2024 ANNUAL REPORT

JEFFERSON COUNTY

HUMAN SERVICES DEPARTMENT

SERVING THE RESIDENTS OF JEFFERSON COUNTY

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JEFFERSON COUNTY
HUMAN SERVICES DEPARTMENT

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April 2025

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

RE: Letter from the Director

I am honored to present the Human Services Department's Annual Report for the year 2024. This report highlights our department's efforts, achievements, and challenges over the past year, reflecting our unwavering commitment to serving the residents of our county.

In 2024, we expanded several key programs to better meet the evolving needs of our community. Notably, we increased staffing in our Compliance program, Children's Long-Term Support and Waiver program, added an Integrated MH supervisor, as well as an additional Emergency Mental Health supervisor and a Medical Office Assistant for our Psychiatrist and Nurse Prescriber consumers. These additional positions were added to deal with the growing program's needs, as well as the increase in community consumers served. These additional positions were able to be added without the request for additional tax levy.

Our department prioritized community engagement, financial stewardship and staff morale and recognition. We maintained a balanced budget while expanding services, demonstrating our commitment to fiscal responsibility. Through diligent grant writing and resource allocation, we secured additional funding that enabled program enhancements without imposing extra burdens on taxpayers.

The Department is proud to share a few of our key 2024 accomplishments:

- Successful opening of the Youth Crisis Stabilization Facility.
- Maintaining a year-end surplus and operating reserve.
- Development of Jefferson Counties Opioid Settlement Plan.
- Introduced a new senior dining vendor with new healthy and ethnic choices.
- Hosted the first ever Foster Care Summit.
- The successful completion of the "**unwinding" of economic support's** pandemic-era stimulus measures back to regular operations.

Despite our successes, we faced challenges, particularly in addressing the increased demand for affordable housing, substance abuse services and referrals in our children's areas grew at an alarming rate.

In conclusion, I extend my gratitude to the County Board, Human Services Board, our dedicated staff, and the community for their unwavering support. Together, we have made significant strides in enhancing the well-being of our residents, and I am confident that, with continued collaboration, we will achieve even greater outcomes in the coming year.

Sincerely,

Brent Ruehlow, Director of 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.

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
Maintenance	Maintain buildings and grounds while planning for future	46	100% of capital projects completed on time and within budget
AGING & DISABILITY RESOURCE CENTER (ADRC)			
ADRC	A one-stop shop provides accurate, unbiased information on all aspects of life related to aging or living with a disability; and serves as the access point for publicly funded long-term care.	46.283, DHS 10	100% compliance with the State contract
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
Senior Dining Program	Serve & deliver, without interruption, well-balanced meals to seniors who request them in our service area, and to those who have the greatest economic or social need.	Older American's Act (OAA)	95% of qualifying individuals who request home delivered meals receive them
Transportation	Provides medical transportation to seniors and people with disabilities and rides to department appointments.	85.21	100% of qualifying individuals who request a ride receive one
BEHAVIORAL HEALTH DIVISION			
Community Support Program	Integrated services for people with severe and persistent mental illness	51 63	72% of all treatment plan goals are met

Program Title	Program Description	Mandates and/or References	Key Outcome Indicator
Community Recovery Services	Residential services for people with mental health and substance abuse	51	100% compliance with CRS rules
Comprehensive Community Services	Recovery based community, mental health, and substance abuse services	Supports 51 services 36	72% of all treatment plan goals are met
Emergency Mental Health	24/7 mobile response to all crisis calls	51	Giving consideration to lethality and acuity, maintain diversion rate to least restrictive setting
Outpatient Integrated Behavioral Health Clinic	Treatment services for substance use including opioid addictions	75	Decrease Brief Alcohol Monitoring Scores
Outpatient Integrated Behavioral Health Clinic	Provide mental health counseling	51 75	PHQ 9 score will improve by 2%
CHILD & FAMILY DIVISION			
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 our Federal 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 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	Case managers and the Family Teaming Coordinator will offer and schedule Family Team Meetings with parents on all out-of-home cases quarterly, post Disposition
CST Wraparound	Multi-disciplinary approach to building community-based MA funded programing for youth.	46	To enhance knowledge of the program and increase community-based referrals, the CST team will share information regarding wraparound services to a minimum of one community partner agency each month
Children's Long Term Support	Support children and youth who live at home or in the community and have substantial limitations.	Federally authorized under 1915(c) of the Social Security Act	Will meet enrollment timeframes (DHS Activity Timeline) 90% of the time. All children are now considered in enrollable status when determined functionally eligible and when entered into PPS. Enrollment into CLTS must occur within 30 calendar days

Program Title	Program Description	Mandates and/or References	Key Outcome Indicator
Intake	Provides a single access point for all children, juvenile and family service needs.	48, 938	100% of all State and Federal timelines will be met
Youth Justice	Provide evidence-based treatment and supervision to all court ordered youth.	938	90% of youth who receive YJ services will be placed in home, in a relative's home, or in the home of a "like kin" caregiver
ECONOMIC SUPPORT DIVISION			
Child Care- Wisconsin Shares	Provides financial assistance for childcare expenses to those who meet income guidelines.	46 and 49	Meet mandated performance standards including 100% timely processing and accuracy
Energy Assistance	Provides financial assistance to those who have a heating expense and meet income guidelines.	46 and 49	Meet mandated performance standards including 100% timely processing and accuracy
FoodShare- Food Stamps	Provides financial assistance to purchase food for those who meet income guidelines.	46 and 49	Meet mandated performance standards including 100% timely processing and accuracy
Medical Assistance and Marketplace exchanges	Provides Health Insurance benefits for those who meet income guidelines.	46, 49 and PPACA	Meet mandated performance standards including 100% timely processing and accuracy

HUMAN SERVICES BOARD OF DIRECTORS

Richard Jones, Chair
Russell Kutz, Vice Chair
Michael Wineke
Kirk Lund
Gino Racanelli
Steve Ganser
Pamela Abrahamsen

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Bonnie Bull
Lisa Krolow
Mary Roberts

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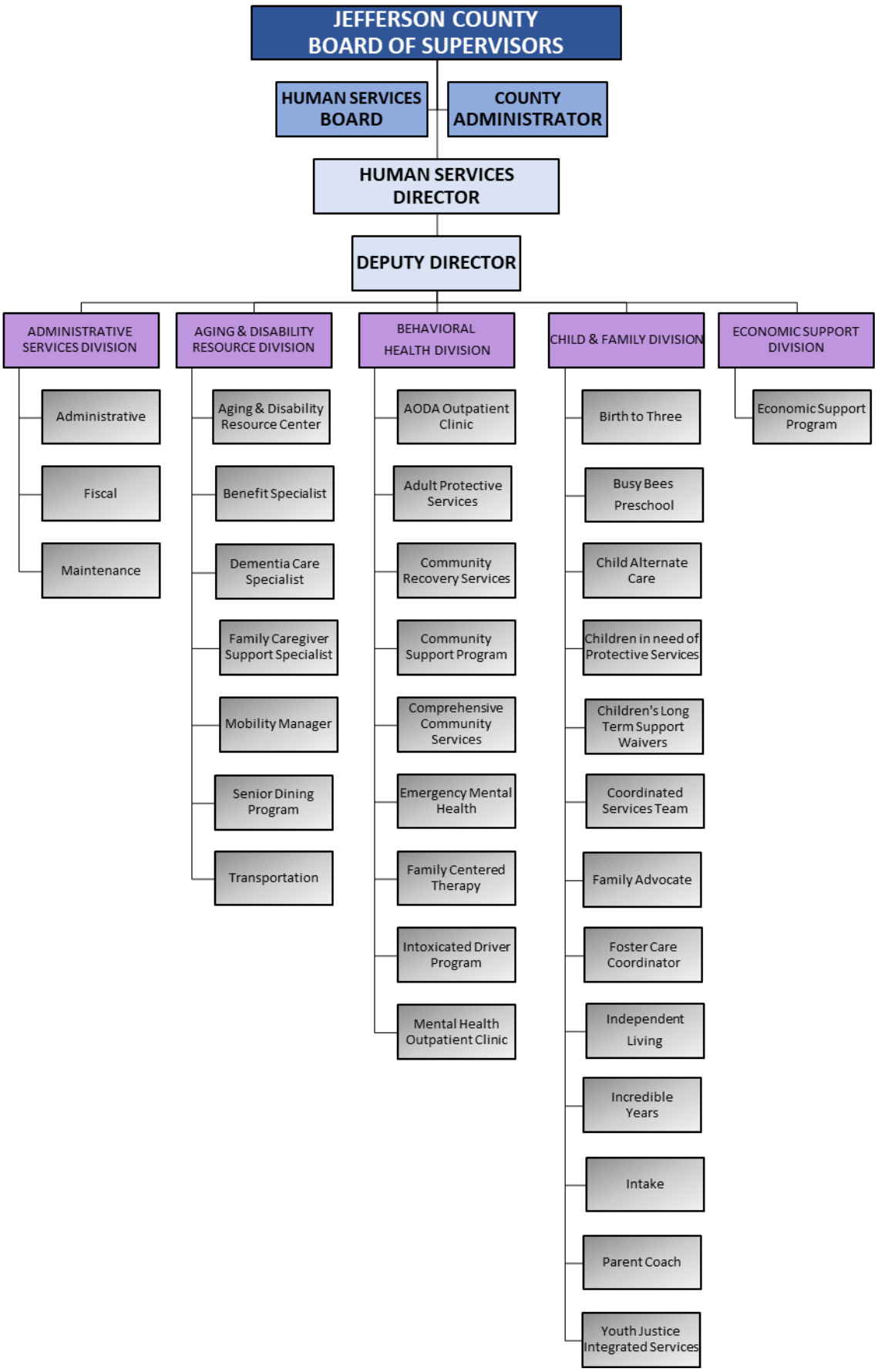
Frankie Fuller, *Vice Chair*
Katie Dixon
Carol O'Neil
Mary Roberts
LaRae Schultz
John Donahue
Todd Weidenhoeft

Michael Hansen, Staff
Tatiana March, Staff
ReBecca Schmidt, Staff
Tonya Runyard, Staff
Dominic Wondolkowski, Staff

Sira Nsibirwa termed 7/1/24


JEFFERSON COUNTY
BOARD OF SUPERVISORS
HUMAN SERVICES BOARD
COUNTY ADMINISTRATOR
HUMAN SERVICES DIRECTOR
DEPUTY DIRECTOR
ADMINISTRATIVE SERVICES DIVISION
AGING & DISABILITY RESOURCE DIVISION
BEHAVIORAL HEALTH DIVISION
CHILD & FAMILY DIVISION
ECONOMIC SUPPORT DIVISION
Administrative
Fiscal
Maintenance
Aging & Disability Resource Center
Benefit Specialist
Dementia Care Specialist
Family Caregiver Support Specialist
Mobility Manager
Senior Dining Program
Transportation
AODA Outpatient Clinic
Adult Protective Services
Community Recovery Services
Community Support Program
Comprehensive Community Services
Emergency Mental Health
Family Centered Therapy
Intoxicated Driver Program
Mental Health Outpatient Clinic
Birth to Three
Busy Bees Preschool
Child Alternate Care
Children in need of Protective Services
Children's Long Term Support Waivers
Coordinated Services Team
Family Advocate
Foster Care Coordinator
Independent Living
Incredible Years
Intake
Parent Coach
Youth Justice Integrated Services
Economic Support Program

ADMINISTRATION

Director, Brent Ruehlow
Deputy Director, Brian Bellford

Administrative Services Division Manager, Brian Bellford
Accounting Supervisor, Mary Jurczyk
Billing and IT Supervisor, Kristie Dorn
Office Manager, Kelly Witucki
Senior Accounting Supervisor, Cathy Swenson

Aging & Disability Resource Division Manager, ReBecca Schmidt
Aging & Disability Resource Center, Dominic Wondolkowski
Senior Dining Nutrition Program Supervisor, Tatiana March
Transportation Supervisor, Michael Hansen

Behavioral Health Division Manager, Holly Pagel
Community Support Program, Marj Thorman
Compliance Officer, Nicole Singsime
Comprehensive Community Services, Tiffany Congdon
Emergency Mental Health, Kim Propp
Integrated Behavioral Health Supervisor, Brooke Kysely
Lueder House, Lauren Stark
Medical Director, Mel Haggart, M.D. – (Contracted)
Mental Health/AODA Manager, Anna Falci

Child & Family Division Manager, Laura Wagner
Birth to Three, Busy Bees Preschool, Beth Boucher
Child Welfare/Coordinated Service Team, Erica Lowrey
Children's Long Term Waiver Support, Mary Behm & Darci Wubben
Lead Foster Care Coordinator, Katie Schickowski
Intake, Heidi Gerth
Parents Supporting Parents Supervisor, Andrea Szwec
Youth Justice Integrated Services, Jessica Godek

Economic Support Division Manager, Jessica Lange
Supervisor, Kathy Busler

TEAMS & STAFF (as of April 1, 2024)

ADMINISTRATION
Brent Ruehlow, Director
Brian Bellford, Deputy Director/*Manager*

Administrative
Kelly Witucki, *Office Manager*
Jonathan Carrizales
Chris Hunkins
Maya Kish
Carlee Pekrul
Dianna Schultz
Meloney Thorman

Fiscal
Kristie Dorn, Supervisor
Mary Jurczyk, Supervisor
Cathy Swenson, Supervisor
Stephanie Bartels
Holly Broedlow
Mary Klein
Penny Klement
Jacob Kostroski
Barb Mottl
Alyson Schmidt
Dawn Shilts
Suzanne Smith
Mary Welter

Compliance
Shauna Schultz, *Supervisor*
Nicole Singsime, *Supervisor*
Lisa Degrandt
Caitlin Jurczyk
Dane Luebke
Rachel Schloesser
Terrence Trzebiatowski

Maintenance
Jared Potter, *Supervisor*
Bruce Fuller
Kiara Kostroski
Greg Miller
Todd Pooler
Lee Schroeder
Michelle Sedlar
Paul Vogel

ADRC DIVISION
ReBecca Schmidt, *Manager*
Dominic Wondolkowski, *Supervisor*
Tatiana March, *Supervisor*

… continued
Michael Hansen, *Supervisor*
Donna Abel
Linda Allegretti
Emma Borck
Tim Christian
Richard Crosby
Alan Danielson
Thomas Dixon
Kristin Draeger
Leigh Fritter
Randall Frohmader
Kimberly Herman
Patti Hills
Erika Holmes
Betty Jaeckel
Karen Koenigs
Wayne Kofler
Mary Kralj
Karla Nava
Jolie Palmer
Rick Pfeifer
Kevin Purcell
Jose Rodriguez
Tonya Runyard
James Schultz
Julie Schultz
Dale Schweitzer
Gina Serna
Tracy Smith
Michael Solovey
Erica Stockfish
Yvonne Torres
Jackie Unke
Shelly Wangerin
Jacquelyn Ward
Mary Weber
Charles Wedl
Leisa Zirbel

BEHAVIORAL HEALTH DIVISION
Holly Pagel, *Division Manager*
Dr. Mel Haggart, *MD*
Mary Bonaccorsi, APNP

Adult Protective Services
Kim Propp, *Supervisor*
Melissa Goodearle
Claire Kuehl
Shelly Theder

Community Support Program
Marj Thorman, *Supervisor*
Anna Bedford
Chris Blakey
Candace Burchard
Cindy Crouse
Martin Groth
Maxwell Groth
Carol Herold
Julie Johnson
Mardy Juhl
Claire Kuehl
Brooke Kysely
Darcy Lalimo
Madelyn Raatz
Jessica Reed
Jasmine Richter
Nancy Schneider
Amy Spies
Sarah Vincent Dunham

Comprehensive Community Services
Tiffany Congdon, *Supervisor*
Brittany Long, *Supervisor*
Stacey Palermo, *Supervisor*
Jamie Tegt, *Supervisor*
Jenna Aalsma
Jerad Adams
Sean Arient
Aaron Bakewell
Laura Bambrough
Hannah Brown
Lori Brummond
Kasey Elmer
Sierra Eno
Joelle Feucht
Cecilia Good
Emily Green
Jesse Gundacker
Brianna Gutheridge
Ashley Hernandez
Heidi Hofmann
Leah Jesse
Breanna Kearney
Kari Kuffer
Samantha Kunstmann
Beth Lane
Jessi Lawrence
Nicole Lemanski

… continued
Kellyjo Messier
Isabella Nagovan
Susan Powers
Sadie Raduenz
Courtney Regnier
Samantha Sims
Kennedy St. Louis
Kenny Strege
Dulce Valadez-Ortiz
Morgan Van Der Ploeg
Brett Wenzel
Tracy Wittwer
Bao Yang
Bee Yang

Crisis & Lueder House
Kim Propp, *Supervisor.*
Lauren Stark, *Supervisor L.H.*
Megan Weinschenk*, Supervisor*
Terry Bolger
Cynthia Bray
Casey Crandall
Sandra Gaber
Amber Gilles
Mary Goodwin
Rebecca Gregg
Susan Hoehn
Art Leavens
Kelly Lueck
Michelle Metz
Larissa Miles
Jennifer Rhodes
Whitney Schroeder
Samantha Sims
Jason Thurmond
Megan Weinschenk

Mental Health & AODA
Anna Falci, *Supervisor*
Brooke Kysely, *Supervisor*
Michele Bahl
Matt Baumann
Lori Brummond
Rabecca Cole
Krista Doerr
Jeannine Eng
Krystal Fredrick
Emily Green
Alex James
Beth Lane

… continued TEAMS & STAFF (as of April 1, 2024)

… continued
Amy Porter
Michelle Rushton
Amanda Sass
Amy Schroeder
Katie Schultz
Emily Stout
Jennifer Wendt
Brianna White
Sara Zwieg

CHILD & FAMILY DIVISION
Laura Wagner, *Manager*

Birth to Three
Elizabeth Boucher, *Supervisor*
Tonya Buskager
Steffani Evans
Jennifer Hoppenrath
Leah Reimer
Molly Willgrubs

Child Welfare & Wraparound
Erica Lowrey, *Supervisor*
Clayton Coleman
Avery Cornford
Tadd Douglas
Beckie Enyeart
Ashley Green
Nicole Hemphill
Payton Justman
Darcy Lalimo
Maggie Messler
Bill Wallace
Eliza White-Pentony
Jenny Witt

Children's Long-Term Services
Mary Behm, *Supervisor*
Darci Wubben, *Supervisor*
Joanna Bredlau
Janis Carpenter
Chelsee Dinamarca
Kristine Feggestad
Paul Gephart
Thomas Hamilton
Brooke Helt
Amy Junker
Alysha Kratochwill

… continued
Meghan Kehoe
Sarah LaPaz
Mary Lenz
Monica Liceaga
Kristen Loudon
Tara Montoya
Lorena Pavon-Alvarado
Laura Rolerat
Cory Roloff
Lindy Schrader
Tracy Warner
Lindsay Zacharias

Parents Supporting Parents
Andrea Szwec, *Supervisor*
Samantha Copus
Alyssa Hake
Jessica Manogue

Foster Care Coordinator
Cherilyn Emond
Katie Schickowski

Intake
Heidi Gerth, *Supervisor*
Kiyena Beatty
Abbey Buelow
Hannah Dohner
Jason Eiler
Jenifer Eilert
Darci Lalimo
John Mock
Amanda Schroeder
Bridget Schwantes
Mackenzie Seeber
Elizabeth Shropshire
Noelle Sopotnick
Ashley Timmerman
William Wallace
Tracy Wittwer

Youth Justice
Jessica Godek, *Supervisor*
Dominic Alvarez
Jessica Breezer
Rebecca Brown
Christina Czappa
Nichole Doornek
Jason Eiler
Kelly Ganster
Chad Hrobsky
Kevin Huddleston

… continued
Brooke Kopps
Lindsey Slatter

ECONOMIC SUPPORT DIVISION
Jessica Lange, *Manager*
Kathy Busler, *Supervisor*
Julissa Bautista-Perez
Susan Brodd
Autumn Dankert
Berenice Delgado
Dana Dietschweiler
Carrie Fischer
Lea Flores
Susan Folts
Lindsay Gonzalez
Manuela Gratz
Kathy Green
Meghan Harris
Melissa Jung
Michael Last
Katie Rogers
Katie Rojas
Kaity Schmear
Moises Sequeira
Becca Snyder
Sarah Stanton

ADMINISTRATION SERVICES DIVISION

~Providing fiscal and maintenance oversight for the Department~

The Administrative Services Division provides fiscal, administrative, and maintenance oversight for the department, as well as general support for all other divisions. These teams are overseen by a Division Manager.

The **Fiscal team** consisted of twelve full-time employees and a part-time employee in 2024. The team ensures that all accounting, billing for client insurance, client financial ability to pay reviews, data entry and analysis, financial reporting, office management, payroll processing, protective payee payments, system and technical analysis, and voucher payments are accomplished for the department. In addition to the Office Manager and Maintenance team, the Division Manager supervises two Account Specialists and three other supervisors, all of whom also supervise other staff. The Advanced Accounting Supervisor supervises the Representative Payee staff and one Account Specialist. The Accounting Supervisor supervises two Account Specialists and a part-time Accounting Assistant. The Billing and IT Supervisor supervises two Account Specialists.

The **Maintenance team** consist of four full-time employees – including a maintenance supervisor, a maintenance worker, and two custodians - and one part-time custodian. They ensure that the vehicles, buildings, and grounds are in working order, and capital projects are completed within budgetary guidelines.

The **Administrative team** is overseen by the Office Manager. Five full-time employees report to the Office Manager. They oversee the front desk, reception, medical records and filing, schedule appointments, and provide administrative support and assistance to our psychiatrist.

FISCAL TEAM

~ Ensuring fiscal responsibility to the citizens of Jefferson County~

The Jefferson County Human Services Protective Payee Program is committed to empowering individuals who receive Social Security and Supplemental Security Income (SSI) benefits to feel they are an integral part of their financial decision-making process. We provide support to these individuals while ensuring we treat every customer with attention, consideration, dignity, and respect. The goal of the program is to ensure their basic needs are met, by managing their benefit payment for those individuals who have been identified as needing a payee.

During 2024, the payee program served approximately 72 people, 66 of which were adults. The remainder of the participants were children in foster care or children of our payee participants. Most of the participants in our program receive either SSDI or SSI. We do assist one consumer that receives a VA benefit that follows the same rules. The adults contributed $61,141 in 2024 to help offset the room and board costs the county pays toward their placements, while the children in the program contributed $23,121 to offset foster care or group home costs. The breakdown of the people we serve in the payee program who participate in other county programs is: 42% in CSP, 19% in CCS, 15% in the Clinic, 7% in Foster Care, 6% in APS, and the remaining 11% are only involved with the Payee Program.

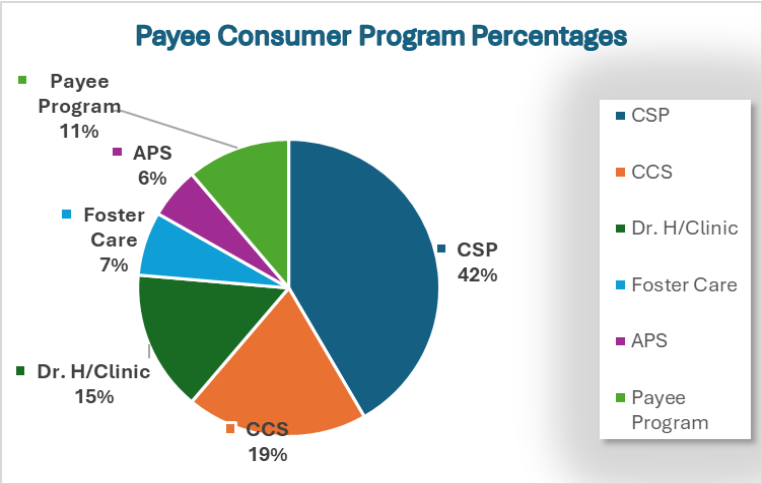
This year the Jefferson County Payee Program implemented debit cards for several of our program participants. We implemented debit because they provide additional flexibility for the consumers, and it can be difficult for our consumers to cash checks.

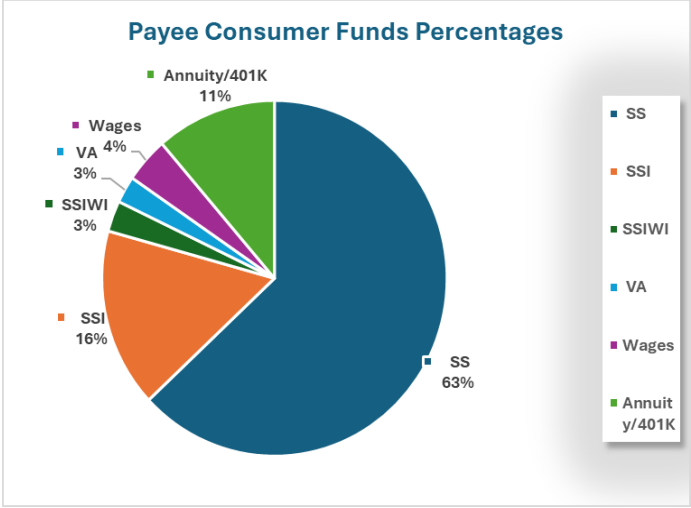
We worked with 14 consumers to activate debit cards in 2024. Two of those consumers did not like them and went back to receiving checks. The rest of the feedback from the consumers using the debit cards has been very positive. They like having their funds loaded directly to their debit card and not having to find a way to pick up a check at Human Services or rely on the postal mail for delivery. We are in the process of bringing four

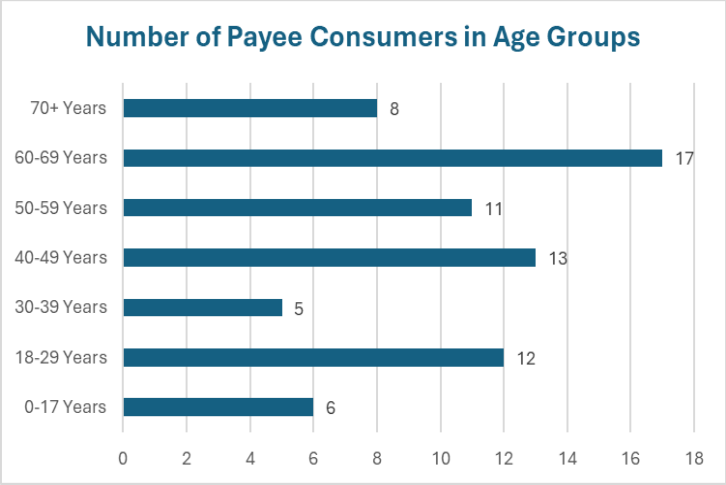
more consumers on board with the debit card process. Our hope is to have all consumers that are able and willing up and running with debit cards in 2025.

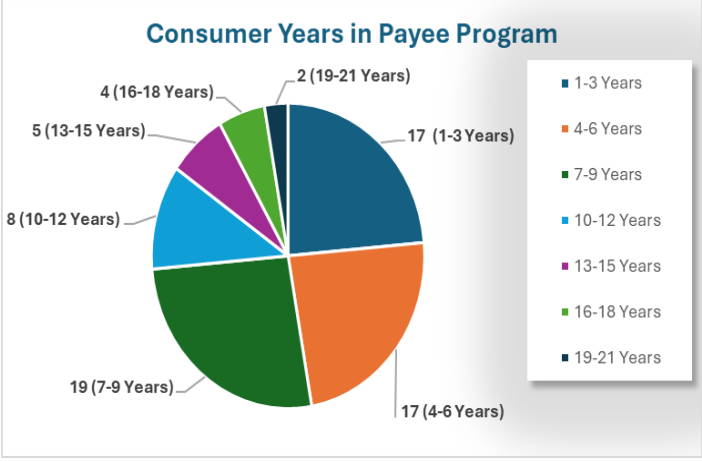
Medicaid also started the process of Medicaid unwinding, which means returning to regular Medicaid operations after the COVID-19 public health emergency. During the pandemic, states were required to maintain enrollment for almost all Medicaid enrollees. This was called the "continuous enrollment condition." States returned to the regular Medicaid review process and some of our consumers lost their Medicaid, while others returned to paying their Medicaid Purchase Plan premium (MAPP), which had been put on hold status during the COVID-19 public health emergency.

The most common reason that our program changes in the number of consumers is that consumers move out of the county, age out of foster care, or they pass away. We also have consumers become their own payee.









Fiscal Statement Summary
December 2024
(Unaudited)

We had a positive fund balance of $1,734,841 at the end of 2024. This included $361,177 in prepaid expenses. Of the remaining $1,373,664 of spendable fund balance, $1,355,321 was approved to be carried over into 2024.

Major Classifications that Impacted the Favorable 2024 Balance

Summary of Variances:

Federal/State Revenue: Overall, State revenues were unfavorable by $4,319,378. Most of this is due to the State mandated change in reporting requirements related to the CLTS program. Payments from the Third-Party Administrator to outside providers were recorded on the County ledgers; however, this is no longer the case starting in 2024. Those payments account for $4,556,355 of this variance. When the CLTS TPA payments are excluded, our state funding was $236,977 favorable. A large portion of this variance was because of the grant revenue associated with the Youth Crisis Stabilization Facility that opened in 2024.

CCS revenues were $6,425,991. This revenue is from billing MA and increased approximately 18% from last year because of increased hours/staff, more billable hours per staff, and the WIMCR settlement. In 2024, we received a WIMCR settlement over $2,064,515, because our costs and billing rates exceed the interim MA reimbursement rate.

WIMCR revenue collections were more than budgeted. We received $3,212,602 from WIMCR, compared to $2,398,037 last year and $1,686,923 in 2022. In 2024, we budgeted $1,900,386. The increase this year is due to the CCS program. We budgeted for $3,195,000 in 2024.

Income Maintenance funding was $90,254 more than budgeted. We received an enhanced income maintenance payment of $146,330 in December 2024, and additional Random Moment Sampling (RMS) funding of $42,492 during the year. Finally, we received Unwinding funding in the amount of $9,596. This was the first year in a while that we did not receive APRA funding.

Type	2024	2023	2022	2022
RMS	$42,492	$53,470	$91,245	$91,245
Enhanced	$146,330	$122,387	$135,745	$135,745
ARPA	$0	$61,090	$41,069	$41,069
Unwinding	$9,596	$23,193	$0	$0
Total	**$198,418**	**$260,140**	**$268,059**	**$268,059**

Children Alternate Care expenses were under budget by $171,684. This includes Shelter and Detention costs. It does not include Kinship payments, which are funded through State revenue.

Hospital/Detox was favorable on a net basis by $39,914:

	2023 Actual	2024 Actual	2024 Budget
Revenue	$551,193	$277,216	$348,699
Expenditures	$1,431,107	$956,273	$1,308,435
Net	$(879,914)	$(679,057)	$(959,736)

Our detox costs were very limited in 2024. We spent $14,848 in 2024, compared to $62,599 in 2023.

The Nutrition Programs were favorable to the budget by $12,964. The GWAAR contracts for nutrition expenses allowed for transferred between various programs. We were able to transfer funding from the 3B program to help cover the Home Delivered Meals cost. Additionally, we received an ARPA re-allocation from GWAAR of $31,761 to help with meal costs.

CRS and adult alternate care costs were $260,657 and $88,889 under budget, respectively. We had a few high-cost placements that ended during the year, which caused this variance.

The Outpatient Clinic billing increased substantially during the year. Outpatient mental health billing has increased significantly over the past few years, because of many factors, such as increased demand for services, new positions (including an APNP), Open Access, contracted billing, telehealth rules, and internal insurance initiatives.

Description	2024	2023	2022	2021	2020	2019
Total Revenue	**$765,588**	**$760,866**	**$607,279**	**$508,451**	**$466,153**	**$308,853**

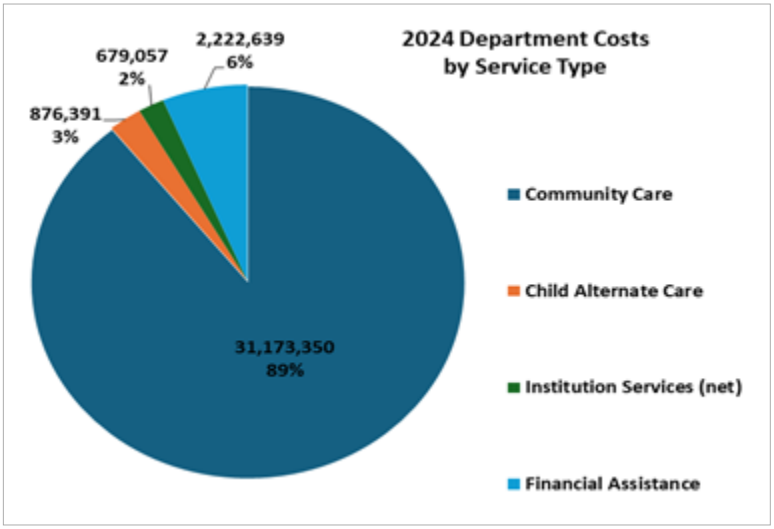
We did not spend any of our $650,000 Operating Reserve in 2024. In 2019, the County Board created an Operating Reserve for the Human Services fund. This reserve was initially set at $650,000. To date, we have not spent any of this reserve. We requested carrying over $650,000 into 2025.

Total 2024 expenditures are shown in the chart below.

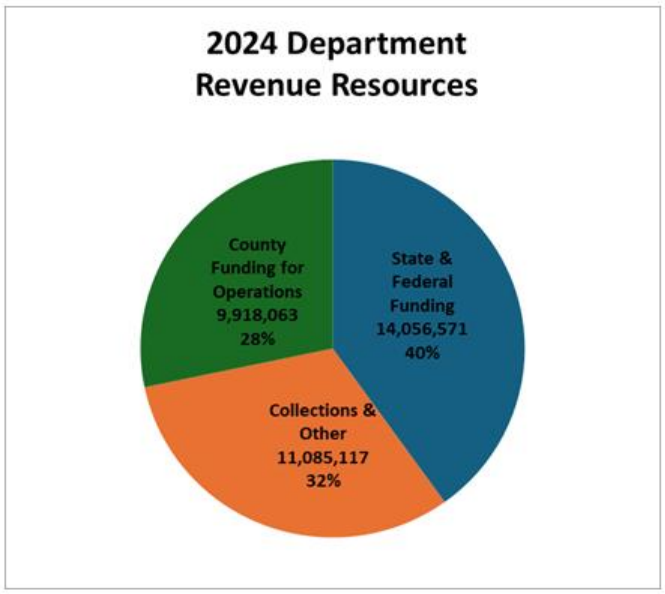
	Dollar	Percent
Community Care	31,173,350	89.2%
Child Alternate Care	876,391	2.5%
Institution Services (net)	679,057	1.9%
Financial Assistance	2,222,639	6.4%
TOTAL	**34,951,437**	**100.0%**
*** Does not include depreciation and county indirect costs. Depreciation was $544,824 and County indirect costs were $807,497.**		

In 2024, expenditures decreased $1,754,630 or 4.8% from 2023. This is because of the CLTS TPA change in reporting. Hospitalization expenses decreased 22.8%, and while child alternate expenses increased 10.8%. If not for the CLTS TPA change, community care expenses would have increased due to staffing increases and demand for services.

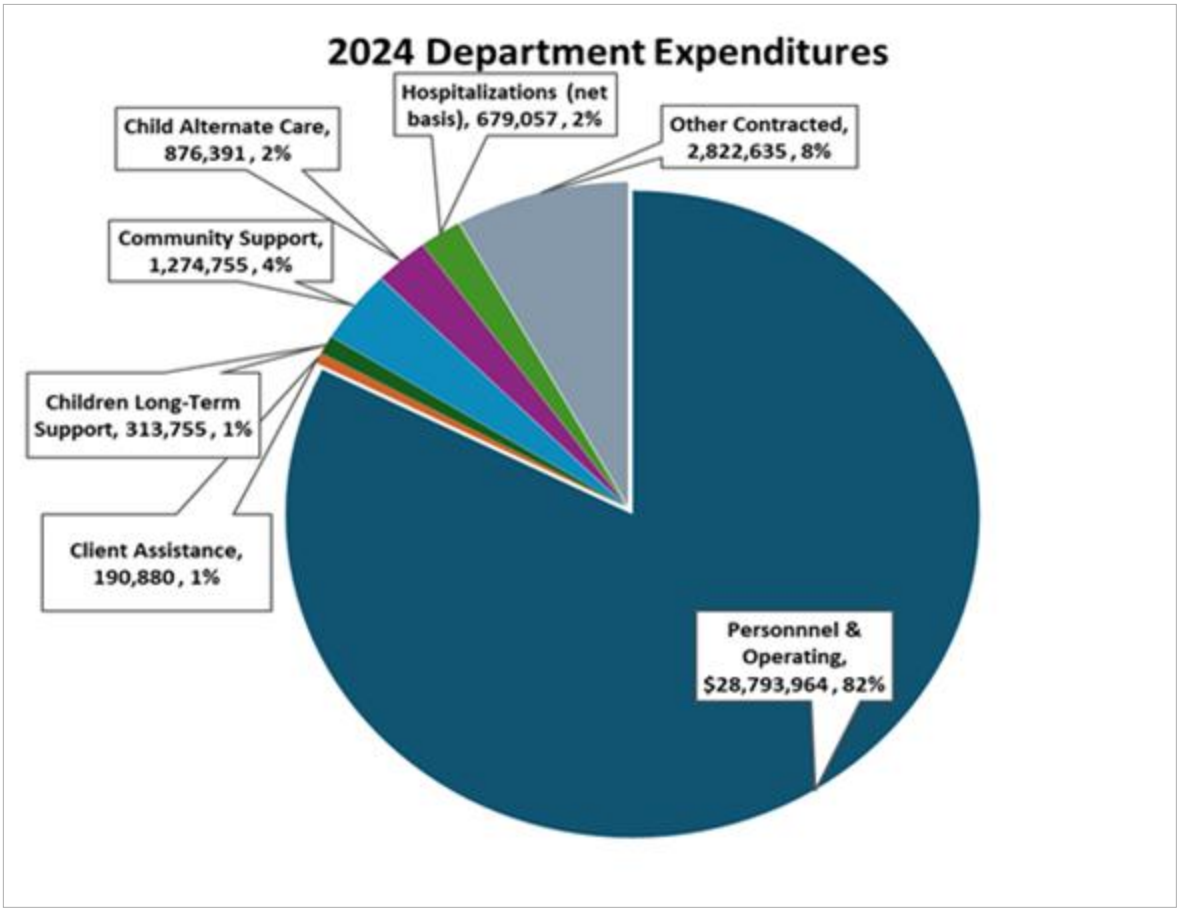
Costs by major service categories are shown below.



Total revenue resources were $35,059,751 in 2024. The funding source continues to be State and Federal Funding.



Total expenditures were $34,951,437 in 2024. Personnel and Operating costs increased by $2,877,060 or 11.1%, because of several new staff positions to provide services and carry out programs and mandates. Hospitalizations are reported on a net basis (i.e., revenue received offsets the expenditures) and decreased from 2023, because of increased diversion. Depreciation and County indirect costs are not included in the totals below. These costs are reportable to the State but are not recorded on the Human Services Ledgers.



FINANCIAL REPORTS

The Financial Reports that follow summarize the Department's resources and expenditures by source and type, target group, and service type. Total resources for 2023, including the County tax levy, were $35,059,751. Total expenditures were $34,951,437.

