth to Three services, will be assigned an Ongoing Services Coordinator. The Service Coordinator is responsible for supporting the family through the Birth to Three process including: assisting in the IFSP (Individualized Family Service Plan) development, scheduling of IFSP reviews, providing resource information, and connecting families with other services. The responsibilities of a service coordinator require them to have frequent contact with families. IFSP reviews are held every six months or whenever there is a change in services.

Birth to Three Service Coordination activities are eligible for reimbursement through the Wisconsin Medical Assistance (MA) Program as Targeted Case Management. To receive reimbursement, MA regulations regarding timelines, documentation and family contact must be met.

In 2014, an average of 69% of Birth to Three families were eligible for insurance through medical assistance. Services were being reimbursed at an average rate of 27%. The decline of reimbursement in 2014 is a result of a change in policy for billing monthly contacts.



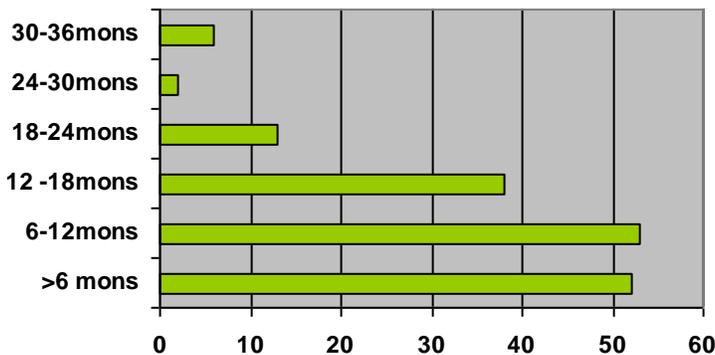
“We had a wonderful experience with this program. Our child grew leaps and bounds. We are so grateful for everything they provided to our son!” -- EB

Services through the Birth to Three Program are individualized to best address the concerns and meet the needs of the child and family. The IFSP is developed based on the evaluation and assessment information collected about a child. The child's present levels of development, family strengths, concerns and resources, along with the expected outcomes for the child are documented in the IFSP. The service plan for the child and the family are also outlined in the IFSP document.

Jefferson County Services	# of children receiving Service in 2014
Educational Services	85
Speech and Language Therapy	219
Occupational Therapy	74
Physical Therapy	76

Birth to Three services provide families and caregivers with the opportunity to receive support in promoting a child's development where she lives, plays and learns every day. Birth to Three Staff connect with children for services in their homes, daycares, playgroups, libraries and parks.

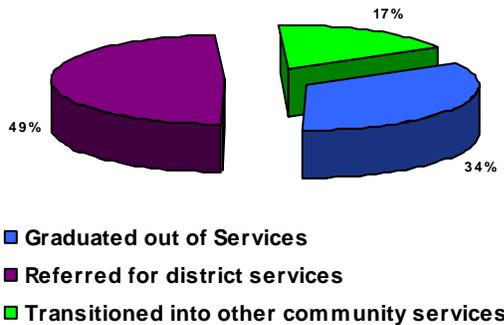
Length of services per child in 2014



During visits, families and caregivers are coached by their child's service providers on ways to enhance the developmental skills needed for the child to reach the outcomes the family identified as important in their Individualized Family Service Plan. Family members and caregivers are then able to use these techniques and strategies to create meaningful learning experiences throughout their child's everyday routines.

Connecting Families with Services After Birth to Three

Most children continue Birth to Three services until they are no longer in need of services or until they turn three years of age. All children exiting Birth to Three services receive transition planning to support moving into their next stages of early childhood. Early childhood transition options include school district programming, Head Start, child care, play groups or other appropriate community services.



“Thank you. Your commitment to the children is deeply appreciated!”
--Amy

Making Connections for Continual Program Improvement

Review of 2014 Goals:

- 1. The Key Outcome Indicators for 2014 were to use the Coaching Model of services with families 100% of the time and to provide the Primary Coach Approach to services with 30% of the families we provided services for.** All program staff demonstrated the use of the Coaching Model of services by completing the Supportive-Based Home Visiting Checklist protocol for fidelity in 2014. Data compiled internally indicates that 44% of the families participating in the Birth to Three Program in 2014 were receiving Primary Coach Approach-based services.
- 2. In line with the state initiatives for 2014, the Birth to Three Program will continue to improve the fidelity of the Primary Coach Approach to services.** All county staff will participate in the Pyramid Model Infant and Toddler Module which focuses on empowering families to enhance their child's development through meaningful interactions and relationships. All county and contracted staff will participate in training based on the Pyramid Model facilitated by staff already trained in the Model and by Resource staff. All county and contracted staff will complete the Birth to Three Training Modules on the Primary Coach Approach to Services. Staff will demonstrate improved fidelity in the Primary Coach Approach by showing a 35% improvement rate program wide on the Supportive-Based Home Visiting Checklist. *This goal has been accomplished. Staff showed an average correct completion rate of 28% on the 38 items in the Supportive-Based Home Visiting Checklist during the baseline peer and supervisor reviews in July of 2014. The peer and supervisor reviews completed in December of 2014 showed an average correct completion rate of 76%. Staff demonstrated a 48% improvement from the baseline rating. Staff participated in training on the Center for Social and Emotional Foundations for Early Learning's Pyramid Model, Rush and Shelden's coaching approach to services and the Wisconsin Birth to Three training modules.*
- 3. The Birth to Three Program will increase visibility and accessibility of services to the Spanish speaking community in the county by participating in two outreach or "child find" activities that offer a variety of bilingual services and resources.** *This goal has been accomplished. The Birth to Three program's bilingual service coordinator participated in outreach at the Watertown Children's Fair and the Watertown Latino Festival. She has been scheduled to conduct developmental screenings in Spanish for the younger siblings of Jefferson County Head Start families during Family Fun Nights in January, March and April of 2015.*
- 4. The Birth to Three county staff will enhance their ability to engage parents in the Birth to Three process and service plan implementation through the use of Motivational Interviewing techniques.** All county staff will complete Motivational Interview training in 2014. *This goal has been accomplished. All Birth to Three county staff participated in the provided 2014 Motivational Interviewing training activities.*
- 5. The Birth to Three Program will focus on improving compliance to Federal Indicator 8C.** Indicator 8C states that all children being referred to the local school district will have a transition planning conference with a representative from the school district and their service coordinator at least 90 days before their third birthday. In 2013, 95% of children transitioned were compliant with Indicator 8C. Staffing agendas will include a list of children who are due for Indicator 8 services. Indicator 8 reports will be run monthly from state data and shared with staff. *This goal has been accomplished. The Jefferson County Birth to Three Program was found to be 100% compliant with the Federal Compliance Indicators in 2014.*
- 6. The Birth to Three staff will develop a handbook to use as a tool for introducing families to the program.** It will include an overview of the mission and philosophy of the program, a description of what to expect from the program and updated policies and procedures. *This goal has been accomplished. The Jefferson County Birth to Three Handbook has been revised and updated to ensure that families are receiving accurate*

information, that they are receiving a functional resource guide and that they are able to make informed decisions regarding programming.

2015 GOALS:

- 1. Key Outcome Indicator: The Birth to Three Program will be issued a notification of 100% compliance with the Federally Compliancy Indicators by DHS based on the annual data review.**
2. The Birth to Three Program will successfully implement a colleague to colleague coaching approach to teaming in accordance with the Primary Coach Approach model of services. Successful implementation will be facilitated through the use of the team meeting guidelines identified as best practices by state leadership.
3. The Birth to Three Program will increase revenue for targeted case management by 10% to ensure sustainability of the colleague to colleague coaching approach to teaming.
4. The Birth to Three Program will develop a community outreach activity dedicated to enhancing parents' and caregivers' capacity to meaningfully engage with the children in their care. The needs and interests of the early childhood community and caregivers will guide activity development.
5. The Birth to Three Program will increase community awareness through the development and distribution of informative reading materials that highlight the program mission and access points.
6. The Birth to Three Program will ensure families are able to make educated decisions regarding insurance access and the Parent Cost Share system by developing a procedure that provides a detailed explanation of benefits and cost share prior to receiving services.

BUSY BEES PRESCHOOL



*~Providing positive early learning experiences throughout
a fun-filled morning ~*

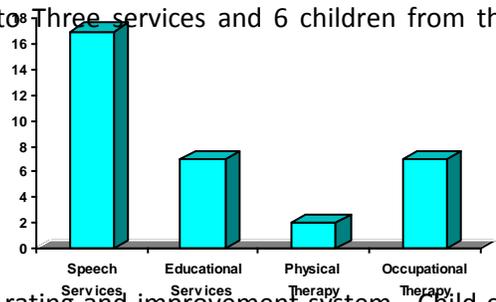
The Busy Bees Preschool Program is open to two and three year old children participating in the Birth to Three Program or from the community. Preschool is held on Tuesday and Thursday mornings from 9:00-11:30am, September through May. A summer session is also offered for five weeks starting in July.

The children enrolled are a combination of six community children, who attend two days a week, and twelve children invited through their participation in the Jefferson County Birth to Three Program. Children participating in Birth to Three services attend preschool for one morning a week.

Busy Bees Preschool promotes a positive learning experience by providing fun-filled, enriching mornings with structured routines and consistent behavior expectations. Children increase their social-skills, self-esteem and overall confidence through understanding and succeeding at our preschool.

Children learn through developmentally appropriate activities in a seasonal thematic manner. 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. Lesson plans address all developmental domains and follow the Wisconsin Model Early Learning Standards.

During the 2014-2015 school year, 18 children receiving Birth to Three services and 6 children from the community participated in programming. Children in the Birth to Three Program were able to interact with their Early Childhood Teacher, Speech and Language Pathologist, Physical Therapist and/or Occupational Therapist during preschool activities.



Busy Bees Preschool completed the YoungStar process (Wisconsin’s Child Care Rating Program) for the 2014–2015 school year. YoungStar is the Wisconsin child care quality rating and improvement system. Child care programs can be awarded up to 40 quality indicator points through the review process and assigned a star rating based on total points earned.

What points measure	Possible Points
Provider’s Education and Training	0-15
Learning Environments and Curriculum	0-13
Professional and Business Practices	0-7
Children’s Health and Well-Being	0-5
Total	0-40 points

How the stars add up	Points Needed
5 Star	33 to 40 points
4 Star	23 to 32 points
3 Star	11 to 22 points
2 Star	0 to 10 points
1 Star	Does not meet standards

Busy Bee’s Preschool was rated as a 5 star program for the 2014 – 2015 school year.

What the stars mean		
	5 Star	Meets highest levels of quality standards
	4 Star	Meets elevated levels of quality standards
	3 Star	Meets proficient levels of quality standards
	2 Star	Meets health and safety standards
	1 Star	Does not meet standards

The YoungStar 2014 report below provides a comparison of the rated child care programs across Wisconsin.

	One Star	Two Stars	Three Stars	Four Stars	Five Stars
Facilities Rated by YoungStar	14	2330	1264	187	370

For participating in the YoungStar program, the preschool was awarded a \$1000 grant. The funds received through the grant provided staff with the opportunity to participate in the Wisconsin Infant and Early Childhood Mental Health Conference held in June.

Review of 2014 Goals:

- 1. The Key Outcome Indicators for 2014 were to use the Coaching Model of services with families 100% of the time and to provide the Primary Coach Approach to services with 30% of the families we provided services for.** All program staff demonstrated the use of the Coaching Model of services by completing the Supportive-Based Home Visiting Checklist protocol for fidelity in 2014. Data compiled internally indicates that 44% of the families participating in the Birth to Three Program in 2014 were receiving Primary Coach Approach-based services.
2. Busy Bees Preschool will complete the YoungStar process and maintain or improve its 4 star rating. Ratings are determined through Wisconsin's Child Care Rating Program based on points earned in four categories: education, learning environments and curriculum, professional and business practices, and child health and well-being practices. *This goal has been accomplished. Busy Bee's Preschool received a 4 star rating in May of 2014.*
3. Busy Bees Staff will update the preschool handbook to include information to orientate families to the program and updated policies and procedures. *This goal has been accomplished. The Busy Bee's Preschool Handbook has been revised to ensure families are receiving accurate information regarding programming, policies and procedures.*

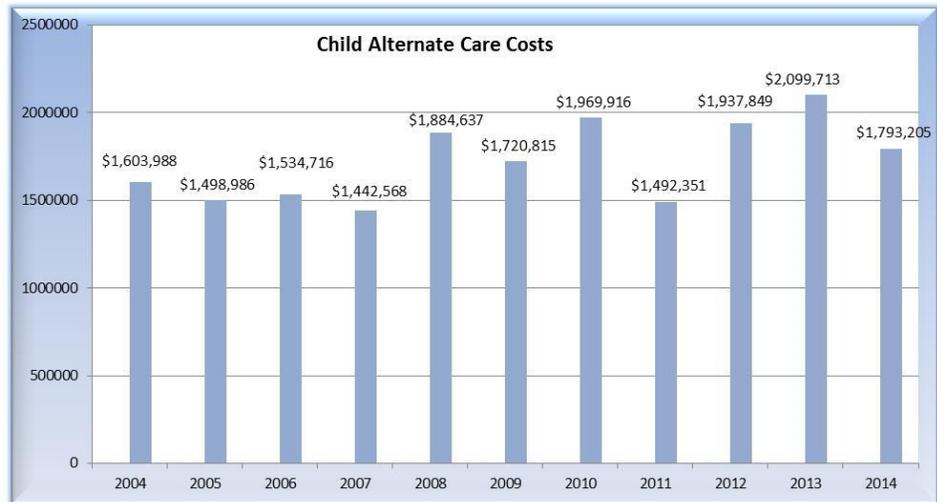
2015 GOALS:

- 1. Key Outcome Indicator: Busy Bees Pre-School will maintain a 4-star rating from the YoungStar Program.**
2. The Busy Bees Preschool will complete the YoungStar process and maintain or improve its 4 star rating. Ratings are determined through the Wisconsin Child Care Rating Program based on points earned in four categories: education, learning environments and curriculum, professional and business practices, and child health and well-being practices.
3. The Busy Bees Preschool will increase parent engagement by developing additional programming to educate parents about their child's growth and development.
4. The Busy Bees Preschool will ensure access to all families in the Birth to Three Program with a child whose development would be enhanced by participating in the preschool by developing an enrollment protocol.
5. The Busy Bees Preschool will participate in activities that enhance support for the local early childhood community.

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.”

The child alternate care team provides a diverse skill set for the residents of Jefferson County which includes licensing Kinship, level 1 and level 2 homes, as well as locating placements at all levels of care to include foster care, group homes, CCI's, juvenile corrections. Pro-actively, staff cultivates and locates respite care and facilitates voluntary placements throughout the year. New in 2014, the foster



care coordinator implemented monthly foster parent support groups, as well as our first annual foster care appreciation dinner which corresponded with National Foster Parent appreciation month in May. In 2014 Jefferson County continued to locate and build stabilization services to avoid long term and highly restrictive placements. Additionally, an emphasis was placed on creating a parent to parent model for biological and foster parents to form a relationship and supportive network of communication pro-actively, in an effort to avoid removal via peer coaching and facilitated respite. In addition, child alternate care developed crisis beds with local foster homes to avoid unneeded and lengthy placements at institutions and hospitals. Through training, psycho-education and collaborative crisis planning, these crisis beds are ready for placements in 2015. Child Alternate Care spends a great deal of the work day locating respites, out-of home placements, as well as licensing foster homes and relative homes for children that are not able to remain in the home or community safely. Great efforts and priority are placed on these placement searches and are determined based on fit, well-being, potential reunification success and proximity to the biological home. These child 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. When this is not possible, other forms of permanency are utilized such as independent living, various forms of guardianship, adoption and other planned living arrangements (OPLA). It is intended that through respites, short-term placements, regular family interactions, and supportive services, children will be reunited with their families as soon as diminished protective capacities are increased and child and community safety is not at risk. Great measures are taken to work with county, contracted, and kinship placements to form a team concept working toward the goal of successful permanency along with the birth family, extended family, informal and formal providers. In 2014 our foster care coordinator licensed 12 level 1 and level 2 homes, in addition to licensing 17 children for kinship placements.

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 creates 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 2014 our department licensed relative homes and placed 16 children into level 1, level 2 and/or kinship homes (family members) to avoid a more restrictive placement setting with an unfamiliar caretaker. Considering our department placed 40 new children in 2014, 40% the children in need of a placement were able to be placed with a familiar relative. This is a major accomplishment toward limiting the trauma that is associated with any removal from home. The licensing of these kinship homes has required additional staff time, resources and creativity, but remains best practice and a goal that begins the instant an out-of-home placement is needed. The level of care needed is determined by the child abuse and neglect assessment tool (CANS). Rates for all providers are set by the state.

As indicated below, 2014 was an unprecedented year in terms of limiting the number of new placements, as well as safely discharging children from care with a variety of forms of permanency via the planning process. There are many factors that have contributed to the success in the area of child alternate care that span agency wide. First, we continued the focus on increased placement scrutiny through the ongoing placing units such as Juvenile Justice and CPS-Ongoing. Furthermore, Permanency Rountables (PRT's), multi-disciplinary staffings and newly developed contracts with providers focusing on mental health and alcohol and drug issues has aided in our effort to decrease out-of-home placements. Additionally, our CST, CLTS, CCS and CSP programs have joined in the agency wide effort to keep children in the home safely with the family systems approach to aid the entire family with superb programming for parents and their children. Finally, the Initial Assesment unit utilized the In-home Safety Services initiative via DCF, to keep 16 children in the home in 2014. This philosphy not only allowed 16 children to successfully remain in the home and avoid the trauma associated with removal, it resulted in a savings of over \$81,000 to the alternate care budget in 2014. This DCF funded program has now resulted in a two year savings of \$177,000 to the alternate care budget.

Entries and Discharges of Children by Calender Year			
Year	Children entering care	Children exiting care	Plus/minus ratio
2014	40	64	-24
2013	56	60	-4
2012	72	68	+4
2011	76	53	+23
2010	61	56	+5

Despite the high number of discharges in 2014, Jefferson County was still able to maintain a high commitment to permanency as 89.1% of children that exited care were discharged with a legally recognized form of permanency by the Department of Children and Families (DCF). Once again this is greatly ahead of the state average of only 38.2%. The break down of the various forms of permanence via discharge in Jefferson County in 2014 consisted of the following:

- 51.6% were reunified to a parent, while the state average was 60.1%
- 12.5% were discharged due to the department setting up a guardianship
- 25% were adopted
- 10.9% reached the age of majority

In 2014, the department dramatically decreased spending on alternate care for children by \$306,508 to \$1,793,205, which is a stark decrease of 15%. This decrease was due to the efforts of the multi-disciplinarian approach from Child and Families and Behavioral Health, as well as contracted and community providers, school districts, the courts and law enforcement. Alternate Care spending is 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 attempts to avoid placements and deter costs in several ways. We have continued to contract with the state to retain legal counsel for situations that require termination of parental rights. We have increased the number of children on long term support (CLTS) waivers and have implemented parent coaches and peer supports for parents in the home. Furthermore, the department added staff in the CLTS and Coordinated Service Teams in 2014 to continue to support in-home placements. Finally, our department relies on the use of respite care to avoid long term placement by providing a short reprieve for parents and their children. We provided 483 respite opportunities in 2011, and increased that number to 518 respites in 2012. Through various quality improvement initiatives, we have since decreased that number to 416 in 2013 and 443 in 2014 respectively, by looking toward informal supports within the family. Many youth account for multiple respites to avoid high cost and traumatic placements, as well as to preserve a variety of current placements.