2024 Resources & Expenditures
(unaudited)

RESOURCES:	2023 ACTUAL	2024 ACTUAL	2024 BUDGET	2024 VARIANCE
State & Federal Funding	$ 17,337,607	$ 14,056,571	$ 18,375,949	$ (4,319,378)
Collections & Other	9,515,066	11,085,117	11,773,943	(688,826)
County Funding for Operations	9,831,815	9,918,063	10,013,337	(95,274)
Total Resources	$ 36,684,488	$ 35,059,751	$ 40,163,229	$ (5,103,478)

EXPENDITURES:	2023 ACTUAL	2024 ACTUAL	2024 BUDGET	2024 VARIANCE
Personnel & Operating	$ 25,916,904	$ 28,793,964	$ 28,429,843	$ (364,121)
Client Assistance	201,776	190,880	281,156	90,276
Medical Assist. Waivers	4,321,529	313,755	5,013,726	4,699,971
Community Support	1,372,691	1,274,755	1,133,268	(141,487)
Child Alternate Care	790,632	876,391	1,048,075	171,684
Hospitalizations (net balance)	879,914	679,057	959,736	280,679
Other Contracted	3,267,496	2,822,635	3,940,682	1,118,047
Reserve Fund	-	-	650,000	650,000
Total Expenditures	$ 36,750,942	$ 34,951,437	$ 41,456,486	$ 6,505,049

SUMMARY	2023 BALANCE	2024 BALANCE	2024 PERCENT of BUDGET
Surplus from operations	$ (66,454)	$ 108,314	0.26%
Prior Year Carry Forward	$ 1,692,981	$ 1,626,527	
Total Net Surplus	$ 1,626,527	$ 1,734,841	4.18%
Lapse to Other Funds	$ -	$ (18,343)	
Remaining Balance	$ 1,626,527	$ 1,716,498	
Depreciation		544,823	
County Indirect Cost		807,496	
		1,352,319	

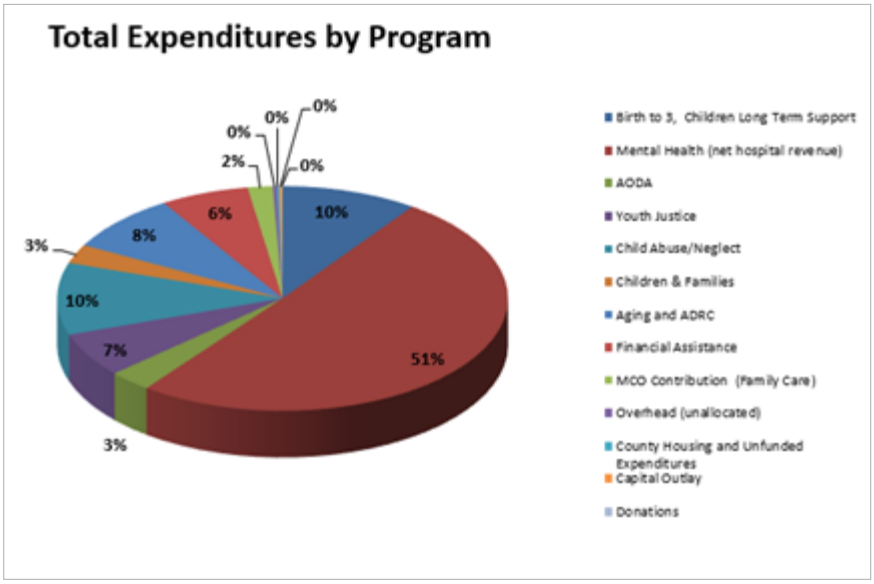
We ended 20224 with a net surplus of $1,716,498 or 4.18% of total budgeted expenditures. Of this surplus, $1,716,498 (which includes $361,177of prepaid expenses) was carried forward in 2025.

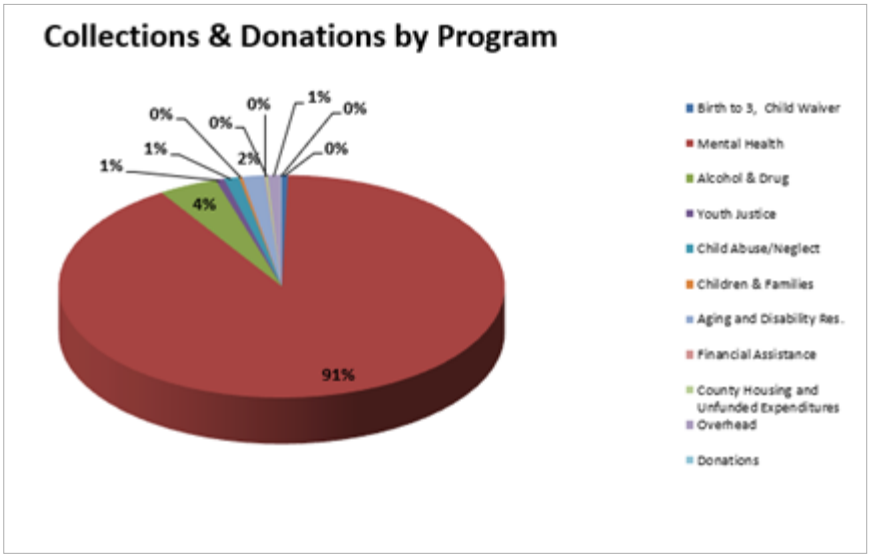
2024 Expenditures, Collections, Funding Streams, and Costs

(does not include Depreciation & County Indirect Costs)

Total Expenditures	
Birth to 3, Children Long Term Support	3,416,539
Mental Health (net hospital revenue)	17,654,290
AODA	1,073,463
Youth Justice	2,233,697
Child Abuse/Neglect	3,625,049
Children & Families	952,824
Aging and ADRC	2,903,545
Financial Assistance	2,222,639
MCO Contribution *(Family Care)*	625,097
Overhead *(unallocated)*	105,976
County Housing and Unfunded Expenditures	63,132
Capital Outlay	64,986
Donations	10,199
TOTAL	34,951,436

Collections & Donations	
Birth to 3, Child Waiver	48,702
Mental Health	10,029,768
Alcohol & Drug	474,831
Youth Justice	68,016
Child Abuse/Neglect	121,540
Children & Families	26,120
Aging and Disability Res.	178,727
Financial Assistance	7,186
County Housing and Unfunded Expenditures	17,764
Overhead	105,976
Donations	6,488
TOTAL	11,085,118

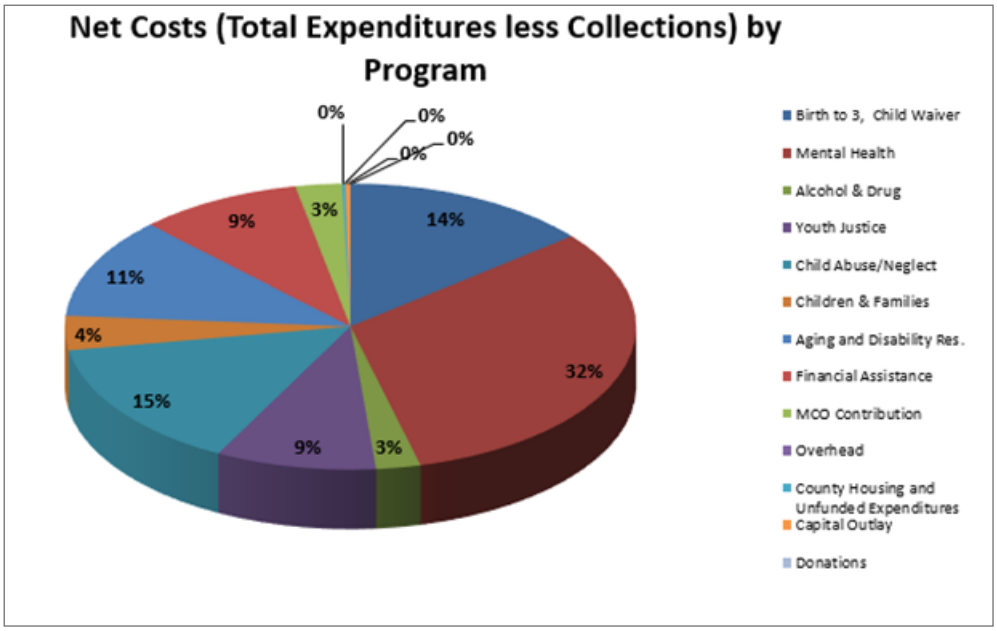


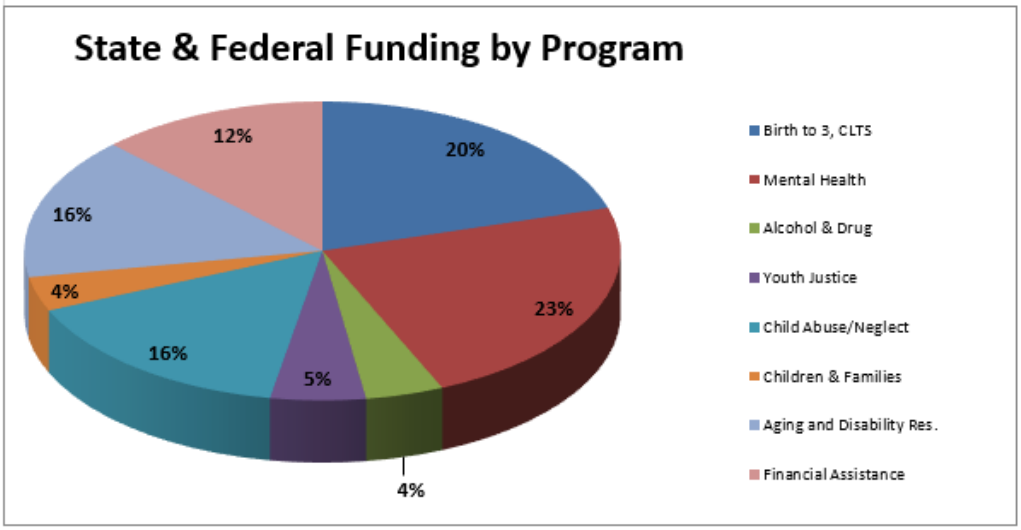


Net Costs (Total Expend less Collections)	
Birth to 3, Child Waiver	3,367,837
Mental Health	7,624,522
Alcohol & Drug	598,632
Youth Justice	2,165,681
Child Abuse/Neglect	3,503,509
Children & Families	926,704
Aging and Disability Res.	2,724,818
Financial Assistance	2,215,453
MCO Contribution	625,097
Overhead	0
County Housing and Unfunded Expenditures	45,368
Capital Outlay	64,986
Donations	3,711
TOTAL	23,866,318

State & Federal Funding	
Birth to 3, CLTS	2,861,390
Mental Health	3,241,891
Alcohol & Drug	595,590
Youth Justice	725,000
Child Abuse/Neglect	2,198,677
Children & Families	520,752
Aging and Disability Res.	2,169,160
Financial Assistance	1,744,112
TOTAL	14,056,571

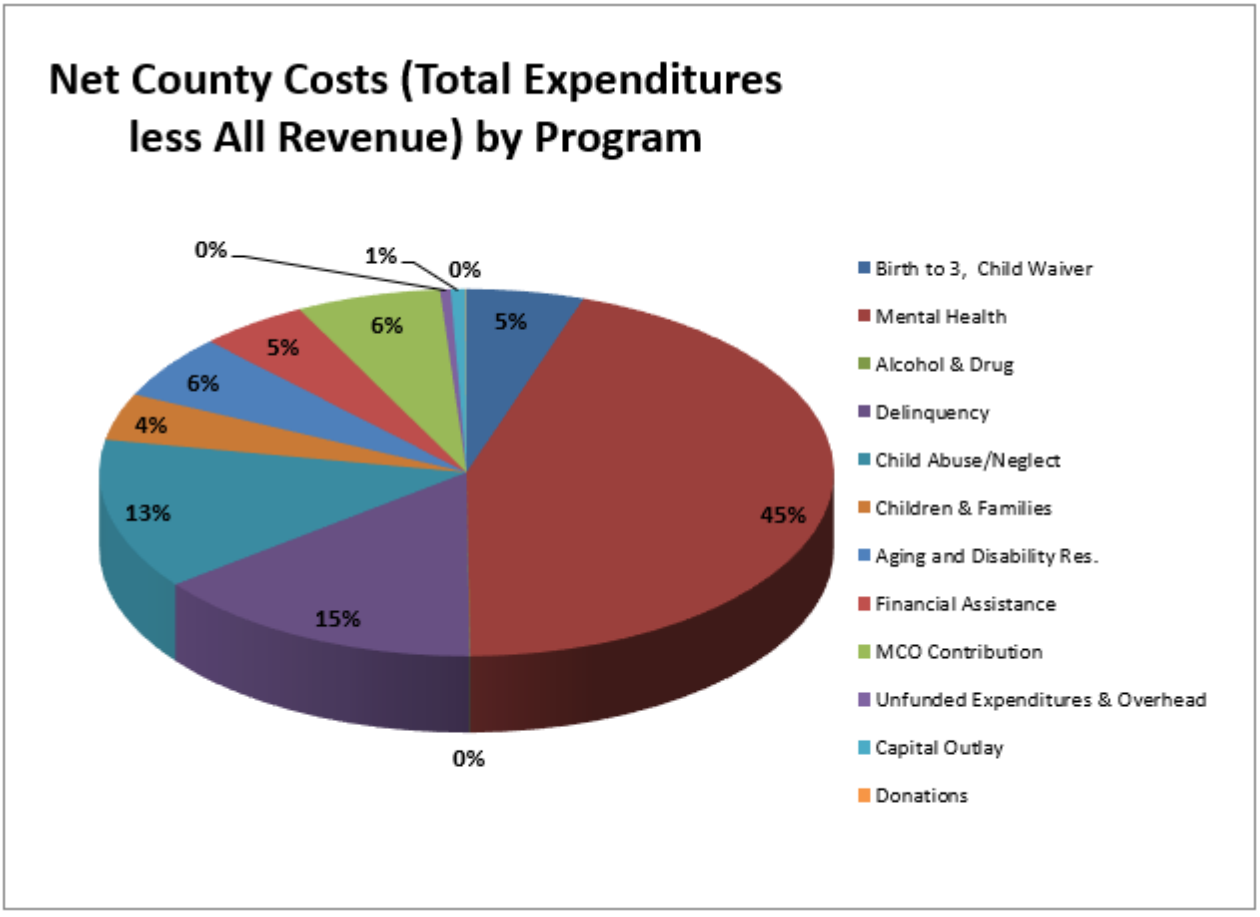
Consortium Economic Support (Financial Assistance)
are classified as State Payments





Net County Cost	
Birth to 3, Child Waiver	506,447
Mental Health	4,382,631
Alcohol & Drug	3,042
Delinquency	1,440,681
Child Abuse/Neglect	1,304,832
Children & Families	405,952
Aging and Disability Res.	555,658
Financial Assistance	471,341
MCO Contribution	625,097
Unfunded Expenditures & Overhead	45,368
Capital Outlay	64,986
Donations	3,711
Tax Levy for Operations	9,809,747

NOTE Calculation of Levy	
Tax Levy Transfer to Human Services Fund	9,918,063
Less: Net Positive (Negative) Balance from Operations	108,314
Tax Levy from Operations	**9,809,749**
Net Positive (Negative) Balance from Operations	108,314
Carryforward from Prior Year	1,626,527
Balance Returned To General Fund	-18,343
2024 Request Approved to be Carried Forward to 2025 (includes prepaids)	**1,716,498**
Tax levy from Operations	9,809,749
Depreciation & Loss on Asset Disposal	544,823
County Indirect Cost	807,497
Total Tax Levy	**11,162,069**



The table below summarizes amounts lapsed at year-end for the past ten years.

Year	Amount	
2024	$18,343	*
2023	$0	
2022	$455,080	
2021	$1,300,000	**
2020	$2,662,730	
2019	$455,357	
2018	$814,742	
2017	$206,012	
2016	$0	
2015	$216,555	
TOTAL	**$6,128,819**	

* Estimated at this point

** This $1.3M lapse was made in 2022 as part of a transfer out.

The chart below summarizes all donations, and community grants the Department received in 2024. It includes various community fundraisers and donations from private individuals and corporations.

DONATIONS AND GRANTS RECEIVED IN 2024			
DONATIONS	**Amount**		**Program**
Various Internal Fundraisers	$	992.80	Child Abuse Prevention
Private Individual Donation	$	300.00	Child Abuse Prevention
Paddy Coughlin's	$	600.00	Child Abuse Prevention
Private Individual Donation	$	1,000.00	Staff Recognition
St. Matthew's Education Account	$	525.63	Foster Parents
Paddy Coughlin's	$	50.00	Pack the Parlor
Various Internal Fundraisers	$	950.00	Pack the Parlor
Various Internal Fundraisers	$	1,086.16	Youth Justice
Julie's Food Truck	$	50.00	Youth Justice
Various Internal Fundraisers	$	175.13	CCS
Premier Bank	$	250.00	ADRC
Jefferson Memory Care	$	69.00	ADRC
Various Internal Fundraisers	$	242.80	ADRC
Jefferson Battle of the Bars	$	5,466.00	Incredible Years
Various Internal Fundraisers	$	242.80	Mental Health Recovery
EZ Promotion and Apparel	$	562.31	Mental Health Recovery
Culvers of Johnson Creek	$	280.00	Mental Health Recovery
Space Coast Credit Union - The Purple Alligator	$	111.00	Zero Suicide
Total Donations	**$**	**12,953.63**	
GRANTS	**Amount**		**Program**
United Way of Jefferson & Walworth Counties	$	530.13	Pillar Grant
Greater Watertown Community Health Foundation	$	6,000.00	Infant Mental Health
Greater Watertown Community Health Foundation	$	500.00	Mental Health Focus Groups
Greater Watertown Community Health Foundation	$	500.00	Children and Families
Total Grants	**$**	**7,530.13**	
Total Donations & Grants	**$**	**20,483.76**	

Review of Staff Mileage and Vehicle Expenses

Since 2009, we have endeavored to reduce staff mileage costs by adding additional fleet vehicles for staff use. The chart below summarizes this data with 2009 as the base year, because Department vehicles were only available on a limited basis then. The cost savings were significant in 2020 for several reasons. First, the COVID-19 pandemic limited travel, reducing mileage and gas costs. Secondly, the County started a fleet management program for its vehicles. The internal service fund handles the purchases of and maintenance of these new cars. This helped reduce the automobile costs and the parts/repairs cost. The goal is to replace vehicles every other year to provide cost savings and ensure County staff have safe and enough vehicles. As can be seen below, the reduction of costs since the beginning of the fleet management program has been significant.

Year-to-Year Comparison of Mileage & Vehicle Expenses							
	2009 Base Year	Average 2010-2019	2020	2021	2022	2023	2024
Total Mileage	$269,112	139,871	50,192	42,852	70,382	67,588	65,043
Gas/Diesel	16,464	38,479	25,730	46,785	76,424	73,421	64,919
Non Capital & Capital Auto	8	33,698	0	0	0	0	0
Vehicle Parts & Repairs	5,837	20,464	14,847	16,757	18,878	32,360	39,532
Total Expense	$291,421	232,512	90,770	106,395	165,684	173,369	169,494
Savings Compared to Base Year		$ 58,909	$200,651	$185,026	$125,737	$118,052	$121,927
Average Saving Since 2009							**$ 92,639**
Savings Compared to 2019			165,885	$150,259	$ 90,970	$ 83,285	$ 87,160
Average Saving Since 2019							**$115,512**

Review of 2024 Goals:

1. **Accurately and timely complete all County, State, and Federal reports, and billing.** The State and Federal governments require the Department to submit numerous budgets and reports as a condition of receiving program funding. We must be compliant with all Medicaid and Medicare requirements. Reporting and billing work charts are maintained to ensure compliance with reporting requirements. As we seek more funding opportunities, more reports are required. Reports have become more involved and complex, as we continue to serve more consumers and teams.
   GOAL RESULT: We complied with reporting requirements, as denoted on work charts for the fiscal team. We were compliant with timely reporting. All billing for 2024 was completed by early 2025.
2. **Transition to a new third-party administrator for the CLTS program.** DHS has contracted with WPS to be the third-party administrator (TPA) for the CLTS program for many years. In 2025, a new contractor will take over. As a result, we will have to work to implement many system and policy changes to ensure we are able to authorize, bill, and collect for our CLTS services.
   GOAL RESULT: The State delayed the implementation of this transition until May 2025. We continue to work diligently towards this goal.
3. **Expand the operations of our Youth Crisis Stabilization Facility.** We currently have contracted staff to provide four beds. We hope to expand to eight beds during 2024. We also want to expand the number of County contracts we have in place. We would like to apply for and continue to receive DHS grant and work toward fiscal sustainability.
   GOAL RESULT: We were able to successfully open male wing in August 2024. We have accepted admissions from many outside counties. We have applied for and been awarded several new State grants to continue to fund the YCSF.

Goals for 2025:

1. **Accurately and timely complete all County, State, and Federal reports, and billing.** The State and Federal governments require the Department to submit numerous budgets and reports as a condition of receiving program funding. We must be compliant with all Medicaid and Medicare requirements. Reporting and billing work charts are maintained to ensure compliance with reporting requirements. As we seek more funding opportunities, more reports are required. Reports have become more involved and complex, as we continue to serve more consumers and teams.

2. **Transition to a new third-party administrator for the CLTS program.** As noted above, this was a goal for 2025; however, it was delayed until 2025. As such, we will look to implement this new process in 2025.
3. **Implement hourly billing for Crisis Stabilization.** We currently bill per diem for work performed at our Lueder House and Matz Center. The transition to hourly billing could provide more efficient and increased billing.
4. **Improve the CCS monitoring and billing process by billing the programs earlier next year than was done this year.**

MAINTENANCE

~Updating Capital for Long-Term Sustainability~

In 2024, Human Services focused on staff safety for many of our projects. These projects included window security film, seven new doors, intercom systems, a secure swipe card entry system at the Lueder House, improved signage around the buildings, swipe doors for the Health Department, outdoor lights at Hillside, and a UPS replacement at Hillside.

Other major projects completed during the year include a new public health vending machine outside of the building for the public to use free of charge, ceiling tiles in the Hillside basement, a concrete slab at CSP, and cabinets in Intake and the Lueder House.

The County also owns triplexes. Throughout the year, we replaced the roofs on both triplexes using ARPA funding.

In addition to the capital projects mentioned above, the County began a fleet management program for staff vehicles at Human Services. In 2020, we replaced nine vehicles and acquired 14 new vehicles. In 2021, we replaced 14 more vehicles. In 2022, we replaced 10 vehicles and acquired 12 new vehicles. We did not make any vehicle swaps in 2023 or 2024 to our fleet program; however, we did acquire a new wheelchair van for the Transportation program. These vans were funded, in part, by assistance from the Wisconsin Department of Transportation.

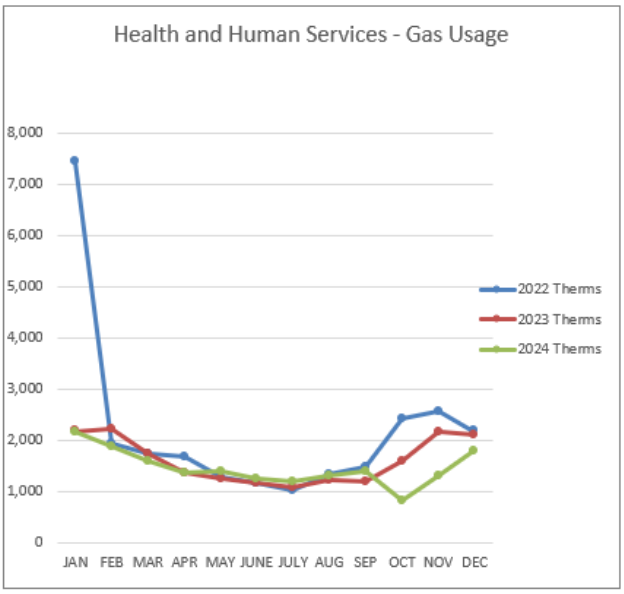
The fleet cars ensure staff have access to vehicles at most times when needed, improve safety in the vehicles, and reduce maintenance and gas costs on the vehicles. Staff drove the fleet vehicles 364,158 miles in 2022 compared to 276,785 miles in 2021. The staff costs for personal vehicle use can be seen on the graphs on prior pages.

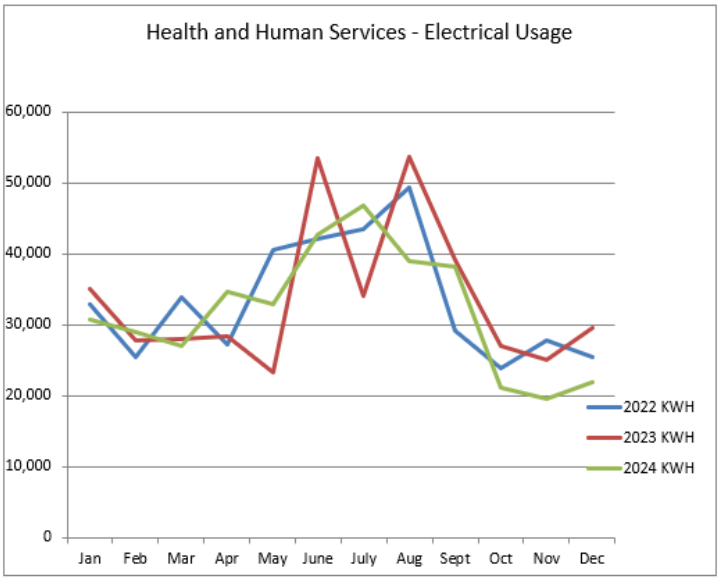
Electrical usage has been consistent in most areas, after increasing for a few years post-pandemic. Moreover, pneumatic controls were replaced with electrical controls. Gas usage is mostly due to the boiler system. The boiler must be left on during the year, to control the heat and offset the air conditioning, as needed.

2024 UTILITY USAGE FOR HEALTH & HUMAN SERVICES BUILDINGS

Health & Human Services - Gas Usage - Therms					
Month	2020 Therms	2021 Therms	2022 Therms	2023 Therms	2024 Therms
Jan	2,295	2,515	7,465	2,184	2,166
Feb	1,952	2,671	1,934	2,231	1,874
Mar	1,521	2,431	1,745	1,745	1,612
Apr	1,113	2,023	1,688	1,383	1,363
May	216	926	1,287	1,251	1,400
June	22	28	1,157	1,171	1,251
July	22	24	1,018	1,097	1,197
Aug	22	15	1,344	1,218	1,309
Sept	160	97	1,489	1,185	1,411
Oct	680	606	2,440	1,592	821
Nov	1,305	1,432	2,564	2,170	1,300
Dec	2,481	2,570	2,184	2,123	1,808
TOTALS	**11,789**	**15,338**	**26,315**	**19,350**	**17,512**

Health & Human Services - Electric Usage - KWH					
Month	2020 KWH	2021 KWH	2022 KWH	2023 KWH	2024 KWH
Jan	19,760	28,400	32,960	35,040	30,684
Feb	18,000	27,920	25,520	27,760	28,894
Mar	20,880	32,240	33,840	27,920	27,118
Apr	12,160	28,720	27,200	28,320	34,663
May	23,440	41,360	40,640	23,200	32,810
June	21,520	42,560	42,080	53,520	42,738
July	28,000	43,120	43,440	34,000	46,878
Aug	21,920	47,920	49,280	53,600	39,019
Sept	19,360	33,760	29,200	39,200	38,266
Oct	22,080	30,080	23,920	26,942	21,186
Nov	29,840	29,120	27,760	24,997	19,518
Dec	27,600	28,800	25,360	29,531	21,880
TOTALS	**264,560**	**414,000**	**401,200**	**404,030**	**383,654**

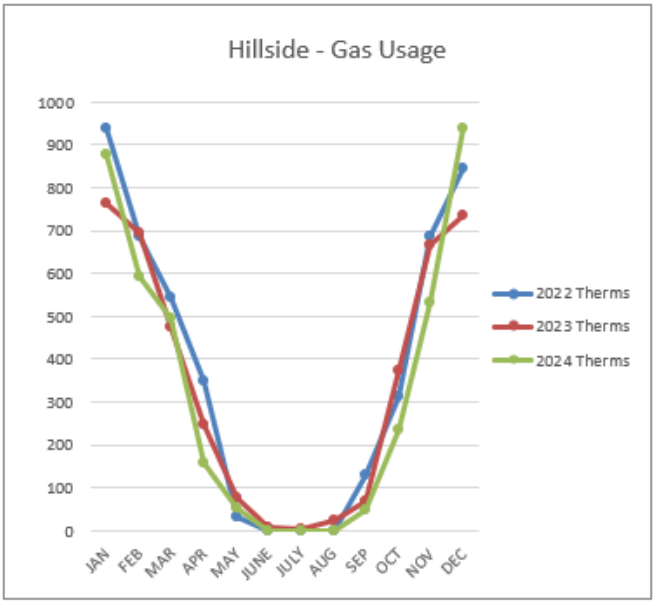


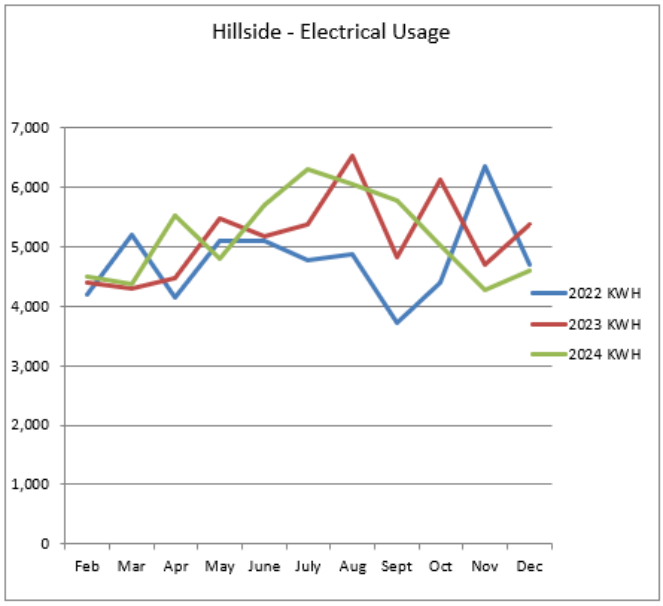


2024 UTILITY USAGE FOR HILLSIDE BUILDING

Hillside Office - Gas Usage - Therms					
Month	2020 Therms	2021 Therms	2022 Therms	2023 Therms	2024 Therms
Jan	867	772	937	763.8	878.8
Feb	719	741	687	694.1	592.2
Mar	494	387	543	477.1	495.6
Apr	333	224	349	248.8	159
May	24	105	31	78	50.6
June	0	4	0	9.5	0
July	0	0	0	4.8	0
Aug	0	0	0	22.7	0
Sept	0	12	128	69.4	49.5
Oct	189	321	313	375.6	234.5
Nov	493	647	688	666.7	532.7
Dec	894	893	845	734.5	940.3
TOTALS	4,013	4,106	4,521	4,145	3,933

Hillside Office - Electric Usage - KWH					
Month	2020 KWH	2021 KWH	2022 KWH	2023 KWH	2024 KWH
Jan	4,440	3,380	4,402	5,644	5,376
Feb	4,280	3,478	4,196	4,393	4,488
Mar	3,920	3,390	5,189	4,295	4,369
Apr	2,720	2,850	4,138	4,467	5,517
May	2,880	3,517	5,096	5,471	4,803
June	3,640	3,600	5,097	5,162	5,700
July	3,960	3,956	4,772	5,361	6,309
Aug	3,361	4,493	4,872	6,536	6,049
Sept	2,974	3,026	3,728	4,809	5,768
Oct	3,496	3,433	4,385	6,132	5,012
Nov	3,199	4,268	6,349	4,694	4,281
Dec	3,359	4,302	4,703	5,382	4,599
TOTALS	42,229	43,693	56,927	62,346	62,271

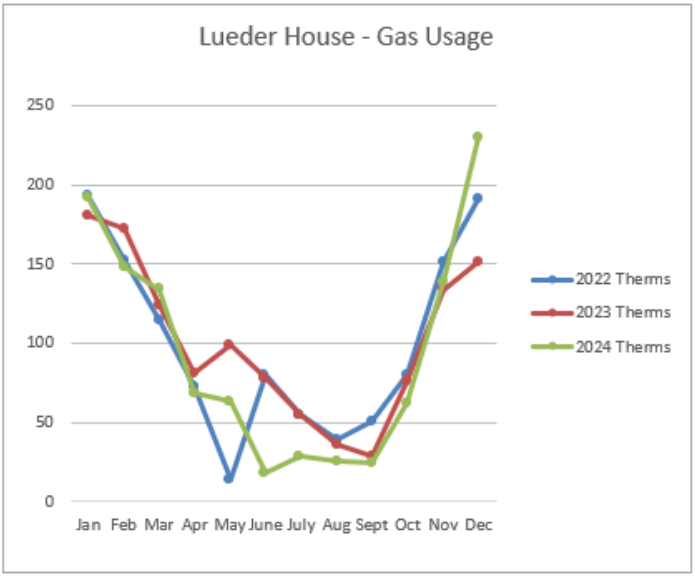


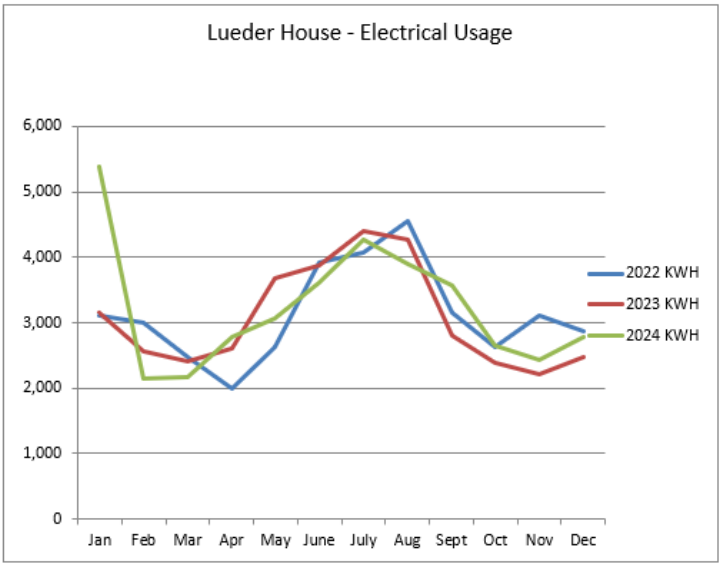


2024 UTILITY USAGE FOR
LUEDER HOUSE

Lueder House- Gas Usage - Therms					
Month	2020 Therms	2021 Therms	2022 Therms	2023 Therms	2024 Therms
Jan	153	178	193	180.9	192.8
Feb	128	155	153	172.1	148.1
Mar	86	81	115	123.9	134.2
Apr	53	91	73	81	68.3
May	59	78	14	99.2	63.5
June	61	34	80	78.3	17.8
July	41	30	55	54.9	28.8
Aug	34	22	39	35.8	26
Sept	51	18	51	28.3	24.8
Oct	128	69	80	76.3	62.1
Nov	90	204	151	134.2	138.7
Dec	172	181	191	151.4	230.3
TOTALS	1,056	1,141	1,195	1,216	1,135

Lueder House - Electric Usage - KWH					
Month	2020 KWH	2021 KWH	2022 KWH	2023 KWH	2024 KWH
Jan	3,560	2,760	3,120	3,160	5,376
Feb	3,320	3,160	3,000	2,560	2,143
Mar	3,280	3,040	2,480	2,400	2,162
Apr	2,400	2,800	2,000	2,600	2,785
May	2,840	3,800	2,640	3,680	3,060
June	3,760	3,600	3,920	3,880	3,617
July	4,080	3,880	4,080	4,400	4,274
Aug	3,440	4,280	4,560	4,280	3,892
Sept	3,400	2,720	3,160	2,800	3,562
Oct	3,520	3,000	2,640	2,398	2,661
Nov	3,240	4,000	3,120	2,215	2,441
Dec	2,920	3,160	2,880	2,483	2,781
TOTALS	39,760	40,200	37,600	36,856	38,754

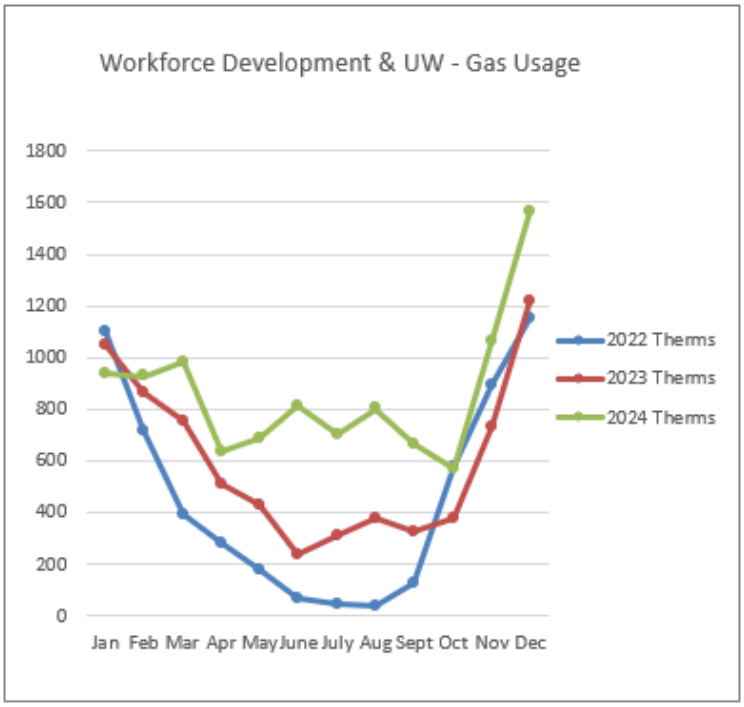


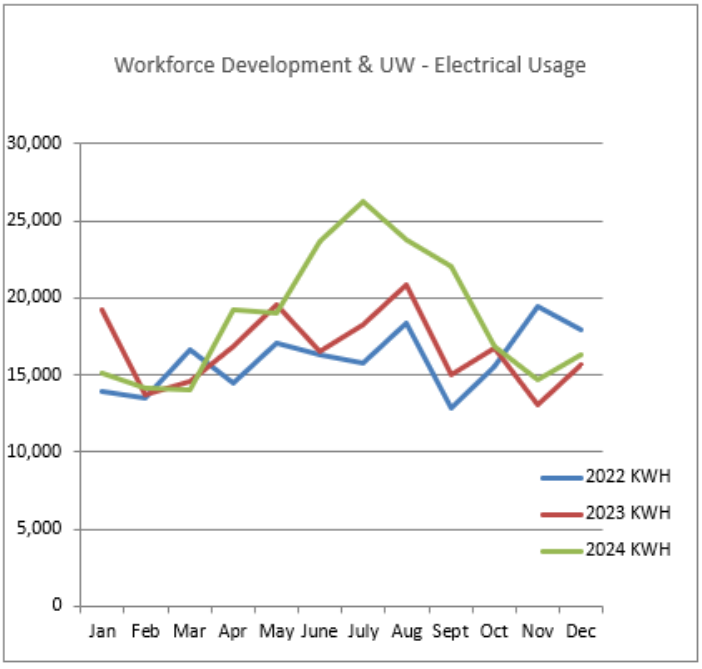


2024 UTILITY USAGE FOR
WORKFORCE DEVELOPMENT CENTER

Workforce Development & UW - Gas Usage - Therms					
Month	2020 Therms	2021 Therms	2022 Therms	2023 Therms	2024 Therms
Jan	772	1013	1101	1051.7	940.3
Feb	632	1064	718	863.8	928.5
Mar	434	694	392	756.2	986.5
Apr	386	324	286	510.7	639.2
May	173	223	183	428.5	689.8
June	8	90	71	235.8	816
July	6	39	46	313.7	700.9
Aug	6	48	41	378.6	803.1
Sept	29	58	127	328.4	670
Oct	451	255	580	380.4	573.5
Nov	702	589	894	733.2	1063
Dec	1229	955	1151	1222.9	1563.3
TOTALS	4,828	5,352	5,590	7,204	10,374