The Department of Children and Families measures each county on a number of placement related performance items which is directly related to the Federal Child and Family Services Review (CFSR). Below is a breakdown of the placement related items:

- **Timeliness to reunification** is a federal benchmark that measures discharged children who are returned home, should be returned home within 12 months of placement. Jefferson County sent 100% of its placements home within 12 months of removal in 2014, which is well above the state average of 76.9%, as well as the federal benchmark of 76.2%.
- **Placement stability** is a federal benchmark that indicates that all children placed outside the home for less than 12 months, should have no more than 2 placements during that placement episode. Jefferson County was able to accomplish this 77.36% of the time in 2014. This is a high mark, but yet below the state average of 85% and below the federal benchmark of 86%.
- **Re-entry into out-of-home care** is a federal benchmark that tracks the re-entry rate of children BACK into care after the discharge from a placement. Jefferson County had 27.91% of children return to care after discharge which is unfortunately an increase from 11.54% in 2013 and above the state average of 19.7% and the federal benchmark of 8.6%.
- **Maltreatment in out-of-home care** is a federal benchmark that tracks substantiated abuse to a child by a facility or foster parent while placed in their care at a rate of 0.57% or less. Jefferson county had 0 incidents of substantiated abuse of children while in care in 2013 as well as 2014, which is better than the federal benchmark and the state average of .14%.

The chart below exemplifies Jefferson County’s placement of youth into some form of out-of-home care from 2009 through 2014. The graph indicates all placements that take place in a given year, taking into account that some children have multiple placements represented in the data. This number represents very short Temporary Physical Custody (TPC) placements all of the way to long term placement episodes. Additionally, the number indicates that we have the need for multiple placements per child, due to court ordered changes, moving from more restrictive to less restrictive as the juvenile re-integrates back into the community, as well as placements that are not a quality fit for the child or juvenile which necessitates a change.

As you can see most individuals requiring placement can be maintained at the foster home level, while others require more restrictive placements such as group home, residential care, or as restrictive setting as we have available, juvenile corrections. As the numbers below indicate, we take great measures to avoid these types of highly restrictive settings and utilize those only when community safety cannot be controlled. Because the needs of children who require alternate care are high, programming efforts, particularly mental health services, are used in conjunction with placements. In 2014 the number of residential placements increased slightly due to a number of high profile delinquents that were not able to be maintained in foster homes and group homes, despite initial attempts. Once again in 2014 we have been able to avoid the use of juvenile corrections completely. A unique look at our alternate care data shows that the total number of day’s youth were in placement in 2014 was 36,415 compared to 2013 when we utilized 48,620 days. Additionally, the average cost for placement was \$48.53 per day in 2013 and dropped drastically in 2014 to \$41.07. This dramatic decrease in costs and the amount of days our youth spent out of the home points out our ability to create short term stabilization placements, avoid placement when appropriate, as well as mobilize safe community plans. Finally, the department had 124 foster care placements in 2014 and we are pleased to share that 65 of those children were placed into relative homes or 52% of our children in community care were able to be placed with relatives or providers with a significant relationship. This a two year trend that the entire department takes great pride in.

ALTERNATE CARE PLACEMENTS - CHILDREN

PROGRAM	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Foster Care (In-County)	30	28	46	39	47	69	98	76	82	110
Treatment Foster Care (In-County)	12	7	7	2	9	11	3	12	NA	
Residential Care Center (Child Care Institution)	7	5	8	8	13	18	6	5	2	6
Child Correctional	3	1	1	1	1	4	3	1	0	0
Child Mental Health Institute	4	3	4	2	2	2	1	4	1	3
Out-of-County Treatment Foster Home	12	21	22	27	33	52	24	42	N/A	17
Group Homes	23	17	12	14	16	29	12	18	11	0
TOTALS	91	82	100	93	121	185	147	158	96	136

Detention Center Placements

A final related statistic in the Child Alternate Care area is our use of shelter and secure detention for youth. During 2014, 76 youth were placed in these facilities at a cost of \$86,060, which is a slight increase in placement from 2013. These increased detention placements are due to a number of severe community incidents that required prolonged planning that ultimately resulted in successful community settings or even placement at home with safety services. These placements are either made by the Juvenile Court or by Human Services staff in order to provide community protection via 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, respites at group homes, and other deterrents made via the case manager and the treatment team. The Child and Family Division takes great pride in keeping the community safe, while limiting the use of secure detention. With the implementation of the GPS monitoring system of juveniles in 2015, the use of shelter and detention should decrease sharply as the wait time for monitoring will be eliminated.

Detention Center Placements								
	2011		2012		2013		2014	
County	Number of Placements	Cost						
Marathon	1	\$ 300	0	\$ -	0	\$ -	0	\$ -
Rock	28	\$ 17,325	26	\$ 32,175	46	\$ 41,250	54	\$ 68,145
Washington	1	\$ 345	0	\$ -	2	\$ 460	1	\$ 230
Waukesha	17	\$ 15,371	9	\$ 11,891	20	\$ 30,900	21	\$ 17,685
TOTALS	47	\$ 33,341	9	\$ 11,891	68	\$ 72,610	76	\$ 86,060

CHILDREN'S LONG TERM SUPPORT WAIVER - CLTS

Children's Long Term Support Program Description

The Children's Long Term Support Medicaid Waiver provides funding for goods and services to help support and maintain children who have been diagnosed with a developmental, physical or mental health disability in their home. Allowable services are adaptive aids, support and service coordination, children's foster care and treatment foster care, communication aids, consumer and family directed supports, consumer education and training, counseling and therapeutic services, daily living skills training, home modifications, nursing services, respite care, specialized medical and therapeutic supplies, and supportive home care.

In 2014 Jefferson County received Capacity Funding through Department of Health Services. The CLTS Capacity Funding Effort was a DHS strategy to partner with and empower County Waiver agencies to serve children currently waiting for CLTS services, improve community connections and supports for children and families currently receiving CLTS services and reduce barriers related to community capacity and capacity building opportunities. The Department of Health Services felt by investing capacity building funding we could increase capacity to service children. In the beginning of 2014 we had a waitlist of 113 children. Each family was contacted by a service coordinator to assess current health and safety needs. Through these contacts we learned that some families moved out of the county, no longer needed the service or the child no longer qualified, allowing us to remove the child from the waitlist or continue on the waitlist until there is a need for services. We were also able to meet some of the children's needs through the Family Support program. For the continuation of this funding, the state recommended that 17 children come off of our waitlist by the end of 2014. By December 31, 2014 we exceeded our performance measure by providing services to 27 new families as a result of the new capacity funding effort. Providing services to these families has allowed these children

to be more independent and be included in their community and family activities. Without this allocation families could have had a wait time of 4-6 years. By the end of 2014 our waitlist was decreased to 50 children waiting for services or a 56% decrease. Through this allocation we hired one full time service coordinator to assist with case load sizes and removing children from the waitlist. Services provided to these families often included ongoing services as listed above, but also may have included special projects, such as van modifications, specialized adaptive aids, and behavioral therapy services. In total 81 children received services via the CLTS program in 2014.

Family Support Program

The Family Support Program is a state-funded program that provides eligible families with a coordinated set of strategies to assist them in the provision of support and guidance to their child with a disability while living at home. Support and funding is based on identified needs to achieve prioritized child and family centered outcomes, which can cover a wide range of assistance options. Twenty-nine families received Family Support funding in 2014. Families received family support for camps, adaptive aids and adaptive equipment. The newly developed advisory committee met three times in 2014. In December of 2014 the advisory committee reviewed the 2015 Family Support Plan. This plan needs to be submitted to the state annually. The advisory committee’s role is to have ongoing input on how to assist the program with methods of enhancing informal support and advocacy for families, monitoring the program and procedures for determining family needs and crisis needs.

Compass

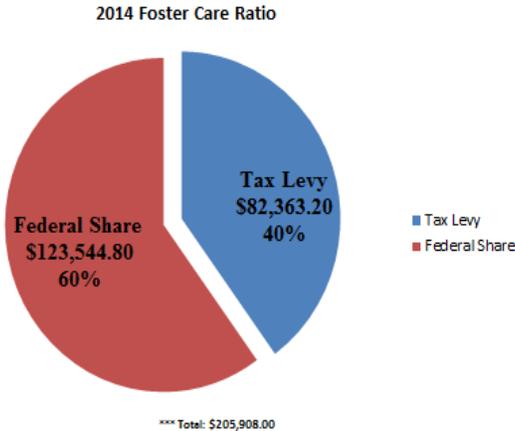
Compass Wisconsin Threshold is a unified point of intake serving Jefferson County families that wish to apply for long-term support services for their child. In 2014 Compass serviced 38 families from Jefferson County through their intake process. Compass completed 25 functional screens with 24 of these screens qualifying the child to be placed on Jefferson County’s waitlist for Children’s Long Term Support services. This is a great benefit to the residents of Jefferson County as Compass acts as a single point of access for many services.

Case (Care) Management Reimbursement

In 2014 Support and Service Coordinators provided 2,009 hours of care management services compared to 1,687 hours in 2013. The provision of these services is to locate, manage, coordinate and monitor all waiver program services, additional services (regardless of funding source) and informal community supports provided to eligible children. Additionally, case management’s role is to assure that services are provided in accordance with program requirements. These services are intended to ensure the child’s health and safety by enabling the child to receive a full range or appropriate service and supports consistent with the child’s assessed needs in a planned coordinated efficient and cost effective manner. The total amount of care management services billed for 2014 was \$140,808.24 with the reimbursement amount of \$133,449.84.

Foster Care Spending Ratio

Ten children resided in foster care, six less children than in 2013. The total annual cost for these 10 children to reside in out-of-home placement cost \$205,908.00. Children Long Term Support Program financially assisted through Federal payment of \$123,544.80 with county tax levy dollars paying only \$82,363.20. Having children in foster care qualify for CLTS is a cost saving measure to the alternate care budget. Foster parents receive extra support and services to maintain the child in a home environment.



Review of 2014 Goals:

1. The Key Outcome Indicator for Children's Long Term Support (CLTS) team in 2014 was that 90% of all children involved in services would remain in the home. According to the statewide tracking system 97.4% (75 out of 77) of the children served via the CLTS program were able to remain in the home. Additionally, 97.1% (34 out of 35) of the children served via the CST program successfully remained in the home.

2. Develop and implement an online training course ensuring providers are qualified and meet the state requirements for service provision by June 2014 as evidenced by the certificate of completion of the training courses. *This goal has been accomplished. For annual year 2014 the Children's Long Term Support Program recruited nine new service providers. County waiver agencies are responsible for assuring that all Medicaid waiver service providers meet the mandated certification standards. The Jefferson County Children's Long Term Support team developed a letter to be distributed to all providers with directives and websites to allow service providers easy access to the required mandated training materials. This training is designed for people providing care to individuals of varying disabilities and ages. The training covers: Disability Basics, Lift and Transfers, Personal Care/Daily Living Skills, Medication Administration, Communication Techniques, Abuse and Neglect, Caring for Challenging Behaviors, Free Time Activities, and Making Connections (meeting/training with the family). Upon successful completion of the online training, providers receive a certificate and are offered the opportunity to be added to an online respite care provider registry. Providers must also complete Jefferson County's Client Rights Training and the Medicaid/Medicare and Third Party Biller Compliance Training. All provider certifications must be filed showing the provider meets standards required by the waiver as well as any other applicable federal, state and local standards. Jefferson County CLTS providers are 100% in compliance with Medicaid mandates.*

3. Build program awareness and educate the community about programming by creating a Children's Long Term Support and Family Support brochure that can be added to the Jefferson County webpage and disbursed to families and external partners by 12/31/14. *This goal has been accomplished. With the assistance of the fiscal department we developed and added an informational link to the Jefferson County Web Page giving an overview of what services are available through the Children's Long Term Support and Family Support programs. The Compass link www.compasswisconsin.org was added to the webpage giving family's information on how to apply for long term support services for their child. A link was developed for parents to reapply for the Family Support program by completing the on line application. When the on line application is completed it is sent directly to our fiscal department and then to the Family Support supervisor allowing families easy access and a one-step application process.*

4. Continue monitoring quality assurance of state mandated requirements for Children's Long Term Support participants at a rate of 95% accuracy or higher. This will be measured through our internal auditing procedure utilizing target case management data, auditing systems and not incurring any disallowances. *This goal has been accomplished. Through the utilization of the auditing systems and the electronic note monitoring system 2014 was a successful year. Through these systems we are able to monitor and reject service notes prior to billing. Due to the new progress note system the CLTS program has had zero disallowances for 2014. Through the progress note system there was a total of 46.25 hours of time rejected due to insufficient documentation. This would have been \$810.30 that would have been disallowed by an auditor.*

5. Service Coordinators will define the provision of services being delivered though Support and Service Coordination when completing their electronic progress notes for compliance of targeted case management and to meet the SPC code service requirements mandated by the state by September 2014. *This goal has been accomplished. As a team we identified the provision of case management services required by the state. This allows for increased efficiency of staff writing progress notes while identifying the service provision that was provided to support the progress note documentation. The supervisor reads all notes assuring that the notes*

contain the allowable provision of service required by the state for the case management service that was provided. With the development and implementation of the electronic notes the supervisor is able to reject notes prior to billing that do "not" meet the case management requirements. As a team we review the case management requirements on a regular basis.

6. The CLTS team will form an Advisory Committee that will meet on a quarterly basis for the Family Support Program, and Community Options Program to meet programming requirements as evidenced by annual Family Support Program plan as well as meeting minutes. *This goal has been accomplished. In 2014 the Family Support committee met three times with the first meeting being held on March 11, 2014. A new advisory committee was developed with the first meeting being held in December of 2014. The committee consisted of the following members: School Social Worker, Community Member/ Service Provider, Fort Atkinson School District Paraprofessional and grandparents of waiver participant. This committee reviewed the newly developed Family Support brochure, how families apply for Family Support, reviewed the on line application process and reviewed the Family Support annual report that is submitted to the state in February of 2015. Committee members discussed outreach options for disbursing information about the programs to special education directors, school family liaisons and the community. The advisory committee recommended that the FSP coordinator or supervisor present information to school in-service staff meetings, have an information table at the Children's Care and Share fair and the Coordinated Services Team resource fair. The Family Support Coordinator attended the Coordinated Services Team Coordinating Committee on November 6th, 2014, where the FSP Coordinator gave an overview of the program and the application process. Outreach about the Family Support program was presented to Community Action Coalition, Headstart, Watertown, Jefferson, and Lake Mills School Districts and Counseling agencies.*

2015 GOALS:

- 1. Key Outcome Indicator: 90% of all children will remain in their home with the home with the use of CLTS and CST services.**
- 2.** Develop and implement an internal policy and procedure for reducing the timeframe from the date of assignment of the referral, through the completion of the functional screen. The total time frame for completion will be 45 days, which will allow families a decreased time sensitive waiting period to obtain the desired services and resources they want for their child.
- 3.** Program supervisor and staff will expand the pool of service providers by providing education and subsequent outreach to technical college's, certified nursing assistant or nursing programs, school paraprofessionals, residential programs and agencies.
- 4.** Develop an internal policy for agency approval to meet the state requirements for high cost projects. This policy will encompass the entire process from bid to completion, allowing projects to be completed in a desired time frame to meet the health and safety needs of the child and family.
- 5.** Develop a tracking system with the Family Support advisory committee using the protocol from the state for determining and prioritizing health and safety needs for families requesting Family Support dollars.

INDEPENDENT LIVING

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

Adolescents face a range of developmental issues, and as teens approach adulthood, living independently becomes a significant goal. While youth with intact families may struggle to achieve self-reliance, youth in out-of-home care face formidable obstacles. The Jefferson County Independent Living Skills (ILS) program, which consists of the Division Manager, the program supervisor and one service coordinator, is a partially federally sponsored program for youth ages 15 ½ to 21 who are either currently in a court ordered out-of-home placement, who have attained 16 years of age and have left foster care for kinship guardianship or adoption, or who have aged out of care by turning 18 while still in placement. Young people who have aged out of care are offered services akin to case management and eligible until they are 21, if not enrolled in school, or 23 if enrolled in post-secondary education prior to age 20, have at least a “C” average, and have maintained contact and case management with the Independent Living Service Coordinator. There are different aspects of the program, which is designed to support a successful transition into adulthood. The Jefferson County Independent Living Services (ILS) program served over 40 youth in 2014.

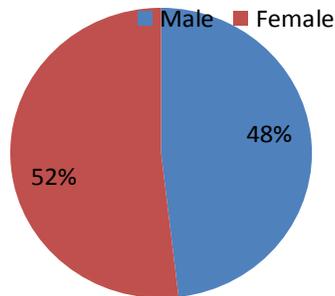
The “John H. Chafee Foster Care Independence Program (CFCIP), part of the ILS program at Jefferson County Human Services Department, offers assistance to help current and former foster care youth achieve self-sufficiency. Activities and programs include, but are not limited to, help with education, employment, financial management, housing, emotional support and assured connections to caring adults for older youth in foster care.” In addition to the services listed above, Jefferson County Human Services uses Chafee funds to purchase birth certificates for employment, school and driver’s license purposes, college application fees, and incentives for completion of goals.

The Educational and Training Vouchers Program (ETV) provides resources specifically to meet the education and training needs of youth aging out of foster care. The ETV aspect of the Independent Living Skills program offers additional dollars for post-secondary educational and training vouchers for youth likely to experience difficulty as they transition to adulthood after the age of 18. This program makes available vouchers of up to \$5,000 per year per youth for post-secondary education and training for eligible youth. ETV funds are instrumental in assisting young adults who have aged out of care pay for all or part of their tuition, text books and other items necessary to begin and be successful in a college or career training setting. Students have to remain enrolled in school and maintain a C average or better in order to receive additional funding.

Youth ages 15-17 years

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, ongoing 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 his/her life. Progress is monitored by team members on a regular basis.

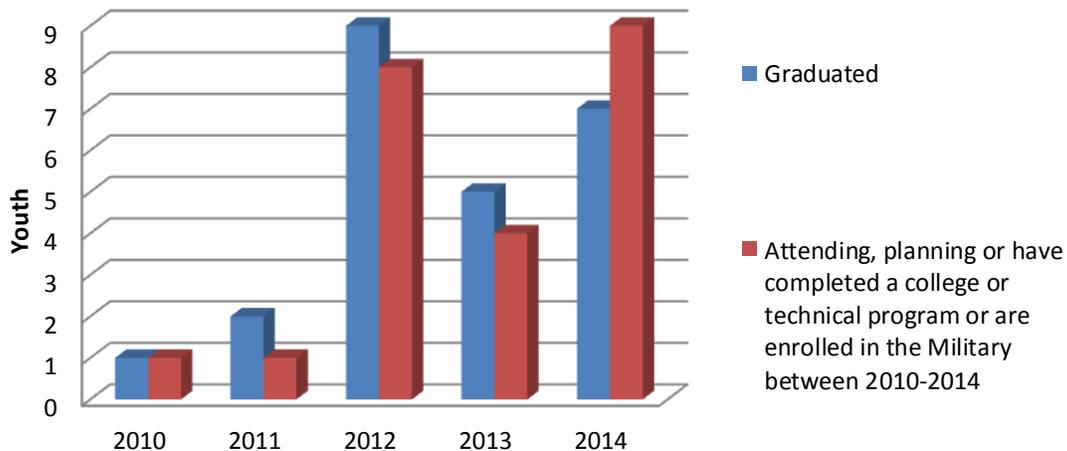
The Gender of 15-17 Yr Old served with Independent Living Skills in 2014



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 complete a life skills assessment to determine the areas of ongoing need, identify personal goals and develop a transitional discharge plan. The transitional discharge plan incorporates the youth's ongoing 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 2014 there were 27 youth ages 15-17 eligible for Independent Living Services. Though 21 of these youth physically resided in another county, they still originated from Jefferson County and received ILS services from Jefferson County Human Services. All 27 eligible youth received an independent Living Service Assessment, and had face to face contact with the Jefferson County Independent Living Coordinator. The number of youth served in this age category nearly doubled from 2013 to 2014.