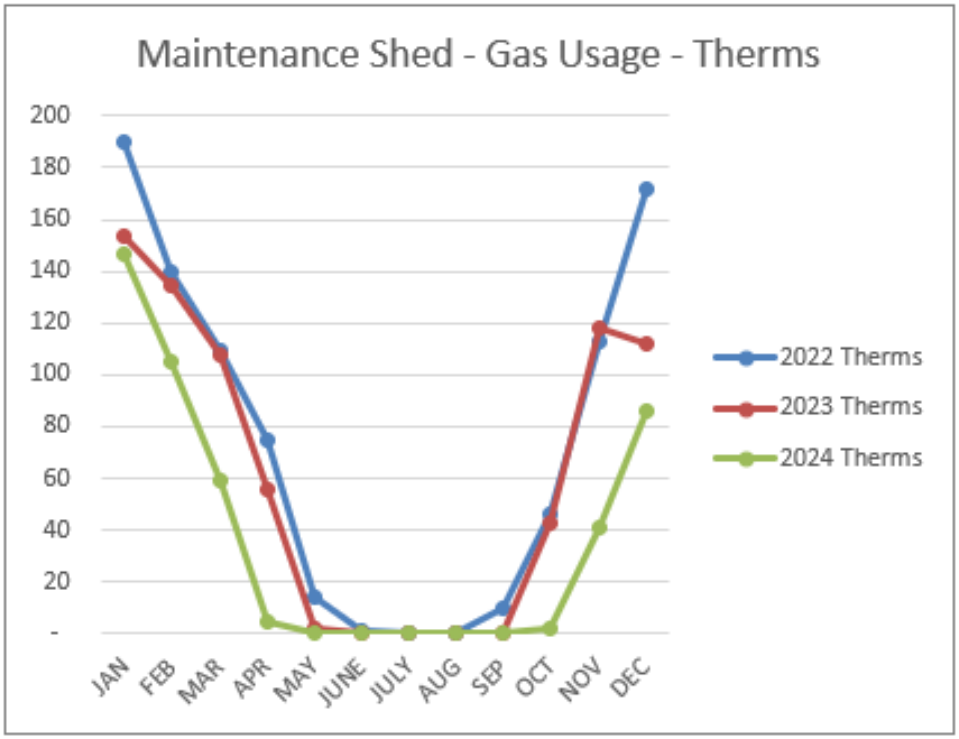
Workforce/UW - Electric Usage - KWH					
Month	2020 KWH	2021 KWH	2022 KWH	2023 KWH	2024 KWH
Jan	14,320	13,920	13,920	19,200	15,058
Feb	14,240	13,760	13,520	13,680	14,172
Mar	13,840	15,760	16,640	14,560	14,066
Apr	10,080	13,520	14,480	16,800	19,249
May	12,880	16,400	17,040	19,520	19,009
June	14,240	16,000	16,320	16,560	23,676
July	14,720	16,080	15,760	18,240	26,200
Aug	13,360	17,680	18,400	20,800	23,813
Sept	12,480	13,840	12,800	15,040	22,051
Oct	12,800	15,520	15,550	16,682	16,892
Nov	14,080	15,840	19,440	13,045	14,634
Dec	14,160	14,480	17,920	15,672	16,293
TOTALS	161,200	182,800	191,790	199,799	225,113





2024 UTILITY USAGE FOR
MAINTENANCE SHED

Maintenance Shed - Gas Usage - Therms					
Month	**2020 Therms**	**2021 Therms**	**2022 Therms**	**2023 Therms**	**2024 Therms**
JAN	109	177	190	153	147
FEB	147	164	140	135	105
MAR	96	84	109	108	59
APR	64	37	75	56	4
MAY	91	14	14	2	-
JUNE	-	-	1	-	-
JULY	-	-	-	-	-
AUG	-	-	-	-	-
SEP	-	-	10	-	-
OCT	52	29	46	43	2
NOV	72	102	113	118	41
DEC	157	147	172	112	86
TOTALS	**788**	**754**	**870**	**726**	**444**



CAPITAL IMPROVEMENTS SUMMARY OF BUILDINGS, EQUIPMENT, AND PHYSICAL PLANT

Hillside House Built in 1938

Head Start renovation 1987
Electrical upgrade early 1990's
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
Remodeled bathroom into two offices 2015
Installed Automated Logic 2016
Installed security cameras 2016
Replaced windows 2016
Replaced sidewalks 2017
Installed Fire Alarm System 2017
Replaced door 2 2018
Remodeled CCS conference room 2018
Remodeled kitchen 2019
New copier lease 2019
Replaced boiler 2020
Added radiators, pipes, and hot water system 2020
Replaced exterior door 2021
LED Lighting Upgrade 2022
Restroom remodel 2022
Water filling station 2022
New offices for Compliance 2022
Window security film 2024
Swipe door for basement entrance 2024
Door in CCS quad room 2024
Basement office ceiling and electrical work 2024
Replaced outdoor lights and excavating 2024
Replaced UPS 2024

Health/Human Building Built in 1980 and addition built in 1995

Remodeled basement 1989
Replaced roof membrane/gutters 2003
Replaced rooftop HVAC unit 2007
Replaced flooring in Health lab and exam rooms 2008
Replaced four rooftop unit heaters 2009
Remodel TPR room 2010
Remodeled Intake area 2010
Seal coat re-stripe parking lot 2010
Added door access control 2013
Replaced flooring 2013
Remodel Viewing room 2013
Replaced office lighting with T8 2013
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 & Health Reception 2014
Added LED lighting 2014
Added BR Glass at main reception 2014
Replaced two entry doors 2014
Replaced sidewalks 2014
Replaced vestibule unit heater 2014
Remodeled three work regions 2014
Added BR Glass in Health Dept 2015
Installed Automated Logic 2016
Installed security cameras 2016
Replaced sidewalks 2017
Replaced Fire Alarm System 2017
Remodeled Watertown Conference 2018
Remodeled Aztalan Conference 2018
Replaced door 8 2018
Parking lot addition at south lot 2018
Started installation of AC units 2018
Installed data room AC 2018
Intake area remodel 2018
Completed AC installation 2019
Front vestibule flooring 2019
Stairway treads and landings 2019
Electronic door access at public entries 2019
New copier lease 2019
Electronic door strikes (3) added 2020
Roof replaced 2020
New siding, windows, insulation 2020
New generator 2020
New HVAC and controls 2020
19 additional parking lot lights 2020
New sewer line 2020
WIC lobby remodeled 2020
Replaced exterior doors – receiving, clinic, and double doors 2021
Preschool flooring 2021
LED lighting upgrade 2022
ADRC lobby flooring 2022
Restroom renovations 2022
Lower level play area flooring 2022
New sewage lift pumps 2023

Expanded generator capacity 2023
Door controls in the health labs 2023
Replaced broom for snow removal 2023
Expanded video storage capacity 2023
Window security film 2024
Public health vending machine installed with concrete slab and electrical work 2024
Cabinets replaced in Intake 2024
Front desk BR door 2024
Replaced back exit door 2024
Intercom system at receiving area 2024
Spanish and other new signs 2024
Swipe doors in Health Dept 2024

WDC/UWX Building Built in 1999

Remodeled call center 2013
Replaced flooring 2014
Added LED lighting 2014
Installed Automated Logic 2016
Installed security cameras 2016
Installed new carpet at WDC 2016
Replaced sidewalks 2017
Replaced Fire Alarm System 2017
Installed new carpet 2017
Installed new boilers 2019
HVAC controls continuation 2019
Return fan VFD 2019
Public entry doors 2019
Electronic door access at public entries 2019
Parking lot improvements 2020
Replaced generator 2020
Replaced air conditioning 2020
Boiler repairs 2021
Roof and gutter work 2021
New bollards along sidewalks 2021New flooring in UW-Extension 2021
New copier lease 2022
Conversion of storage space into cubicles 2022
New HVAC 2022
LED Lighting Upgrade 2022
New lobby flooring 2022
Three new card readers in CLTS area 2023
New door in CLTS area 2023
Window security film 2024
Replaced doors 6 and 7 2024

Lueder House/CSP Built in 1996

Remodeled/Added C
SP offices 2004 – 2010
Replaced A/C condensing unit 2012
Added LED outside lighting 2013
Modified deck 2013
Painting 2013
Replaced all flooring 2014
Completed backup generator 2015
Installed new furnace 2016
Security Cameras Installed 2016
Installed new roof shingles 2016
Reconstructed rear entry 2016
Replaced sidewalks 2017
Replaced Fire Alarm System 2017
Started rebuilding of retaining wall 2018
Completed retaining wall 2019
Graded and started asphalt 2019
Rear concrete sidewalk 2019
Lower level entry door 2019
Electronic door strikes (1) added 2020
Replaced bolts and joists on deck 2020
Created a new supervisor office 2021
LED lighting upgrade 2022
Leaf guards 2022
Window security film 2024
Concrete slab 2024
Cabinets replacement 2024
CSP intercom system
Lueder House swipe door and intercom 2024

County-Owned Housing

Purchased two apartments in Fort, Rodgers St., and Jefferson St. 2021
Electrical work, Rogers St., and Jefferson St. 2021
Two new furnaces, Jefferson St. 2021
New carpet and flooring, Dodge St. 2021
Built secure storage units 2022
Replaced garage door at Dodge St 2022
Tree removal 2023
Security cameras and lights installed 2023
New roofs on both units 2024

Review of 2024 Goals: All goals were met. Capital projects completed on time and within budget. Those that were not completed were carried over in 2025.

Goals for 2025

1. Complete capital projects, including numerous safety improvements to facilities, and those that are carried over from 2024.

2. Continue to use the fleet management program to expand and improve our fleet. Swap several aging cars in 2024.
3. Work with the Facilities Manager to ensure maintenance and custodial services are provided effectively and efficiently across all County buildings, not just at Human Services.

Compliance Program

Compliance: paving the way to growth

The Compliance Department of Jefferson County Human Services is dedicated to ensuring adherence to federal, state, and local regulations, as well as internal policies and procedures. Our mission is to promote ethical conduct, accountability, and transparency in all operations related to human services programs.

The Compliance Program is uniquely placed in the Division of Administrative Services. However, the Compliance Officer reports to the Director in an effort to further exemplify the role of independent reviewer and evaluator of all programming, while not aligning with a single program or area. The Compliance Officer position serves several crucial functions for the agency. First, this role is trained and equipped to receive and investigate all consumer complaints via interviews, collateral contacts and file reviews. Second, the Compliance officer handles all reported HIPPA concerns or violations in consultation with the Corporation Counsels office. Finally, this position directly and independently receives anonymous complaints from internal and external stakeholders via a confidential and secure complaint line. The Compliance Officer is tasked with ensuring compliance requirements are built into the design and implementation of all billing and reporting systems.

To assure compliance with federal and state programming, the Compliance Officer handles all our Civil Rights reporting duties, HIPPA training and ensures that all new staff are trained in the Jefferson County Human Services Code of Conduct standards.

The Compliance Program consists of five full time employees. The Compliance Officer and five full-time Administrative Specialists. Each Admirative Specialist is assigned to a specific team within the Behavioral Health Division to help assure compliance needs are met within that program. The specific role of each Compliance member varies to include but not limited to reviewing case notes, service plans, assessments and reviews to assure congruence with all billing practices and codes.

This report highlights the department's achievements, challenges, and initiatives undertaken during the last year.

Highlights of 2024

- A new full-time position was added in 2024 to address our continued growing compliance needs.
- The Compliance Program monitored over 10,000 notes per month and completed 100's of chart reviews throughout the year.
- Compliance Plans were developed in additional areas of the agency outside of Behavioral Health.
- Updated and revised the agency wide confidentiality policy.

Review of 2024 Goals:

1. Hire additional staff to continue to address the growing need of Compliance among the behavioral health teams. *Accomplished.* One additional staff member was hired to assist with the growing number of CCS consumers.
2. Update Agency Policies. *Accomplished*. All agency polices related to compliance were reviewed and updated with the assistance of Corporations Counsel when needed.
3. Continue to expand the Compliance Program within other Departments. *Accomplished*. The Compliance Officer attended the various division meetings to assess need and areas of assistance.
4. Create a Lead Compliance position to help with the growing needs of the Compliance Program. *Not accomplished.* After strategically examining the needs of the Compliance Team, it was determined that an additional Compliance specialist was needed, rather than a lead staff member.

Goals for 2025:

1. Increase Compliance staff to support the ever-growing and evolving department and agency.
2. Create an algorithm to monitor productivity levels of the Compliance team to assist with weekly output of notes.
3. Create and develop policies and procedures that increase efficiency and accuracy of charts, progress notes, and billing, while decreasing in the corrections required of staff.
4. Create a clear list of scope and responsibilities between teams and Compliance.
5. Re-instate yearly HIPAA training agency wide to promote better understanding and decrease HIPAA violations.
6. Promote a better understanding of the teams and departments that Compliance interacts with daily.

AGING & DISABILITY RESOURCE DIVISION

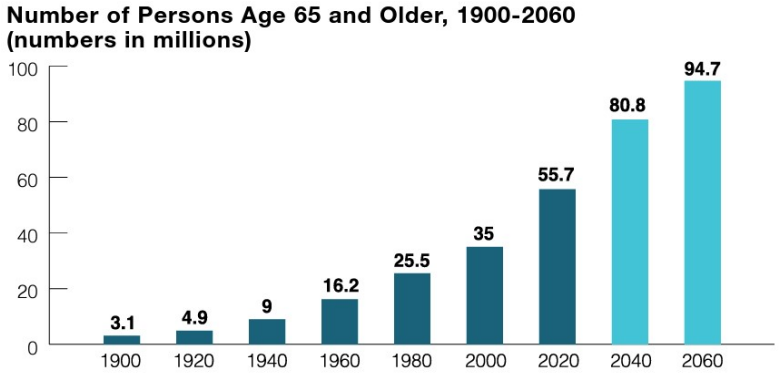
~To equip, empower and engage individuals living with disabilities, seniors, and their caregivers, by connecting them with support and services while honoring their ability to make informed choices. ~

The Aging & Disability Resources Division of Jefferson County Human Services encompasses many programs and funding streams that provide services and support to seniors, adults with disabilities, children with disabilities as they transition into adulthood, and people with Alzheimer's disease or another form of dementia and their caregivers. Services and support are intended to help people live with a high degree of independence in their own homes and communities for as long as they desire. We adhere to the principles of Motivational Interviewing to help people achieve their best possible outcomes.

Wisconsin is the birthplace for ADRCs. The long history of ADRC development started in the 1990s as people in Wisconsin came together to develop the concept of an ADRC. The first ADRCs in Wisconsin began operation in 1998 and expanded to cover the entire state by 2013. Across the country, people can get help to learn about services available in their area because ADRCs in Wisconsin blazed the trail.

Here at Jefferson County ADRC, our vision is to equip, empower and engage individuals living with disabilities, seniors, and their caregivers, by connecting them with support and services while honoring their ability to make informed choices. Our mission is to advocate for and help people achieve their goals by providing them with comprehensive information, assistance, and opportunities to engage in the public policy process so they can make informed decisions and remain in charge of their lives.

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 Older Americans Act (OAA) specifies that these funds should be directed to individuals with the greatest economic and social need "with particular attention to low-income seniors, including low-income minority individuals, seniors with limited English proficiency and seniors residing in rural areas." The growth of the aging populations in Jefferson County in the coming decades will create opportunities and challenges for our long-term support and services. Between now and 2040, the proportion of the population age 65 and over will increase significantly. Strategic planning of programs and services is needed currently to meet the demand of future consumers. Jefferson county is projected to have slightly higher than average percentage of community members over the age of 65 in the years to come.



Note: Lighter bars (2040 and 2060) indicate projections.
Source: U.S. Census Bureau, Population Estimates and Projections

The OAA provides a framework under which the Division's two oversight committees operate: the ADRC Advisory Committee and the Nutrition Project Council.

Aging & Disability Resource Center Advisory Committee

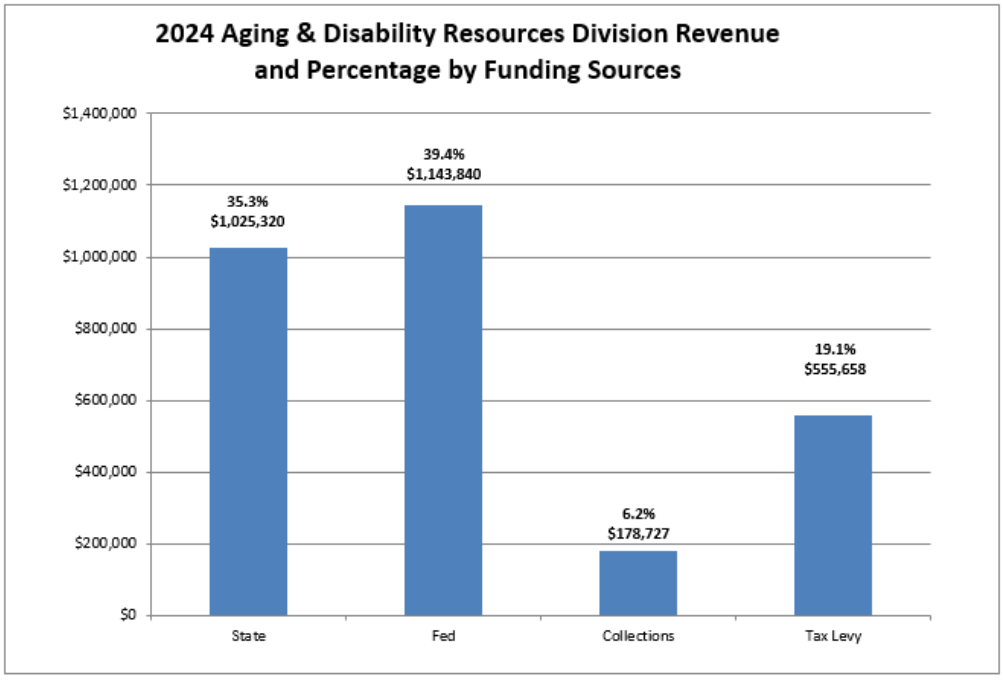
ADRC Advisory Committee Members are ambassadors of the ADRC. These committee members act as a conduit between the ADRC and the community members it serves. The committee members help to "spread the word" about the ADRC and about the services the ADRC provides, as well as to bring identified needs from the community to the ADRC for consideration. This committee is actively involved in oversight and planning efforts on behalf of the division's constituents and is responsible for advising the Human Services Board about programs, policies, and unmet community needs.

Nutrition Project Council

This council is responsible for advising the Senior Nutrition Program Supervisor on all matters relating to the delivery of nutrition support services, including making recommendations regarding days and hours of meal site operations, site locations, setting the annual "suggested donation," and making recommendations regarding meal site furnishings with regards to persons with disabilities.

To remain a customer driven organization, we challenge ourselves to envision the future, reinvent how we do business, push through barriers and advocate for system changes that will make a positive difference for our community. With the population shift we are expecting as the Baby Boomer generation navigates the later years of their lives, we will need to listen to our aging community members and their caregivers to learn how we can best meet their unique needs.

We have a responsibility to our community consumers to provide meaningful support and services, while also upholding our responsibility to be good stewards of tax-payer dollars. Through intentional listening sessions and comprehensive surveys, the ADRC consults with community partners and citizens to learn about the unmet needs of individuals who are aging or living with a disability in our community. It is important that we understand not only what the needs are but also the delivery methods most desirable to and effective for the consumers. To maximize our effectiveness, we need to consider new and creative ways to provide support and services to our community. Successfully achieving these goals while also efficiently utilizing the funds generously available to us defines our core purpose at the Aging and ADRC of Jefferson County. The table below reflects the overview of the entire budget of this division for 2024.



AGING AND DISABILITY RESOURCE CENTER

"Your Bridge to Support"

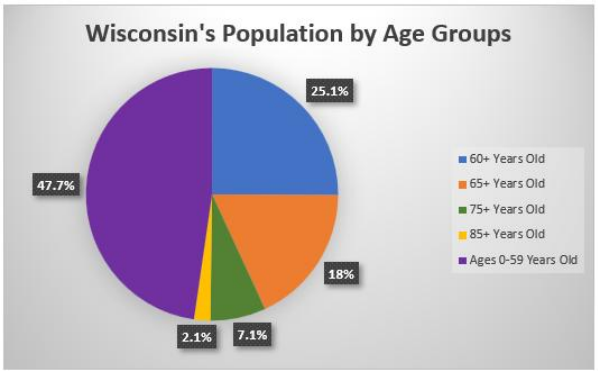
The Aging and Disability Resource Center (ADRC) of Jefferson County is a welcoming and accessible place where older adults, people with disabilities, transitioning youth, families, caregivers, and professionals alike can receive unbiased, reliable information and guidance on a wide variety of topics and programs. The ADRC promotes individual choice, supports informed decision-making, and makes every effort to minimize confusion and streamline access to needed services and resources. By empowering people to find resources in their local communities and make informed decisions about long-term care, the ADRC helps people conserve their personal resources, maintain self-sufficiency and dignity, and delay or prevent the need for potentially, expensive long-term care.

The ADRC of Jefferson County serves as the single access point for publicly funded long-term care programs, providing eligibility determination and enrollment counseling for the state's managed long-term care programs (Family Care and Partnership) and self-directed supports waiver programs, IRIS (Include, Respect, I Self-Direct). ADRC staff also provide option counseling, short-term case management, and advocacy support to ensure that our consumers remain as independent as possible. ADRC services are always free, confidential and if desired, anonymous. The staff at the Aging and Disability Resource Center of Jefferson County (ADRC) are committed to providing flexible and personalized assistance. Whether in person, through office and home visits, via virtual conferencing, or through phone, text, or email, we are here to meet you where you are and offer support in the way that best suits your needs. Our team is dedicated to ensuring that everyone can easily access the resources and guidance they require, regardless of their preferred communication method.

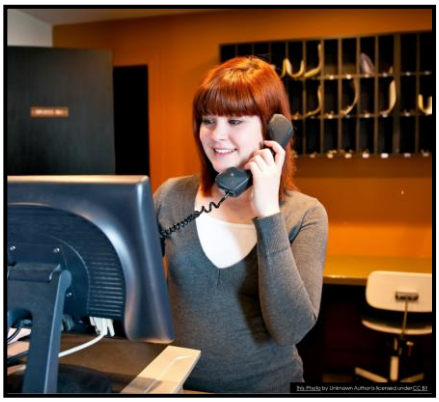
ADRC operations are funded by state contract general purpose revenue (GPR) and federal reimbursement dollars. The 2024 ADRC State contract was $645,540 compared to $652,828 in 2023 ($7,288 less). With 100% time and task reporting, staff have averaged a federal reimbursement rate of 46% in additional dollars to support all ADRC operations. Despite the great federal reimbursement rate, the ADRC overspent all ADRC contract dollars by $91,629.50. During the year, our fiscal department kept the ADRC well informed of the deficit. The factors that go into the overspending are the higher costs of health care for employees, one additional staff (hired in 2022), higher salaries, cost adjustments through the years and the % allocation changes.

The Bureau of Aging and Disability Resources (BADR) recognizes that the current formula to determine ADRC contract dollars creates an inequitable distribution of funding among ADRC's, as the current formula does not consider elements associated with health and social inequity; does not adjust for the increased need for ADRC services; and does not account for the needed cost of living adjustments. BADR also recognizes additional general-purpose revenue (GPR) funding to our state's ADRCs is needed to keep pace with providing quality services to the aging and disabled populations of Wisconsin. The 2023-25 Governor's budget did include an increase of $11 million annually for ADRC's. Those additional funds were not made available to ADRC's in 2024 and should be released in 2025. The need

for increased financial support will be ongoing and so the request for the 2025-2027 Governor's budget is an increase of 19.9M. Although the 2025-27 budget has not been finalized, the re-estimate adds only 3.8M GPR over the biennium.



Per WI. Department of Health Services (P-01213A) updated 01.29.25 with source U.S. Census, American Community Survey, 2019-2023 five-year estimates, Wisconsin's estimated population is 5,892,023. Of the nearly 6 million people, 25.1% are 60+ years old and 18% (or 1,062,121) are persons 65+ years old. There is another (7.1% or 419, 886) individuals 75+ years old. From the same source. In Wisconsin, 10% of the population ages 18-64 are living with a disability. Many of these individuals will need long term care options counseling and the number will continue to grow as America is hitting "peak 65" in 2024 as record numbers of boomers reach retirement age. Data indicates, each day in the United States 10,000 people turn 65, and the number of older adults will more than double over the next several decades and represent over 20% of the population by 2050 (Source: UN Population Division). The good news is people are living longer, healthier lives. Healthy lifestyles, planning for retirement, and knowing your options for health care and long-term care are more important now than ever before. Our customer base has grown, and it is for this and many other reasons, why ADRC's are so needed and an important community partner.



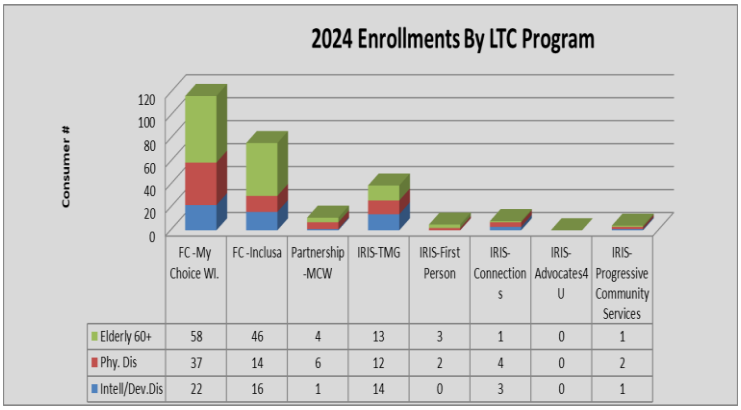
In 2024, the ADRC of Jefferson County was a very busy place once again. We began using a new database, known as Peer Place, on 11.6.24. The new system has different search profile capabilities compared to the last system (Wellsky) and therefore, there is not an exact comparison. From Jan-Oct. 2024 ADRC staff documented 7,786 unduplicated calls (Wellsky) with another 898 client units served during Nov-Dec 2024 (Peer Place) for a total of 8,684 contacts for the year; well above the two previous years. In 2024 the ADRC was fully staffed all year with no vacant positions. To remain competitive with today's workforce, several staff continued to work a mix of office (primary), and remote work (1-2 days/week) as allowed in the personnel ordinance for Telecommuting and Remote Work Policy and Procedure.

ADRC 2022-2024 Contacts Summary

Month	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	**Totals**
Total Calls 2022	652	682	804	649	642	703	608	746	725	727	660	662	**8260**
Total Calls 2023	613	619	744	582	615	792	616	744	781	732	687	557	**8082**
Total Calls 2024	770	787	816	746	746	825	769	790	798	739	456	442	**8684**

Public benefits for long-term care (LTC) programs are the most common conversation ADRC staff have with our callers. Many of those conversations are preliminary in nature, while for others, the need is more immediate. Resource Specialist (RS) assists customers with financial (Medicaid) and functional screen eligibility followed by enrollment counseling. In 2024, staff enrolled 260 individuals into Family Care, Partnership, or IRIS (I Respect, I Self Direct) programs compared to 235 in 2023. The target group for those 260 customer enrollments includes 126 Elderly ,77 Physically Disabled and 57 Intellectual or Developmentally Disabled (IDD).

In 2024, two Managed Care Organizations (MCO) served Jefferson County, namely My Choice Wisconsin and Inclusa. Additionally, there were five IRIS Consultant Agencies (ICA) that individuals could choose to enroll in, namely TMG, First Person, Connections, Advocates4U and Progressive Community Services. In 2025, two additional Family Care programs will be available in Jefferson County, provided by Community Care and Lakeland Care. There will also be a second Partnership program available, namely Independent Care Health Plan or I-Care. The chart below details the long-term care enrollments over the past year.



	FC -My Choice WI.	FC -Inclusa	Partnership -MCW	IRIS-TMG	IRIS-First Person	IRIS-Connections	IRIS-Advocates4U	IRIS-Progressive Community Services
Elderly 60+	58	46	4	13	3	1	0	1
Phy. Dis	37	14	6	12	2	4	0	2
Intell/Dev.Dis	22	16	1	14	0	3	0	1

Each year, the ADRC facilitates quarterly meetings between the Managed Care Organizations, IRIS Consultant Agencies and Income Maintenance to address any customer discrepancies and to maintain open lines of communication. In 2024, ADRC staff assisted callers with other public benefits such as Medicare, Food Share and low-income housing. Thirteen individuals were also assisted and approved by DHS to receive the SSI-E exceptional expense supplement ($95.99/mo.).

Initiatives and Highlights of 2024:

2024 was another unique year, as we found ourselves still working in an era of the Public Health Emergency Unwinding. March was the first month in which we had a mix of Public Health Emergency (PHE) and regular annual renewals for public benefits. For many individuals, “reviews” were unfamiliar to them, creating an increase in the number of individuals contacting the ADRC for assistance with their benefit renewals or case “reviews”. Several individuals were subject to Medicaid Purchase Plan (MAPP) premiums that resulted in disenrollment from their long-term care program. Our Resource Specialists worked closely with Income Maintenance and assisted many of these individuals with re-enrollment into their long-term care program.

There are fourteen required “core services” in the 2024 contract between DHS and ADRCs. Many of these core services are covered in detail throughout this annual report. Information and Assistance is by far our largest service category. The Resource Specialist and our Administrative Assistant are the primary contacts for most incoming calls and emails. They assist by providing information and resources, and when necessary, they refer individuals to additional support services within ADRC, Human Services, and our community. Another core service, options counseling, is a person-centered interactive decision-support process that typically includes face-to-face interaction and is more than providing a list of service providers or programs for people to choose from. The ADRC is required to provide counseling to individuals to meet long-term care needs and factors to consider in making long-term care decisions. Enrollment counseling, also known as “choice,” counseling, is another core service provided to customers who have been found to be eligible for and are considering enrolling in one of Wisconsin’s publicly funded long-term care programs. Maintaining an adequate skill level in these roles is important and thus, ADRC supervisors/managers are required to observe staff performing one of these core services once per year. The requirement was met in 2024.

Youth Transitional Services

Transitional Services to assist young people transition from high school into the adult service systems is another important core service. ADRC staff work closely with the Children Long Term Care Services (CLTS) program regarding referral, LTC eligibility and disability benefits counseling. The Youth Transition Coalition (aka CCOT) facilitated by the ADRC, supports students and young adults with disabilities by sponsoring events open to the public. In March 2024, multiple students, teachers, and volunteers from various school districts attended the sponsored event “Moving Forward” at MATC-Watertown campus. The event provides valuable information to students with disabilities as they transition into adulthood and assist them with post-secondary planning.

Senior Farmers Market Nutrition Program

Each year, the ADRC-Aging Division issues checks (vouchers) to eligible seniors for the Senior Farmers Market Nutrition Program (SFMNP). As part of the ADRC's distribution efforts, we offered 14 outreach sites in June for the convenience of our residents and 137 of the 210 available checks were issued at those venues. The checks were also distributed at our office. Per the Department of Health Services (DHS) and an end-of-the year report, Jefferson County issued all 210 vouchers ($9,450) and had a voucher coupon redemption rate of 68% ($6,471 redeemed). The statewide average is 74%.

Marketing and Outreach is a core service that plays a vital role in ensuring the long-term sustainability of the ADRC while actively serving the community through public education. In 2024, we successfully engaged with the community through a variety of events and initiatives aimed at raising awareness and providing essential resources.

2024 Marketing Highlights:

- **5.1.24:** 2nd Annual Watertown Senior Care Fair at Watertown Senior Center
- **5.22.24:** Older Americans Month - ADRC Display at Volunteer Recognition Dinner
- **6.29.24:** Veterans Benefits Block Party, Fort Atkinson
- **8.7.24:** National Night Out at Jefferson Fair Grounds
- **10.24.24:** Veterans Regional Benefits Expo at Watertown Elk's Lodge
- **11.6.24:** Life After High School Services and Supports, Jefferson High School
- **11.8.24:** Jefferson Memory Care 10-Year Celebration
- **11.16.24:** Faith Community Church, Fort Atkinson
- **July:** Appearances at the Lake Mills, Watertown, and Fort Atkinson Farmers Markets

These events helped to strengthen connections within the community and ensure that individuals had access to valuable information and resources provided by the ADRC.

Review of 2024 Goals:

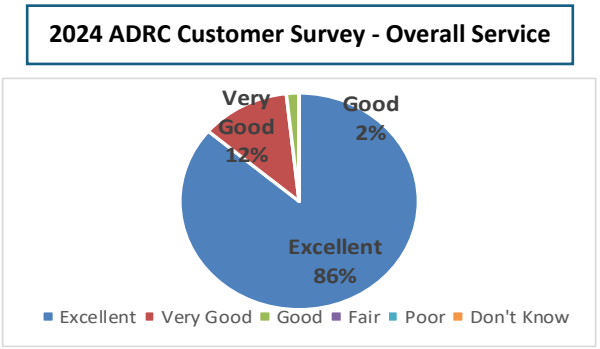
Key Outcome Indicator:

100% of all initial in-person appointment requests (i.e. home, office, hospital, SNF or CBRF visit) shall be scheduled and conducted within ten (10) business days following the customer's request or later if preferred by the customer.

- **Goal met.**
  - ADRC staff were 496 out of 496 in compliance with the KOI.

Additional 2024 Goals:

1. **100% compliance with the State Contract.**
   - **Goal primarily met.**
     - There are multiple requirements in State Contract known as the "Scope of Services". Compliance is monitored through regular case reviews, data analysis, and staff training. On occasion, the supervisor does find that a signed Client Service Agreement is not included in the file. Also, on occasion there is a missing case note. When these are found, staff then resolved the discrepancies. Training and supervision are provided for staff on a regular basis. The ADRC supervisor completed one option or enrollment counseling observation and report per staff by 12.31.24.
2. **90% of all Customer Satisfaction Surveys returned will have a favorable opinion of their experience with the ADRC.**
   - **Goal met.**
     - 60 surveys were returned, with 56 respondents indicating they would recommend the ADRC to others (4 surveys did not answer this question). 98% of customers rated our overall service as "Excellent" or "Very Good."



3. **Provide one or more community outreach events aimed at marketing to the Spanish speaking population.**
   - **Goal met.**
     - 3.12.24: Multilingual Family Event at Watertown School District – Two bilingual staff members represented the ADRC and made 30 individual contacts.
     - 7.20.24: Jefferson's 2nd Annual Fiesta Latina – Two bilingual staff members engaged with the community, making 35 individual contacts.
     - 9.14.24: Fort Fall Fiesta – Two bilingual staff members marketed the ADRC, connecting with 42 individuals.

4. **The ADRC will complete one Quality Improvement (QI) project.**
   - **Goal met.**
     - The Disability Benefits Specialist (DBS) and Elder Benefits Specialist (EBS) programs did not have a consistent method of obtaining honest feedback from their clients on their experience with the DBS/EBS programs. Over the last several years, the DBS/EBS programs has offered "Welcome to Medicare" classes and participants complete a survey at the end of the workshop. In 2024 a new survey was developed to receive year-round information about the quality of their work and any need for program improvement. The Q.I. team consisted of three benefit specialists, ADRC Admin. Assistant and supervisor. To pilot the new survey, each benefit specialist selected 30 closed cases from date range May-July 2024. Of those 90 cases, 30 EBS and 30 DBS clients randomly mailed the survey. There was a 33% response rate with approximately 20 surveys returned. Year-to-Date, a few more surveys have been returned. The completed surveys have provided valuable feedback about our programs and has validated staff work. For example, all 30 individuals initially survey answered "yes" they would recommend the ADRC to others.

5. **TV in the waiting room program running.**
    - **Goal Met.**
        - Each month, a set of approximately 30 video slides were displayed on the TV in the ADRC Lobby for the public to learn more about the ADRC, upcoming events, and the monthly Senior Dining menu.

<u>Goals for 2025:</u>

Key Outcome Indicator:

100% of all long-term care functional screens must be determined no later than 30 days from the date the ADRC receives a request or expression of interest. If there is a delay in determining functional eligibility, the ADRC will notify the customer in writing during the 30-day time-period and if done so, then the Key Outcome Indicator will be considered met.

<u>Additional 2025 Goals:</u>

1. 100% compliance with the State Contract.
- There are fourteen core services in the Scope of Services (aka the State Contract). The core services include Marketing, Outreach and Public Education, Information & Assistance, LTC Options Counseling, Dementia Services, Pre-Admission Consultations (for example, referrals from nursing homes), Elder and Disability Benefits Counseling, Access to Publicly-Funded Long Term Care, Enrollment and Disenrollment Counseling, Access to Other Public and Private Benefits, Access to Emergency/Crisis Intervention and Adult Protective Services, Customer Rights and Advocacy, Community Needs Identification and Youth Transition Services. In 2025, the ADRC will continue to facilitate the quarterly MCO/ICA/ADRC/IM meetings and the monthly Jefferson County Youth Transition Coalition (CCOT) meetings. The ADRC supervisor will also complete one option or enrollment counseling observation and report per staff by 12.31.25.

2. **90% of all Customer Satisfaction Surveys returned will have a favorable opinion.**
3. **Provide two or more community outreach events aimed at educating the Spanish speaking population.**
    - Continue to promote the ADRC and raise awareness of programs and issues relating to aging and people with a disability especially to our underserved Spanish speaking population.
4. **The ADRC will complete one Quality Improvement (QI) project.**
    - Per the Scope of Services**,** at least one focused performance improvement project is required annually to improve ADRC quality and customer satisfaction. Quality improvement is essential to the ADRC and is an attainable goal.

DEMENTIA CARE SPECIALIST (DCS) PROGRAM

The Dementia Care Specialist position supports individuals in Jefferson County who are living with Dementia, their caregivers, and the Jefferson County Community in creating safe and welcoming public spaces for individuals living with Dementia. This is accomplished through educational programming for caregivers and community businesses, offering supports and social connections for caregivers, as well as offering tools and programs developed to enhance the quality of life for individuals living with Dementia. Jefferson County has employed a Dementia Care Specialist since January of 2013. Funding for the position comes from state GPR dollars and federal Medicaid matching funds of $80,000 via the ADRC contract between the county and the Department of Health Services. In 2024, 1,727 contacts were made through dementia consultation, support, resources, and education coordinated by the Dementia Care Specialist. Programs offered through the Dementia Care Specialist included but were not limited to:

Memory Cafes

A Memory Café is a social gathering for those who are experiencing early-stage dementia, mild memory loss, or mild cognitive impairment (MCI) to attend with a family member, friend, or care partner. Topics range from butterflies to baseball. A Memory Café is a safe place to have fun, share experiences, and stay socially connected.

In 2024, 8 Jefferson County libraries were involved in the Bridge's Library Memory Project. This project offered Memory Cafes as part of their programming. The Dementia Care Specialist of Jefferson County has worked closely with the libraries to offer and encourage our residents to attend these fun and interactive events. Together with the Watertown Dementia Awareness Coalition, 3 opportunities to attend a Memory Café occur each month around Jefferson County.

Memory Camp

Memory Camp is a supported summer camp experience for those with mild to moderate dementia, their care partners, and/or families, which is held at Moon Beach, Camp AWESOME, in St. Germain, WI. The Dementia Care Specialist collaborated with Jefferson's non-profit organization, Tomorrow's Hope, to send one family to this special camp in 2024. These campers had their camp fees, gas, and snacks to get there, provided through donations to Tomorrow's Hope. Our campers shared wonderful stories of valuable time spent together enjoying the outdoors. This was the second year attending for one of our families.

Community Awareness

In 2024, the Dementia Care Specialist focused on outreach and awareness in Jefferson County. Several community events were attended by our Dementia Care Specialist: Lake Mills Farmer's Market, Whitewater Farmer's Market, Jefferson's National Night Out, Watertown Senior Care Fair, just to name a few. At each event, an information table is set up to share all about the Dementia resources available through the ADRC. Our animated pets are always a big hit with visitors of all ages, bringing lots of people by to learn more about the valuable services and resources we offer.

Purple Tube Project

The Dementia Care Specialist continued to support the Purple Tube Project in 2024. The Purple Tube Project is an effort to identify individuals living with dementia to our first responders such as, police, EMS, and firefighters. Everyone receives a purple tube containing forms to fill out important information about health issues, emergency contacts, personal likes and dislikes, medications, etc. The tubes are stored in the refrigerator. In the event of an emergency at a person's home who, first responders will be alerted when entering the individual's home that they have a dementia diagnosis and will have vital information available in their purple tube in the refrigerator.

Caregiver Events

Several Community events occurred in 2024 in support of Dementia awareness and caregivers. The Dementia Care Specialist collaborated with the Jefferson County libraries and provided the first annual Family Caregiver Day held at the Dwight Foster Library in Fort Atkinson. Attendees were able to participate in crafts, bingo, pet therapy dogs, photo opportunities, and listen to the Lake Mills orchestra.

Caregiver Picnic

The Dementia Care Specialist and the Family Caregiver Support Specialist teamed up to provide a caregiver picnic for family caregivers in June at Dorothy Carnes Park in Fort Atkinson where caregivers learned about yoga and enjoyed a nice lunch. The Dementia Care Specialist also teamed up with 2 surrounding counties in November for a Caregiver Pamper Day offered at The Fort Atkinson Club. This event was held in honor of National Family Caregiver Appreciation Month. At this event, free massages were offered, along with education on helpful gadgets and ways to promote self-care. They also enjoyed a wonderful catered lunch. At both events, free respite was provided so that caregivers could get a little time away from caregiving to connect with other caregivers, learn something new, and get a well-deserved break while their loved one was safe and entertained. We have had overwhelmingly positive feedback about these events and the relationships caregivers are forming with each other.