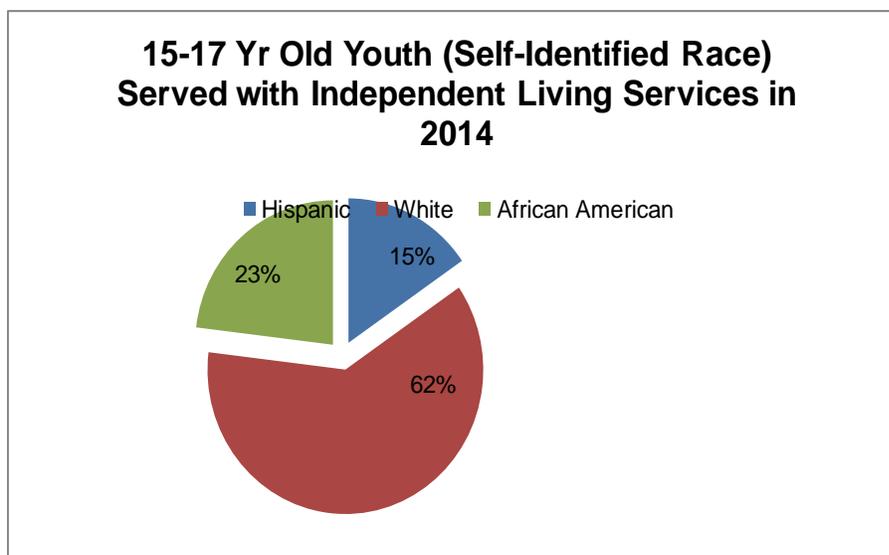
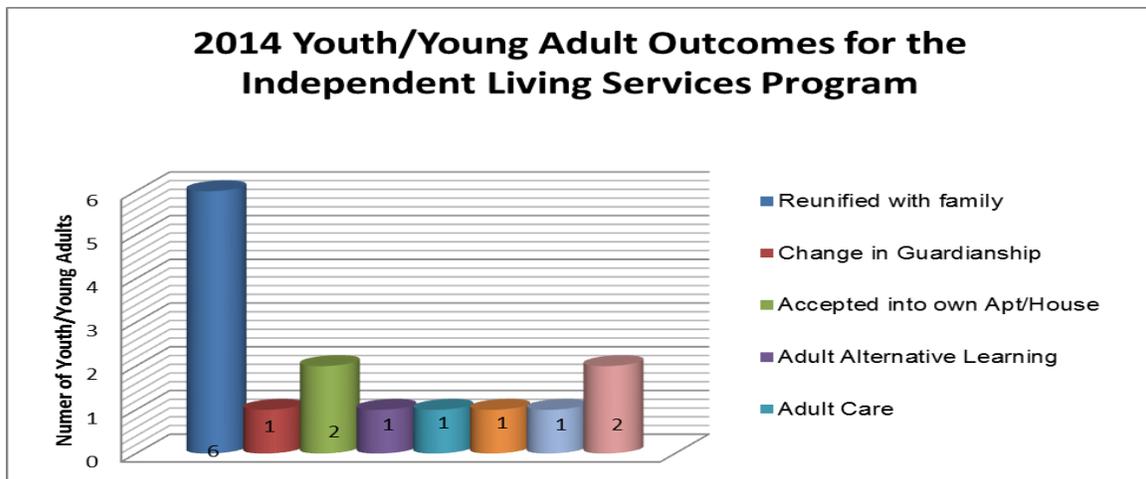
Youth 15-21 receiving Independent Living Services who Graduated and those who are Attending, Planning or have completed a college, technical program or are enrolled in Military services between 2010 - 2014



Aging out Increases Risk of Homelessness

Though there are differing opinions about actual numbers related to homelessness in young adults who age out of care, all studies that have been completed demonstrated an increased risk. According to a Chapin Hall study that followed 700 people who aged out of care from 2003 until 2011, including participants from Wisconsin and other parts of the Midwest, 36 % of those participants had experienced homelessness by the age of 26. In order to track these statistics locally, Jefferson County complies with State and Federal mandates to administer the National Youth in Transition Database (NYTD) to all 17 year old youth in foster care, and 19 and 21 year olds after they age out of care. This program is relatively new, and no long term data has been gathered. However, JCHSD saw this issue first hand in 2014 after individuals we serve in the Jefferson County ILS program experienced homelessness.

To address a piece of this complex issue, in the spring of 2014 the Legislature passed and the Governor signed 2013 Wisconsin Act 334, which extends out-of-home care and other supports to youth in the child welfare system to age 21 for those youth who are enrolled in school full time under an Individualized Education Program. The new law became effective August 1, 2014. Though we do not have any consumers who have qualified or requested this service, we are excited about the possibilities it may offer certain individuals in this population. Homelessness in those who age out of care is an issue that we do not take lightly and have included it as a goal area in 2015. We are also excited for new upcoming programming that could greatly assist this population.



Review of 2014 Goals:

1. **The key outcome indicator was that 80% of youth would attend a post-secondary education program (i.e., college, tech school or military).** According to data processed by the ILP coordinator, 48% of young adults in the ILS program who had aged out of care were enrolled in a post-secondary educational program in 2014. Though this number is lower than originally projected, the program did not take into consideration that some of 18-21 year old ILS consumers were engaged in other positive endeavors, such as full time employment or homemaker, when developing the goal.
2. Increase community awareness and develop open dialogue by providing two presentations to the general public or selected audiences about the challenges youth in foster care experience. *This goal has been accomplished. We exceeded this goal as two youth made two different presentations and three youth completed voice-overs for a video company with whom the State of WI is partnering.*
3. Increase participation in the Southern Wisconsin Youth Advisory Council by 25% by providing information regarding details of the council and meeting dates to each youth currently receiving services, as well as all new referrals. *This goal has been accomplished. We increased participation by 100% as three consumers joined in 2014.*
4. Increase or initiate youth participation in planning by offering youth who are currently in or have aged out of the foster care system a chance to share their stories and voice their opinions about what works and areas for improvement at team meetings, child welfare training opportunities or other appropriate venues. *This goal has been accomplished. We were able to connect one young adult who aged out of care to participate in a Statewide Citizen Review Panel (CRP). We also provided transportation and lodging for two of these young adults to sit on a panel at a statewide conference and share some of this information.*
5. Provide youth with advocacy opportunities throughout the State and County allowing them to have a voice in their future by participating in one or more of the following committees or events: State Youth Advisory Council meetings, State Citizen Review meetings and Kids Advocate Day. *This goal has been accomplished. Youth were offered a total of 15 advocacy opportunities throughout the State and County allowing them to have a voice in their future.*
6. Increase the number of youth who have aged out of care attending post-secondary education by 25%. *This goal has been accomplished. We increased this number to six, which is an increase of 50 %.*
7. Decrease the number of youth in care that drop out of school before graduating with a diploma, GED, or HSED and the number of young adults who have aged out of care that drop out of post-secondary education before acquiring a certificate or degree by 50%. *This goal has been accomplished. In 2013 one of our youth dropped out of post-secondary education prior to completion and we are happy to report that no one dropped out in 2014. This is, in part, due to the diligent efforts and consistent contact offered to these young people by our ILS Coordinator.*
8. Increase collaboration efforts with nearby counties by maintaining attendance at the Southeastern WI regional ILS Quarterly meetings for IL staff to network, share information and educate each other on program policies and procedures and new events. *This goal has been accomplished. The ILS Coordinator attended all available quarterly meetings, creating great collaboration possibilities that will serve our alternate care youth and the young people who have aged out of care.*

2015 GOALS:

- 1. Key Outcome Indicator: 90% of IL youth and young adults who have aged out of care will enroll in the military, work program or secondary education program.**
2. Participation in the Youth Advisory Council will increase by 50% in 2015.
3. Under the supervision and guidance of the Jefferson County ILS program, the Youth Advisory Committee will meet a minimum of four times this year to set and work on goals, present speakers on activities, develop and a fiscal budget of expenses they need to achieve these goals.
4. The Jefferson County Youth Advisory Committee will provide a minimum of four presentations in various forums about challenges youth/young adults of foster care experience, how they conquered these obstacles, what they are doing today to change the system and to develop an open dialogue and community awareness.
5. The ILS Coordinator will provide youth/young adults with a minimum of 16 advocacy opportunities that provide information on how to obtain the tools to live safe, healthy, independent lives. These events are offered throughout the State, County and local communities and allow them to have a voice in their future and develop leadership opportunities.
6. 100% of the youth who receive IL services who are enrolled in a high school educational program will complete all school requirements to move onto the next grade, or if eligible, graduate with a diploma, HSED or GED.
7. The number of young adults attending post-secondary education will increase by 50%.
8. 100% of young adults who age out of care will be provided services to obtain and maintain safe, stable and affordable housing.

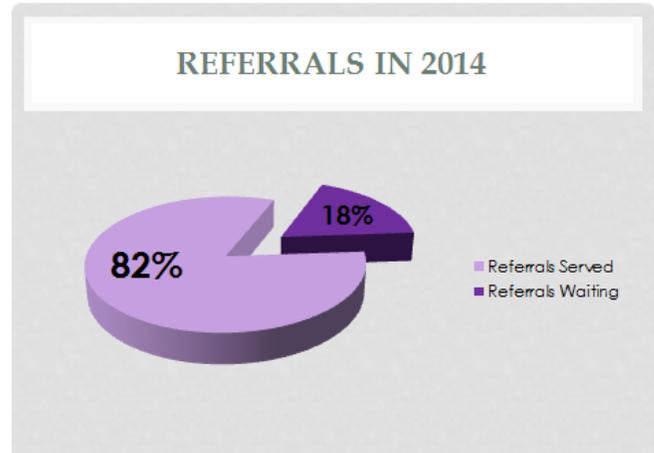
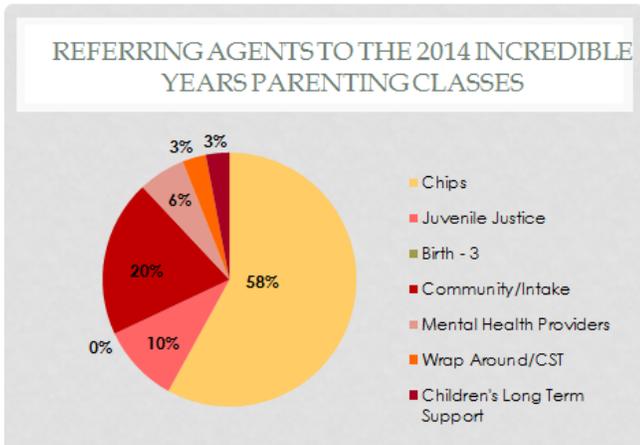
INCREDIBLE YEARS PARENTING PROGRAM