Review of 2024 Goals:

Key Outcome Indicator

Provide 2 Dementia Friendly Business Trainings.

- **Goal met**
  - A total of 3 trainings were successfully completed.

Additional 2024 Goals:

1. **Offer 2 new in-person support groups**
   - **Goal met.**
     - 2 in-person support groups started for Dementia Caregivers
     - 1 virtual support group for people living with MCI (mild cognitive impairment) and early-stage dementia
2. **Offer 2 SAVVY Caregiver sessions**
   - **Goal was not met.**
     - Offered 1 class – not enough registrants
3. **Offer 4 Community Engagement Events**
   - **Goal met.**
     - Offered Caregiver picnic lunch
     - Offered Family Day
     - Offered "A Day at the Club"
     - Offered "Caregiver Card Club"
     - Offered "Polar Path Walk"
4. **Expand collaboration with libraries**
   - **Goal met.**
5. **Offer 2 6-week PTC sessions**
   - **Goal met.**
     - Offered session in May – not enough registrants
     - Offered session in September with 12 registrants

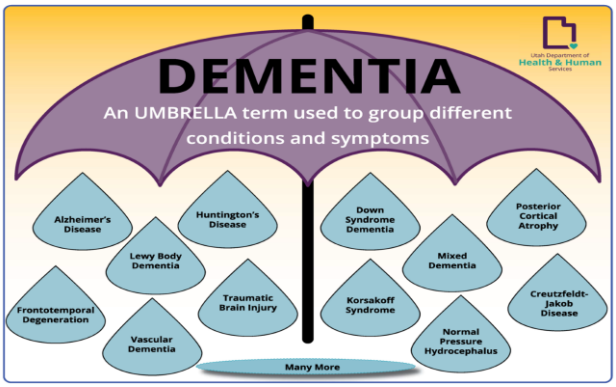
Goals for 2025:

Key Outcome Indicator

Offer Powerful Tools for Caregivers, SAVVY Caregiver, Timeslips, Dementia Live and Music & Memory, Boost Your Brain & Memory.

Additional 2025 goals:

1. Offer 2 new in-person support groups.
2. Offer 4 Community Engagement Events.
3. Expand collaboration with libraries.



DISABILITY BENEFIT SPECIALIST (DBS) PROGRAM

The Disability Benefit Specialist (DBS) program helps adults with disabilities who are encountering problems with private or government benefit programs. DBS staff are highly knowledgeable in the following areas: Medicare, Food Share, Social Security Disability, Supplemental Security Income (SSI), and Medical Assistance. Disability Benefit Specialists are trained and guided by attorneys who specialize in disability benefits law.

In 2024, the ADRC of Jefferson County was a very busy place once again. We began using a new database, known as Peer Place, on 11.6.24. The new system has different search profile capabilities compared to the last system (Wellsky) and therefore, we are no longer able to pull the total number of contacts per month or year. With the new database, the shift is from the volume of contacts (Wellsky) to the number of clients served and number of units (time) provided to each customer. From January 1st, 2024 - October 29th, 2024, staff documented 310 individuals assisted directly with 426 case issues. There was a total of 312 cases. Several other individuals were assisted with telephone or mail contact. Through applications and appeals, the tracked economic outcomes for Jefferson County residents totaled $1,378,869 in federal dollars compared to $265,935 in State, for a total of $1,645,026, up until October 29th, 2024, when we were no longer able to track in the previous database. We were certainly on pace to exceed the 2022 and 2023 monetary impact numbers. The monetary impact could have also been significantly higher had length of time that Social Security is taking to process cases not increased so drastically. The average amount of time to process has gone from about 3 to 5 months prior to 2020 to 5 to 7 months in 2021 to 9 to 12 months in 2022, towards the end of 2023 to length of time for Social Security case processing began to come back down to about 8 to 10 months. In 2024 the length of time to process a case with Social Security remained about 3 to 9 months, most cases falling in the 7-to-9-month range.

Review of 2024 Goals:

Key Outcome Indicator:

Increase the number of attendees at Welcome to Medicare workshops by 20%. In 2023, there were 21 total Jefferson County participants.

- **Goal met**
  - 65 individuals participated in our "Welcome to Medicare" presentations.

Additional 2024 Goals:

1. Continue to develop and enhance the information on the DBS portion of the ADRC Website.
   - **Goal met**
2. Provide at least one internal presentation to ADRC staff on public benefits.
   - **Goal not met**
     - Will be revisited in 2025.

Goals for 2025:

Key Outcome Indicator: Offer nine "Welcome to Medicare" classes throughout the year.

Additional 2025 Goals:

1. Continue to develop and enhance the information on the DBS portion of the ADRC website.
2. Provide at least one internal presentation to ADRC staff regarding public benefit updates.

AGING PROGRAMS

~ "The Older Americans Act clearly affirms our Nation's sense of responsibility toward the wellbeing of all of our older citizens." President Johnson 1965**~**

In 1965, Congress enacted the Older Americans Act (OAA), which established the Administration on Aging (AoA) and state agencies on aging to address the social services needs of older people. The Act, with its seven Titles, is considered the major vehicle for promoting the delivery of social services to the aging population.

Title III: Grants for State and Community Programs on Aging

Title III formula grants support the activities of 56 state agencies on aging and 655 area agencies on aging. These agencies act as advocates on behalf of, and coordinate social service programs for, older people. While Title III services are available to all individuals aged 60 and older, they are specifically targeted at those with the greatest economic or social need.

Part A – General Provisions

The purpose of this title is to encourage and assist State and Area Agencies on Aging to foster the development and implementation of comprehensive and coordinated systems to serve older individuals.

Part B – Supportive Services

The Older Americans Act, and more specifically Title III, is the only federal supportive services program directed solely toward improving the lives of older people. Under current law, these funds must be used for serving the rural elderly, those with greatest economic and social need including specific objectives for low-income minority older people.

Part C - Congregate and Home Delivered Meals

Adequate nutrition is necessary to maintain cognitive and physical functioning, to reduce or delay chronic disease and disease-related disability, and to sustain a good quality of life. The OAA requires that meals must meet the requirements for the one-third daily recommended dietary allowances. The nutrition program also provides nutrition education, counseling, and screening, and often is the gateway to other services.

Part D - Disease Prevention and Health Promotion

Health promotion is the process of enabling people to increase control over, and to improve their health. Disease prevention covers measures not only to prevent the occurrence of disease, but also to prevent its progress and reduce its consequences once established. Participants are required to provide disease prevention, health promotion, and information programs at appropriate locations.

Part E - National Family Caregiver Support Program

This program offers five essential services for family caregivers, including:

- Information about available services for caregivers.
- Assistance in accessing supportive services.
- Individual counseling, organization of support groups, and caregiver training.
- Respite care.
- Supplemental services, on a limited basis, to complement the care provided by caregivers.

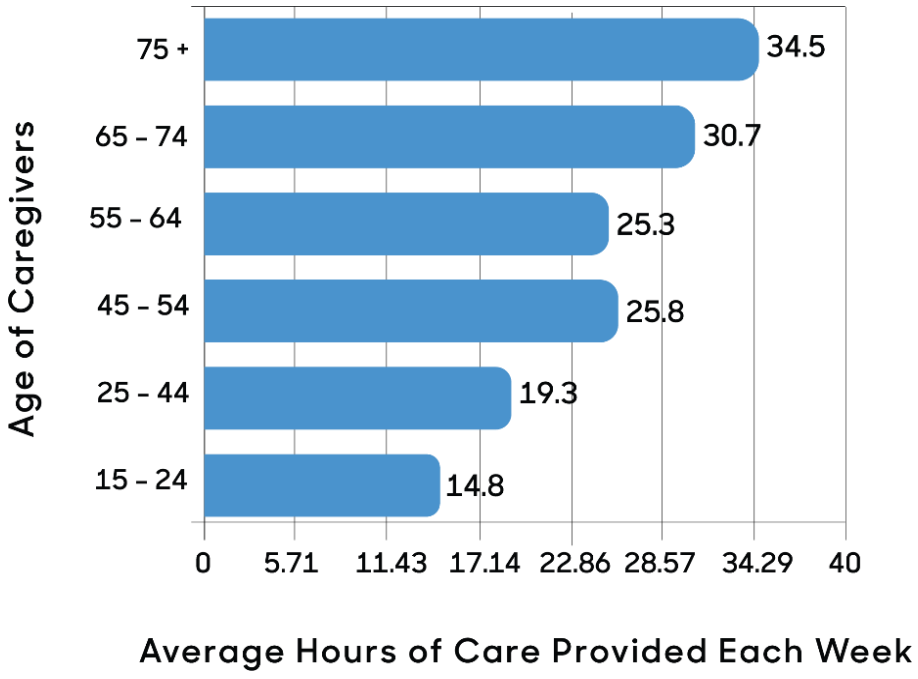
FAMILY CAREGIVER SUPPORT PROGRAMS

In 2020, the National Alliance on Caregiving (NAC) and AARP released their list of U.S. caregiving statistics. The report revealed that 53 million people in the U.S. characterize themselves as caregivers. This is up from 43.5 million in 2015, meaning that nearly one-fifth of the U.S. population now cares for a loved one. At this rate of growth, the number of people providing home caregiving supports today is staggering.

Here are additional facts and statistics from the report:

- 61% of caregivers are women, and 39% are men.
- 24% of family caregivers care for more than one person.
- 26% expressed difficulty coordinating healthcare.
- 26% caregivers care for someone with Alzheimer's disease or dementia.
  - This is up from 22% in 2015.
- 23% say that being a caregiver has made their own health decline.
- 21% characterize their health as fair to poor.
- 61% of caregivers work in addition to providing care.
- 45% have experienced financial hardship due to caregiving.

The Family Caregiver Support Specialist position is designed to coordinate and facilitate the Alzheimer's Family Caregiver Support Program (AFCSP), the Older Americans Act (OAA) Title IIIE - National Family Caregiver Support Program (NAFCSP), and OAA Title IIIB- Support Services programs. The table below demonstrates the average number of caregiving hours provided each week to a loved one. It is clear from this table that as people age their caregiving responsibilities tend to increase significantly. Supporting these caregivers is vital to assist aging individuals to remain in their homes and live as independent as possible for as long as possible.



Alzheimer's Family Caregiver Support (AFCSP)

The Alzheimer's Family and Caregiver Support Program or AFCSP was a program 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. Funding allocated for 2024 was $40,500, and can be used to cover in-home help, medical equipment, prescriptions medications, respite care, adult daycare, assistive devices, and transportation.

Title IIIE - National Family Caregiver Support (NFCSP)

The National Family Caregiver Support Program was created by the Administration on Aging in October 2000. The total GWAAR funding allocation for 2024 was $39,806 with a required minimum match of $13,269. The program helps families sustain their efforts to care for older relatives by providing them with support and services. This program serves grandparents raising grandchildren as well. This past year 8 new families have been supported under this program in which grandparents over the age of 60 are receiving support to assist them in caregiving for grandchildren.

Title IIIB - Supportive Services Program

Older Americans Act (OAA) Title III B funds provide supportive services to enhance the well-being of elders and to help them live independently in their home environment and the community. These funds are designated for legal services, access assistance, and in-home support services.

Individuals aged 60 or older are eligible for OAA Title III B services. Preference is given to older people with the greatest economic or social needs. Particular attention is given to low-income older individuals, low-income minority elders, individuals with Limited English Proficiency, and individuals residing in rural areas. Supportive Services are the second-largest funding category under Older American's Act (OAA). The total GWAAR funding allocation for 2024 was $78,332 with a required minimum match of $8,704.

Review of 2024 Goals:

Key Outcome Indicators:

Participate in 2 community engagement events throughout the year.

- **Goal met**

Additional 2024 Goals:

1. Educate Aging staff Unit on advocacy resources
   - **Goal met**
2. Distribute Community Resource Guide to Spanish Speaking locations
   - **Goal not met**
   - **This goal was not achieved but will be carried over into the 2025 goals.**

3. Creative Ways to Respite – brochure in English and Spanish
    - **Goal met in English. Spanish version will be carried over to 2025 goal.**
4. Volunteer Connection – Add creative way to experience respite brochure
    - **Goal met**
5. Quarterly articles on caregiving/caregivers in the newsletter
    - **Goal met**
6. Collect feedback from the caregiver event participants and incorporate their suggestions as much as possible into the next caregiver event.
    - **Goal met**
7. Caregiver survey
    - **Goal met**

Goals for 2025:

Key Outcome Indicators

Participate in 2 community engagement events throughout the year.

Additional 2025 Goals:

1. Record Case Management Time for Reimbursement.
2. Use remaining ARPA funds.
3. Send POA paperwork with directions to each participant in caregiver programs.
4. Distribute Community Resources guide to Spanish speaking locations.
5. Translate the Creative Ways to Respite brochure to Spanish.

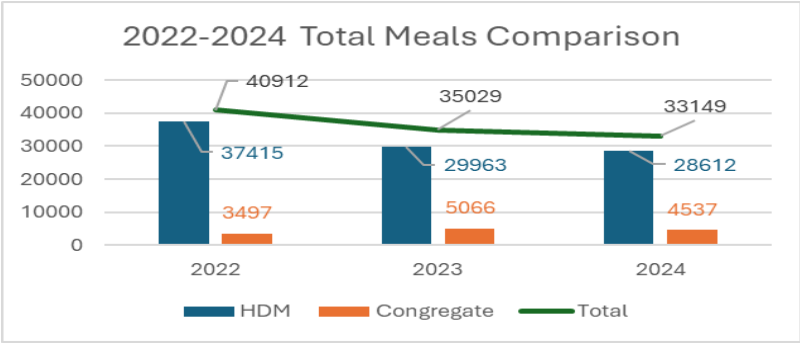
SENIOR NUTRITION PROGRAMS

The Senior Nutrition Program, enacted by Congress in 1972, is a section of the Older Americans Act (OAA) that provides grants to support nutrition services for older adults throughout the country. The objectives of this program are to improve the dietary intake of participants, provide nutrition education, and offer participants opportunities to form new friendships and informal support networks.

The Senior Nutrition Program consists of the Home Delivered Meal (HDM) Program and the Congregate Dining Program, also known as Senior Dining or in-person dining. The HDM Program provides a well-being check, nutrition education, and a hot- nutritious meal delivered to a participant's home. The Senior Dining Program offers meals, nutrition education, and the opportunity to socialize with others at in-person dining meal sites throughout Jefferson County.

The goals of the Elderly Nutrition Program are:

- To reduce hunger and food insecurity
- To promote socialization of older individuals
- 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.



In 2024, the Nutrition Program served 28,612 home delivered meals and 4,537 in-person (congregate) dining meals. This following chart compares the total home delivered, and congregate meals served by the Nutrition Program in 2022, 2023, and 2024.

The Senior Nutrition Program is funded by a combination of federal and state funds, local public and private funds and participant contributions. Senior Nutrition Programs receive Title III-C-1 funds, from the State, for the congregate meal program and Title III-C-2 funds, from the state, for the home delivered meal program. The Nutrition Services Incentive Program (NSIP) is a resource that provides additional grant funding to the program, contingent upon meeting OAA Law and Federal Regulation requirements.

NOAA or “Not Older Americans Act” are meals that are provided to clients who do not fall under the eligibility requirements for use of Title III funding, more specifically, those who are under 60 years of age. Senior Nutrition Programs must recover the full cost of the meal for any client who receives a meal from the Senior Nutrition Program and is under the age of 60. Long-Term Care (LTC) Programs can contract with the Senior Nutrition Program to provide meals to long-term care program clients. The Senior Nutrition Program must recover the full cost of these meals from the LTC program, as Title III funds must not be used to subsidize these meals. NOAA and LTC meals are not included in the NSIP meal counts. Below is a breakdown of the total meals served by the three different care programs in Jefferson County for 2024.

	HDM	Congregate	Total Meals
Title III	27,011	4,516	31,527
NOAA	0	21	21
LTC	1,601	0	1,601
Total	**28,612**	**4,537**	**33,149**

The Senior Nutrition Program is the largest program, in terms of dollars spent, under the Older Americans Act. Funding for the program in 2025 is estimated as follows: Title III C-1 (Congregate) estimate of $99,262 and participant contributions of $15,000. Title III C-2 (Home-Delivered) estimate of $156,859, $19,630 of program income from Long Term Care Programs, and $79,455 of participant contributions. Senior Community Services Program (SSCS) funds will also be used for the senior nutrition programs, that amount is $7,986. The NSIP estimate for 2025 is $22,072.

Home Delivered Meal Assessor (HDM Assessor) provides an in-depth assessment of nutritional risk, food insecurity, activities of daily living, and instrumental activities of daily living for home delivered meal participants. If needs are identified, the HDM Assessor provides basic nutrition education and referral to other community programs and resources. In addition, the HDM Assessor provides nutrition education via table tents, in-person food demonstrations, or in-person nutrition presentations to congregate meal participants, at least quarterly, per the grant requirement. The Senior Nutrition Program Supervisor provides monthly nutrition education handouts to all home-delivered meal participants, which are included with the contribution statements mailed to participants' homes.

Volunteer Recognition Banquet

In 2024, we hosted a Volunteer Recognition Banquet to honor all the wonderful volunteers that work with our Senior Nutrition Programs, Elder Benefit Program and Transportation Programs. 323 invitations were sent out to volunteers from around the county, 165 volunteers replied and attended the event. This year’s theme was Spring, with a show put on by Bill Bossingham, a one-man band, also known as HORSE. A catered meal was also provided with opportunities for each program’s leadership to share their appreciation and a few stories from over the year. Very positive feedback was received from the attendees.

Photos taken by Tonya Runyard Photography.

Review of 2024 Goals:

Key Outcome Indicator:

90% of new home-delivered meal participants will be assessed in their home within four weeks of beginning meal service to determine the individual's need for nutrition and other services.

- **Goal met January 2024 – August 2024. *Void* September 2024-December 2024.**
  - As of September 1st, 2024, the nutrition program implemented a new Meal Prioritization policy, as recommended by the State, to prioritize meals for individuals with high and moderate needs over those with low needs. Low needs individuals are offered in-person dining services due to their ability to get out of their home independently. This policy change resulted in home assessments being conducted before individuals could begin receiving home-delivered meals, rendering the original goal inaccurate.

Additional 2024 Goals:

1. By December 31, 2024, implement a Gift Certificate Program that enables community members to purchase certificates as gifts for congregate diners.
   - **Goal met.**
     - In April 2024, the nutrition program rolled out a new and improved gift certificate program. Community members may "purchase" gift certificates on a contribution basis and give them to friends and family members to be used at any of the senior dining site locations. Gift Certificates are available at all dining sites or from the Nutrition Program office.

2. By December 31, 2024, provide two shelf-stable meals to interested Nutrition Program participants for emergency preparedness.
   - **Goal met.**
     - A survey was sent to all participants on the HDM program in September 2024. Approximately 107 participants responded, requesting Shelf Stable Meals at that time.
     - 240 (120 Chicken Salad and 120 Chili) meals were ordered in October 2024.
     - Two meals for each participant were packaged and distributed in November 2024.
     - Extra stable meals are distributed if participants request additional meals, as well as, to participants who start home delivered meals during the winter months.
3. Maintain active quality control log for contracted caterers in accordance with the updates to the 2024 Catering Contract.
   - **Goal met**.
     - A log was maintained throughout 2024 to track quality control issues with food delivered to senior dining sites. This log ensured accountability, holding the caterer responsible for any food that could not be served. As a result of these on-going issues, the Nutrition Program initiated a Bid for Proposal (BID) process in late 2024, which led to contracting a new caterer for 2025.
4. By December 31, 2024, establish a pilot location for My Meal My Way restaurant model in Jefferson County.
   - **Goal changed**.
     - After assessing interest from local restaurants, it was determined there was limited enthusiasm for implementing the My Meal My Way model. Following discussions with the state, it was agreed that pop-up dining events would be a more feasible alternative.
     - Three pop-up dining events were planned for the last three months of 2024.
     - Frist pop-up event October 22, 2024, Jefferson dining site, catered by Bon-Ton, 24 total people attended.

- November 21st, 2024, Watertown dining site, 11 people attended, 22 people signed up but due to inclement weather, some did not attend.
- December 12th, 2024, Lake Mills dining site, catered by Becky Palm (Rosie's Place) of Jefferson, 37 people attended, 45 signed up but again due to inclement weather, some did not attend.

5. By December 31, 2024, increase community engagement/interactions for program participants with completion of a minimum of 4 serving-learning projects.
   - **Goal met**.
     - Rock River 4H Clover – decorated placemats for Valentine's Day.
     - January – March 2024: Lisa K. from UW Extension provided nutrition programs to participants at two dining site locations: Fort Atkinson and Watertown.
     - Rock River 4H Clovers—created Holiday Placemats for participants in November.
     - Rock River 4H Clovers—created Holiday Cards for participants in December.
6. By December 31, 2024, distribute a flyer to Congregate and HDM participants with information on obtaining vaccinations recommended for older adult populations. (GWAAR Requirement)
   - **Goal met.**
     - Flyers provided by Jefferson County Health Department and sent to participants October 2024.
7. Increase the number of volunteers by coordinating outreach recruitment interactions within the community.
   - **Goal met.**
     - Provided volunteer recruitment flyers to Nutrition Project Council members for distribution.
     - Attended the Lake Mills Volunteer event in December 2024.

Goals for 2025:

Key Outcome Indicator:

Complete home assessment within 14 days of participants requesting home delivered meals.

Additional 2025 Goals:

1. By December 31, 2025, complete annual staff training on Meal Prioritization Tool.
2. By December 31, 2025, there will be an increase in Congregate meal options.
3. By December 31, 2025, explore starting community garden for the senior nutrition program.
4. Move appropriate participants from HDM to Congregate dining.
5. Educate participants on the importance of contributions.
6. Increase the average meal donations to $3.00.
7. Promote nutrition education to the community through ESMMWL program.

HEALTH PROMOTIONS

Health promotion is the process of enabling people to increase control over, and to improve their own health. Disease prevention covers measures not only to prevent the occurrence of disease, but also to prevent its progress and reduce its consequences once established. County ageing units are required to provide disease prevention, health promotion, and informational programs at appropriate locations.

At the national level, many priorities focus on maintaining good health and preventing or managing illness or injury. The Greater Wisconsin Agency on Aging Resources (GWAAR) and the Department of Health Services (DHS) continually provide county aging units with a variety of materials for distribution. There are several evidence-based prevention programs promoted by Greater Wisconsin Agency on Aging Resources (GWAAR) and DHS. In 2024, the GWAAR budget for prevention programs was $5,809. Additionally, we received $9,148 in ARPA funding for this program, which needs to be utilized by September 30, 2024.

Review of 2024 Goals:

Key Outcome Indicator:

The Aging and Disability Resource Center of Jefferson County will offer six Evidence-Based Health Promotion and Disease Prevention Educational programs throughout 2024.

Evidence-Based Health Promotions to be offered in 2024:

- **Goal Partially Met:**
  - 5 Evidence Based Health Promotion Programs were offered throughout the year, these 5 courses were offered more than once each, meeting the offering 6 programs goal.
  - Powerful Tools for Caregivers - A program designed to provide family caregivers with tools necessary to increase their self-care and confidence. The program improves self-care behaviors, management of emotions, self-efficacy, and use of community resources.
  - Savvy Caregivers - A program designed specifically for family caregivers of people with Alzheimer's disease or other forms of dementia that reduces caregiver burden and caregiver stress.
  - Eat Smart, Move More, Weigh Less (ESMMWL) - A 15-week online healthy eating program that uses strategies proven to work for weight loss and maintenance. ESMMWL is delivered in an interactive, real-time format with a live instructor. Administrator – NC State University.
  - Stepping On - A program intended for community-residing, cognitively intact, older adults who are at risk of falling, have a fear of falling or have fallen one or more times per year. The program offers strategies and exercises to reduce falls, increase self-confidence in making decisions, and change behavior in situations where older adults are at risk of falling.
  - Strong Bodies - A workshop that increases muscle mass and strength, improves bone density, improves self-confidence, improves sleep, and reduces risk for osteoporosis and related fractures, diabetes, heart disease, arthritis, depression, and obesity. Was Strong Women-Strength Training Exercise Program. Administered by UW-Madison Division of the Extension.

TRANSPORTATION SERVICES

Jefferson County Specialized Transportation Program

Jefferson County offers transportation services for elderly residents and individuals with disabilities through the s.85.21 Specialized Transportation Program. Priority is given to medical appointments and nutrition-related needs. The 2025 program budget is $597,591, funded by: $229,550 from the s.85.21 contract (with a 20% local match), Payments from Managed Care Organizations (MCOs), Participant contributions, 5310 Grant funds, County tax levy.

Mobility Manager Program

Since 2019, the Mobility Manager Program connects seniors and individuals with disabilities, and others to transportation options. In 2025, it will receive $90,203 through the 5310 Grant to continue its mission.

Vehicle Operating Grant

For 2025, the County was awarded a 5310 Vehicle Operating Grant of $61,113, supplemented by a $20,371 local match to purchase a new vehicle for the transportation program.

Driver Escort Program

In 2024, the Driver Escort Program provided 11,571 one-way trips for elderly and disabled residents. Supported by one coordinator, 15 part-time drivers, and seven volunteers, the program logged 14,428 hours and 241,789 miles. It remains a vital part of Jefferson County's transportation services

Driver / Escort Ridership

Quarter	2017	2018	2019	2020	2021	2022	2023	2024
Q1	1,051	1,305	1,154	2,371	1,804	2,292	3,147	2873
Q2	1,160	1,302	1,829	1,329	1,958	3,060	3,129	2852
Q3	1,080	1,063	1,956	1,404	2,241	3,086	3,052	2966
Q4	1,150	1,352	2,056	1,592	2,651	3,406	2,986	2880
Total	**4,441**	**5,022**	**6,995**	**6,696**	**8,654**	**11,844**	**12,314**	**11,571**
Y-to-Y Change (%)		**13.1**	**39.3**	**-4.3**	**29.2**	**36.9**	**4.0**	**-6.0**

The Aging and Disability Resource Center (ADRC) of Jefferson County plays a vital role in supporting local veterans by coordinating transportation services to nearby VA hospitals and clinics. This essential service ensures that Jefferson County veterans can access the medical care they need without transportation barriers. The vehicles used for this program are generously provided by the Jefferson County VA office. In 2024, the VA transportation service experienced a notable 5.9% increase in usage compared to the previous year, reflecting its growing importance in meeting the needs of the veteran community.

VA Van Ridership

Quarter	2017	2018	2019	2020	2021	2022	2023	2024
Q1	134	139	310	253	118	162	154	156
Q2	208	156	247	16	126	231	174	155
Q3	193	230	259	68	190	269	123	137
Q4	160	210	249	89	174	288	144	182
Total	**695**	**735**	**1,065**	**426**	**608**	**950**	**595**	**630**
Y-to-Y Change (%)		**5.8**	**44.9**	**-60.0**	**42.7**	**56.3**	**-37.4**	**5.9**

Review of 2024 Goals:

Key Outcome Indicators:

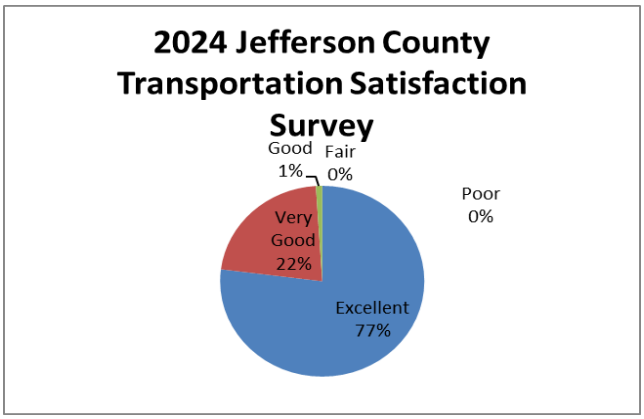
95% of qualifying medical ride requests are successfully fulfilled.

- **Goal Met**

Additional 2024 Goals:

1. Over 95% of surveyed riders would recommend our transportation service to others.
   - **Goal met**
2. Provide opportunities for at least 75 consumers each month to engage in meaningful social interactions through group rides or group events.
   - **Goal met**
3. 100% of unmet qualified medical ride requests were tracked to monitor community needs throughout 2024.
   - **Goal met**
4. Consumers were surveyed at the end of 2024 to gauge satisfaction with services and to gather information about unmet needs**.**
   - **Goal met:** 100% of the consumers surveyed rated our transportation service as “Good”, “Very Good, or “Excellent”.

During 2024, rider satisfaction surveys were distributed to clients to gather feedback on the overall customer experience. 100% of the consumers surveyed rated our transportation service as “Good,” “Very Good,” or “Excellent.”



5. Provide Weekday Evenings & Weekend Service Hours for our Driver Escort/Volunteer Program.
    - **Goal met**
6. Provide 1000 recreational/nutritional (non-medical) one-way trips by end of 2024 using designated 85.21 project funding (Shopping Van Project & The Day Trip Project).
    - **Goal met**

The Shopping Bus Project offered transportation services for seniors and individuals with disabilities, ensuring they had access to weekly shopping opportunities at popular local stores. Similarly, the Day Trip Project provided transportation for these individuals to visit unique destinations and popular attractions within roughly a 1-hour drive from Jefferson County. The primary goal of both initiatives was to promote an active and socially engaging lifestyle throughout the year. The day trip locations were thoughtfully chosen to cater to diverse interests while also offering enriching educational and cultural experiences.

Goals for 2025:

Key Outcome Indicators:

95% of qualifying ride requests are provided.

Additional 2025 Goals:

1. Greater than 95% of surveyed riders would recommend our transportation service to others.
2. Provide opportunities (group rides or group events) for at least 75 consumers each month to have meaningful social interaction.
3. 100% of unmet ride requests will be tracked to monitor community needs throughout 2025.
4. Consumers will be surveyed at the end of 2025 to gauge satisfaction with services and to gather information about unmet needs.
5. Provide Weekday Evenings & Weekend Service Hours for our Driver Escort/Volunteer Program.
6. Provide 1000 recreational/nutritional (non-medical) one-way trips by end of 2025 using designated 85.21 project funding (Shopping Van Project, Day Trip Project, and Corridor Van Service).
    - The Shopping Van project would provide a transportation service for seniors and people living with disabilities to have weekly shopping opportunities at popular stores in the community.
    - The Day Trip Project would provide a transportation service for seniors and people living with disabilities to enjoy unique places and popular attractions that can be reached within 1-2 hours of driving time from Jefferson County. The overall goal of this project would be to help individuals to have an active and social lifestyle all year round. The locations of the day trips would be selected to appeal to a variety of interests, but also to provide educational and cultural experiences as well.
    - The Corridor Van Service will provide interurban transportation mobility options by providing Highway 26 Corridor bus routes to cities with connections to local city cab services.
7. In 2025, Jefferson County will continue to expand its transportation services for the elderly and those living with disabilities by adding additional vehicles and drivers.

Transportation Supervisor/ Mobility Manager

The **Transportation Supervisor/Mobility Manager** is responsible for overseeing community transportation planning, coordination, navigation, and travel training. Their role is to help individuals identify, secure, and maintain transportation options that best meet their unique needs and preferences.

This position involves collaborating with various community transportation services to enhance service coordination, develop or expand accessible transportation resources, and promote these resources to residents, businesses, and organizations throughout Jefferson County.

Additionally, the Transportation Supervisor works closely with partner agencies to implement initiatives that promote mobility, health, and wellness, with a particular focus on seniors and individuals living with disabilities.

Review of 2024 Goals:

1. The Transportation Supervisor/Mobility Manager will provide information to seniors and people with disabilities on the transportation options to accommodate their needs.
   - **Goal met.**
2. The Transportation Supervisor will work closely with all existing transportation services in the county to ensure service coordination and to complement and not duplicate these services.
   - **Goal met.**
3. The Transportation Supervisor will initiate activities with other agencies to promote mobility, health, and wellness with a focus on seniors and those living with disabilities.
   - **Goal met.**
     - In 2024, a "Wednesday Walks" program was organized to promote mobility and wellness for seniors.

4. In 2024, the Transportation Manager / Mobility Manager will lead & coordinate the Shopping Van Project and the Day Trip project to promote healthy living activities for seniors and those living with disabilities.
   - **Goal met.**

Goals for 2025:

1. The Transportation Supervisor/Mobility Manager will provide information to seniors and people with disabilities on the transportation options to accommodate their needs.
2. The Transportation Supervisor will work closely with all existing transportation services in the county to ensure service coordination and to complement and not duplicate these services.
3. The Transportation Supervisor will initiate activities with other agencies to promote mobility, health, and wellness with a focus on seniors and those living with disabilities.
4. The Transportation Supervisor will also pursue these specific activities:
    - In 2025, the Transportation Manager / Mobility Manager will again lead & coordinate the Shopping Van Project and the Day Trip project to promote healthy living activities for seniors and those living with disabilities.
    - Develop and implement a Volunteer Recruitment plan to obtain a new volunteer every quarter on average.
    - Research new ride sharing software to possibly purchase/lease in 2025.
    - Increase interurban transportation mobility options by partnering with local agencies to provide weekly Hwy 26 corridor Bus routes for shopping before 2026.

ELDER BENEFIT SPECIALIST (EBS) PROGRAM

Elder Benefit Specialists (EBS) are advocates who are trained to help older people who are experiencing problems with public or private benefit programs. Jefferson County employs two specialists, one is full-time, the other part-time. In addition to the primary role to provide advocacy for Jefferson County seniors, the EBS program continued to host monthly Medicare workshops.

In 2024 the Elder Benefit Specialists assisted people navigating the Medicare Part D Open Enrollment process. Educational letters were sent out to all clients seen by the benefit specialists over the past year. The ADRC website was updated with information and step by step directions for how to complete this important task. Individuals that needed more assistance were invited to come into our office to work through the process directly with the Benefit Specialists. This year about 132 people came in for 1 on 1 assistance with the Open Enrolment process over an 8-week enrollment period. The feedback provided shared that this additional service to the Jefferson County community is greatly appreciated.

Review of 2024 Goals:

Key Outcome Indicator:

DBS staff will co-present with EBS staff at nine "Welcome to Medicare" Workshops.

- **Goal met:** There were eight Welcome to Medicare Workshop presentations completed. EBS staff assisted with presenting at five of the workshops.

Additional 2024 Goals:

Increase number of attendees at Welcome to Medicare workshops by 20%; 21 total Jefferson County participants in 2023.

- **Goal met:** Over course of 2024, we had 65 total Welcome to Medicare participants, an increase of over 209%.

Goals for 2025:

Key Outcome Indicator:

DBS staff will co-present with EBS staff at four or more "Welcome to Medicare" Workshops.

Additional 2025 Goals:

- Offer to host a Welcome to Medicare workshop out in the community at each of the following sites, Fort Atkinson Senior Center, Jefferson Senior Center, Waterloo Library, Watertown Senior Center, and Lake Mills Club 55.

Additional 2025 Goals:

- Offer in person appointments 1x each month at Fort Atkinson Senior Center and Watertown Senior Center.

The Aging and Disability Resource Center (ADRC) of Jefferson County provides information about resources and support on all aspects of life related to aging or living with a disability. The ADRC is a one-stop shop for older adults, people with disabilities and their caregivers and families. ADRC staff are unbiased and knowledgeable professionals who listen to concerns, help clarify options and direct people to appropriate resources. The ADRC is also the access point for information about long-term care options and applying for public benefits. Services provided by the ADRC are free and available to all Jefferson County residents regardless of income or assets.

BEHAVIORAL HEALTH DIVISION

~Providing evidence-based treatment programs that are recovery oriented, trauma informed, person centered, and responsive to the needs of our County residents~

In 2024, the Behavioral Health Division continued to address the growing demand for mental health and substance use services in our community. We maintained both in-person and telehealth services to accommodate the varying needs of our consumers. By offering high-quality, evidence-based practices, we were able to effectively meet the increased demands. Our behavioral health services continued at the seven school districts, providing school-based mental health support and expanded to an additional branch location at The Collective in Watertown, ensuring accessibility.

While we have seen some improvement in recruitment efforts, challenges persist in hiring qualified clinicians, a trend that is being experienced across the field for various reasons. We remain committed to enhancing our recruitment and retention strategies, while also evolving our organizational culture to make it the best possible workplace for our staff.

Below is a high-level synopsis of the Division's programs and 2024 initiatives as well as funding summary. A detailed report from each of the team follows.

The Behavioral Health Division of Jefferson County Human Services is structured into four teams, each offering evidence-based treatment options that support individuals' recovery. We provide an integrated, county-staffed service delivery system while contracting for additional services as needed. With over 100 full-time employees in various roles across our four teams, we are committed to excellence in care. In 2024, several Division employees achieved Level 2 certification in Team Cognitive Behavioral Therapy. All staff continued their training in motivational interviewing, along with other key evidence-based practices such as Dialectical Behavior Therapy, the Matrix Model, Family-Centered Treatment, Cognitive Behavioral Interventions for Substance Use, and Eye Movement Desensitization and Reprocessing Therapy (EMDR). The Division teams are:

Emergency Mental Health/Crisis Intervention Services: This is the first point of contact for requesting mental health and/or substance use services and responding to any type of crisis call. We are staffed 24 hours a day, seven days a week at human services and have crisis workers embedded in four different law enforcement jurisdictions throughout Jefferson County. As part of our crisis services, we operate the Lueder House Crisis Stabilization facility, which is a state licensed eight bed community based residential facility for adults with mental illness, who need crisis stabilization services. In 2024, we opened The Matz Center, an eight-bed youth crisis stabilization facility, in Watertown, licensed under DHS 50, serving youth experiencing a mental health crisis.

Outpatient Integrated Behavioral Health Clinic: The Clinic provides integrated mental health and substance use treatment, licensed under DHS 75.50 to provide individual and group psychotherapy for children and adults with same day access. We have a full-time psychiatrist and a full-time nurse prescriber along with 15 clinicians to provide a wide array of evidenced based practices. In 2024, we opened a branch location in Watertown.

Comprehensive Community Services Program (CCS): CCS provides more intensive mental health and substance use treatment with an extensive service array for children and adults. We have Bachelor and Master level service facilitators. We provide Peer Support, Recovery Coaching and offer Family Centered Treatment as well as other evidence-based practices. We continued to add specialty providers to our treatment roster and 2024 yielded 19 additional contracted providers to the Jefferson, Rock and Walworth CCS region.

Community Support Program (CSP): CSP serves people who are diagnosed with a severe and persistent mental illness. This is a mobile team that offers an array of services in the community for consumers. The CSP team includes a Peer Support Specialist, Bachelor CSP professionals, Master level clinicians and a Registered

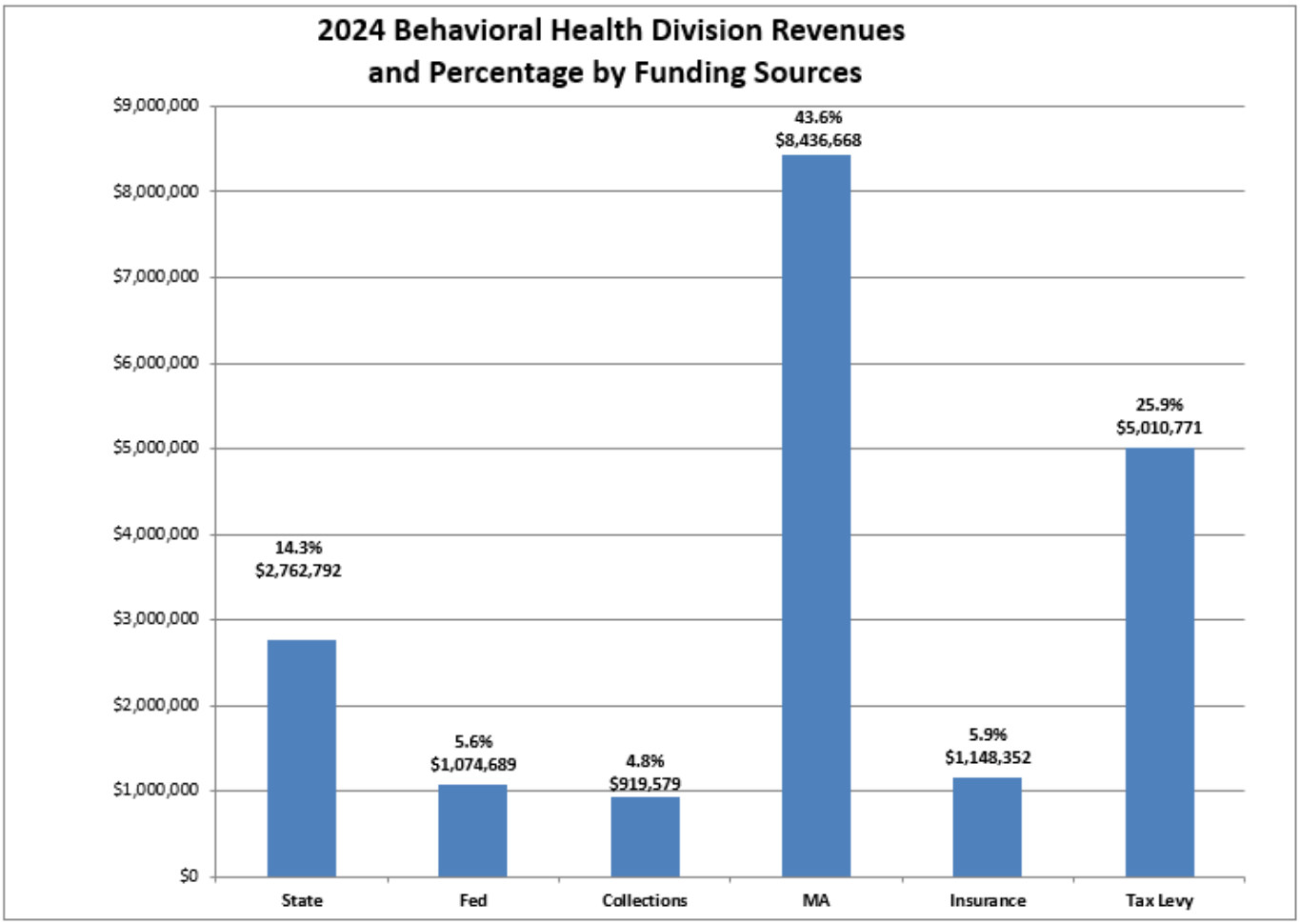
Nurse. In 2024 the CSP contracted for additional psychiatry hours, offering additional needed support and working towards fidelity to the Assertive Community Treatment model.

Our Medical Director is a licensed adult and child psychiatrist and addictionologist. He oversees all treatment programs and authorizes all necessary services. We are also fortunate to have a full-time psychiatric nurse prescriber and a part-time psychiatrist in our CSP program.

We are committed to meeting the needs of all county residents, and we recognize the importance of collaborating with community stakeholders to achieve this. In 2024, we successfully established a fully operational outpatient clinic branch in Watertown. We have crisis workers embedded within the Watertown, Jefferson, Fort Atkinson, and Lake Mills Police Departments, ensuring prompt and effective support. Additionally, we will host the 15th Crisis Intervention Training in Jefferson County for law enforcement officers.

In partnership with the Greater Watertown Health Foundation and Wisconsin Community Services, we also opened The Matz Center, a Youth Crisis Stabilization Facility, in January of 2024. We remain dedicated to working with community partners to find new ways to ensure that all individuals have access to the services they need.

Below is a summary of the Division's funding sources:



Following are detailed reports from each of the Division's teams, which include data on the number of people served and a review of our services and yearly goals.

EMERGENCY MENTAL HEALTH CRISIS INTERVENTION SERVICES

~We believe mental health and substance use issues are most successfully treated, whenever possible, with a voluntary entity into treatment and services. ~

Our Emergency Mental Health (EMH) Crisis Intervention Services were certified under DHS 34 in October of 2007. People who need EMH services are defined under Wisconsin Administrative code DHS 34 as a person who is experiencing a mental health crisis or is in a situation likely to turn into a mental health crisis if supportive services are not provided.

Under this administrative code the following services are required and are provided by our agency:

- **Telephone services** – Providing callers with information, support, counseling, intervention, emergency services coordination, and referrals. These services are available 24 hours a day, 7 days a week, and include a direct link to mobile crisis services, law enforcement, or other programs capable of offering immediate, onsite response to any emergency. The required services are available by calling 920-674-3105. After hours, on weekends, and during holidays, callers can reach these services by dialing 920-674-3105 and pressing 7 to connect to a crisis worker.
- **Mobile Crisis Services** – Providing onsite, in-person intervention for individuals experiencing a mental health crisis. In accordance with Wisconsin guidelines, mobile crisis services shall achieve one or more of the following outcomes:
    - Immediate relief of distress in a crisis.
    - Reduction in the level of risk present in the situation.
    - Assistance provided to law enforcement officers who may be involved in the situation by offering services such as evaluation criteria for emergency detention under s. 51.15, statute.
    - Coordination of the involvement of other mental health resources which may respond to the situation.
    - Referral or arrangement for additional mental health services which may be required.
    - Follow-up contacts to ensure that intervention plans developed during the crisis are being carried out.
    - Availability for at least 8 hours a day, 7 days a week during the times when mobile services are most needed (though our crisis team is available onsite 24/7/365).
    - Flexibility to meet individuals in their homes or other community locations such as schools, churches, hospitals, or police stations.
    - Walk-In Services – Provides face-to-face support and intervention at designated locations on a scheduled basis. The Jefferson County Human Services crisis team offers walk-in services Monday through Friday from 7:30 AM to 5:30 PM at the Human Services Agency.

The services listed above are available to anyone experiencing a mental health crisis in Jefferson County, regardless of age.

2024 brought new resources and opportunities for diversion. The Matz Center, youth crisis stabilization facility, opened its doors, initially accepting female youth. By August, the center expanded to include male youth and became fully operational. This provided a valuable resource, allowing us to keep young people close to home while offering the essential stabilization services they need.

The crisis team is made up of nine full-time crisis workers, an administrative assistant, a crisis supervisor, and a crisis manager. Additionally, four crisis workers are embedded with law enforcement jurisdictions, either part-time or full-time, allowing for quicker responses to mental health crises. All crisis workers are trained in suicide assessment, counseling against lethal means, the Columbia Suicide Severity Rating Scale, Dialectical Behavior Therapy skills, Brief Cognitive Therapy for Suicide Prevention, motivational interviewing, and are certified

juvenile intake workers. They receive comprehensive training each year to ensure their skills and knowledge remain current with evidence-based treatment and practices.

CRISIS SURVEYS AND FEEDBACK

Satisfaction surveys are sent out monthly, soliciting feedback on our services. These surveys look at response timeliness, staff professionalism, how well staff explain options, whether the person feels heard regardless of the outcome, and whether the experience helped them access the services/supports needed. Seventeen surveys were returned last year; 89% of respondents gave a positive rating, 7% gave a neutral rating, and 4% gave a negative rating. Upon reviewing the comments, the negative ratings were mostly related to the group home placement rather than the services provided by the crisis team. Several positive comments were included in the surveys, such as:

- "Everyone was very kind."
- "I feel they did a good job."
- "Thank you for your time and help."
- We also received suggestions for improvement and constructive feedback regarding follow-up, phone calls, and other areas where we can improve. We will focus on this feedback on our goals for 2025.

KEY OUTCOME INDICATOR

Our key outcome indicator, or the quantifiable metrics that show how well our program is performing, is our diversion rate, i.e., the capacity to connect someone with voluntary treatment services versus initiating a court order or emergency detention for treatment services. We adhere to the statute requiring the least restrictive setting for each person and strive to have the best possible outcome for the person in crisis. To do this, we consider several factors. We complete a standardized suicide assessment and consider lethality, means, opportunity, age, gender, access, and history. When possible, we divert the person to an unlocked facility. There are times when diversion is not feasible, and we must initiate emergency detention. In these cases, safety planning is not possible because the individual is unwilling to seek voluntary services, and the risk of harm to themselves or others is deemed to be high. All assessments are completed by highly trained and qualified crisis workers and are staffed with a licensed mental health professional before making a final decision on how to move forward.

Year	2022	2023	2024
Total # Assessments	353	297	308
Total # Emergency Detentions	75	73	69
Total # Diversions	278	224	239
Percentage of Diversions	79%	75%	78%

EMERGENCY DETENTIONS

We track and review factors regarding people who were placed under emergency detention. These include whether they were in county-based treatment services, incarcerated, enrolled in a managed care organization, and if they went to Winnebago Mental Health Institute (WMHI). The chart below shows a comparison of the last three years. As you can see from the chart, emergency detentions for people incarcerated have decreased and remained low over the last two years. Our adult emergency detentions have remained the same over the last three years, and the return to more restrictive for adults decreased by almost half from the year before. Our emergency detentions and return to more restrictive for youth have decreased since last year. Part of the decrease for youth may be attributed to using youth crisis stabilization facilities and the opening of the Matz Center, a youth crisis stabilization facility in Watertown. There is an increase in emergency detentions for individuals who are enrolled in a managed care organization.

	2022	2023	2024
Participating in Jefferson County Mental Health Services	24	18	20
Youth Emergency Detention (ED)	14	12	10
Adult ED	61	61	62
Adults at Winnebago Mental Health (WMHI)	36	22	27
Youth at WMHI	12	7	17
Individuals ED' d from Family Care, Partnership, or IRIS (FC,P, I)	11	4	16
Individuals at WMHI from FC,P,I	9	2	12
Adults Returned to More Restrictive (RTMR)	24	30	16
Youth RTMR	0	5	1
Adults RTMR at WMHI	13	12	2
Youth RTMR at WMHI	0	2	0
Individuals ED from the Jail	3	3	1
Revocation of settlement agreements	3	6	1

CRISIS INTERVENTION TEAM TRAINING

In 2024, we held our eighth Crisis Intervention Team (CIT) Training for law enforcement that included a focus on youth. Crisis Intervention Team training is a community initiative designed to improve the outcomes of police interactions with people living with mental illnesses. CIT programs are local partnerships between law enforcement, mental health providers, local NAMI chapters, and other community stakeholders. Jefferson County is part of the Southeast Wisconsin NAMI chapter. CIT programs provide 40 hours of training for law enforcement on how to better respond to people experiencing a mental health crisis. Effective CIT programs are based on strong relationships between law enforcement, mental health care providers, families, and people living with mental illness. CIT is a long-lasting, evolving partnership based on mutual goals.

YOUTH CRISIS SERVICES

Jefferson County Human Services participated, along with other counties, in the Children's Crisis grant, which allowed us to fund Dialectical Behavior Therapy training and attendance at the State Crisis Conference. In 2024, Jefferson County utilized funds from the crisis grant of $750.00 for training aimed at educating parents on trauma and children's mental health. Two Comprehensive Community Services mental health providers were able to use $5,100.00 to become trained in Dialectical Behavioral Therapy for Children in October. Finally, $598.00 was utilized for the EMH workers to attend the annual Crisis Intervention Conference.

The chart below shows data for 2022, 2023, and 2024 regarding assessments and diversions for youth under 18 years of age. Our assessments have increased this year, as has our diversion rate. The Matz Center, a youth crisis stabilization facility, opened in Watertown in 2024. This has contributed to our increase in diversions from emergency detentions. Of the 108 diversions we had in 2024, 49 of those were admissions to the Matz Center, which equated to 45% of the total diversions.

	2022	2023	2024
Total # Assessments	93	70	118
Total # Emergency Detentions	14	12	10
Total # Diversions	79	58	108
Percentage of Diversions	85%	83%	92%

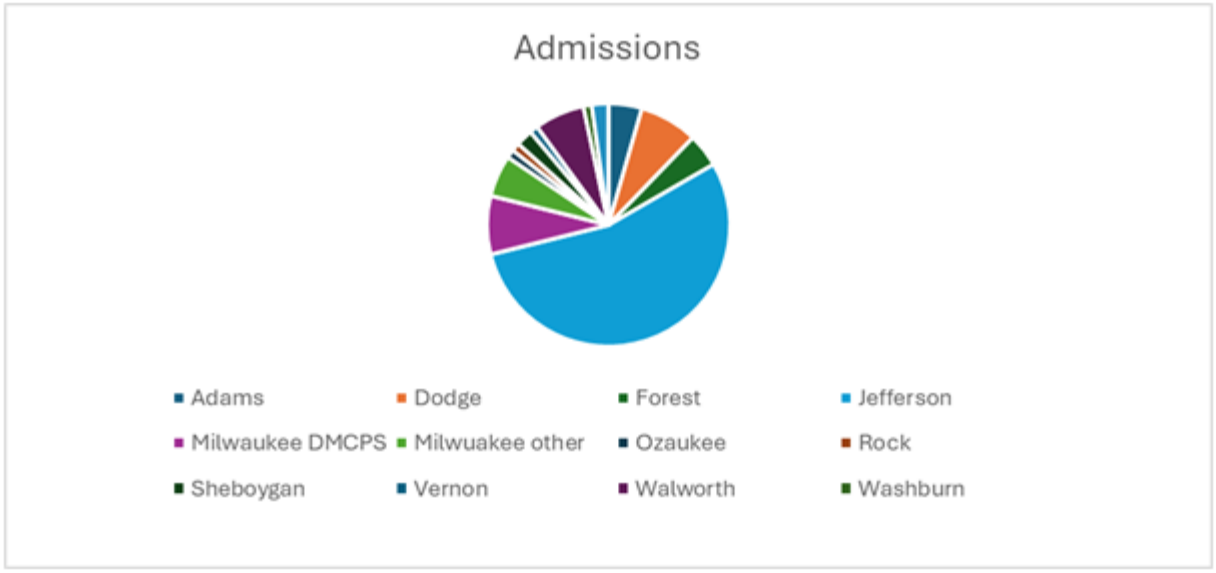
The Matz Center--Youth Crisis Stabilization Facility

Matz Center is a Youth Crisis Stabilization Center located in Watertown, WI. The facility can serve up to eight youth across the gender spectrum. Each young person has their own individual room. Four of the rooms have a private bathroom located just outside the bedroom. The other four bedrooms have one bathroom for two bedrooms. Jefferson County Human Services holds the license for the facility and has contracted with

Wisconsin Community Services (WCS) to provide staffing and programming. In 2024, the Matz Center opened in January and began serving females. In August 2024, the facility fully opened to serve youth in all eight beds.

The ribbon-cutting ceremony for the Matz Center took place on January 8th, 2024.

Our first year of admissions at The Matz Center yielded 90 admissions from 12 different counties/agencies. Of the 90 admissions Jefferson County accounted for 49 of those admissions with 39 youth being admitted. Some youths were admitted multiple times. The average length of stay was 8 days for all youths and 9.5 days for Jefferson County youth. The pie graph below demonstrates the breakdown of counties relating to the number of admissions.

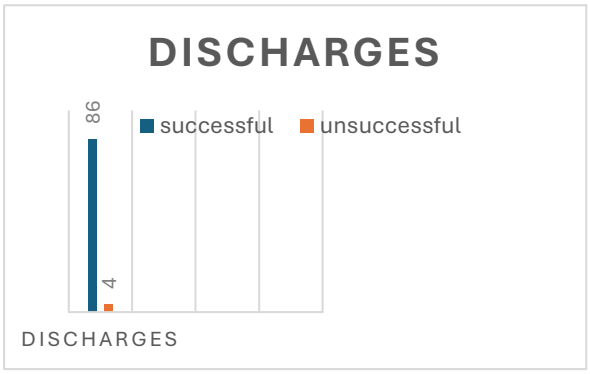


In determining a successful discharge, the reason for referral is reviewed and success is defined by minimizing the current crisis, along with the youth returning to a stable state compared to their condition at the time of admission. Success may also include:

- Transitioning with potential improvements ready to be implemented, such as new skills to utilize, a crisis/safety plan, and new referrals/services.
- The necessary time and space were given.
- Youth believe they can manage distress effectively.

Unsuccessful discharge is defined as when the youth leave in an active crisis or state of distress (e.g., youth kicking cars, youth punching staff).

Below is a graph showing the discharge outcomes for all 90 admissions. Jefferson County achieved a 100% successful discharge rate.

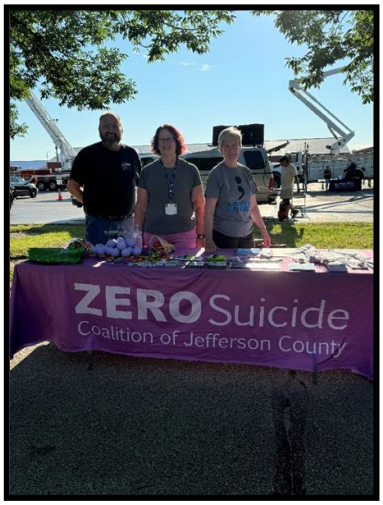


Voices for Hope Suicide Prevention Team

In 2024, our Zero Suicide team changed its name to Voices for Hope. During 2024 we continued our outreach and attended many community events including but not limited to the Jefferson County Fair, Watertown National Night Out, Lake Mills National Night Out, City of Jefferson Police Department National Night Out, Jefferson County Health department open house, Cambridge High School girls' soccer mental health night, various wellness fairs and events at schools.

In 2023, we saw a drastic increase in the number of deaths by suicide in Jefferson County. This increase was seen across the nation. In Jefferson County, 23 individuals died by suicide. In 2024, we saw a decrease in the number of individuals dying by suicide. Jefferson County had 13 confirmed deaths by suicide, with some pending data. This is a dramatic decrease from the prior year.

In 2025, Voices for Hope will continue to participate in community events to distribute resources and educational materials to the citizens of Jefferson County. Additionally, we will host our first Run/Walk for Suicide Prevention in Watertown at Riverside Park on September 13, 2025.



Review of 2024 Goals:

1. **Key Outcome Indicator:** Maintain the current emergency detention diversion rate whenever possible, by continuing to review and improve voluntary options.
   - Our diversion rate in 2024 was 78% which was a 3% increase from the year prior. For youth, our diversion rate increased 9% from the year prior. We reviewed the emergency detentions from 2024 and will continue to do so in 2025.
2. **Provide CIT training for Law Enforcement Officers serving in Jefferson County by December 2024**.
   - CIT was offered at the end of October 2024. 11 officers attended CIT in 2024.
3. **Track diversion rates for youth and compare them to the number of admissions to the Matz Center by December 2024.**
   - 45% of total diversions were admissions to the Matz Center.
4. **Create a committee to review deaths by suicide and use the information to help with suicide prevention measures.**
   - This goal will be ongoing. Our agency does death reviews for those individuals who die by suicide while in services with our agency. In 2025, we would like to expand this through our partnership with the Jefferson County Medical Examiner to review all deaths by suicide within our county.
5. **For each emergency detention, a review will be conducted by crisis and team members to look at what changes, if any, could be made and what resources are needed to divert emergency detentions.**
   - This will be an ongoing goal. The Crisis Manager and the Crisis Supervisor were able to review all emergency detentions from 2024 creating an excel spreadsheet to track data and look for trends. In 2025there will be a review team to look at what else, if anything could have been done in lieu of the emergency detention.
6. **Start taking male youth by June 2024, at the Matz Center.**
   - The Matz Center did start taking male youth from Jefferson County in July 2024 and then in August of 2024 the male side was completely opened.
7. **Continue to build programming around embedded crisis workers with law enforcement, including but not limited to policies, procedures, job expectations, and memos of understanding.**
   - There are two MOU's in place with local law enforcement agencies. With the hiring of a crisis supervisor who oversees the embedded workers there is the opportunity for more contact with the different jurisdictions.
8. **Continue to develop crisis co-response with a certified peer specialist**.
   - This was not achieved in 2024 and will be a focus for 2025.

Goals for 2025

1. Key Outcome Indicator: Maintain current emergency detention diversion percentage, whenever possible, by continuing to review and improve voluntary options.
2. Provide CIT training for Law Enforcement Officers serving in Jefferson County by December 2025.
3. Track diversion rates for youth and compare to the number of admissions to the Matz Center by December 2025.
4. Create a committee to review deaths by suicide and use the information to help with suicide prevention measures. This goal will be ongoing.
5. For each emergency detention a review will be conducted by crisis and other behavioral health supervisors to look at what changes, if any, could be made and what resources are needed to divert emergency detentions. This will be an ongoing goal.
6. Continue to build programming around embedded crisis workers with law enforcement, including but not limited to policies, procedures, job expectations, and MOU'S.
7. Continue to develop crisis co-response with a certified peer specialist.
8. Continue to build capacity in Voices for Hope committee; obtain additional committee members, raise awareness in the community, and facilitate a run/walk in Watertown at Riverside Park for suicide prevention by September 13, 2025.

LUEDER HOUSE

The Lueder House serves as our adult crisis stabilization facility. It is an 8-bed facility licensed as a class A CBRF (community based residential facility) by the state of Wisconsin. This facility is staffed 24 hours a day, 7 days a week, 365 days a year by a manager and six full-time crisis stabilization workers. Lueder House serves as an important resource, allowing for stabilization when hospitalization is not necessary.

In 2024, there were 63 total admissions at the Lueder House and of those, 16 were unhoused when they were admitted. The average length of stay for consumers was 23 days. We had 48 unique individuals who were served by the Lueder House in 2024, as several were admitted more than once for crisis stabilization services. Of the 63 admissions, 15 admissions were between 30-174 days. The average length of stay for those admissions was 71 days. The Lueder House continued to provide a wide array of supports around activities of daily living such as menu planning and cooking, daily goal sheets, sleep protocol, exercise groups, and DBT skills coaching. Lueder House staff also assisted people in applying for benefits, housing, and employment.

In 2024, we billed Medicaid $401,324 for stabilization services at the Lueder House and received $126,330 in reimbursement.

ADULT PROTECTIVE SERVICES (APS)

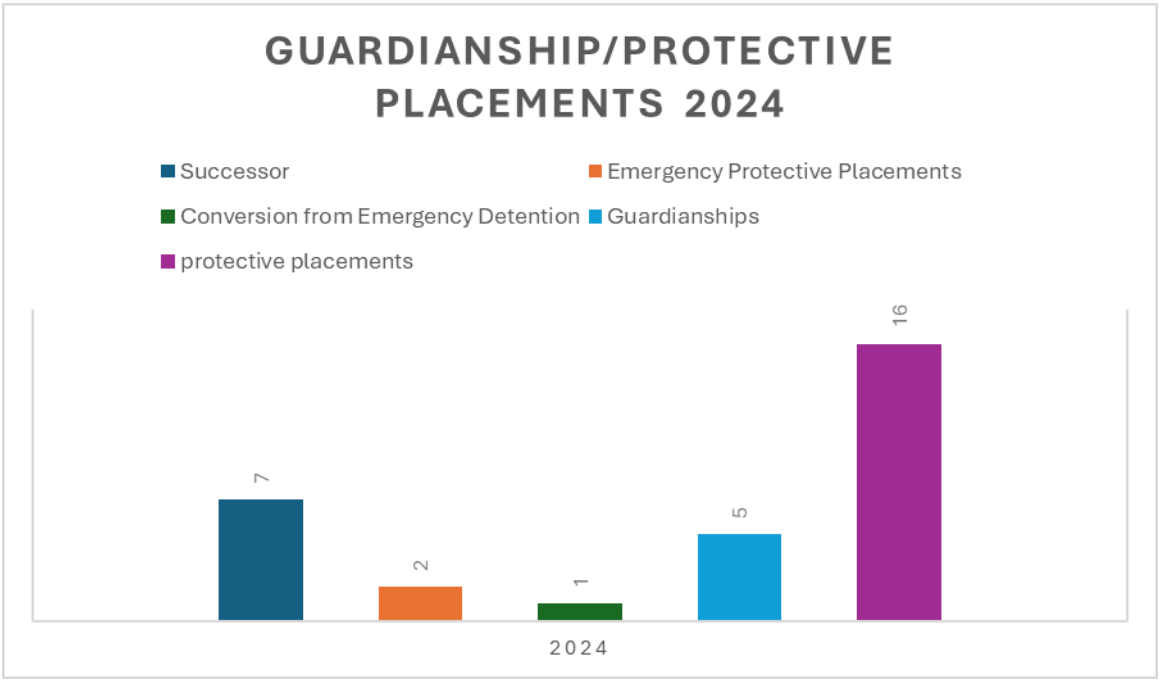
Adult protective services are set up to aid elder adults and Adults-at-Risk who have been abused, neglected, or exploited.

The Human Services Department of Jefferson County is the designated "lead agency" for receiving and responding to allegations of abuse or neglect of adults ages 60 and over as well as adults-at-risk ages 18-59. The Adult Protective Services department within the Human Services Department takes primary responsibility for receiving and responding to allegations of abuse, financial exploitation, neglect, and self-neglect. 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. APS services are mandated by state statutes and are severely underfunded. Several different statutes establish the county's responsibilities in responding to these situations.

Adult Protective Services advocates for the least restrictive interventions with the intention of utilizing guardianship as a last resort. APS reviews whether Power of Attorney documentation can be completed versus pursuing guardianship, to minimize the infringement on an individual's liberties.

In 2024 the state transitioned from using Wisconsin Incident Tracking System (WITS) to using Wisconsin Reporting for Adult Protective Services- (WRAPS). According to Department of Health Services, WRAPS will collect similar data on APS investigations but has been updated to improve the user experience and to better align Wisconsin data collection with national standards for Adult Protective Services programs. The new reporting system will also include different user roles and tools to assist counties in managing caseloads and exploring local data. APS data collection is both statutorily required and extremely important to capture program activity and prevalence rates of abuse and neglect reported to APS units in Wisconsin.

Also new in 2024, the state of Wisconsin requires guardian(s) to complete the Guardianship Training through the UW Green Bay partnership. The APS staff assists the proposed guardian(s) in accessing the training and ensuring they are completing it. If the proposed guardian(s) doesn't have online access, then APS will provide them with a paper copy and ensure the test is submitted to UW Green Bay. The average time to complete this training is 2 hours. The chart below shows the breakdown of new guardianships and protective placements.



In 2024 there were 120 annual protective placement reviews with 6 being completed by CCS/CSP with the help of APS. 34 of the 120 are located outside of Jefferson County. This results in APS staff traveling anywhere from one hour to up to three hours away to visit in person and doing the review to submit to court.

There were 23 contested reviews of protective placements last year. These all had full due process hearings (typically two court hearings). APS is responsible for coordinating data collection from MCO/placement setting/medical records/bank records that are requested by counsel, assisting the court-ordered Psychologist with scheduling visit for eval of ward, and ensuring transportation is coordinated for the ward to/from court.

The Adult Protective Services department is a department of two full-time APS workers and one part time APS worker with 444 open cases they oversee. This is an increase of 117 cases from 2023. In addition to open cases, new calls come in daily. These referrals require return calls, case coordination, investigations, and in-home visits. The APS Social Workers work closely with the Jefferson County Court System, public health departments, police, fire, and crisis services, banks, Managed Care Organizations, hospitals and medical providers, assisted living facilities, nursing homes, as well as with family members, friends, and other natural supports for clients. There was a total of 3,446 contacts which included phone calls and emails regarding cases. Below is a graph showing contacts by month.

The chart below breaks down the different types of investigations that were conducted in 2024. There were 61 cases identified for investigations.

On June 15, 2024, we observed World Elder Abuse Awareness Day by providing informational materials for the community to take. In addition, the APS team displayed a banner at the Annex Road entrance to raise awareness. As part of the event, the APS team distributed keychains, as shown in the image pictured below.

The Adult Protective Services Team is funded through various sources. GWAAR provides Elder Abuse funding for direct services. DHS also provides an Adult Protective Services allocation. These contracts were for $24,998 and $74,409 in 2024, respectively. Additionally, in 2024, DHS provided an additional $8,831 Adult Protective Services grant from American Rescue Plan Act funding to enhance, improve, and expand the ability of APS to investigate allegations or abuse, neglect, and exploitation. None of these contracts require a county match.

Review of 2024 Goals:

1. APS will learn the new WRAPS system and input the required data into the system for 2024.
   - APS staff went through the training, requested access, and entered the appropriate 2024 data.
2. APS will continue to meet to discuss data specifically; what data is being collected, data trends, and tracking the needs of the program.
   - APS meets weekly to review this data and in 2024 we were able to collect more data. We should also be able to extract data each year from the WRAPS system.

Goals for 2025:

1. Enter data into WRAPS promptly throughout the year as evidenced by data in the system.
2. Provide more awareness regarding the function of APS and other topics related to Elder Abuse. This will be evident by community engagement, training, etc.
3. Participate in I-Team meetings quarterly.
4. Plan an event for Elder Abuse Awareness on June 15, 2025.

OUTPATIENT INTEGRATED BEHAVIORAL HEALTH CLINIC

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

The Outpatient Integrated Behavioral Health Clinic serves Jefferson County residents with mental health and substance use concerns. The clinic offers same-day, walk-in, and virtual services for community members in need of support. In 2024, there were 507 ***new*** clients entered into mental health treatment and 331 ***new*** clients entered substance use treatment with 126 ***new*** children enrolled into services.

As the chart below indicates, the clinic provided mental health services to 1051 individuals and substance use services to 607 individuals. In addition to services through the Outpatient Integrated Behavioral Health Clinic, staff also provided therapy to 35 Comprehensive Community Services Program (CCS) adults. These numbers include clients seen by the Psychiatrist and Nurse Prescriber as well as those seen by clinic therapists. In 2024, 1,398 individuals were seen by the Psychiatrist and Nurse Prescriber.

In 2024, 225 children were seen for mental health treatment through the outpatient clinic and an additional 29 children through the Comprehensive Community Services Program (CCS) ranging from elementary school-aged children to high school.

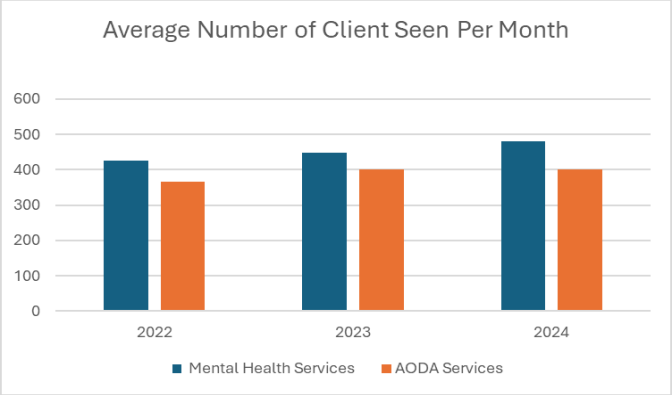
Total Number of Clients Enrolled

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
MH Clinic	661	718	802	774	930	1,381	937	880	893	1,045	1,051
AODA Clinic	327	393	406	447	547	680	598	538	534	596	607
Totals	988	1,111	1,208	1,221	1,477	2,061	1,535	1,418	1,427	1,641	1,658

Participants of the clinic are offered same-day, walk-in or virtual "open access" enrollment services. Throughout this process, principles of hope and empowerment are integrated into clinic services. Starting with a clinical assessment completed during open access services to the treatment plan, which is created based on the client's input, strengths, and resources to support clients in leading the life they desire.

All clinic staff are trained in evidence-based practices to support clients with ongoing mental health and/or substance use needs. Services are provided in the least restrictive manner, decreasing the disruption of the individual's life while still providing support for recovery services that include a wide array of evidence-based practices.

The clinic staff consists of a Medical Director/Psychiatrist, a Psychiatric Nurse Prescriber, fifteen full-time Psychotherapists, one full-time intake Psychotherapist, as well as a Community Outreach Worker and the Clinic Manager. Four of these psychotherapists are providing school-based mental health services. Staff are dually trained to provide mental health and substance use treatment. Clinic staff provided mental health and/or substance use services to an average of 882 people per month in 2024. The chart below outlines the number of clients seen per month based on recent years.



The clinic is also responsible for overseeing many civil commitments in our county and providing treatment for the individual on the commitment. Under WI § 51, individuals assessed as being a danger to themselves or others due to a mental health disorder may be subject to involuntary detention. If the court determines that treatment is necessary, these individuals are placed under an order for treatment, typically lasting for six months. The individual can seek treatment either through the outpatient mental health clinic or, if they have other resources, from a provider in the community. Approximately 35 individuals were placed under an order for treatment pursuant to WI § 51.45.

In 2024, clinic staff provided individual psychotherapy services in nine schools throughout Jefferson County. Locations included Fort Atkinson High School, Fort Atkinson Middle School, Watertown High School, Watertown Middle School, Johnson Creek School District, Waterloo High School, Whitewater High School, and Whitewater Middle School.

The clinic maintains its certification under the Wisconsin Department of Health Services (DHS) 75.50 as an Outpatient Integrated Behavioral Health Treatment Provider and operates licensed branch offices at the following locations:

- The Collective, Watertown
- Riverside Middle School
- Watertown High School
- Johnson Creek School District
- Fort Atkinson Middle School
- Fort Atkinson High School
- Whitewater Middle School
- Whitewater High School
- Jefferson Middle School
- Jefferson High School

The branch location at The Collective in Watertown employs several staff members who provide full-time psychotherapy services to residents in the Watertown area.

The clinic was licensed in 2024 through DHS 75.51 as an Intensive Outpatient Treatment provider and will be able to provide intensive non-residential treatment services of at least 9 hours a week per client. These services will utilize Cognitive Behavioral Therapy for substance use disorders to support clients in their recovery and relapse prevention.

Review of 2024 Goals:

1. Clinic staff will become trained in EMDR and implement this evidence-based practice to support adults who have experienced adverse and traumatic events.
   - *Outcome:* The clinic did send staff to be trained in EMDR. The clinic has developed a referral form, process, and tracking procedure to support the implementation of this new model.
2. The clinic will implement a new Clinic Supervisor position to support clinic needs, including clinical supervision, program development, staff development and implementation of evidenced based programming.
   - *Outcome:* The clinic implemented a new clinic supervisor position.
3. The clinic will continue to provide same-day open-access services to community members in need of immediate mental health and/or substance use treatment. Clinic staff will track data and increase open access spots as needed.
   - *Outcome:* The clinic continues to provide open access services to community members, offering services five days a week and are responsive to ongoing data collection based on community needs.

4. The clinic will maintain a branch location in Watertown and will expand the services offered at this location.
    - *Outcome:* The clinic has maintained a branch location in Watertown. The clinic had such a demand for services in this location that additional space was secured to allow for two full-time therapists to be in the Watertown location.
5. The clinic will apply for and provide Intensive Outpatient Programming to meet the complex needs of community members who require more intensive services to support their mental health and/or substance use symptoms.
    - *Outcome:* The clinic applied and was certified through DHS to provide Intensive Outpatient services.
6. The clinic will provide ongoing substance use treatment groups focusing on relapse prevention, harm reduction, and increasing recovery-based community support.
    - *Outcome:* The clinic has continued providing substance use treatment groups. These evidence-based groups include Prime for Life, Cognitive Based Interventions for Substance Abuse (CBI-SA), and DBT Skills. Several clinic staff members trained in Prime for Life in 2024, and 18 participants attended this group in the last year.
7. The clinic will continue to partner with Jefferson County Human Services Student Cohort to provide ongoing internship opportunities to advanced standing, clinical graduate students.
    - *Outcome: The* clinic has partnered with the JCHS Student Cohort to provide internships to four clinical graduate-level students. These students have worked towards learning, implementing therapeutic models, conducting clinical assessments, and clinical documentation to allow for billing.
8. The clinic was awarded the QTT Culturally Responsive Grant and will identify agency needs and implement best practices to ensure the clinic meets all cultural and linguistically appropriate standards (CLAS).
    - *Outcome:* The clinic has identified needs and utilizes these funds to enhance services. This has included purchasing signs in Spanish, training and education for staff as it relates to marginalized groups as well as a contract with a Spanish speaking therapist.
9. The clinic will continue to provide psychotherapy services throughout DHS 75 licensed branch locations within the school districts in Jefferson County.
    - *Outcome:* The clinic has maintained its 10 branch locations under DHS 75.50 and has provided ongoing services from these sites.
10. Clinic staff will continue to provide TEAM-CBT treatment. Staff will attend regular scheduled TEAM-CBT consultation groups, and all new staff will be trained in providing TEAM-CBT therapy.
    - *Outcome:* The clinic has one Level II Team CBT certified staff and three other staff that are eligible for this certification. Clinic staff attend ongoing Team CBT consultations and utilize Team CBT material.
11. Clinic staff will offer DBT groups. This will include adult DBT groups as well as DBT groups for children/adolescents/families.
    - *Outcome:* The clinic offered several groups in 2024, including two DBT skills groups and a DBT Emotion Regulation Skills System group. The clinic continues to make strides towards the implementation of child, adolescent and family groups.
12. Clinic staff will offer and provide DBT treatment. Staff will continue to enhance their DBT knowledge through a weekly consultation group as well as internal and external trainings. All new staff will attend internal DBT foundational training.
    - *Outcome:* All clinic staff are trained in DBT, and staff provide DBT treatment. The Clinic facilitates two DBT skills groups as well.
13. Clinic staff will continue to participate in the Strengthening Treatment Access and Retention-Quality Improvement (STAR-QI) NIATx project with the Department of Health Services.
    - *Outcome:* The clinic participated in the STAR-QI program and successfully developed and implemented drug testing policies and procedures to align with best practices.
14. Clinic staff will continue to implement evidenced based practices for children, including TF-CBT, DBT-C and CBT. Ongoing consultation, professional development and training will be provided to support clinic staff with the implementation of these treatment modalities.

- *Outcome:* Clinic staff continue to provide evidence-based services to children utilizing an array of modalities. Staff attend regular clinical consultation as well as supervision for support with ongoing implementation of these models.

15. The clinic will align with best practices for providing substance use treatment outlined by SAMSHA. Including, the utilization of drug testing in a therapeutic setting and ongoing recovery focused groups.
   - *Outcome:* The clinic successfully partnered with Millennium Drug Testing to provide ongoing drug testing services as outlined in SAMSHA's best practice model. Drug testing policies and procedures were developed and implemented.

Evidence-Based Practices Utilized in 2024

1. **Dialectical Behavior Therapy (DBT)** is a cognitive-behavioral treatment that was originally developed to treat chronically suicidal individuals diagnosed with borderline personality disorder (BPD), and it is now recognized as the gold standard psychological treatment for this population. Also, research has shown that it is effective in treating a wide range of other disorders such as substance dependence, depression, post-traumatic stress disorder (PTSD), and eating disorders (http://behavioraltech.org/resources/whatisdbt.cfm). Clinic staff facilitated two DBT skills groups throughout the year to support individuals with learning and implementing skills to support them in their symptoms management.
2. **Motivational Interviewing (MI)** is a goal-directed, client-centered counseling style designed to elicit 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 become its key goal. (https://store.samhsa.gov/sites/default/files/d7/priv/tip35_final_508_compliant_-_02252020_0.pdf) The clinic is utilizing this therapy protocol in both group and individual sessions. Clinic staff have received intensive motivational interviewing training by MINT trainers periodically since 2014, which will continue throughout 2023. All new staff members are required to attend both Level I and Level II Motivational Interviewing (MI) trainings.
3. **Medication-Assisted Treatment** for opioid addiction via the use of Buprenorphine, Vivitrol, and Naltrexone. (http://www.ncbi.nlm.nih.gov/books/NBK64164/).
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 were trained in cognitive behavior therapy and CBT is used in both group and individual sessions.
   - **TEAM-CBT:** TEAM-CBT is a framework for conducting measurement-based CBT treatment. (Feeling Good Institute | What Is TEAM-CBT Therapy | Dr. David Burns). This evidenced based therapy combines elements of traditional CBT processing with dynamic elements to produce rapid change with clients. Testing, empathy, agenda setting, and methods are key components of this model which supports with addressing cognitive distortions and decreasing mental health and AODA symptoms. Twelve clinic staff were trained in TEAM-CBT and continue attending bi-weekly consultation group to effectively implement TEAM-CBT.
5. **Collaborative Assessment and Management of Suicidality training (CAMS)**. CAMS is a therapeutic framework for suicide-specific assessment and treatment of a client's suicidal risk. CAMS is first and foremost a clinical philosophy of care. It is a therapeutic framework for suicide-specific assessment and treatment of a patient's suicidal risk. It is a flexible approach that can be used across theoretical orientations and disciplines for a wide range of suicidal patients across treatment settings and different treatment modalities. The clinician and patient engage in a highly interactive assessment process and the patient is ultimately engaged in the development of their treatment plan. Every session of CAMS intentionally involves the patient's input about what is and is not working. All assessment work in CAMS is collaborative. The patient is said to be a co-author of their treatment plan (http://cams-care.com/cams/?pgnc=1).