~Classes encourage participants to connect with other parents and enhance parenting skills~

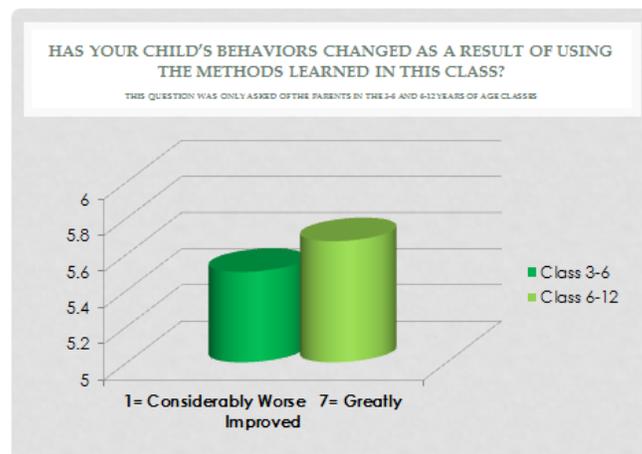
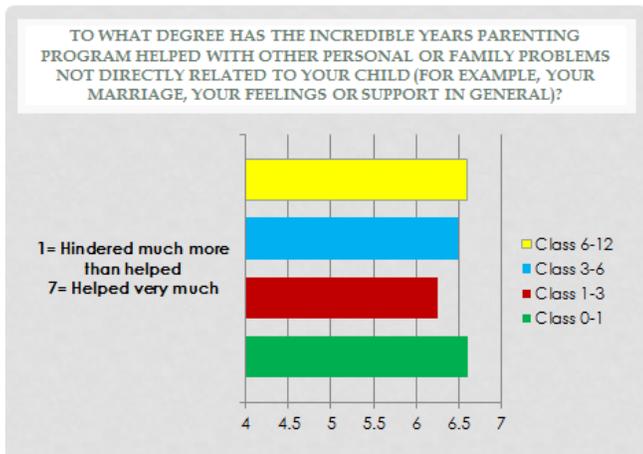
Jefferson County Human Services offers parents, caregivers, guardians and family members the opportunity to participate in the Incredible Years Parenting series. The program focuses on children in four distinct parenting groups: 0-1 years, 1-3 years, 3-6 years and 6-12 years. All classes encourage participants to connect with other parents and enhance parenting skills, use play to build relationships, develop an understanding of developmental stages, limit setting, and increasing the overall joy of parenting. In 2014 we offered five parenting classes eliminating the waitlist of 31 referrals. All referrals were contacted and offered the opportunity to take the class. Some parents declined the opportunity to attend the class due to conflicts with the time of the class being offered, work schedules, or simply found other resources that met their needs. Each class had at least two self referrals from the community, whereas the remainder of the class was made up of consumers of other services at the Department. In 2014 the program coordinator developed an incentive program offering participants IY "dollars" for attendance, role playing and completion of homework. Incentives are related to class discussion and instruction providing a transfer of learning for parents. Parents

are given IY “dollars” to spend on items that would enable them to continue using the skills and techniques learned during class time at home.

The following graphs summarize the number of referrals, who was referred, and the program outcomes.



Each Incredible Years (IY) class is given a survey at the end of the last session. Depending on which class the parent attended, the questions varied.



Note: The colors not represented in the chart were not chosen by the IY participants even though they were offered as an option. This chart is based on the 0-1, 1-3, and 3-6 classes.

What was most helpful to you?

"It really helped to make me a better father and a loving father to my family and children" ~Parent in 6-12 class

"Helped me realize that I am not the only one having trouble" ~Teenage parent in 0-1 class

"Listening to other people's problems with their kids and listening to the group also talk about their kid's behaviors. Makes you know that kids aren't perfect." ~Parent in 3-6 class

What did you like most about the program?

"Learning to be a better parent, just because I am a parent does not mean that I have all the answers."

~ Parent in 6-12 years class

"Being with other parents and getting their suggestions, hearing what they did and handled things and to know that you're not alone." ~ Parent in 6-12 class

"They helped me learn to be a better mother by telling me the things I need to know that I didn't know.

~ Parent in 0-1 class

Review of 2014 Goals:

1. Collaborate with local school districts and community partners to collaboratively teach the Incredible Years parenting class as a county wide initiative. *This goal has been accomplished. In 2014 Jefferson County Human Services collaborated with Fort Health Services in Fort Atkinson to teach an IY parenting class. This class was taught by a nurse from the Jefferson County Health Department and a Family Development worker from Human Services.*
2. Provide a county wide Incredible Years training with the Incredible Years trainer(s) to increase the pool of certified teachers to meet the high demands of the Incredible Years Parenting referrals. *This goal has been accomplished. The pool of trainers was increased by having a certified trainer (teacher) from our agency teach with other staff to become qualified to be certified trainers. We increased our cadre of IY teachers by five staff due to this train the trainer method. Due to staff turnover we have lost some of these teachers and will have to continue to train new staff.*

2015 Goal:

1. Provide a parenting class to enhance the social and problem solving skills, as well as the emotional literacy, to parents of "At-Risk" children ages four to eight years of age.

ECONOMIC SUPPORT DIVISION

~Providing and Coordinating Resources to Strengthen Families~

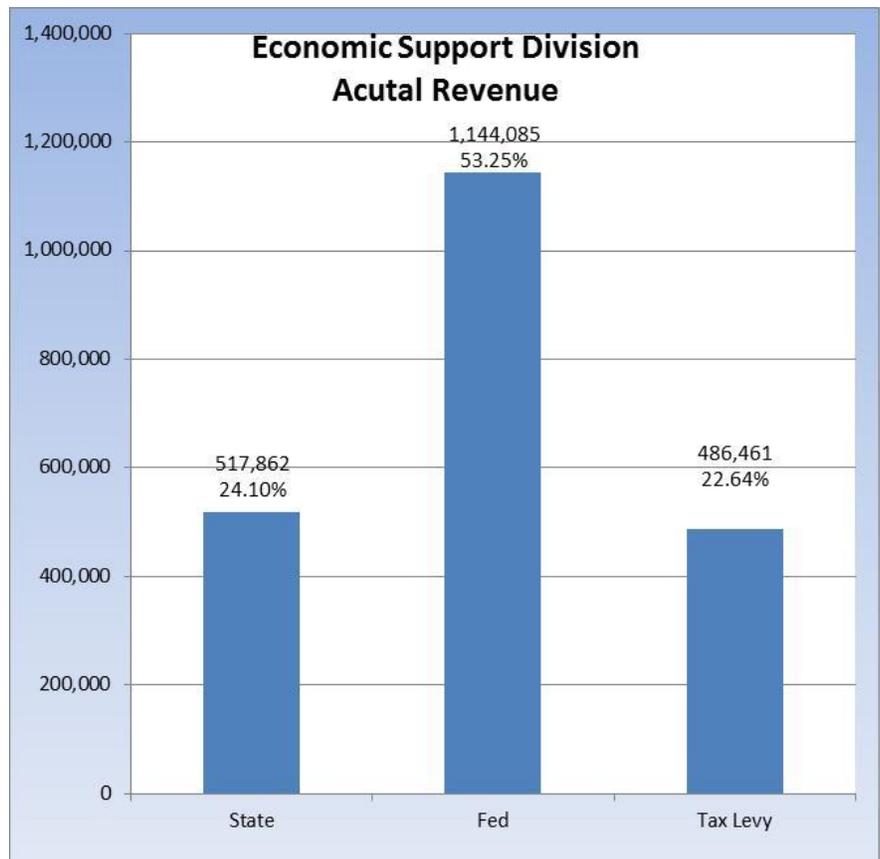
Access for individuals and families to timely, accurate benefits, an understanding of benefit programs, quality customer service and connections to resources are the major focus of the Economic Support Division.

The Economic Support Programs for Jefferson County are administrated at the Workforce Development Center (WDC). Our location at the Workforce Development Center provides staff with the ability to coordinate the services of the on-site providers: Job Service, the Department of Vocational Rehabilitation, Opportunities, Inc., WORKSMART Programs, and the Jefferson County Economic Development Consortium. Our community partner connections also result in greater service coordination. These partners include: Community Action Coalition, Goodwill Industries, 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 for customers who live in one county and are employed in another.

If you are interested in learning more about the current job listings and resources available to meet your workforce needs, the websites of wisconsinjobcenter.org and comeherefirst.org are your answer. We also provide monthly calendars at the WDC displaying the dates of employment workshops, skills training and job fairs. In 2014, 15,140 duplicated visitors accessed the center's services with an average of 1,262 individuals per month. If you have any questions about services, please contact our office at 920-674-7500.

In December of 2014, our Economic Support programs provided assistance to 7,731 Jefferson County households. Customers may be receiving assistance from Medicaid, BadgerCare, FoodShare, Wisconsin Shares or Energy Assistance. Additionally, our Jefferson County customers may receive financial assistance from the Jefferson St. Vincent de Paul Society. US Census data in 2012 reported that there were 8,263 people living in poverty in Jefferson County or 10.2%. Currently, the poverty rate for Jefferson County is 11.2%. The poverty rate in the State of Wisconsin is 13.2%.

The Economic Support Division of Jefferson County provides residents with access to financial assistance and employment programs. These programs were developed to support financial stability for households. The Economic Support staff assist the customer in applying for benefits,



processing the benefits, making changes in their

situations, explaining program requirements, assessing possible fraud and coordinating referrals to other resources. All Economic Support staff process Healthcare and FoodShare benefits in addition to staff who also specialize in programs such as Child Care, Family Care and Children First. Jefferson County is part of a seven county area called the Southern Consortium which includes the counties of Crawford, Grant, Green, Iowa, Lafayette, and Rock. There are 10 consortiums and Milwaukee County within our State. Together we coordinate job functions, manage the workload,

develop trainings, and implement policy to increase efficiency. One of the coordinated functions is the Southern Consortium Call Center (SCC). When calling the SCC number (1-800-794-5780), the customer will be in direct contact with an Economic Support worker from any of these counties who has access to their case information and is readily available to help. We have 22 full time Economic Support staff who manage the 7,700 households in Jefferson County currently receiving assistance.

The Division's revenues come from County, State, and Federal funds as is reflected in the graph. In 2013-2014, the Economic Support Division received additional funding from the Affordable Care Act. This funding was used to hire new staff to process the increased workload of health care applications directed to us from the Federal Marketplace. Also, changes to the BadgerCare eligibility guidelines increased the number of individuals eligible for this program. Our division has also cross trained an Economic Support worker to be a certified application counselor (CAC). She has the knowledge to assist individuals in applying at the Federal Health Care website for affordable insurance. This position is able to serve all residents of Jefferson county, not only low income households. The Energy Assistance Program funds are directly contracted to Energy Services who provide financial assistance for customer's home heating expenses.

The Division's overarching goal remains to ENHANCE AND MAINTAIN A SUCCESSFUL INCOME MAINTENANCE CONSORTIUM. The key outcome indicators of our success will be measured by our ability to meet timeliness, accuracy and customer satisfaction performance standards established by the State of Wisconsin. Quarterly, monthly and weekly reports specifically addressing each aspect of these key indicators are reviewed and monitored continuously. Accordingly based upon data obtained, staff trainings and procedural changes are designed to consistently meet these standards.

Following is a brief description of the Economic Support programs and the number of customers who received assistance from these programs in 2014.

ECONOMIC SUPPORT PROGRAMS

The Economic Support Programs provide financial assistance for low income households and those experiencing a financial loss. Often our services are necessary when an emergency such as homelessness or medical needs emerges. Each program serves a specific population and has different income guidelines and requirements. Self-sufficiency for Jefferson County families and individuals is the ultimate division goal. The number of customers requesting financial assistance from Economic Support Programs continue to increase each year.

In 2014, the number of households receiving assistance was 10,585 unduplicated recipients for all Medicaid and FoodShare programs. These 2014 recipients include 6,341 adults and 4,271 children.

Caseload Growth

2011 6,020 households receiving assistance
 2012 7,177 households receiving assistance
 2013 7,384 households receiving assistance
 2014 7,731 households receiving assistance

Requests for assistance can be initiated by contacting the Economic Support Division located at the Workforce Development Center at 920-674-7500 and requesting to speak to an intake worker, coming into the agency, calling the Southern Consortium Call Center at 1-888-794-5780 or by applying on line at www.access.wi.gov. An intake worker is available every day as the first point of contact for all the customer’s assistance requests. The worker will assess the customer’s needs, initiate the application, process any changes, and coordinate the appropriate referrals to community resources.

SOUTHERN CONSORTIUM CALL CENTER (SCC) - the call center concept began in January of 2012 and is comprised of specific Economic Support staff from seven counties who all work together. The counties are: Crawford, Grant, Green, Iowa, Jefferson, Lafayette, and Rock. Our mission is to provide quality customer service by answering calls and processing changes quickly and easily for the customer. Directing the customer to the call center agents to apply for benefits, report changes or ask questions allows the on-going case managers to focus their time on processing applications and reviews. In 2014, the Southern Consortium Call Center agents answered and helped 32,876 callers in the first quarter—32,328 callers in the second quarter-- 34,409 callers in the third quarter and finally 33,272 callers in the fourth quarter for a yearly total of 132, 885 calls. This was accomplished with an average speed of answer of 4.24 minutes and a call answer rate of 89.52%. In 2014, the call center handled 95,513 calls. This increase in calls received reflects the complicated changes to our benefit programs as well as the constant changes to our customer’s financial situations. The call center agents must meet State established performance standards in the timeliness and number of calls answered, length of call, customer wait time and the accuracy of their benefit processing. The Southern Consortium caseload in 2014 was 45,465 households. Jefferson County has 18% of the full caseload. The following chart shows the Southern Call Center statistics for all of 2014.

Southern Consortium Call Center Statistics

	Calls Offered	Calls Answered	Answer Rate	Average Speed of Answer/Mins	Average Talk Time/mins	Average Handle Time	Longest Waiting Call /mins
January	11171	10693	95.72%	1.98	5.61	5.9	14.23
February	10563	10070	95.33%	2.4	5.69	5.98	14.35
March	13494	12113	89.77%	4.46	6.02	6.31	19.22
April	12599	11524	91.47%	3.78	5.75	6.04	19.02
May	11159	10372	92.95%	3.14	5.78	6.08	18.15
June	11616	10432	89.81%	3.96	5.77	6.06	18.28
July	12759	11509	90.20%	4.04	5.79	6.09	17.9
August	12769	11275	88.30%	4.43	5.91	6.2	20.3
September	14372	11625	80.89	7.12	6.01	6.3	23.45
October	13954	11758	84.26	6.17	6.09	6.37	119.65*
November	11048	10038	90.86	4	6.02	6.3	19.83
December	13193	11476	86.99	4.95	6.02	6.3	19.9

*The state has not been able to tell us what caused this to happen

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: BadgerCare, Medicaid, Medicaid Purchase Plan, Family Planning Waiver, Medicare Beneficiary, Family Care and Nursing Home programs. Each program has its own specific financial and non-financial criteria for eligibility. The eligible customer receives a Forward Health card which is taken to the health care provider. Most Medical Assistance customers must also participate in a Health Management Organization. At the Medicaid website <http://dhs.wisconsin.gov> you can access information on the individual program benefits and requirements.

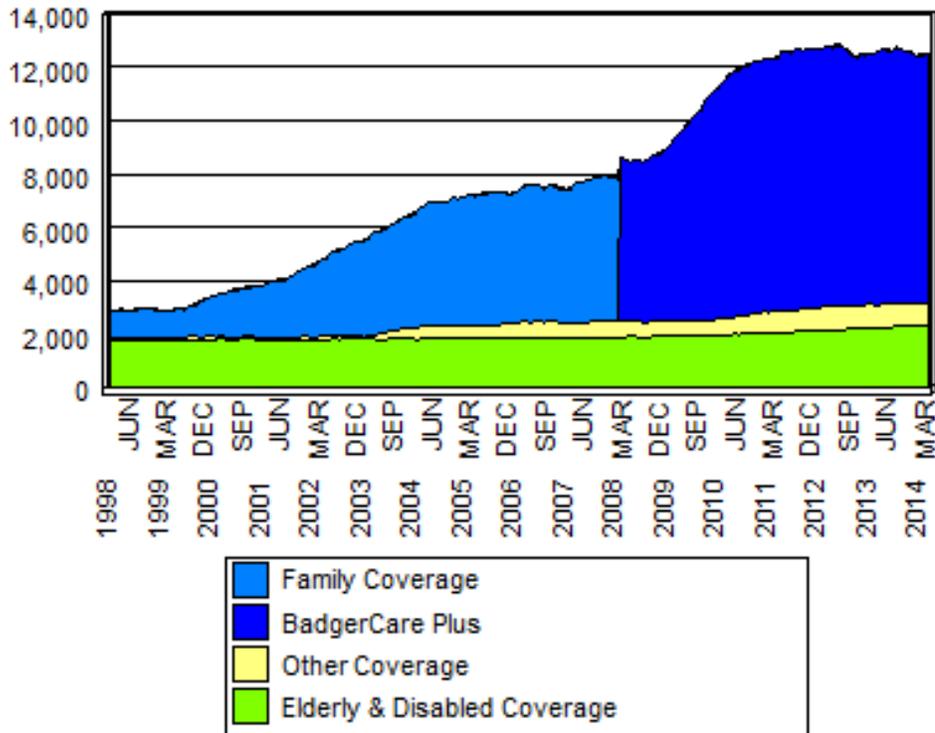
BADGERCARE - in 2014, major changes occurred in the BadgerCare program based upon the Affordable Health Care Act. Previously, the BadgerCare program eligibility guidelines provided medical assistance to parents with children under age 19, pregnant women and a limited number of childless adults based upon available funding. The income limit was 200% of poverty for adults and 300% of poverty for children. The new program has decreased the income limit for adults to 100% of poverty and directs those who are above the income limit to apply for health insurance coverage at the Federal Marketplace.

Additionally, eligibility for BadgerCare is now determined using IRS tax filing information which is also used for Marketplace eligibility. If a customer applies at the Marketplace for private health insurance and is potentially eligible for Wisconsin Medicaid their application is routed back to their home county for processing. Conversely, if they applied for Medicaid in Wisconsin and are determined to be ineligible their application is automatically transferred to the Marketplace for review. The Economic Support Division received Affordable Care Act funding in 2013 and 2014 to add additional staff to process the large volume of new applications we received and to manage the increased workload in the Southern Consortium Call center by answering questions, explaining program changes, and gathering tax information.

During the initial phase of the new health care laws, we established a Regional Enrollment Network (REN) consisting of county health care providers, free clinics, agencies, libraries, institutions of higher education and community organizations. The Jefferson County REN held public informational sessions, created press releases and most importantly coordinated services so when an individual requested help at any of the network agencies they received comprehensive services and referrals to meet their needs. The connections developed continue to improve access and effective services for all.

In 2014, The Southern Consortium received additional DHS funding to create a Regional Enrollment Network Coordinator (REN) position. Previously, the coordination of services varied by county and lacked the consistency and effectiveness needed to reach all State residents regarding Health Care availability. Jefferson County agreed to receive the funding and hired a bi-lingual coordinator. Their responsibilities include coordinating targeted outreach for all the counties, developing information and enrollment events, facilitating meetings with community partners and being a liaison between the Market Place and BadgerCare programs. Additionally, they are connected to the Statewide network of REN coordinators and share best practices. During the 2014 enrollment period, numerous enrollment events occurred within our consortium and the resource/ event list was sent monthly to more than 300 contacts. After open enrollment, a survey was sent to the contacts to evaluate the activities. 77.22% of respondents believed the community partnerships were very effective tools in outreach strategies. 55.56% of the community based organizations also believed that the partnerships established were very effective. As the changes in healthcare reform continue, the REN coordinator's ability to connect organizations and resources remains essential.