6. **Trauma-Focused Cognitive Behavior Therapy (TF-CBT)** is a components-based model of psychotherapy that addresses the unique needs of children with PTSD symptoms, depression, behavior problems, and other difficulties related to traumatic life experiences. TF-CBT addresses the multiple domains of trauma impact, including but not limited to post-traumatic stress disorder (PTSD), depression, anxiety, externalizing behavior problems, relationship and attachment problems, school problems, and cognitive problems. TF-CBT includes skills for regulating affect, behavior, thoughts and relationships, trauma processing, and enhancing safety, trust, parenting skills, and family communication. (http://www.nctsn.org/sites/default/files/assets/pdfs/tfcbt_general.pdf). Three of the Clinic Therapists are certified in providing trauma-focused cognitive behavior therapy, and one additional clinic therapist was trained in 2022.
7. **The Cognitive-Behavioral Interventions for Substance Use** (CBI-SU) curriculum can be delivered as a stand-alone substance abuse intervention or incorporated into a larger program, particularly those designed for clients in the corrections system. As the name of the curriculum suggests, this intervention relies on a cognitive-behavioral approach to teach participants strategies for avoiding substance abuse. The program places heavy emphasis on skill-building activities to assist with cognitive, social, emotional, and coping skill development. Such cognitive-behavioral strategies have routinely demonstrated high treatment effects, including when used with a correctional population. The University of Cincinnati (UC) serves as the sole owner and proprietor of the copyright in the CBI-SA manual and training program. An adolescent version is also available.
   https://cech.uc.edu/content/dam/refresh/cech-62/ucci/overviews/cbi-su-overview.pdf
8. **Mindfulness-Based Relapse Prevention** (MBRP), a mindfulness-based aftercare approach, integrates core aspects of RP with practices adapted from MBSR (mindfulness bases stress reduction) and MBCT (mindfulness-based cognitive behavior therapy). Identification of high-risk situations remains central to the treatment. Participants are trained to recognize early warning signs for relapses, increase awareness of internal (i.e., emotional, and cognitive) and external (i.e., situational) cues previously associated with substance use, develop effective coping skills, and enhance self-efficacy. Mindfulness practices included in MBRP are intended to raise awareness of triggers, monitor internal reactions, and foster more skillful behavioral choices. The practices focus on increasing acceptance and tolerance of positive and negative physical, emotional, and cognitive states, such as craving, thereby decreasing the need to alleviate associated discomfort by engaging in substance use.
   https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3280682/#R24
9. **The Matrix Model** provides a framework for engaging stimulant (e.g., methamphetamine and cocaine) users in treatment and helping them achieve abstinence. Individuals learn about issues critical to addiction and relapse, receive direction and support from a trained therapist, and become familiar with self-help programs. Treatment materials draw heavily on other tested treatment approaches and, thus, include elements of relapse prevention, family and group therapies, drug education, and self-help participation. Detailed treatment manuals contain worksheets for individual sessions; other components include family education groups, early recovery skills groups, relapse prevention groups, combined sessions, urine tests, 12-step programs, relapse analysis, and social support groups. https://nida.nih.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/behavioral-therapies/matrix
10. **Dialectical Behavior Therapy for Children (DBT-C)** was specifically developed to address the treatment needs of pre-adolescent children experiencing severe emotional dysregulation and related behavioral challenges. These children experience emotions on a different level and are much stronger than their peers. The transaction between an invalidating environment and a child's heightened emotional needs may lead to psychopathology. Research shows that such children are at an increased risk to develop alcohol and substance use problems, suicidality and non-suicidal self-injury, depression, anxiety, and personality disorders in adolescence and adulthood (Althoff, Verhulst, Retlew, Hudziak, & Van der Ende, 2010; Okado & Bierman, 2014; Pickles et al., 2009). The main goals of DBT-C are to teach these children

adaptive coping skills and effective problem-solving and to teach their parents how to create a validating and change-ready environment. https://behavioraltech.org/dbt-for-children/

11. **Eye Movement Desensitization and Reprocessing (EMDR)** is a psychotherapy that enables people to heal from the symptoms and emotional distress that are the result of disturbing life experiences.
    Repeated studies show that by using EMDR therapy, people can experience the benefits of psychotherapy that once took years to make a difference. It is widely assumed that severe emotional pain requires a long time to heal. EMDR therapy shows that the mind can heal from psychological trauma as the body recovers from physical trauma. Some of the studies show that 84%-90% of single-trauma victims no longer have post-traumatic stress disorder after only three 90-minute sessions. Another study, funded by the HMO Kaiser Permanente, found that 100% of the single-trauma victims and 77% of multiple trauma victims no longer were diagnosed with PTSD after only six 50-minute sessions. In another study, 77% of combat veterans were free of PTSD in 12 sessions.

There has been so much research on EMDR therapy that it is now recognized as an effective form of treatment for trauma and other disturbing experiences by organizations such as the American Psychiatric Association, the World Health Organization, and the Department of Defense. (https://www.emdr.com/what-is-emdr/)

Goals for 2025:

1. Clinic staff will implement EMDR to support adults and adolescents who have experienced trauma. Staff will track and report outcome data measures to support ongoing implementation.
2. The clinic will continue to provide same-day open-access services to community members in need of immediate mental health and/or substance use treatment.
   - Clinic staff will track data and increase open access spots as needed.
   - Clinical staff will coordinate with ongoing systems of care including administrative support, EMH, financial intake and other staff to ensure implementation of open access services.
   - The clinic will expand on the same day, open access services to the Watertown branch location.
3. The clinic will maintain its certification under the Wisconsin Department of Health Services (DHS) 75.50 – Outpatient Integrated Behavioral Health Treatment Provider at our branch location in Watertown.
4. The clinic will maintain its certification under the Wisconsin Department of Health Services (DHS) 75.15 – Intensive Outpatient Treatment Provider and will provide IOP services to adults.
5. Clinic staff will provide ongoing substance use groups focusing on relapse prevention, harm reduction, and increasing recovery-based community support.
6. Clinic staff will provide ongoing mental health wellness groups utilizing evidence-based practices to support consumers' biopsychosocial needs.
7. Clinic staff will provide ongoing anger management groups to support consumers with emotion regulation and processing of cognitive distortions.
8. Clinic staff will offer DBT groups. This will include adult DBT groups as well as DBT groups for children/adolescents/families.
9. Clinic staff will offer Emotion Regulation Skills System groups for consumers with cognitive impairments to support diverse learning needs.
10. The clinic will continue to partnerships with local universities and Jefferson County Human Services Student Cohort to provide ongoing internship opportunities to advanced standing, clinical graduate students. This will include clinical students billing for services rendered.
11. The clinic will continue to provide psychotherapy services throughout DHS 75 licensed satellite locations within the school districts in Jefferson County.
12. Clinic staff will continue to provide TEAM-CBT treatment. Staff will attend regular scheduled TEAM-CBT consultation groups, and all new staff will be trained in providing TEAM-CBT therapy.
13. Clinic staff will offer and provide DBT treatment. Staff will continue to enhance their DBT knowledge through a weekly consultation group as well as internal and external trainings. All new staff will attend internal DBT foundational training.

14. Clinic staff will attend and complete the Maternal Infant Mental Health Capstone Program.
- Staff will provide appropriate screening, assessment, diagnostic and therapeutic intervention services to support the mental health of infants, young children and their families.
- Staff will partner with Birth to Three, Jefferson County Health Department and other internal departments to provide coordinated services for young children.

15. All clinic staff will submit a Motivational Interviewing (MI) recording for coding and feedback to ensure ongoing compliance and fidelity implementation.

16. The clinic will follow complete assessment and recommendations from the Culturally and Linguistically Appropriate Service (CLAS) standards as required by the Department of Health Services (DHS) and Bureau of Prevention Treatment and Recovery (BPTR).

INTOXICATED DRIVER PROGRAM

Each county in the State of Wisconsin is responsible for establishing and providing intoxicated driver program assessments; Jefferson County Human Services is the designated single intoxicated driver assessment facility in Jefferson County, mandated under DHS 62 to provide an assessment and formulate a driver safety plan for persons who operate a motor vehicle while under the influence of intoxicants or other drugs (OWI) and who voluntarily, or by court order or by order of the Wisconsin Department of Transportation undergo an intoxicated driver assessment and complete a driver safety plan (DSP). The intent is to engage the individual in assessment, education, and treatment services that address the client's inclination to drive under the influence and their substance use problems so that the client may regain safe driving capability.

Only an intoxicated driver assessor (IDP-AT) may conduct assessments and develop driver safety plans. The principal method for assessment is a personal interview with the client using the Wisconsin Assessment of the Impaired Driving tool (WAID). Assessments may include the following: information provided by other people; a review of relevant records or reports on the client; an interview using substance use disorder diagnostic criteria; an approved mental health screening tool; or additional information-gathering measures, instruments, and tests, including alcohol or drug testing, or lab tests deemed to be clinically useful and approved by the designated coordinator.

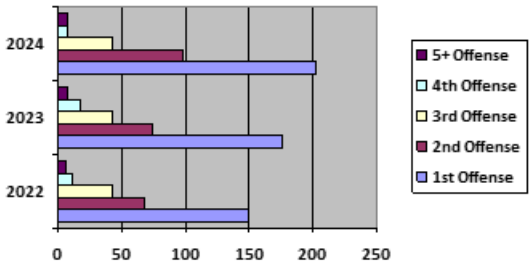
Assessment findings are documented on the Order for Assessment and Driver Safety Plan Report identifying the WAID criteria supporting the finding along with a description of the evaluation instruments applied during the assessment; assessment findings include irresponsible substance use, irresponsible substance use – borderline, suspected substance use dependency, substance dependency, or substance dependency in remission. Based on the assessment findings, a driver safety plan is developed with one of the following recommendations: traffic safety education, treatment, and other service recommendations; or traffic safety school and treatment. In addition to the recommendations stated, the driver safety plan may recommend any of the following: victim impact panel, case management, intensive supervision, mental health or psychiatric evaluation or services, and follow-up interviews with the assessment facility.

If a substance use disorder is not identified, the individual assessed is referred to completing a traffic safety program for a first offense (Group Dynamics, GD) or second offense (Multiple Offender Program, MOP). The Group Dynamics Program is a highway safety initiative within Wisconsin that aims to assist people involved in their first alcohol or other drug-related traffic offense to make permanent changes in their irresponsible drinking and driving behavior and attitudes. There is a minimum of 21 classroom hours contained in this alcohol or other drug educational program. The Multiple Offender Program is a specialized education course for individuals who have received two or more charges. In addition to providing alcohol education, the course focuses on modifying the unhealthy attitudes and behaviors that foster repeat irresponsible impaired driving. The course emphasizes strategies and techniques that assist individuals in changing high-risk attitudes and behaviors related to substance use and driving. Small group sessions and participation of a concerned other, for a minimum of two sessions, along with self-evaluation techniques, are utilized. The course is conducted over 30 classroom hours and a follow-up evaluation three months after the last classroom session.

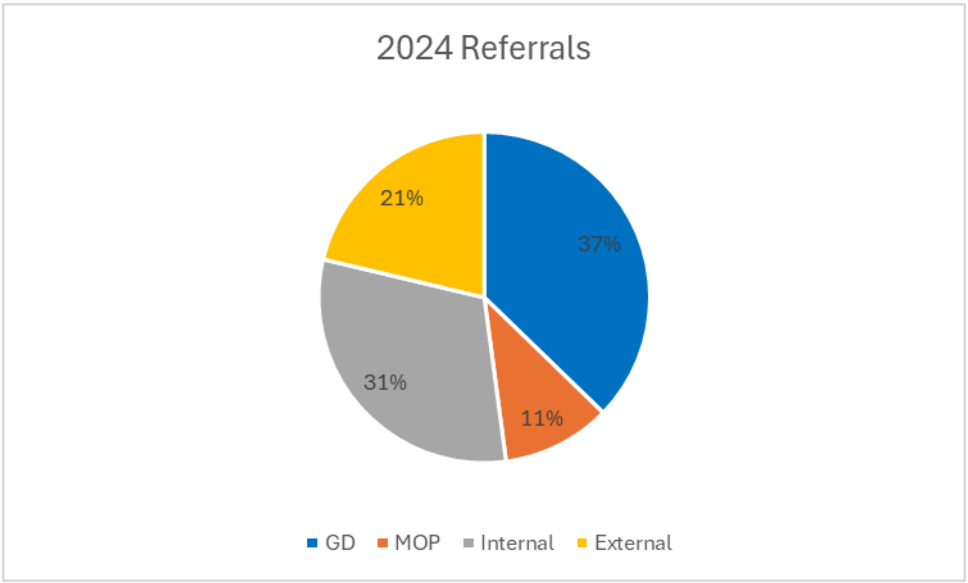
If substance use treatment is recommended, the individual is referred to a provider that is licensed under DHS 75, via a substance use treatment provider licensed under DHS 75.49, or outpatient integrated behavioral health treatment services licensed under DHS 75.50. The individual is responsible for completing the driver safety plan within a year. Failure to complete the plan will result in non-compliance, leading to further restrictions or the potential loss of driving privileges. In addition to completing the assessments, the assessor is responsible for monitoring the individual's compliance with the DSP and reporting status updates to the Wisconsin Department of Transportation.

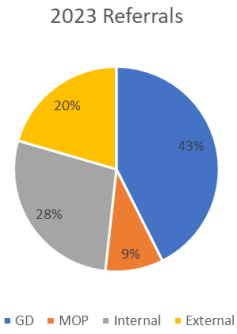
In 2024, the IDP program completed 356 assessments and developed Driver Safety Plans from each. Of the assessments completed, 202 individuals were first-time OWI offenders, accounting for 56.7% of the total. Additionally, 97 individuals had their second OWI offense, 43 had three lifetime OWI offenses, 7 had four lifetime OWI offenses, and 7 had five or more lifetime OWI offenses.

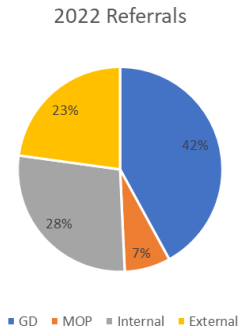
OWI	2022	2023	2024
1st Offense	150	176	202
2nd Offense	67	74	97
3rd Offense	42	42	43
4th Offense	11	18	7
5th Offense or more	6	7	7
Total	276	317	356



In 2024, 133 consumers were referred to Group Dynamics (GD) and 38 consumers were referred to the Multiple Offender Program (MOP) which accounts for 48% being referred to completing a traffic safety program. A total of 186 individuals (52% of completed assessments) were referred to outpatient substance use treatment with 76 individuals (21%) being referred to a private outpatient clinic in the community that is DHS 75 Licensed, and 110 individuals (31%) were referred to the Jefferson County Outpatient Integrated Behavioral Health Clinic at Human Services which is an increase of 3% from 2023.







COMPREHENSIVE COMMUNITY SERVICES PROGRAM (CCS)

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

VISION STATEMENT: To provide the most effective services and resources to consumers of the CCS program to assist them with living their most authentic/best life possible as they work toward recovery from mental health and substance use conditions.

The Jefferson County Comprehensive Community Services Program (CCS) completed its eighteenth 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 in February of 2022. In 2023, the Division of Quality Assurance Behavioral Health Certification Section began issuing non-expiring certificates. Continued certification will be based on compliance with the administrative code. Biennial on-site surveys will continue to be conducted.

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 use 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 helps participants on their journey towards recovery.

CCS offers an array of psychosocial rehabilitative services which are tailored to each 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 support services; psychotherapy; and substance abuse treatment.

General Data:

During 2024, 271 consumers ranging in age from 6 to 75 received services reflecting an increase of two compared to the number of people served in 2023. Throughout 2024, 64 new consumers were admitted, and 70 consumers were discharged. Of the consumers admitted to the program, 41 were children and 23 were adults. Of the consumers discharged, 28 were children and 42 were adults.

Consumers had diagnoses of: schizophrenia, schizoaffective disorder, delusional disorder, bipolar disorder, major depressive disorder, disruptive mood dysregulation disorder, borderline personality disorder, post-traumatic stress disorder, various anxiety disorders, reactive attachment disorder, attention deficit hyperactivity disorder, obsessive compulsive disorder, conduct disorder, oppositional defiant disorder, intermittent explosive disorder, eating disorders, adjustment disorders, substance use disorders, cognitive disorders and autism.

The CCS staff consists of a Psychiatrist, CCS Manager, three CCS Supervisors/Mental Health Professionals (One for the child and adolescent team, one for the family centered treatment team and one for the adult team), twenty-two full time CCS service facilitators, three full time CCS family centered treatment psychotherapists, four full time psychosocial rehabilitation providers, one full time LPN, one full time administrative assistant and four full time administrative specialists.

Key Outcome Indicators:

For the year 2024, the CCS goal was to maintain the percentage of service plan objectives accomplished at 72%. The overall percentage of service plan objectives accomplished in 2024 was 77%. 76% percent of the objectives for children were accomplished and 80.5% of objectives were met by adults in the program. The CCS team will strive to maintain the percentage of service plan objectives accomplished at 72%.

Consumer Satisfaction:

The CCS program conducts consumer satisfaction surveys for consumers and their families who have been enrolled in the CCS program for a minimum of six months. In 2024, there were 198 eligible consumers for these surveys of which we received 130 responses.

The CCS program conducted an adult consumer survey for adults aged 18 and older to measure the consumer satisfaction of our program regarding a positive experience. We had 65 adult respondents out of 89 who were eligible this year. Below is the means and percentages table which breaks the survey down into the following categories: overall mean, satisfaction, participation, access, outcomes, functioning, connectedness, and quality. The mean and scale values range from 1.0 to 5.0. The item wordings in all statements are positively phrased, so a value closer to 5.0 represents a more positive experience. All categories remain at or above a mean score of 3.6 along with 83% of consumers who had responded with an overall domain average greater than 3.5.

Means and Percentages for Adult (aged 18 and older) Consumer Satisfaction Survey Scales

	ADULT Overall Means	Scale 1 Satisfaction	Scale 2 Access	Scale 3 Quality	Scale 4 Treatment Planning	Scale 5 Outcome	Scale 6 Functioning	Scale 7 Social Connectedness
Average for all consumers	4.2	4.5	4.4	4.5	4.5	3.8	3.8	3.6
% Of consumers with a domain average greater than 3.5	83%	95%	92%	92%	94%	72%	69%	67%

The CCS program conducted a Youth Consumer survey for youth aged 13-17 to measure consumer satisfaction of our program regarding a positive experience. We had 38 Youth respondents out of 60 who were eligible. Below is the means and percentages table which breaks the survey down into the following categories: overall mean, Satisfaction, Participation, Access, Culture, Outcomes, and Social Connectedness. The mean and scale values range from 1.0 to 5.0. The item wordings in all statements are positively phrased, so a value closer to 5.0 represents a more positive experience. All categories remain at or above a mean score of 3.7 along with 80% of consumers had responded with an overall domain average greater than 3.5.

Means and Percentages for YOUTH (aged 13-17) Consumer Satisfaction Survey Scales

	Youth Overall Means	Scale 1 Satisfaction	Scale 2 Treatment Planning	Scale 3 Access	Scale 4 Cultural Sensitivity	Scale 5 Outcome	Scale 6 Functioning	Scale 7 Social Connectedness
Average for all consumers	4.0	4.1	4.1	4.2	4.3	3.7	3.8	4.1
% Of consumers with a domain average greater than 3.5	80%	82%	84%	87%	97%	59%	68%	84%

The CCS program conducted a Family survey for children aged 12 and younger to measure the family satisfaction of our program regarding a positive experience. We had 27 family respondents out of 49 who were eligible. Below is the means and percentages table which breaks the survey down into the following categories: overall mean, Satisfaction, Participation, Access, Culture, Outcomes, and Social Connectedness. The mean and scale values range from 1.0 to 5.0. The item wordings in all statements are positively phrased, so a value closer to 5.0 represents a more positive experience. All categories remain at or above a mean score of 3.4 along with 82% of consumers had responded with an overall domain average greater than 3.5.

Means and Percentages for FAMILY (aged 12 & younger) Satisfaction Survey Scales

	FAMILY Overall Means	Scale 1 Satisfaction	Scale 2 Treatment Planning	Scale 3 Access	Scale 4 Cultural Sensitivity	Scale 5 Outcome	Scale 6 Functioning	Scale 7 Social Connectedness
Average for all consumers	4.1	4.2	4.5	4.4	4.6	3.4	3.5	4.4
% Of consumers with a domain average greater than 3.5	82%	81%	96%	96%	100%	56%	59%	85%

Administrative:

In 2024 the CCS program was reimbursed an estimated $4,306,599 from Medicaid for services provided to consumers. This is an increase of $124,917 from 2023. CCS also recovered $2,064,515 in 2024 from the WIMCR reconciliation from the year 2023. In addition, CCS received an additional $53,862 from MA in 2024 for services provided in 2023.

We continue to focus on compliance, collaborative documentation, training and increasing our network of community providers.

As is occurring across the behavioral health field, multiple staff resigned in 2024. This resulted in increased recruitment, interviewing, and training of new staff. It has been more challenging to recruit applicants, thus vacant positions are taking much longer to fill. We offer an extensive employee recognition program.

Housing and Homelessness

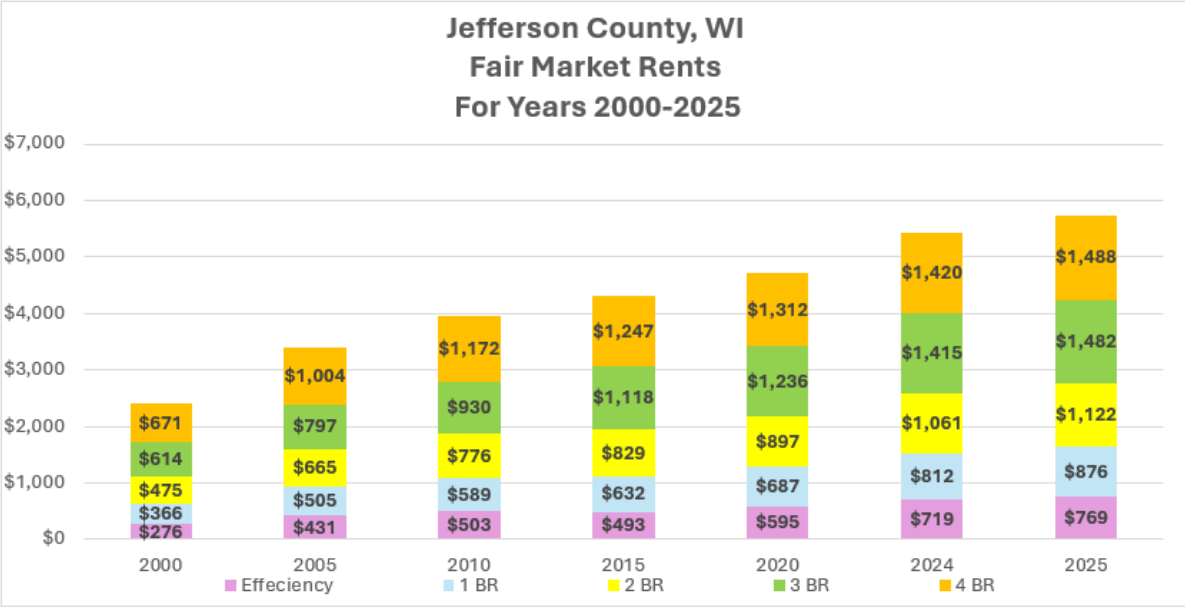
In 2024, CCS Psychosocial Rehabilitation Worker/Housing Specialist served a total of 24 households with Psychosocial Rehabilitation, Peer Support and Housing case management services. Of these 24 households, 11 met the Federal Definition of being homeless (meaning literally homeless, at imminent risk of homelessness within 14 days, Homeless under Federal statues or fleeing Domestic Violence).

In addition to serving the homeless households with information and referrals to community resources that can provide assistance for current unmet needs, staff provided a wide array of other services such as mediation services with landlords to assist the household members with maintaining current housing, provided learning opportunities to landlords and tenants to ensure landlords and tenants understand their right and responsibilities and fair housing laws, education around illegal evictions (such as shutting of utilities or changing the locks unlawfully), and partnered with local community agencies to avoid individuals from being evicted or having to leave their home due to landlord negligence of a property.

One of the bigger challenges consumers reported this year is the increased costs of rent. We are all too familiar with these challenges across America and Jefferson County is no exception. In working to support individuals experiencing homelessness, one of the many challenges we have encountered is the fair market rent requirements within the homelessness assistance programs. If an individual or family becomes eligible to receive assistance, they must find rental property within certain monthly rent limits. These monthly rent limits

are called Fair market rent (FMR) and are calculated by the US Department of Housing and Urban Development (HUD). Below is a graph that shows what the Fair Markets rents have been from the years 2000 to 2025.

You will see in the chart below, in just 25 years the Fair Market Rent for a 2 Bedroom increased from $475 in the year 2000 to $1,122 in 2025 for an increase of 136% while a 3 Bedroom increased from $614 in the year 2000 to $1,482 in 2025 for an increase of 147%.



In November of 2024, CCS staff raised awareness to Jefferson County Human Services Department and the community by decorating the display board within the agency, displaying a “Hunger and Homelessness Awareness Month is in November” banner on the county property and by selling hats from a local provider that notes that homelessness in not just a national challenge.

Staff also collaborated with several different initiatives and organizations throughout the State of Wisconsin including but not limited to: Wisconsin Continuum of Care – Balance of State (WI COCBOS), Point of Time (PIT) study (that occurs 2 times a year-winter and summer) which consists of staff conducting a physical count of physically homeless in our community in Jefferson County, Jefferson County Homeless Coalition, Homeless Coalition of Fort Atkinson, and other community events that bring attention to the needs and unmet needs of this population. The Homeless Coalition of Fort Atkinson was instrumental in obtaining 2 homes from Fort Healthcare and providing these 2 homes to families in Jefferson County that were previously homeless in the Fort Atkinson School District, by providing homes with reduced rents for up to 2 years. Habitat for Humanity is in the process of securing locations in Jefferson County to build homes for our families, and a housing development is in process of building additional homes for residents near the High School in Fort Atkinson. Without the collaboration of communities and staff at Jefferson County, none of this would be possible. Overall, these projects were great successes!

Children/Adolescents

VISION STATEMENT: We will engage both children and families to enhance resilience, promote growth, and help consumers explore their goals to achieve and maintain a life worth living. We are non-judgmental and empathic in our practice. We strive to provide quality and evidence-based mental health care.

In 2024, the CCS program served 125 children, ages 6 to 17; of these children, 70 were males and 55 were females. Forty-one children were admitted to CCS and 28 were discharged. Of the 28 discharged, 10 children moved out of the county, 7 children chose to withdraw from the program, 1 refused services for more than 3 months, and 10 children met their discharge criteria.

In 2024, two adolescents were under a mental health commitment order, and both orders were extended during the year. Additionally, two youth were placed on a 90-day settlement agreement, and both successfully completed these mental health agreements in 2024.

There was a total of 15 youth admitted for psychiatric hospitalizations. Five of these youth were admitted on more than one occasion. Fourteen of the youth had voluntary admissions, one youth as admitted involuntarily to the hospital via emergency detentions, while another youth admitted involuntarily per a return to a more restrictive environment.

Eleven youth spent time at one of the three Youth Crisis Stabilization Facilities in Wisconsin. Four of these youth used the crisis stabilization facility on more than one occasion.

Two youth in the CCS program needed a higher level of care and were placed in residential treatment facilities. One of these youth was able to successfully discharge from the residential facility back into community living.

In 2024, the average number of adolescents who were interested and looking for work throughout the year was 40 per month. Three consumers volunteered for at least one month out of the year. The number of youths who held a part time job in 2024 was 21 per month. The number of youths who held a full-time job in 2024 was less than 1 per month on average.

In 2024, the CCS Child/Adolescent team continued to provide quality services to the youth in our community. We had one Service Facilitator II trained in Dialectal Behavioral Therapy for Children (DBT-C). DBT-C is an evidenced based treatment for children ages 6 to 12. DBT-C therapists work with both the child and the caregivers. There is a large parent/caregiver component to DBT-C, helping the parents learn to regulate themselves so they can effectively help their children and become the "therapist" for their child. DBT-C assists children (and caregivers) with problem solving and regulation skills much like traditional DBT, with modifications so that our younger kids can understand and implement the skills. Our DBT-C trained service facilitator started providing this treatment to 2 families in 2024 and will continue to provide this to the children in our program. We currently have 1 Service Facilitator II going through level II training of TEAM CBT. TEAM CBT adds additional structure to traditional CBT. TEAM stands for Testing, Empathy, Assessment of Resistance, and Methods. CCS offered a group to youth ages 13-17, the group used the curriculum from the *Emotion Regulation Skills System for Cognitively Challenged Clients* by Julie F Brown. CCS contracted with Lesson's in Harmony to provide equine therapy. Service facilitators were able to go out to the farm to meet the amazing animals consumers get to work with. We also worked with Music Speaks to provide therapy in creative ways. We also contract with providers trained in TF-CBT and DBT.

Family Centered Treatment (FCT)

VISION STATEMENT: FCT empowers families to heal intergenerational trauma by learning new skills and managing life stressors through enhancing family resiliency. The FCT team will work with families in crisis to stabilize and/or reunify the family unit. FCT will utilize family strengths and community resources to increase confidence so that families can function independently.

Jefferson County continues to implement Family Centered Treatment (FCT) through the CCS program. FCT is an evidenced based practice that is home, community, and collaborative-based while being committed to family preservation and reunification. FCT addresses the needs of a family, recognizing that what affects one family member affects all family members, through a more intensive treatment to strengthen the rapport with the family, which includes skill development, coaching, therapeutic enactments, and intergenerational trauma

treatment. FCT allows family systems to restructure critical areas of functioning and utilizes emotions to strengthen attachments, as well as addresses trauma through a systemic and intergenerational lens while being broad enough to be able to provide services for a variety of families and youth.

FCT enrolled and served 36 Jefferson County families in 2024. There were 25 discharges. Of those 25 discharges, 19 were classified as completed to the fidelity to model. The other 6 were early discharges at the request of the families.

The FCT team was comprised of one supervisor and two FCT psychotherapists with a total of three staff members implementing the FCT model with families. In December of 2024, we added a third FCT Psychotherapist to the team. The FCT team also has a Service Facilitator and had a social work intern from January 2024 to May 2024 from UW Whitewater. The FCT team currently has two vacant psychotherapist positions that can be filled in the future as the program needs change. The FCT program also continues to focus on training and implementation of the Family Centered Treatment model with the FCT psychotherapists providing services. The FCT Supervisor currently holds an FCT Level I and Level II certification and FCT Supervisor certification, allowing her to provide full oversight in the field certification of all new staff.

Jefferson County FCT 2024 Program Development:

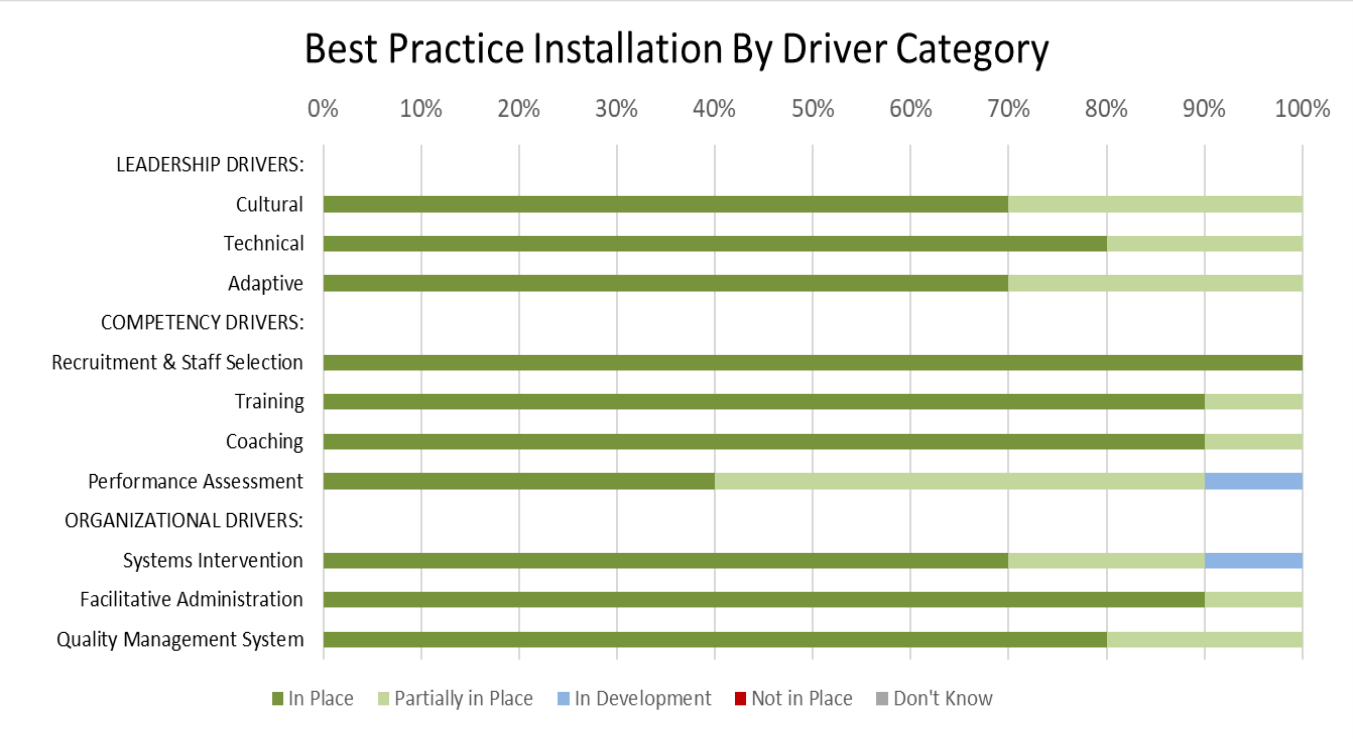
Family Centered Treatment Title Definitions

Title	Certification	Requirements	Capabilities
Level I FCT Clinician	FCT Certification	• Completion of the online Wheels of Change FCT Certification Series • Completion of online FCT Required Reading Series • Completion of passing scores on 16 field-based check offs • Submission of all required material to FCT Foundation for Certificate and Certification ID.	• Perform FCT without restrictions. • Certification good for 2 years pending renewal.
Level II FCT Clinician	FCT Trainer Certification	• Level I Certification and/or FCT Supervisor Certification • LII reliability check-offs with a LIII or higher. • Submission of all required material to FCT Foundation for Certificate and Certification ID.	• Perform FCT without restrictions. • Can certify Level I. • Certification renewal in conjunction with LI certification deadline.
FCT Supervisor	FCT Supervisor Certification	• Completion of the FCT Supervisor Curriculum online • Completion with passing scores on 4 field-based check offs and offline assignments. • Approval by LIII for final 'walk through' • Submission of all required material to FCT Foundation for Certificate and Certification ID.	• Can supervise FCT sites without restrictions. • Certification good for 5 years pending renewal.

Staff in the process of completing training meet all CCS/FCT training timelines and can implement the FCT model with families. The FCT team continues to receive weekly consultation and support from the FCT Foundation which has allowed staff to enhance their knowledge of model fidelity and clinically consult regarding acute cases to ensure appropriate model delivery.

In March of 2024, the FCT team attended the FCT National Conference in Atlanta, Georgia. The theme for the conference was Inspire, Innovate, Implement. The conference had over 200 attendees, made up of 64 organizations from 21 states.

The FCT program underwent an annual Licensing Review in November of 2024, the following was reviewed: updated Implementation Driver Assessment, review of client records to include dosage, service notes, fidelity, and all supervision notes. Results from this were reviewed and analyzed by the FCT Foundation and include the following:



Installation drivers review three main categories (leadership, competency and organizational) with 10 subsections to provide feedback regarding current infrastructure regarding implementing and sustaining any evidence-based practice in the human services field. Jefferson County's FCT program improved the best practices across all categories measured, with the most noticeable gains in cultural, training, coaching and recruitment and staff.

Adults/Older Adults

VISION STATMENT: We connect adults to community resources and internal services while assisting each person to get their basic, mental health, and substance use needs met.

In 2024, the CCS program provided services for 146 adults/older adults aged 18-75. Out of these 146 consumers, 4 were considered elderly. Of this adults/elderly population, 52 were males and 94 were females.

In 2024, 23 adults/elderly were admitted to CCS and 42 were discharged. Seven individuals moved out of county, 13 individuals withdrew from CCS, as they did not want to continue receiving this level of intense involvement; six individuals were discharged for successfully meeting discharge criteria; one consumer was administratively discharged; four consumers were incarcerated, one consumer passed away, one consumer needed a higher level of care; one consumer refused services for three months; seven consumers Medicaid funding ended, and one consumer was unable to be reached for a 3-month period despite diligent efforts by the service facilitator.

During 2024, one adult was under a chapter 51 mental health commitment order. This order was dismissed in 2024 due to the consumer moving out of the county. Two consumers were under a settlement agreement order with one successfully completing this order in 2024 and the other order due to expire in 2025.

There were 17 voluntary psychiatric admissions. There were three emergency detentions.

12 adults spent time at Crisis Stabilization Facilities in Wisconsin. Three of these adults used a crisis stabilization facility on more than one occasion.

Two consumers were admitted to residential treatment facilities to assist with treatment for their substance use disorders.

Out of the total adult/elderly consumers enrolled in CCS in 2024, the average number of adult/elderly consumers looking for employment was 43. Six consumers volunteered for at least one month in 2024. The average number of adult/elderly consumers who held a part time job in 2024 was 20 consumers. The average number of adult consumers who held a full-time job in 2024 was six consumers.

In 2024, the CCS Adult Team continued to provide community-based services to individuals in our local community; these services were based on, though not limited to, case management, mental health therapy, and substance use therapy. We have offered several evidence-based groups to include the following: Enhanced Illness Management/Recovery, Dialectical Behavioral Therapy (DBT) skills for adults, and Emotion Regulation Skills System for Adults. Our two CCS Rehabilitation Workers headed up a fundraising and awareness event in November 2024 for Homelessness Awareness Month, in which we partnered with a local business to create/sell hats with a "Housing is a Human Right" image. We continued our efforts in Harm Reduction, accessing and distributing supplies to individuals who would benefit from them. We engaged in a Diversity Equity and Inclusion (DEI) Book & Movie Club for those staff who wished to engage in dialogue about aspects of cultures that may be different from our own. We had one staff member participate in the Hope for Heroes committee and one staff member participate in the Diversity committee.

Service Plans/Reviews as it pertains to all CCS consumers:

Consumer service plans are reviewed every six months. There were 367 service plan reviews for the year 2024. 77% of consumer objectives were met. One hundred percent of the objectives were met for 119 of these service plan reviews.

The children met 76% of their objectives throughout 2024. There was a total of 189 children's service plan reviews for the year 2024. One hundred percent of the objectives were met for 81 of these service plan reviews.

The adults/elderly met 80.5% of their objectives throughout 2024. There was a total of 176 adult service plan reviews for the year 2024. One hundred percent of the objectives were met for 82 of these service plan reviews.

We continued to use person-centered planning when developing service plans with consumers and their recovery team. This approach to conducting the meeting and writing the plans has had a positive response from consumers, family members, contracted providers, and natural support. 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. The plans also inform the consumer and recovery team members of the services they are to receive. This increases accountability since everyone on the team knows their responsibility in assisting the consumer in building recovery.

Additional service providers:

The Jefferson County CCS program along with our regional partners, Rock and Walworth counties, contracted with 65 organizations throughout 2024. 19 of these organizations were new CCS contracts in 2024. Jefferson County CCS utilized 18 of these organizations to provide services to Jefferson County consumers. Because therapists, psycho-social rehabilitation workers, peer support specialists, occupational therapists, parent coaches, Psychiatrists and APNP's employ psychosocial rehabilitation practices, their services were billable to Medical Assistance through the CCS program.