The following chart shows the number of customers on Medicaid programs in Jefferson County since 2010. In December of 2014, 12,471 individuals were receiving BadgerCare/Medicaid benefits. The first graph shows the increase in Medicaid recipients for Jefferson County since 1998. The second chart shows the increase in Medicaid recipients for Jefferson County since 2010.



Recipients of Medical Assistance

BREAKDOWN OF MEDICAID RECIPIENTS

Caseload on December 31st	Families	Nursing Home	Elderly Disabled	Totals
2010	10,117	243	1,976	12,356
2011	10,331	243	2,139	12,713
2012	9,983	227	2,181	12,391
2013	9,911	193	2,355	12,459
2014	9,791	171	2,509	12,471

FOODSHARE-(SNAP) is a Federal Program funded by the USDA that provides a monthly Foodshare allotment to low income customers to purchase food. 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 which supports our local economy. Customers in search of employment may volunteer to participate in the FoodShare Employment and Training program (FSET) and work in coordination with a

Financial Employment Planner to develop their employability resources and learn job skills. Beginning in April of 2015, FSET participation will be mandatory for able bodied adults without children. In December 2014, the FoodShare benefits issued to Jefferson County recipients totaled \$924,736 for that month. The chart below shows the average monthly number of Foodshare customers and the average monthly amount of benefits paid from 2011 to 2014 for Jefferson County. The Foodshare website is <http://dhs.wisconsin.gov/foodshare>.

NUMBER OF FOODSHARE RECIPIENTS SINCE 2011

Year	Average Monthly Recipients	Average Monthly Groups	Monthly Average Total Payments	Calendar YTD Total Payments
2011	7,954	3,250	\$829,374	\$9,952,491
2012	9,025	4,063	\$961,232	\$11,534,783
2013	9,467	4,355	\$996,763	\$11,964,155
2014	9,161	4,385	\$924,736	\$12,021,570

WISCONSIN SHARES-CHILD CARE - is a Federal and State funded 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 directly to the child care provider, with the family responsible for the co-payments. In December 2013, the number of families receiving child care assistance was 249 households with authorizations for 339 children. Additionally, the Child Care case managers certify in home child care providers, participate in local children’s fairs, and present trainings for providers. The website for child care is <http://dcf.wisconsin.gov/childcare/wishares>.

CHILDREN FIRST- is a State funded program that provides employment and training services for noncustodial parents who are not currently paying their child support. Participation in the program is court ordered. The primary goal of the program is to improve the ability of the parent to pay court ordered child support. The Children First case manager assesses the customer’s barriers, provides guidance and connects them to employment resources. The funding is based upon the number of customers in the county’s Child Support caseload and is used to provide financial assistance for their job search activities. In 2013, the Children First program served 10 noncustodial parents. In 2014, the Children First case manager worked with 11 parents.

JEFFERSON ST. VINCENT DE PAUL SOCIETY - provides our division access to local funds for the Jefferson School District customer’s emergency needs such as rent and utilities, unmet by other programs. The household can receive a payment only once in a two year time period. In 2013, 147 households received \$16,956.00 in emergency funding. In 2014, 186 households received assistance totaling \$19,804.08. Their generosity continues to be greatly appreciated.

HOME ENERGY ASSISTANCE- is a Federal and State funded program that provides a single 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 2013, 2,536 households received \$1,094,351 in energy assistance payments with additional crisis funding to 258 households in the amount of \$112,441. In 2014, 2,737 households received energy assistance in the amount of \$1,171,243 and 215 households received additional crisis funding in the amount of \$118,130 with the average crisis payment being \$549. Program information can be found at <http://heat.doa.state.wi.us>.

Review of 2014 Goals:

1. Key Outcome Indicator: MEET AND EXCEED THE AGENCY PERFORMANCE STANDARDS FOR APPLICATIONS, REVIEWS AND DOCUMENT PROCESSING. In the last six months of 2014, the Economic Support staff met and exceeded the 95% timeliness processing standard with an average monthly rate of 98.21% for timely processing. The Southern Consortium error rate from January 2014 to November 2014 was 8.16% for FoodShare benefit errors and 7.35% for Medicaid benefit errors. This was based upon the 83 reviews done from all seven counties. Additionally, we referred 22 cases in 2014 for fraud investigation.

2. Key Outcome Indicator: THE SOUTHERN CONSORTIUM CALL CENTER WILL MEET AND EXCEED THE PERFORMANCE STANDARDS. The Call Center began 2014 with an answer rate of 95.72% and an average talk time of 5.61 minutes. We ended the year with an average speed of answer of 86.99% and an average talk time of 6.02 minutes. The call volume increased from 10,693 calls in January to 11,476 calls in December 2014. Our speed of answer did not meet the standard in 2014 due to the additional increase of calls from the changes in the BadgerCare Program and Affordable Care Act. All the consortiums across the state saw a decrease in their answer rate. Our answer rate is steadily increasing in 2015. Our statistics are constantly reviewed and changes made to have each county provide additional agents. We also have determined high volume hours and days which have delegated higher agent to customer ratios. We continued to have bi-weekly meetings/ trainings of all agents to be assured of consistency and accuracy across counties. The consortium has developed a process guide that encompasses all aspects of their job functions for agent reference.

3. Key Outcome Indicator: THE CUSTOMER WILL RECEIVE RESPECTFUL, PROFESSIONAL CUSTOMER SERVICE THROUGHOUT THEIR INVOLVEMENT WITH THE DIVISION. The Division sends out monthly customer satisfaction surveys and continues to receive positive comments on our benefit issuance and quality of customer service. All comments are reviewed for possible enhancements to our current service.

In 2014, Jefferson County was the host agency for our consortium's Management Evaluation Review (MER) conducted by DHS staff. The review involves interviews with staff, customers and outside partners as well as accuracy, processes and training. Only minimal procedural errors were observed for the seven counties. Jefferson County was recognized for their team work and best practice of patterning staff and having an intake case manager available each day.

4. Key Outcome Indicator: STAFF WILL INCREASE THEIR INVOLVEMENT IN COMMUNITY ORGANIZATIONS AND COMMITTEES. In 2014, the Regional Enrollment Network Coordinator provided many informational and enrollment sessions in coordination with local partners in the seven counties to assist individuals applying for health insurance at the Federal Market Place. The coordinator established more than 300 active contacts including healthcare providers, libraries, technical colleges, tax preparers and insurance agents. The Economic Support staff participated in the Ready Kids for School program, a Continuum of Care housing committee, the Watertown CARES Clinic and prepared the materials for a budgeting calls they will begin providing in 2015.

5. Key Outcome Indicator: DEVELOP A SYSTEM TO CONTACT CUSTOMERS PRIOR TO CLOSURE OF BENEFITS. FoodShare customers are required to complete a six month report form in order to continue receiving benefits. Often this form is not returned timely, the benefits close and the customer must reapply to receive the needed FoodShare benefits. In July, of 2014, we began to send duplicate six month report forms to those

customers who did not return it timely. This has proven very successful in increasing the rate of return and helping the customer avoid the crisis of not having food when needed.

THE OVERARCHING GOAL FOR ECONOMIC SUPPORT IS TO ENHANCE AND MAINTAIN A SUCCESSFUL INCOME MAINTENANCE CONSORTIUM.

2015 GOALS:

1. Key Outcome Indicator for Medical Assistance & Market Place Exchanges, Foodshare-Food Stamps, Child Care, and Energy Assistance: Meet mandated performance standards.

2. MEET AND EXCEED THE AGENCY PERFORMANCE STANDARDS FOR APPLICATIONS, REVIEWS AND DOCUMENT PROCESSING. These focused goals include timeliness, accuracy, program integrity and customer satisfaction. The key outcome indicators will be measured by Income Maintenance Management reports, DCF reviews, Quality Assurance reviews, the CARES dashboard and Fraud data.

3. THE SOUTHERN CONSORTIUM CALL CENTER WILL MEET AND EXCEED THE PERFORMANCE STANDARDS. The focused goals include timeliness of response, customer service, accuracy of benefits, complete documentation and continued improvement. The key outcome indicators are measured by the weekly agent performance report, the IM project call statistics and Quality Assurance reviews.

4. THE REGIONAL ENROLLMENT COORDINATOR WILL CONTINUE TO EXPAND THE ENROLLMENT NETWORK AND ACTIVITIES WITHIN OUR SEVEN COUNTY CONSORTIUM. The focused goals include Marketplace access for all through informational and enrollment events, direct connections to certified application counselors or assisters and consistent outreach to community organizations. The key outcome indicators will be measured by surveys, number of customers attending activities and numbers of those who successfully apply at the Marketplace.

5. MAINTAIN AND DEVELOP ADDITIONAL SYSTEMS TO CONTACT THE CUSTOMERS PRIOR TO CLOSURE OF BENEFITS. The focused goals include having the customer return needed documents timely to prevent closure of benefits. Presently, we are sending duplicate documents to remind the customer of information needed. We plan to develop an internal system for late reviews and other documentation. The key outcome indicators will be measured by the number of number of closed cases, the reason for closure and number of cases remaining opened occurring from our prevention strategies.

6. DEVELOP AND MAINTAIN CONSISTENT METHODS FOR STAFF TRAINING. The focused goals will provide staff with the needed materials and resources to process benefits accurately and timely. The key outcome indicators will be measured by Quality Control Review data, Income Maintenance Management reports and CARES Worker Web Dashboard reports. Additionally, we will work with our consortium trainer to complete individual case reviews and call center monitoring to determine areas for additional training.

FINAL COMMENTS:

Individually and as a team we remain dedicated to providing and coordinating financial resources for the residents of Jefferson County. Each month we send out customer satisfaction surveys evaluating our services to randomly selected households. The responses provide us the knowledge of areas to improve and the confirmation that we are making an impact. Written responses from the 2014 customer surveys share “ I would just like to say thank you, without your help I would not be where I am today. Thank you for helping me and my son!”—“When I first applied, I cried. I didn’t want to accept help. But as a young widow, I couldn’t do it on my own. The worker is so knowledgeable and compassionate. I was blessed the day he became my “worker”” and finally, “ I don’t have any suggestions at this time for Jefferson County. We have always had an easy and lovely experience”. These kind comments and a simple thank you remind the Economic Support staff of how important are the benefits that we issue and the connections we make with others.

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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:

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