CCS Coordinating Committee:

The CCS Coordinating Committee is currently comprised of consumers, staff, and individuals from the community. During 2024, the committee met quarterly via Zoom for scheduled hour-long meetings. The meetings focused on updates regarding CCS policies/programming and regionalization, community events, and community resources. The coordinating committee additionally reviewed new and/or updated CCS policies procedures, 2023 annual report information, 2023 consumer satisfaction survey results and Quality

Improvement Plan during the year. Lastly, the committee elicited feedback about what may improve CCS in the future.

CCS Jefferson, Rock & Walworth (JRW) Regional Coordinating Committee:

During 2024, our CCS program worked with Walworth County and Rock County (our regional partners) to continue to focus on consumer satisfaction and progress toward consumers' desired outcomes. We continue to utilize a tracking system for additional identified quality improvement areas and review the data with the regional coordination committee and integrate the feedback into future development of quality improvement plans/processes. The JRW leadership team updated our regional CCS Orientation and Training checklists and developed an improved policy and procedure for certifying providers.

As part of the regionalization efforts, the JRW leadership team informed all staff and providers of training put on by the State throughout the year. Our region hired a trainer who is a licensed clinical social worker/certified peer specialist to put on a training called: Interacting with individuals experiencing challenging mental health symptoms. This training was well received by those who attended. Additionally, our region informs staff and contracted providers of training offered by other organizations as well.

NIATx 2024:

The aim statement of the 2024 project:
95% of client files will be formatted to an identified consistent standard by September 2024 to assist the team in having a consistent format.

This project focused on decreasing the margin of error, decreasing time in creating or recreating documents, increasing audit success, increasing consistency, and reducing compliance errors while reducing stress and burnout for all staff. This project was successfully implemented across 95% of client charts.

The Nifty Note NIATx project started in the fall of 2024 to develop a standard and streamlined training/note adherence process. CCS Staff, Compliance Staff, and Behavioral Health Division Manager met bi-weekly to work on several items to include the following: updating SPC code lists to include descriptions of when to use these codes/CCS service arrays, updating the CCS mentor training checklist, updating EMH training checklist where to find guide along with updating the CCS training checklist/where to find guide. This project will continue into 2025.

Review of 2024 Goals:

1. Key Outcome Indicator: Meet 72% of all service plan objectives.
   - This goal was accomplished. We met 77% of service plan objectives.
2. All CCS staff will be trained in Motivational Interviewing.
   - All current and new staff have been trained in MI.
   - In August 2024, Michelle Rushton provided CCS with a Motivational Interviewing Learning Lab (MILL) training to continue to help support the team with our implementation of Motivational Interviewing.
3. CCS staff trained to provide DBT treatment will continue to enhance their DBT knowledge by attending consultation groups, as well as internal and external trainings.
   - The Child/Adolescent team had one service facilitator, and one supervisor trained in DBT-C. Additionally, staff attended DBT trainings through UW-Green Bay in 2024.
   - The adult team consistently met for DBT Consult, scheduled for bi-weekly meetings.
4. CCS staff trained to provide TEAM-CBT treatment will continue to attend scheduled TEAM-CBT consultation groups to enhance their knowledge.
   - The child/adolescent Team had two staff being trained in TEAM CBT level I and one of the service facilitators moving on to level two TEAM CBT.
   - The Adult Team had two staff attending TEAM CBT throughout this year.
5. All CCS staff will be trained in the administration of Narcan.
   - Roughly 50-75% of CCS staff are currently trained in this area.

6. Facilitate DBT Skills groups for adults.
    - This goal was achieved throughout 2024.
7. Facilitate Enhanced-Illness Management and Recovery group for adults.
    - This goal was achieved in 2024.
8. Facilitate Emotion Regulation Skills System group for teens.
    - This goal was achieved, and CCS provided this as a 12-week group.
9. Facilitate a youth social skills group.
    - This will be a goal that CCS works to achieve in 2025.
10. The CCS Diversity/Inclusion/Equity book & movie club will meet quarterly to discuss our shared knowledge of viewpoints that may be different than our own.
    - This goal was achieved.
11. All FCT staff will be FCT level one certified within one year of their hire date.
    - This goal was achieved.
12. Develop contracts to support identified treatment needs
    - Our Region developed 19 new contracts.
13. Participate in the State NIATx learning collaborative.
    - This goal was achieved.

Goals for 2025:

1. Key Outcome Indicator: Meet 72% of all service plan objectives.
2. All CCS staff will be trained in Motivational Interviewing.
3. CCS service facilitator I's will be trained to provide DBT skills to consumers
4. CCS service facilitator II's will participate in DBT training/consultation group to enhance knowledge of DBT Therapy provided to consumers.
5. Two CCS staff will be trained in TF-CBT and implement it with at least 1 consumer.
6. CCS Staff who have not been trained in TEAM CBT will attend "5 Secrets of Effective Communication." and "Agenda Setting" trainings in 2025.
7. Facilitate a youth and/or teen social skills group.
8. Onboard two new CCS Team Leads.
9. Facilitate an Adult Interpersonal Effectiveness group.
10. All FCT staff will be FCT level one certified within one year of their hire date.
11. FCT staff, due for recertification, will complete all FCT recertification requirements.
12. Develop contracts to support identified treatment needs.
13. Develop and implement improved policies and procedures.
14. Identify and implement one NIATx change project.

COMMUNITY SUPPORT PROGRAM

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

The Community Support Program (CSP) is an evidence-based practice based on Assertive Community Treatment for people with serious mental illness such as Schizophrenia, Schizoaffective Disorder, Bipolar Disorder, and Major Depression. People who are in the CSP also need help in a range of life areas such as education, vocational, psychiatric, health, activities of daily living, financial, and social or family relationships. The goals of the program are to assist people in moving forward in their recovery by helping them to achieve identified goals. The services can be titrated up or down depending on the individuals' current needs. The program strives to keep people in the community living the type of life they want to live. To achieve these goals, the program offers a variety of services, including psychotherapy, group therapy, case management, crisis intervention, medication monitoring and support, vocational assistance, and psychosocial rehabilitation to assist people in meeting their needs. Individual treatment plans are developed to work toward the goals the person chooses. Services are provided by a team of professionals, as all mental health services are provided through the community support program as part of the model.

The year 2024 brought some significant changes for the Community Support Program, which were able to bring the team closer to fidelity for Assertive Community Treatment. Dr. Mel Haggart, who had worked with the CSP during its entire existence at Jefferson County, stepped down to take on more hours in CCS and the Outpatient Clinic. Dr. Rebecca Radue has joined the team as a contracted psychiatrist, providing 20 hours of support each week. We were able to increase fidelity to the ACT model by starting home visits for some of our consumers in crisis or with mobility issues. We were also able to remove most telehealth services from CSP and return to in-person appointments for CSP consumers.

A bachelor-level CSP professional I position was converted to a second bachelor-level RN position, and another RN position was created. This will allow the level of nursing staffing to consumer ratio to meet fidelity in the ACT model. This year also continued to bring challenges in staffing. The RN position, as well as a master's level CSP Professional position, remain vacant going into 2025. As in much of the rest of the country, recruiting qualified mental health and nursing staff was difficult. Services continued without interruption to CSP consumers despite these challenges.

In 2024, the CSP program served 117 individuals. There were nine new admissions and fourteen discharges. Discharge reasons are as follows: three people passed away, six consumers moved out of county, one individual went to an intensive outpatient program, one person was discharged due to long term incarceration for legal issues, one consumer was better served by long term care, one individual obtained VA services and transferred to their care, the final individual was able to move to less intensive services. The number of consumers served was again slightly lower than in past years as the team had multiple staff vacancies for most of the year due to difficulty in hiring qualified applicants. The team included a psychiatrist, CSP Manager, Clinical Coordinator, four bachelor-level CSP professionals, seven master's level CSP professionals, a mental health technician, a program assistant, and a full-time RN and an LPN contracted through the health department for 24 hours. Three staff in CSP in 2024 were also certified peer support specialists. CSP serves consumers across the life span from adolescents to older adults.

For the year 2024, there were only 16 psychiatric hospitalizations (down from 34 in 2023) and 14 admissions for physical health (also down from 23 in 2023). There were 13 Lueder House admissions (down from 17). People were better able to manage symptoms in the community. Several factors may have influenced this, including the increase in nursing and psychiatrist time and the full return to face-to-face contact this year. Twenty-four consumers were employed or volunteered for at least some part of 2024.

Within the Assertive Community Treatment model, the team continues to provide a variety of evidence-based practices. These include:

1. Motivational interviewing (MI): An evidence-based approach used to enhance motivation for change in various areas, including health, substance use, and life goals. All CSP staff are trained in motivational interviewing and provide this to each consumer in CSP to assist them in meeting their recovery goals.
2. Enhanced Illness Management and Recovery (E-IMR): An evidence-based approach for people with a severe and persistent mental illness and substance use that focuses on education across a variety of topic areas and skill training and works toward assisting people in meeting their goals.
3. Dialectical Behavior Therapy (DBT): An evidence-based practice to assist people in building a life worth living as well as addressing target behaviors such as suicidal ideation, acts of self-harm, and substance use. The treatment includes skills training, coaching calls, individual therapy, and a consultation group for the people providing the therapy. All staff are trained to teach the skills, and most consumers are offered some version of mindfulness and other pertinent skills.
4. Collaborative Assessment and Management of Suicidality (CAMS): This is an evidence-based treatment structure developed to help people who are struggling with suicidal ideation. All the people served by the program experiencing significant suicidal ideation are offered either CAMS or DBT.
5. Bucket Approach for Tobacco Cessation: All new staff were trained in the Bucket Approach in 2024.
6. Cognitive Behavior Therapy for Psychosis (CBT-p): An evidence-based practice that helps individuals experiencing psychosis to help manage the thoughts they are experiencing.

In 2024, the CSP continued to implement a consumer satisfaction survey offered by the state that will compile yearly data and track it from year to year. The CSP program conducted an adult consumer survey for adults aged 18 and older to measure the consumer satisfaction of our program regarding a positive experience. We had 50 adult respondents out of 117 who were eligible this year. Participant rates have improved in the last two years. New ways of distributing the survey were implemented this year, as well as incentives for staff encouraging consumers to complete the survey. Below is the means table, which breaks the survey down into the following categories: overall mean, satisfaction, participation, access, outcomes, functioning, connectedness, and quality. The mean and scale values range from 1.0 to 5.0. The item wordings in all statements are positively phrased, so a value closer to 5.0 represents a more positive experience.

Detailed Participant Satisfaction Survey Report

Jefferson County: 2024

Community Support Programs (CSP)

The Wisconsin Department of Health Services, Division of Care and Treatment Services, Bureau of Prevention Treatment and Recovery contracts with Behavioral Health Evaluation Strategies (BHES) to collect and analyze submitted Mental Health Statistical Improvement Program (MHSIP) participant surveys.

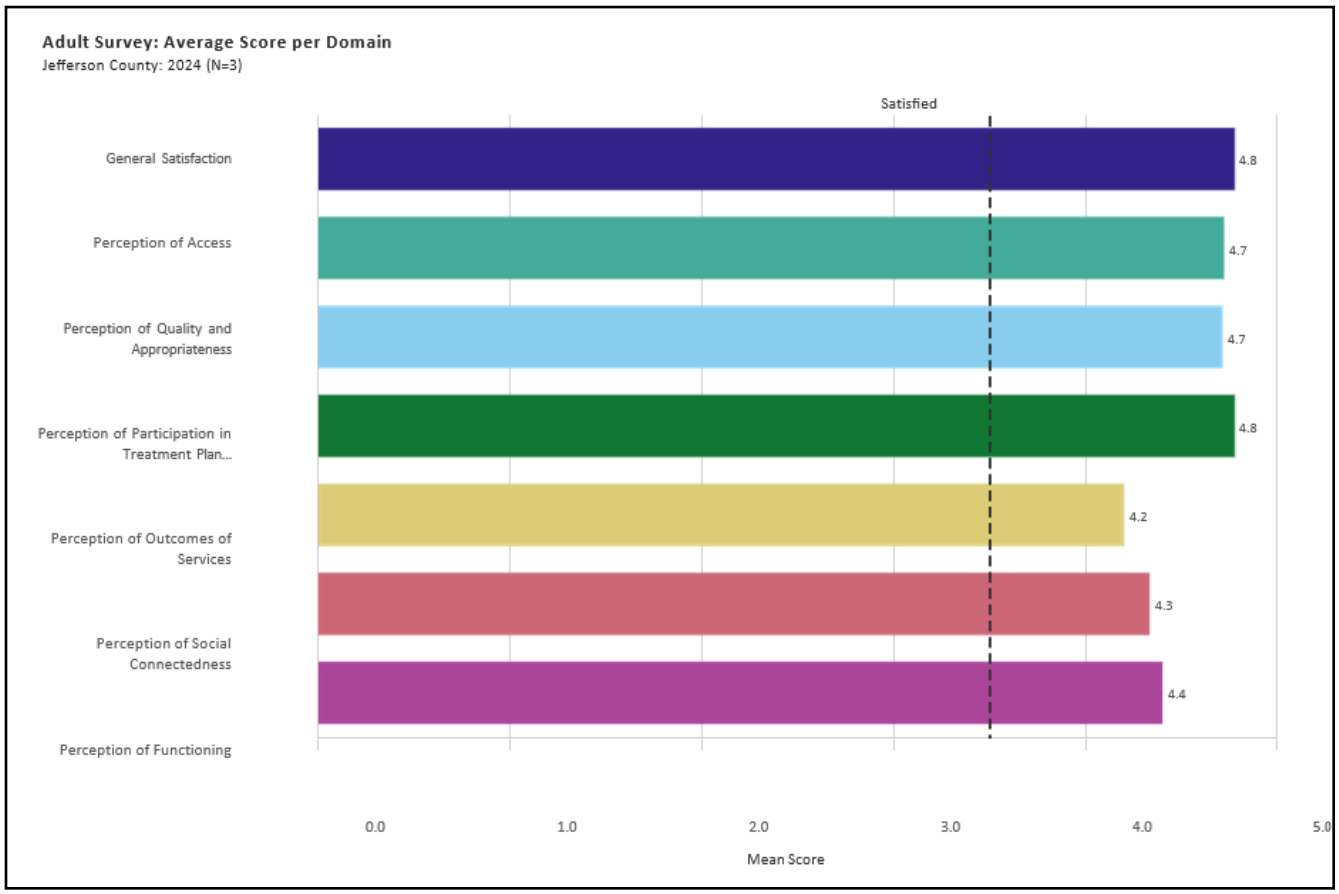
Counties and tribes across the state use these surveys to gauge and improve satisfaction among participants who receive mental health and/or substance use services through Comprehensive Community Services (CCS) programs, Coordinated Services Teams (CST) Initiatives, Community Support Programs (CSP), and Coordinated Specialty Care (CSC) programs.

The bar charts display aggregated data describing respondents' replies to questions with the following option

Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	Not Applicable
1	2	3	4	5	–

Average Score per Domain: CSP

Each graph displays the average score for all items within each domain. A score above 3.5 indicates a positive average response.



In 2024, most areas of satisfaction improved, with the overall means score improving from 4.3 to 4.6 on the five-point scale. This survey continues to indicate that consumers are generally satisfied with the program and the services they receive.

Review of 2024 Goals:

1. **Continue to provide Motivational Interviewing (MI) training in team meetings on the third Friday of the month.**
   All new hires in CSP were able to attend the intensive 3.5-day Motivational Interviewing training when hired. MI booster sessions in team meetings in 2024 included topics such as hope in motivational interviewing, practicing MI as a large group role playing consumers, reflections and change talk.
2. **Supervisory staff will accompany all staff to a sampling of sessions to monitor quality and provide coaching feedback as needed.**
   The Clinical Coordinator and CSP Manager accompanied staff to challenging sessions, modeling skills such as motivational interviewing or teaching processes.
3. **Coach and code at least one client interaction from each staff member.**
   Motivational Interviewing recordings were collected and scored for fidelity to the model for CSP staff.
4. **Participate in the ACT NIATx project with the state to run quality improvement projects to increase our fidelity to the ACT model.**
   Five members of the CSP team formed a quality improvement project focused on decreasing no-shows for psychiatry appointments. Changes such as ending telehealth services and changing to in-person, reviewing the upcoming psychiatry appointments at team meetings, and following up on no-shows were implemented. The NIATx team shared the results of the project at the state close out session.
5. **Dedicate one team meeting per month to ongoing training in topics such as benefits, medical assistance billing, person-centered planning, etc.**
   Topics were discussed such as the Medicaid Handbook, completing paperwork, and ACT components.

6. **Form a work group to look at staff onboarding and training procedures.**
   Changes were made, including expanding shadowing time with staff and supervisors and developing more policies and procedures as well.
7. **Form a new consumer council and assist them in plans for activities and fundraising.**
   A pool group was formed for consumers in the CSP that met at the bowling alley in Fort Atkinson. A timeline was set for the development of the consumer council, and consumers were asked about their needs and ideas.
8. **Continue to train the team in CBT for Psychosis (CBT-P) and begin implementing this in treatment plans for some of the individuals who experience psychosis.**
   The clinical coordinator began assembling videos for training. Some staff watched more of the training and began implementing it with consumers.
9. **Have a monthly meeting focused on diversity issues, complete a transfer of learning activity, and problem solve ways to improve access and experience for everyone in CSP.**
   A staff member began attending the diversity committee meetings and presenting the transfer of learning activities in a monthly team meeting.
10. **Track outcome measure for ACT fidelity outcomes of consumers employed, hospital admissions, Lueder House admissions, and emergency room visits and work on improving these outcomes.**
    These outcomes were tracked, and the CSP Manager began looking at data and trends from 2023 to 2024.
11. **Assist the consumers in meeting 72% of goals throughout the year.**
    Staff assisted consumers in achieving an average of 80.65% of their objectives in 2024,

Goals for 2025

1. Identify two areas of ACT fidelity to make improvements toward full fidelity during 2025.
2. Conduct at least one consumer activity.
3. Organize at least one CSP fundraiser to raise funds for consumer-related needs.
4. Train the staff in Enhanced Illness Management and Recovery (EIMR).
5. Offer at least one treatment group during the year.
6. Develop policies and procedures around the nursing role and medication.
7. Meet the key outcome indicator of helping consumers meet at least 72% of their treatment plan objectives.

COMMUNITY RECOVERY SERVICES

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

Community Recovery Services (CRS) serves individuals with Medicaid who qualify based on the mental health and substance use functional screen in Jefferson County. The goal of CRS is to help people living with a mental illness make the most of life. CRS clients work with service providers to improve their quality of life in the community. Services provided include peer support, employment support, and community living support. The CRS program can help people remain in the community or in a residential setting. CRS helps individuals living with mental illness reach their full potential through consumer choice, person centered planning, and a focus on recovery.

Overview of 2024:

- 21 consumers were served in 2024 (8 admission and 9 discharged).
- Two consumers were discharged due to incarceration and were no longer eligible for community-based services.
- Two consumers were discharged due to death.
- One consumer's funding was transferred to a Managed Care Organization, so they no longer needed CRS.
- Five consumers moved out of supportive living and were able to live independently in the community.
- Two consumers left a supported residential setting and continued in CRS, receiving only peer support.
- Nine consumers received the peer support service for the first time in 2024.
- The Wisconsin CRS program completed a state review of Jefferson County's CRS services with no negative findings.
- London Lodge Supervised Apartment was added as a new CRS provider in 2024.

Review of 2024 Goals

1. Move at least three people out of placement services into a more independent living situation.
   - This goal was surpassed as seven people moved into independent living settings.
2. Open at least six more people to peer support services that are in the Community Support Program.
   - This goal was surpassed, as nine people were admitted to peer support services in CRS.
3. Train a supplementary staff to assist in the provision and monitoring of CRS services.
   - One of the CSP staff began to be trained in the CRS program as backup for the lead worker in CRS.

Goals for 2025

1. CRS will discharge at least one person from residential placement into a more independent living situation.
2. CRS will work to admit six more CSP consumers to peer support.
3. CRS Coordinator and Manager will work on developing policies and procedures for the program.

CHILDREN, YOUTH & FAMILIES DIVISION

Welcome to the Children, Youth, and Families section of our Annual Report. The Children, Youth and Families (CYF) Division is comprised of one division manager, seven supervisors, and over 60 staff. Together, they are part of the following teams that provide interventions, services, and programming to children, youth, and families in our community that are preventative, state mandated, voluntary, or court ordered:

- Intake Unit
- Children In Need of Protection or Services (CHIPS) Ongoing Team
- Youth Justice (YJ) Ongoing Team
- Alternate Care
- Parents Supporting Parents (PSP) Program
- Coordinated Services Team (CST) Program
- Children's Long Term Support (CLTS) Program
- Birth To Three Program

While each of our Division's teams has a very different and specialized area of focus, we work collaboratively and collectively with the shared mission, vision, and values of:

- Children and youth deserve to be safe and loved members of thriving families and communities
- Provide family-focused, collaborative, and strength-based services to families
- Keep families together and provide in-home services and resources when possible

Our CYF Division takes pride in our work together and strives to partner with our other Divisions across the Agency, as well as with our community and legal stakeholders. These partnerships include:

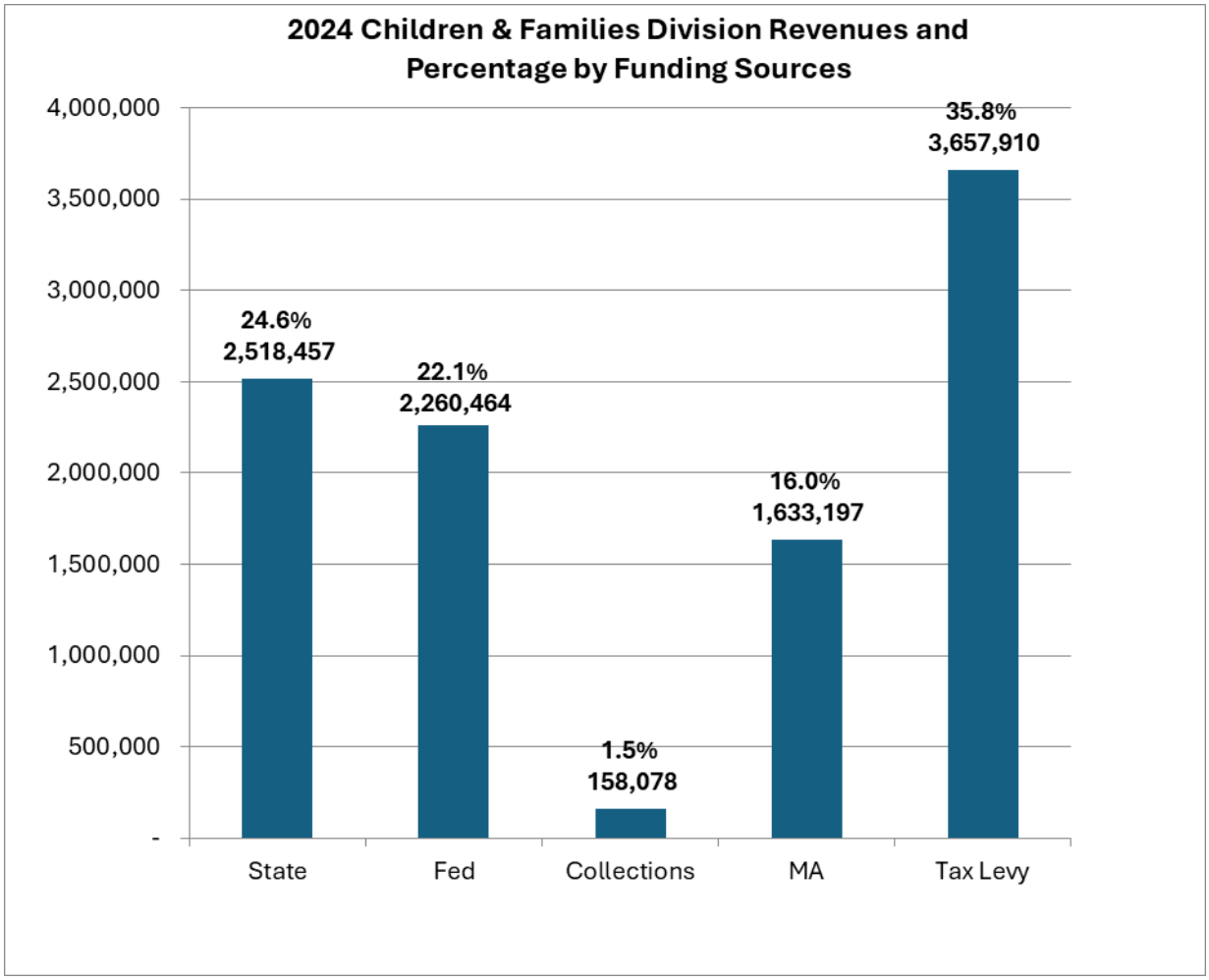
- Judicial Engagement Team (JET)
- Child Abuse Prevention Month
- Youth Justice Awareness Month
- Children In Crisis Response Guide & Multidisciplinary Team
- Mandated Supporter outreach
- Monthly case reviews between CYF and Behavioral Health Division leadership
- Monthly Permanency Roundtables
- Ongoing outreach with school districts, law enforcement jurisdictions, and community partners
- Share & Care Fair participation
- Career Fair participation
- Local and statewide presentations
- Community based programming
- Foster parent and kinship events

The interventions, services, and programming provided by our Division are guided by the Wisconsin Department of Children and Families (DCF) and the Wisconsin Department of Health Services (DHS) and we continue the longstanding tradition of participating in opportunities and initiatives offered by both these sectors, which have included:

- Targeted Safety Support Funding
- Family First Funding
- Youth Justice Innovations Grant

- Foster Parent Grant
- Parents Supporting Parents Innovations Zone
- Citizen Review Panel
- Promoting Safe and Stable Families
- Infant Mental Health

These opportunities and initiatives not only increase our array of services and resources, but they also continue to provide funding support that is instrumental in offsetting costs. Our Division is very mindful of being good stewards of our funding and resources as our revenue comes from county tax levy, as well as state and federal funding, as denoted in the following graph.



We are honored to serve Jefferson County and to be able to offer a variety of services and programming. Our ability to meet families where they are, and to provide support to help children, youth, and families thrive, allows us to have positive impacts and change lives. We are proud of the meaningful work we carry out and the following section of this Annual Report will provide stories, data, and achievements specific to our Children, Youth, and Families Division that we hope are informative and impactful.

Birth to THREE Program

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

The Birth to Three Mission Statement

The Birth to Three Program is committed to children with developmental delays under the age of three and to 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.

What is Early Intervention

Early intervention is the term used to describe the services and support that are available to infants and toddlers with developmental delays and disabilities and their families. It is a special education program that supports a child's development through a variety of services provided by qualified professionals.

The Birth to 3 Program is Wisconsin's early intervention special education program. The Jefferson County Birth to Three Program serves families with children under the age of 3 who have delays or disabilities. A team of service providers partners with families to support growth and learning. Family culture, beliefs, and individualized outcomes help shape what and how services are provided.

Partnering with An Early Intervention Team to Support Child Development

When a child is found eligible for the Birth to Three Program, the child's family is supported by a full team that helps the child learn, interact, and thrive at home, in childcare, and during other everyday activities like going to the library, store, or park. The early intervention team may include:

- A service coordinator
- An early childhood special education teacher
- A speech, occupational, and/or physical therapist
- Other professionals or service providers as necessary

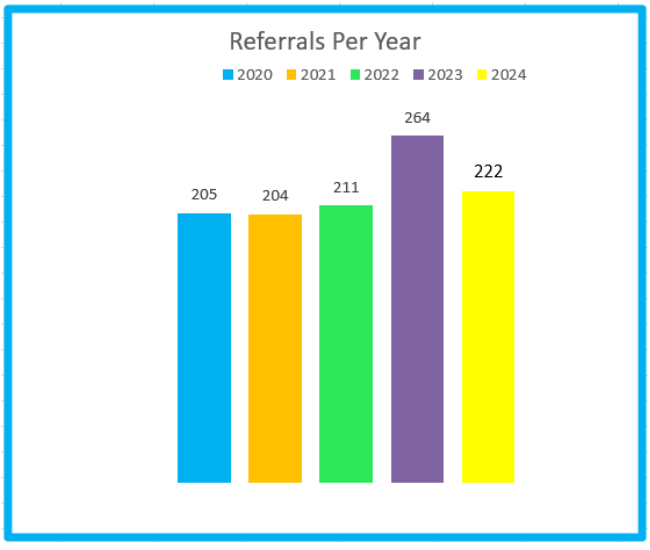
How the Birth to Three Program Supports Families

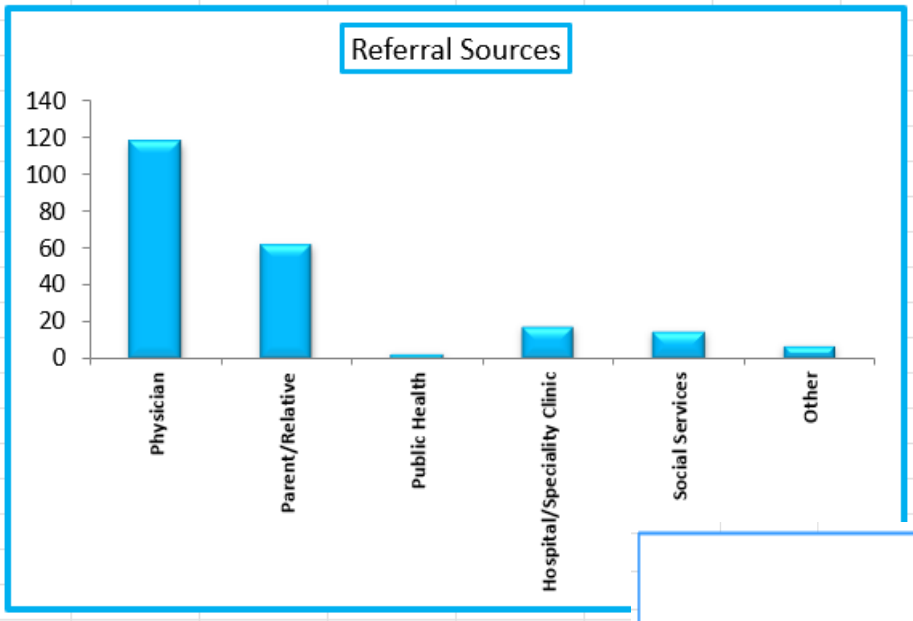
The Birth to Three Program supports families as the child's first and best teacher. Families learn about:

- Communicating about their child's needs
- Helping their child learn and grow
- Knowing and exercising their rights as their child's parent
- Maintaining a healthy, early, and strong relationship with their child

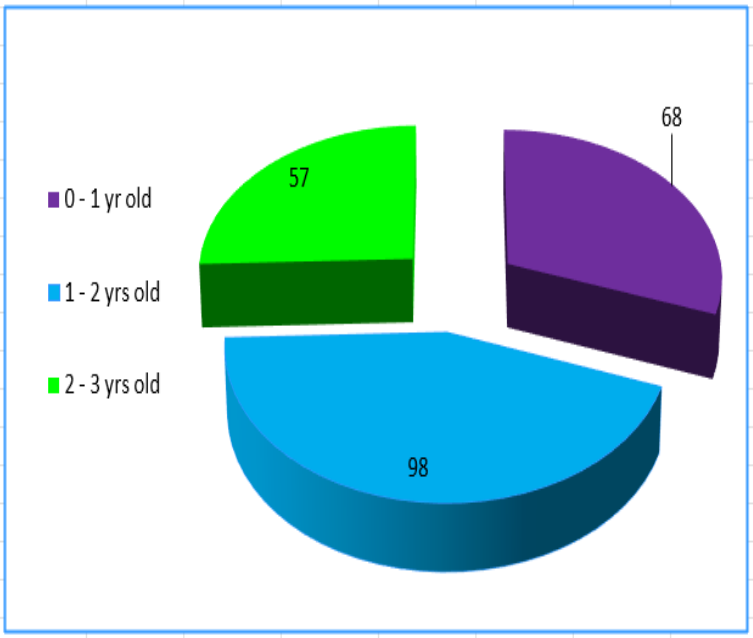
Referral

Anyone with concerns for a child's development can make a referral to Birth to Three. Most Jefferson County's referrals come from medical providers and parents. Referrals are also received from hospitals, specialty clinics, childcare, and local social service agencies.





Data shows that efforts in 2023 and 2024 to educate referral sources on the importance of refering as soon as concerns about a potential delay is recognized have been successful.



Referral Trend

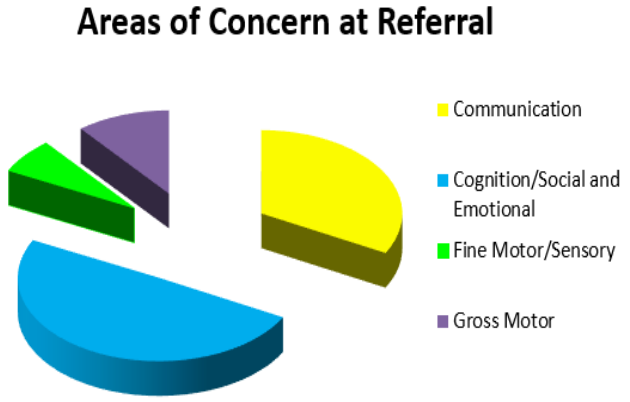
Children are being served earlier

Age at referral	2022	2023	2024
0-1 yrs old	20%	27%	30%
1-2 yrs old	48%	42%	44%
2-3 yrs old	30%	26%	26%

Evaluation and Assessment

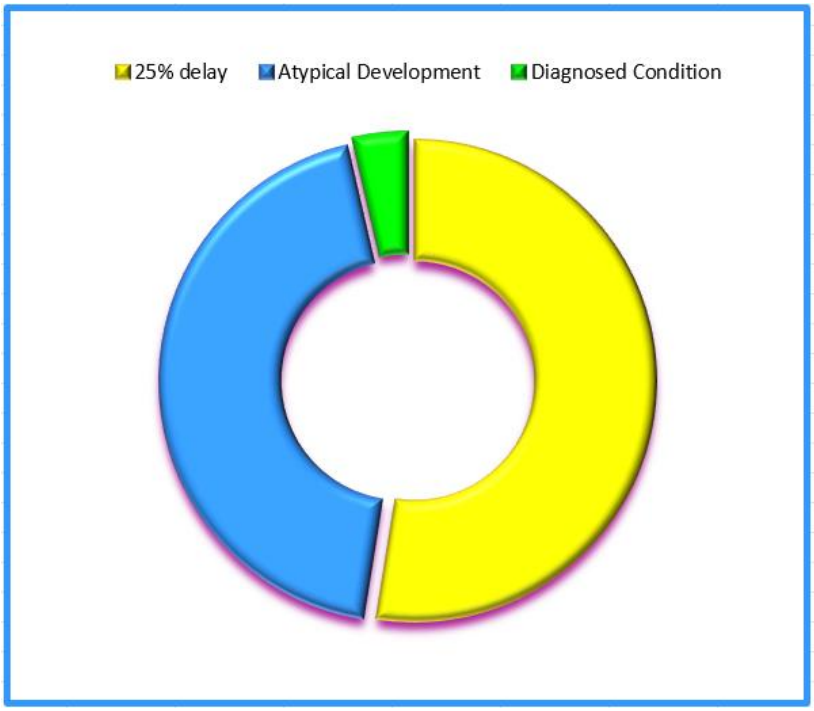
Birth to Three evaluations, combined with family assessments, provide a comprehensive view of how a child functions within the context of their family and everyday routines.

Evaluation and assessment information is collected through parent interviews, observations of the child, and a play-based, standardized evaluation tool. The Birth to Three team creates a developmental summary from the collected information to share with the family. The summary guides the discussion regarding the child's eligibility for services.



Joint evaluation practices were started in 2024. Each child was evaluated by at least two providers using the *Developmental Assessment of Young Children.*

Eligibility



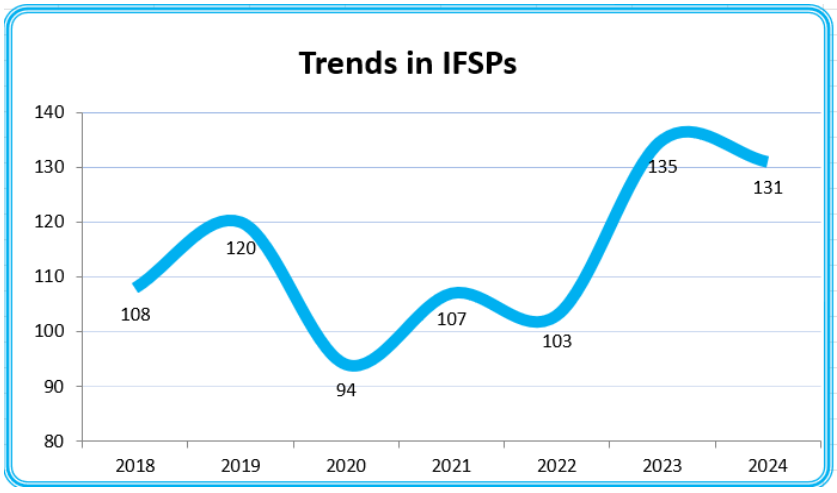
Children are determined eligible for Birth to Three services based on one of three criteria:

- Significant (25% or more) delay in any area of development
- Atypical behaviors that are negatively impacting development
- A diagnosed condition likely to result in developmental delay

139 children were found eligible for Birth to Three services and 131 children accepted services in 2024

Individualized Family Service Plan (IFSP)

After a child is determined to be eligible for services, the Birth to Three team, along with the family, develops a service plan individualized to the family's priorities and concerns. The child's present levels of development, the family strengths and resources, and the expected outcomes for the child are documented in the IFSP. The document is reviewed at least every six months or whenever there is a change in services.



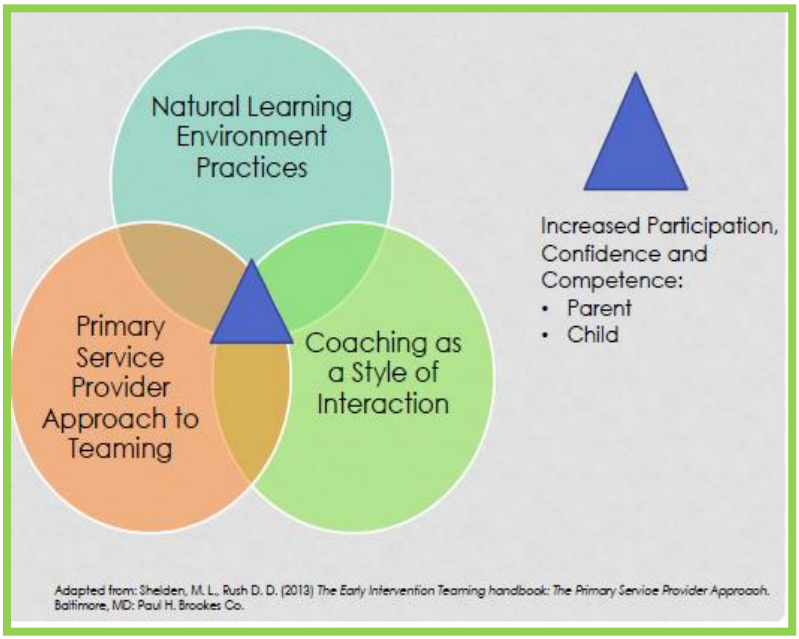
Ongoing Services

Jefferson County Human Services employs six staff to facilitate Birth to Three programming. One program supervisor oversees five full-time service coordinators that have multiple roles. Service coordinator roles include intake and ongoing service coordinators, point of referral, early childhood educators, and coaches for the TalkReadPlay Home Visiting program. Rehab Resources, a division of Greenfield Rehabilitation Agency, Inc., is contracted to provide therapy services. Programming is supported by three speech therapists, an occupational therapist, and a physical therapist.

266 families received ongoing services in 2024
206 IFSP's were reviewed in 2024 compared to 151 in 2023

The full team meets weekly to discuss service provision for families. Each child's services are reviewed at least quarterly. Service coordinators meet with each family every six months to review their child's development and progress toward the goals written in the service plan.

Jefferson County Birth to Three services are founded on three key evidence-based practices. These practices are recognized as essential to building effective programming by the Office of Special Education (OSEP) and the Wisconsin Birth to Three Program. They integrate families' experiences and priorities, research in early development, and professional expertise to create individualized and meaningful services.



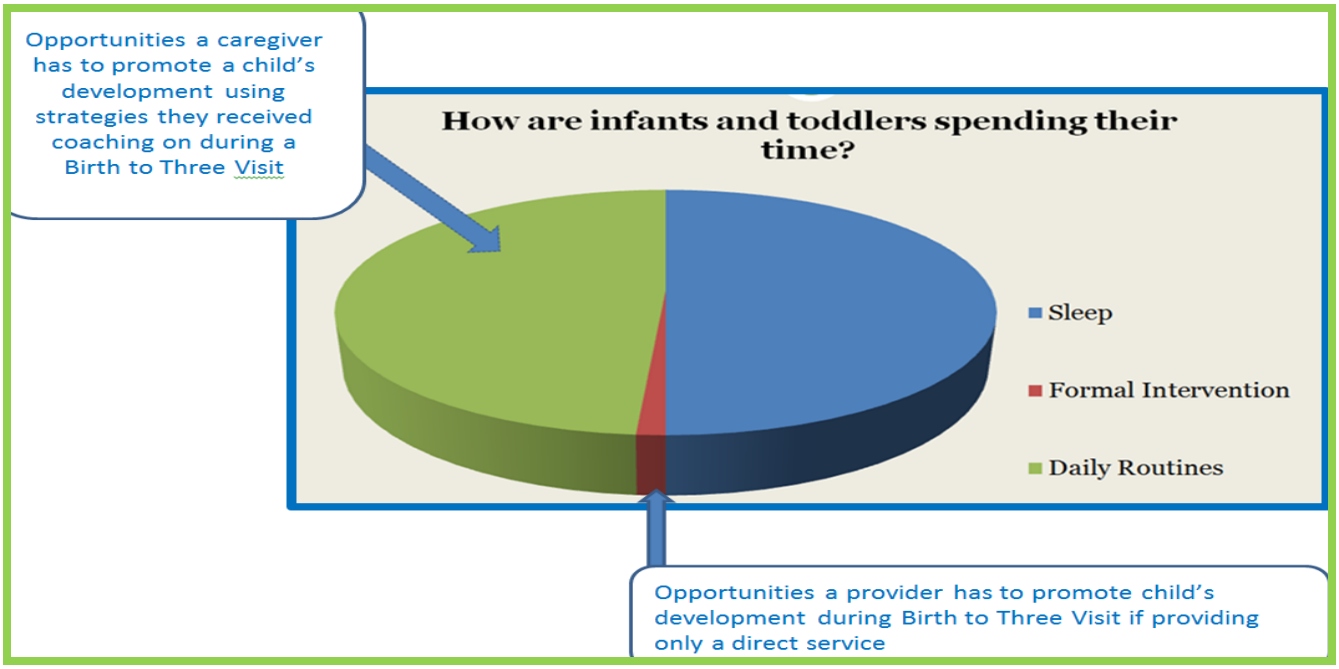
- **Natural Learning Environments**

Research shows that children learn best when they are doing things that interest them within their everyday routines and activities with their caregivers. This may include family homes, community spaces, and other places they go in their day-to-day life. Natural environments are not only the places but also include the people, activities, toys, and other objects that are part of the child's everyday life. Sticking with what is familiar to children means they are ready to learn right away because they don't need to get comfortable or acclimated to a new situation.

Jefferson County Birth to Three uses a family routines assessment to gather information about the child's interests, how families spend their days, how they engage in their communities, what is going well, and where they feel they could use support.

➢ **Caregiver Coaching as a Style of Interaction**

Birth to Three providers work closely with parents and caregivers to build their skills and confidence in promoting their child's development. Through coaching, providers share strategies, support problem solving, and create action plans to promote child development and learning. Research shows that increasing the capacity of the parent or caregiver to promote their child's development significantly impacts child and family outcomes.



➢ **Primary Service Provider Approach to Teaming**

In Birth to Three, a family has a team of providers to help support their child's development. There is one point person or primary service provider who serves as the main support for the family. This ensures that parents receive consistent, unduplicated, timely, individualized, and comprehensive support.

The Jefferson County Birth to Three Team includes members with expertise in early childhood education, parent education, infant and family mental health, speech and language, occupational therapy, physical therapy, feeding, and sensory processing.

Transition Planning

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

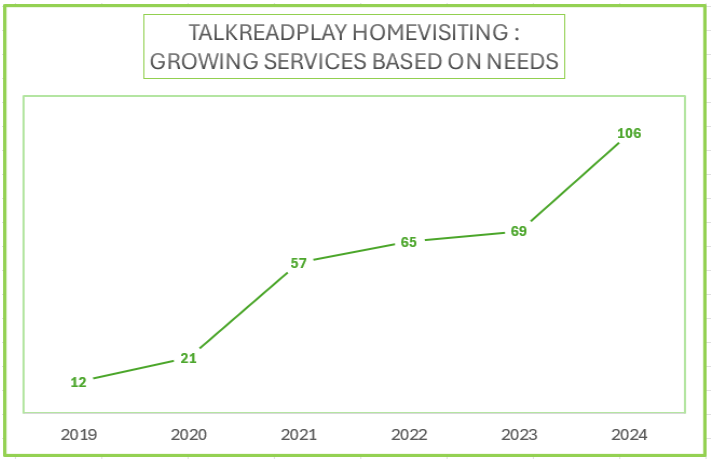
Transitions for children turning three:

49% were transitioned into an early childhood setting to continue services

51% were not in need of early childhood programming beyond Birth to Three

Birth to Three Initiatives in 2024 and Commitment to Responsive Services

Six years ago, TalkReadPlay Home Visiting was developed as a parent education service specifically designed to support caregivers who had questions about how their child learns and grows. Birth to Three became a partner in the TalkReadPlay campaign launched by the Greater Watertown Community Health Foundation. The campaign was developed to affirm parents as their child's best teacher and increase awareness of the importance of early brain development. The program continues to expand in response to the needs of children and families in the community. As of 2024, the TalkReadPlay Home Visiting service array has three components ensuring Birth to Three can support caregivers where they are at and when they need it most. Over 100 families have received support through TalkReadPlay Home Visiting since it started in 2019.



- **Parent Education**

As noted above, TalkReadPlay Home Visiting program was developed as a service specifically dedicated to supporting caregivers in being their child's first and best teacher. This service is provided in the form of coaching for caregivers in how to more effectively nurture growth and learning. Its foundation was built on the concepts and tools of the Parents as Teachers (PAT) curriculum and Brazelton's Touchpoints approach to family support.

PAT is an established curriculum designed to increase caregivers' knowledge of child development and foster positive parenting practices. Touchpoint offers a paradigm shift that builds provider-family relationships and highlights the caregiver-child dyad as a crucial tool for promoting development. The benefits of specialized support through parental education are highlighted in the growing number of families accessing it each year.

TalkReadPlay Home Visiting: Parent Education 2024
Trained Providers: **4**
Caregivers Supported: **27**
Hours of Service: **580**

- **Infant Massage (IM)**

Program data has historically shown that the number of children receiving services under the age of one in Jefferson County is below the state average. In 2020, a Birth to Three provider's dedication to enhancing services for very young children led to the addition of the second component of TalkReadPlay Homevisiting: Infant Massage (IM). IM offers the unique opportunity to promote healthy attachment and development using nurturing touch. It is evidence backed practice proven to support parent-child bonding, self-soothing in infants, and regulation of the autonomic nervous systems. The IM curriculum includes six sessions where the provider models massage strokes on a doll as the caregiver practices on their child. Families also learn about their baby's unique development by exploring topics such as infant behavioral states and cues, infant reflexes, sleep patterns, periods of crying, and Shaken Baby prevention.

The process of integrating IM into programing enhanced the team's ability to recognize qualifying factors in very young children and offer support much earlier. IM has also proven to be a helpful entry point to potential services when families are unsure about moving forward. Jefferson County now has three providers offering ongoing IM services countywide, creating the capacity to meet the needs and interests of multiple caregivers in a variety of settings.

TalkReadPlay Home Visiting: Infant Massage 2024
Trained Providers: **3**
Caregivers Supported: **17**
Hours of Service: **120**

The significant increase in the number of children under one qualifying for and receiving services is evidence that this TalkReadPlay Home Visiting component is filling the prior gap in services for very young children. Not only has IM proven to be a beneficial service for Birth to Three families, but it has also fostered unique community partnerships. In 2024, providers partnered with a childcare provider to host an IM course. Six families and staff joined to learn about massage techniques, how to read cues, and how to bond with the infants in their care.

Percentage of Children under one qualifying for services
2024: **56%**
2023: **48%**
2022: **33%**

- **Childcare Supports Services (CCS)**

In 2022 and 2023 the Inclusive Birth to Three Child Care Pilot subsidized the cost of childcare for Birth to Three families. Recognizing that children in Birth to Three may require specialized care outside of the scope of typical early care training, and in response to research showing children with developmental delays are disproportionately asked to reduce hours or leave centers, Birth to Three began exploring ways to offer specialized support in early care environments.

Birth to Three reached out to 17 local childcare providers to offer registration for the *Conscious Discipline: Building Resilient Schools and Homes* course in May of 2022. Seventy-one providers registered for the one-year subscription to the 10-module course. The course focuses on understanding and effectively responding to children's social and emotional needs in the preschool setting. Efforts to support childcare continued into 2024 through offering a second registration for the *Conscious Discipline: Start Strong* course. The 73 providers who participated in the course learned about building strong foundations for early brain development and mental health.

The focus on offering support in childcare during 2022 and 2023 led to the development of the Childcare Supports (CCS) component of TalkReadPlay Home Visiting. The first CCS services were piloted in February of 2024. They were designed to help childcare staff understand the unique abilities and needs of children in Birth to Three. The services included an outreach to directors about CCS, guidance on how to support the child's abilities and needs in the childcare setting, and practice-based coaching for classroom staff on strategies and techniques for optimizing growth and development.

The children involved in the initial pilot were able to successfully maintain childcare placements while receiving CCS. Childcare staff reported that Birth to Three's support help them more consistently meet the child's needs, mitigate challenging behaviors, and promote learning. The success of the pilot led to CCS being officially offered as the third component of the TalkReadPlay Home Visiting service array in August of 2024.

TalkReadPlay Home Visiting: ChildCare Supports 2024
(September to December 2024)
Trained Providers **3**
Centers Supported: **7**
Caregivers Support: **9**
Hours of Services: **35**

Commitment to High Quality Services

The Wisconsin Birth to Three program identified joint evaluations for eligibility using a common tool as a priority in 2023. Joint evaluating is recognized for being a family-centered, comprehensive approach to collecting developmental information. To prepare county programs for implementation of joint evaluating, the Birth to Three professional development system analyzed and recommended two potential evaluation tools. In alignment with best practices, the Jefferson County Birth to Three team piloted both tools in 2024. Staff identified the Developmental Assessment of Young Children (DAY-C) as the preferred tool. In March, the team had successfully transitioned to joint evaluating with the DAY-C.

Joint Evaluations in 2024

From March to December, 143 joint evaluations were completed by the Birth to Three team using the Developmental Assessment of Young Children

Program Outcomes

Birth to Three programs in the state of Wisconsin are monitored using an integrated system of compliance and results measures. The federal government has identified eight essential components of high-quality early intervention programming on which counties report compliance.

The Jefferson County Birth to Three Program was recognized for 100% compliance with Federal Indicators in 2024!

Wisconsin Birth to Three also monitors Child Outcome ratings as a measure of high-quality programming. Child Outcome ratings report a child's progress toward three nationally recognized outcomes as required by the U.S. Department of Education: Positive Social-Emotional Skills, Acquiring and Using Knowledge and Skills; and Taking Appropriate Actions to Meet Needs. States set targets for performance on each indicator. Each indicator has two summary statements that show programs effectiveness. County Birth to Three determinations for the federal fiscal year are issued in July of the following year. Below are the results of the July 1, 2022- June 30, 2023, determination audit issued to Jefferson County in July of 2024.

Summary Statement 1: Percent of children who substantially increased their rate of growth by the time they turned 3 or exited the program.

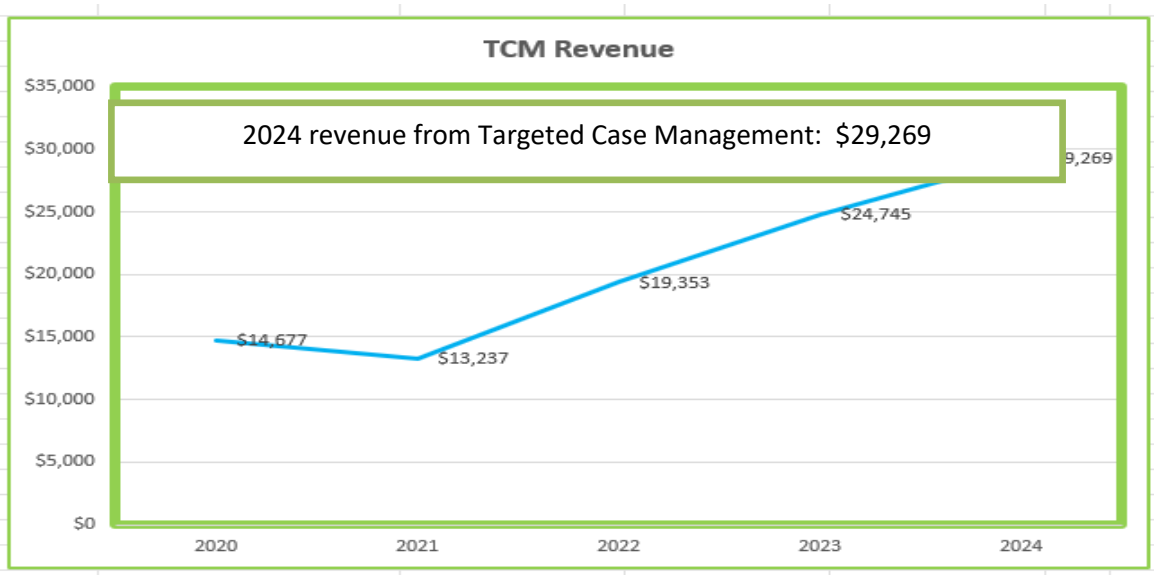
Child Outcomes	State Target	2021-2022	2022-2023
Positive social/emotional skills	**57%**	**61%**	**66%**
Acquisition and use of knowledge and skills	**51%**	**70%**	**73%**
Use of appropriate behaviors to meet their needs	**62%**	**79%**	**82%**

Summary Statement 2: Percent of children who were functioning within age expectations by the time they turned 3 or exited the program.

Child Outcomes	State Target	2021-2022	2022-2023
Positive social/emotional skills	**37%**	**44%**	**36%**
Acquisition and use of knowledge and skills	**29%**	**24%**	**30%**
Use of appropriate behaviors to meet their needs	**41%**	**42%**	**57%**

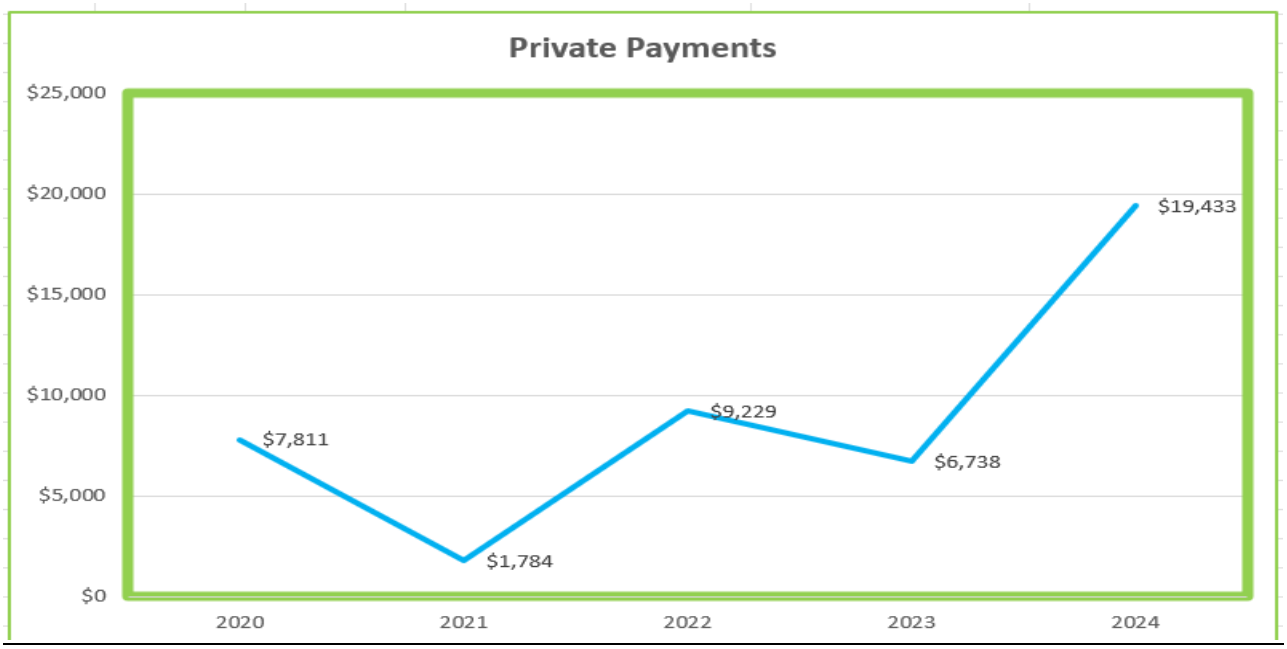
Sustainability

Birth to Three is funded through a variety of sources. Private insurance, the federal government, the state of Wisconsin, and Jefferson County Human Services provide funding to support programming. Birth to Three service coordination is eligible for reimbursement through Wisconsin Medical Assistance (MA), as Targeted Case Management (TCM).



County Birth to Three programs are responsible for collecting reimbursement through the Parent Cost Share Program. Families deemed able to contribute to the cost of services per the guidelines developed by the state are billed at a monthly rate. Rates are based on family size and family income. Cost Share payments can range from $25 to $150 a month and are not directly related to reimbursement provided by insurance. Parent Cost Share billing is monitored monthly to ensure families are not being asked to pay more than the cost of services to the county.

2024 revenue from Parent Cost Share: $19,433



Review of 2024 Goals:

Key Outcome Indicator: **The Birth to Three Program will be issued with a notification of 100% compliance with the Federal Compliancy Indicators by DHS based on the annual data review.** Birth to Three received a notification of 100% compliance with the Federal Compliancy Indicators in 2023. ***This indicator was met.***

1. Ensure that the TalkReadPlay Home visiting program is responsive to the needs of the children and families we serve by expanding on the family education and counseling component of Birth to Three services. The team will seek out opportunities to build the array of services under the TalkReadPlay Home visiting umbrella by adding to the Parents as Teachers curriculum. ***This goal was attained***. The TalkReadPlay Home visiting umbrella now offers three specialized services that support caregivers in building nurturing, positive relationships with newborns, infants, and toddlers at home and at childcare. In 2024, Birth to Three developed a new service focused on building the confidence and competence of caregivers in helping children with developmental delays successfully participate in childcare environments. Childcare Support services officially became available in September of 2024. To bolster efforts in supporting childcare, the two newly certified Infant Massage (IM) providers worked with Gingerbread Childcare to host an IM course for staff and families. At the beginning of 2024, the two providers joined the other IM specialist in being able to offer ongoing services significantly increasing the program's capacity to meet the needs of families with newborns.
2. Ensure high quality service provision through regular communication with families and team members as evidenced by an increase in monthly documentation of collateral and family contact as billable targeted case management or TCM. ***This goal was attained***. The 2024 billable services, including TCM, significantly increased through intentional collateral and family contact with enhanced documentation. All billable service documentation increased from 66% in 2023 to 81% in 2024. Billable TCM documentation increased from 56% to 79%.
3. Continue to support high quality services that promote the social and emotional health and wellbeing of families participating in the Birth to Three program by having 75% of direct service staff maintain Infant Mental Health Endorsement through the Wisconsin Alliance for Infant Mental Health through 2024. ***This goal was attained***. Seven staff held WAIMH endorsement as Infant Mental Health Specialists going into the 2024 endorsement renewal year. All seven providers met the requirements to renew endorsement for 2025 through their professional development activities. These activities included participating in Reflective Supervision with the program infant mental health consultant and attending the annual WAIMH conference.
4. Ensure that programing aligns with state identified best practices by transitioning to the use of one of the two recommended evaluation tools. By Fall of 2024, Jefferson County Birth to Three will have identified and successfully put into practice a common evaluation tool for qualifying children for services. ***This goal was attained***. Birth to Three staff identified the Developmental Assessment of Young Children (DAY-C) as the tool to use for determining program eligibility in a joint evaluation process. In March, the team had successfully transitioned to the use of the DAY-C. The Birth to Three team completed 143 joint evaluations with the DAY-C from March to December of 2024.
5. Ensure that Birth to Three is making continued progress toward proficiency in Motivational Interviewing (MI) skills. Each team member will create a professional development goal related to MI to be documented on their 2024 annual performance reviews. ***This goal was attained***. All Birth to Three direct service staff completed the MI taping and coaching process in 2024. All staff developed a goal for enhancing MI skills that was included in their annual performance reviews.

Goals for 2025:

Key Outcome Indicator: **Ensure comprehensive services through regular family and team communication as evidenced by an 80% approval rate in billable case management documentation.**

1. Ensure that the Childcare Supports (CCS) program is responsive to the needs of children in childcare settings through continued program development and community outreach. By Summer of 2025, CCS

outreach materials will be developed and shared with directors. By Fall of 2025, the team will create a comprehensive collection of tools and resources to enhance programming.

2. Promote family engagement in community resources that align with their goals and priorities. At least 65% of files audited will have documentation that the family received support in identifying or participating in community resources, activities, or events.
3. Increase family input on programming by restructuring the family surveying process. A more robust data collection procedure will be in place by June, generating a 10% increase in the number of families giving feedback in 2025.
4. Align with the state identified best practices in Ongoing Child Assessment (OCA) by transitioning to the use of a state recommended tool in 2025. By the end of the year, Birth to Three staff will participate in the OCA training and successfully integrate the new tool into programming.
5. Ensure that Birth to Three is making continued progress toward proficiency in Motivational Interviewing (MI) skills. Each team member will create a professional development goal related to MI to be documented on their 2025 annual performance reviews.

CHILDREN'S ALTERNATE CARE UNIT

As shared throughout this Annual Report, the Children, Youth, and Families Division strives to keep families together and provide in-home services and resources; however, when this is not possible, the need to place children and youth outside their homes might be necessary to ensure child and community safety. Removals, regardless of length, have a profound impact on children, youth, and families; therefore, it is of the upmost importance that a safe and appropriate placement is found. Factors that are considered include the caretaker's commitment and ability to meet the child or youth's needs, proximity to schooling or childcare, the caretaker's ability to keep siblings together, proximity to the birth home of the child or youth, and potential reunification success.

Who We Are:

Our Children's Alternate Care Unit is comprised of one Foster Care Coordinator and one Kinship Care Coordinator. Both coordinators carry out a variety of roles and responsibilities that support our foster homes and kin providers so they in turn can provide for the physical, emotional, and social needs of the children and youth placed in their care.

Our Foster Care Coordinator recruits and licenses foster homes, as well as helps facilitate placements in these homes and other placement settings, such as group homes and residential care. Our Foster Care Coordinator also facilitates respites in order to preserve in-home placements and provide short reprieves for parents and caretakers when stressors are playing out within the home. Our Kinship Care Coordinator oversees our voluntary and court ordered kinship care cases, as well as our subsidized guardianship cases.

Events and Highlights in 2024:

Our Coordinators are very passionate about the work they do and support our foster parents and relative providers in many ways. Since 2019, our Foster Care Coordinator has been awarded the Foster Parent Grant which supports the retention of foster parents, foster parent training, and improving normalcy opportunities for children in out-of-home care. In October 2024, our Kinship Care Coordinator was awarded our second year of Relative Caregiver Support Grant funding which furthers our ability to engage and assist relative care providers in obtaining benefits and services to meet their family's specific needs and the needs of the children they are raising. Some of the most notable activities our Coordinators hosted in 2024 were:

- The annual Christmas Party for our foster families and children in care is an event with interactive games, pizza, gifts, and time with Santa
- An outing at the Watertown Aquatic Center for youth and their relative care providers was an event which allowed for fun in the sun while also creating connections with one another
- The annual Back to School Bash is an event where foster families get to enjoy a picnic together and receive fully stocked bags of the school supplies needed for each child
- The annual Roller-Skating Party is an event where the local roller skating rink is rented out for the night and a private event of roller skating and food is provided to our foster parents
- The annual Foster Parent Appreciation Dinner is an event where our licensed foster parents are honored with a dinner reception and gifts

In addition to these activities, our Foster Care Coordinator hosted our very first Foster Parent Conference in the fall of 2024. This conference was a one day event in which foster parents were able to network and receive training hours and certification required for their licensure. The focus of the conference was lived experience, shared parenting, and trauma-informed parenting. What made this conference even more meaningful was that the presentations were done by our Youth Justice Supervisor who is also a former foster parent, our Parent Partners, one of our foster parents, and a former CHIPS parent who was able to successfully achieve reunification with her children.

And last but certainly not least, our Foster Care Coordinator nominated one of our foster homes for the 2024 Department of Children and Family's (DCF) Outstanding Foster and Adoptive Family Awards. Recipients were chosen based on their experiences supporting shared parenting, cultural and community connections and the well-being of the children in their care. The Witzigmann Foster Home was one of only ten families selected for this outstanding award which was presented to them on November 21st by DCF and Governor Evers. The Witzigmann's were honored for their exceptional commitment to foster care and family preservation through partnership with the biological families. They encourage family involvement by including the family in the decision-making process at the start of any placement. The Witzigmann's have been a Jefferson County foster home for the past six years and have supported countless children and continue to serve as mentors for newly licensed foster families.

2024 Legislative Updates:

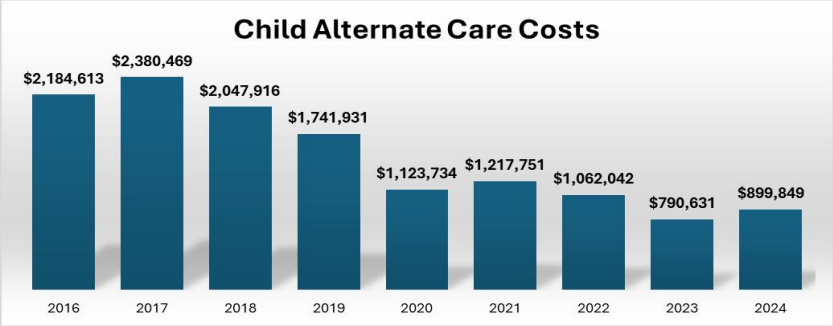
On March 14, 2024, Governor Evers signed into law 2023 Wisconsin Act 119 which expands kinship care programming. The legislation, also known as "like-kin legislation", took effect as of January 2025 and expands the definition of "relative"; expands the definition of "kinship care provider" to include "like kin"; allows courts to order placement with "like kin"; supports kin caregivers; and respects how families self-define kin. This is extremely exciting news as it broadens who is eligible to care for children, when alternate care is necessary, and provides the financial support necessary for these placements.

Noteworthy Data:

Our efforts to keep families together and reduce the proportion of children and youth served outside their community or in congregate care settings continue to be evident in our alternate care data. The graph below shows the number of children and youth placed in alternate care since 2017 and provides a breakdown of the types of placements. As the data shows, the number of residential care, group home, foster care, and detention/shelter care placements have steadily decreased in the past eight years, while the number of kinship care placements continues to increase.

	2017	2018	2019	2020	2021	2022	2023	2024
Residential Care Centers	9	7	9	4	4	5	2	1
Group Home	16	6	8	7	6	2	1	2
Foster Care	106	104	114	107	91	77	74	76
Foster Care (Out Of County)	8	1	5	1	6	0	1	1
Supervised Independent Living	2	0	0	1	0	0	0	0
Kinship (Court Ordered Only)	20	15	25	23	14	7	10	7
Detention/Shelter	14	11	15	11	10	6	7	1
Hospital/Institutions	0	2	3	0	0	1	1	2
Kinship (Voluntary)	30	31	32	38	46	50	46	46

These outcomes have a direct correlation to the alternate care budget and the data below shows that our efforts have helped keep alternate care costs steady the past five years, despite increasing costs and a decreasing budget.



A funding source that has been instrumental in offsetting alternate care costs is through Children's Long Term Support (CLTS) Waiver Programming. When a child or youth that is enrolled in CLTS is placed in foster care, the Waiver Program can provide funding support, which as the data below outlines, has historically been over half the cost of these alternate care costs.

Year	CLTS Placements	Alternate Care Cost	CLTS Funded	Percentage Support
2017	6	$97,698	$56,665	58%
2018	12	$115,728	$67,122	58%
2019	14	$147,221	$86,860	59%
2020	14	$125,248	$73,896	59%
2021	19	$234,507	$143,063	66%
2022	17	$292,489	$181,580	62%
2023	21	$335,185	$200,154	60%
2024	20	$279,364	$165,042	60%

Our Alternate Care Unit's ongoing support and collaboration with agency staff, community partners, foster parents, and kin providers have led to the many successes that are highlighted in this section. Our Foster Care Coordinator and Kinship Care Coordinator look forward to the initiatives and opportunities that 2025 will provide.

CHILDREN IN NEED OF PROTECTION AND SERVICES (CHIPS)

~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.~

An Overview of the CHIPS Team

Child maltreatment is a major concern and can be a precursor to a myriad of health and well-being issues. 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. Many reports are also received from schools, police departments, physicians, and other service providers or professionals. Each report is handled according to Wisconsin State Statutes Chapter 48 requirements for child abuse investigation and child protection. Once a report is made, our Intake staff handles the investigations through court disposition.

Our Child Protective Services workers are required to continuously 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 the intervention of the court. While other cases do not require action on our part at all, both types of decisions carry potential benefits and consequences for families and the department. Once a determination has been made that a case will move forward either through the court process or on an informal basis, the Children in Need of Protection and Services (CHIPS) team becomes involved. Ongoing work is being assigned earlier in the life of the case, whether the case is being resolved with a formal petition or informal dispositional agreement. This ensures that the family interaction plan and safety plans are implemented and followed in accordance with standards and party agreements. This progressive practice allows for a more seamless transition for the family between Intake and Ongoing staff and enhances the engagement process with the family throughout the life of the case.

The Children in Need of Protection and Services (CHIPS) team is comprised of a supervisor, eight ongoing case managers and two-family development workers. The ongoing case managers are responsible for monitoring open CHIPS orders and collaboratively planning with families to meet both the elements of the court order and the family's goals. The Family Development Workers (FDW) main role and assistance to case managers comes through facilitating supervised family interactions, assisting with transportation needs, and providing parent coaching. Additionally, FDW's will let case managers know when they have available time in their schedules to fill and are more than willing to complete other tasks that may arise such as drug swabs, compiling data, and assisting with the organization and distribution of the multitude of donations that are received from the community.

Once a case is transferred to the Ongoing 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 overriding factors such as poverty, domestic abuse, unmet mental health treatment needs, medical concerns for the child which may not be treated or sufficiently addressed, chronic homelessness, criminal charges, and sentences, and significant AODA treatment needs. To address these issues, the CHIPS team works closely 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), the Mental Health Clinic, as well as the Agency Medical Director, Dr. Mel Haggart. The CHIPS team also works closely with community providers, including area hospitals and clinics, PAVE (Protect, Advocate, Validate, Educate), local law enforcement agencies, the Corporation Counsel's Office, schools, and private child-placing agencies.

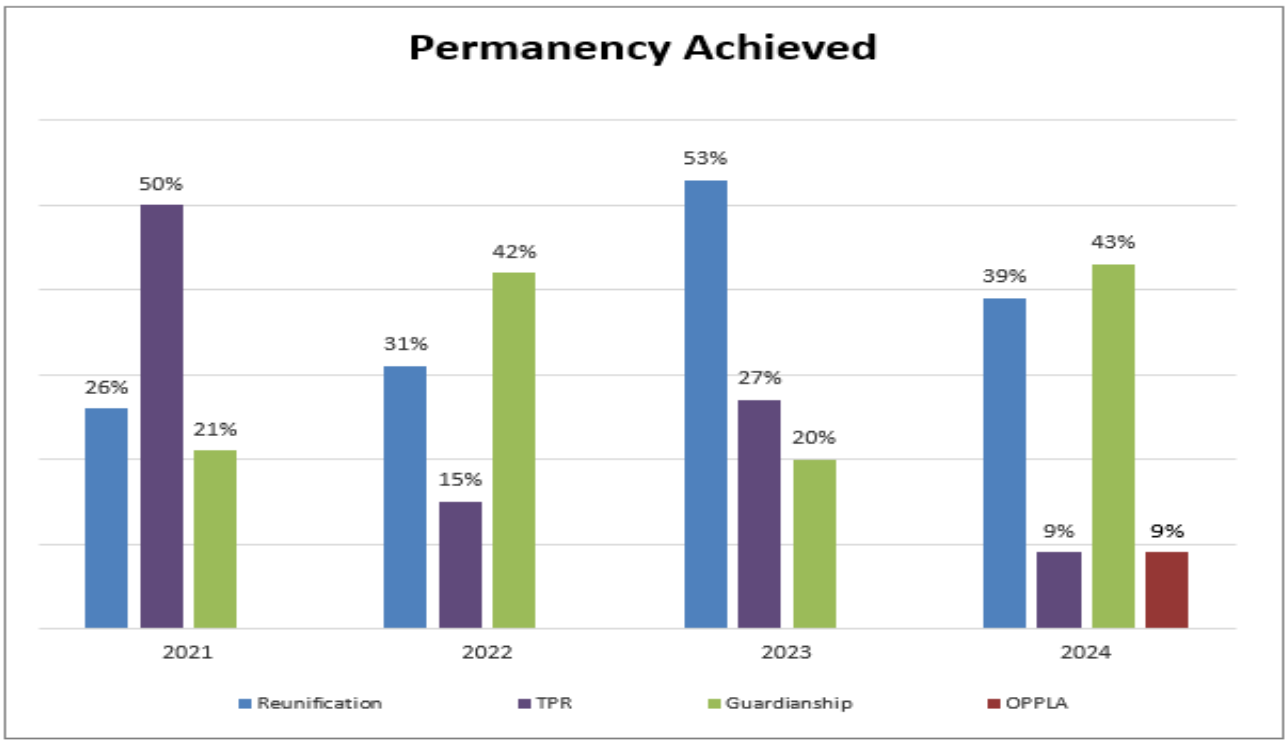
The CHIPS team approaches each case with goals aimed at ensuring the safety of the children involved, while at the same time providing for their permanence. If children are placed outside the home at any time, permanence options include reunification with parent(s), Ch. 48 Subsidized Guardianship, Termination of Parental Rights, and Adoption or other planned permanent living arrangements (OPPLA). In 2024, the number of children placed outside of their home remained steady for the second straight year. This is due to the continued efforts made from the very start of a case with safety planning and the use of the families' own

informal support to ensure that the children be able to safely remain in the home. The in-home safety cases typically require additional staff time for coordination and frequent communication with all participants to ensure that the safety plan is followed, and the children remain safe.

Noteworthy Trends and Data

Throughout 2024, the number of open cases did not demonstrate much fluctuation. At the low end there were 46 open cases, and the high end saw 55 open cases. This number has shown little deviation from similar numbers over the last few years and gives case managers the ability to spend more time on each individual case and manage the safety plans effectively. Regarding out-of-home care, the CHIPS team was responsible for 49 children placed in out-of-home care at the start of 2024 and 52 children placed in out-of-home care at the end of the year. This number again experienced little fluctuation throughout the year with 53 as the high and 43 as the low. The CHIPS team oversaw 37 children who were subject to in-home orders at the start of 2024 and there were 30 children subject to in-home orders at the close of the year, this number fluctuating between a low of 28 and high of 47.

In 2024, the CHIPS team helped 23 children who had been placed in out-of-home care find permanence. The two children were the subject of Termination of Parental Rights (TPR) proceedings that were finalized in 2024. Both were still in the process of being adopted at the start of 2025. Nine children were reunified with one or both biological parents. Ten children found permanency via Guardianship in accordance with their Permanency Plans, and in 2024 there were two youth who "aged out" or found permanency via OPPLA, meaning they turned 18 while still placed in care. The graph below shows the permanency trends over the last 4 years. As a matter of note in 2021, the percentage of TPR's was significantly higher than typical years due to the backlog of proceedings from the COVID pandemic.



Success Stories

In 2023, an Ongoing Case Manager was assigned a case involving a toddler who was badly burned on the palms of his hands and had not received any medical care. There were also concerns about physical abuse due to various stages of bruising on his face, as well as concerns regarding his mother's mental health. Because of the safety concerns, the toddler was placed with his grandmother and received the medical care he needed, including surgery for the burns on his hands.

Eventually the grandmother stated that she could not care for the young child long-term, and reunification efforts were not looking successful. The child was placed with a family who became licensed and were an adoptive resource. Ongoing reunification efforts continued with the parents but were ultimately unsuccessful. In 2024, both parents voluntarily terminated their parental rights. This child spent 545 days in foster care but was ultimately able to reach permanency through adoption by his foster parents. The ongoing case manager was touched by the foster parents and siblings' true love for the little boy and how the little boy flourished in their care.

In April 2023, the Department received a report after a toddler was brought into the ER after being found non-responsive and not breathing. After being administered Narcan, the toddler began responding. This child and their toddler sibling were removed from the parents' care and placed into a foster home due to concerns of neglect. Through a lot of support from the Parents Supporting Parents program, a strong partnership between foster parents and biological parents, and an amazing amount of hard work and commitment, these parents were able to work to address the conditions of return established by the Court and achieve trial reunification with their children in less than 9 months. The trial reunification went smoothly, and parents continued to move forward, not looking back, to rebuild their family which now included a new baby along with their two young children. The parents continue to have a strong relationship with the foster family, who have now become informal support for this family. The father successfully graduated from Drug Treatment Court, which was celebrated in October. This family has overcome significant obstacles and barriers to ensure that their family remains together in a healthy and stable home. Their hard work and dedication were reflected in our ability to terminate their order and end the Department's involvement three months early - a well-deserved early Holiday celebration!

Noteworthy Initiatives and Accomplishments

The key outcome indicator used by the CHIPS team in 2024 was new. The goal was "Case managers and the Family Teaming Coordinator will offer and schedule Family Team Meetings with parents on all out-of-home cases quarterly, post Disposition." This vision entailed case managers and the family teaming coordinator meeting with parents (starting with new cases initially) and their support systems. The goal is to assist the parents in meeting goals to move forward in the case and have their support there to assist should a roadblock occur. Ultimately this would move cases forward timely for permanence and success by breaking down larger goals into small steps and helping them understand timelines and opening the door for more discussion. The meetings are parent directed and are meant to be facilitated by the family teaming coordinator to be more neutral and less directive than the case manager leading the meeting. The case managers did offer and held 20 family team meetings for families throughout the year. The meetings proved to be helpful for goal setting, general case understanding, and some families requested to have follow-up meetings when goals were achieved to set new goals.

The CHIPS team works closely with many internal and external service providers to achieve desirable case outcomes. The CHIPS team enjoys the support of having two Family Development Workers. The primary role of the Family Development Worker is to supervise family interaction between parents and children placed out-of-home. However, providing court testimony, one-on-one services, and other case aid duties that arise are also very prominent. The purpose of the Family Development Worker's position is to provide services to families and assist case managers in placing children in-home on a permanent basis. This includes providing in-

home services when children remain placed with their parents as well as services to assist families in getting their children placed back in the home when they are in out-of-home care. This is achieved by supporting families through one-on-one modeling/teaching of parenting skills, providing transportation to various appointments, and tracking and documenting client progress as it relates to set goals. Family Development Workers are the eyes and ears of the case managers as this role involves seeing many of the case participants on a frequent basis. The Family Development Workers are also involved with the Incredible Years Parenting Class and Child Abuse Prevention Month.

When a Family Development Worker becomes involved in a case, they receive a referral from a case manager that includes parent and child information, a brief description of why services are being requested, what those services are, any unique needs related to the children or parents, and parental/family strengths. This allows the Family Development Workers to provide individualized services based on the needs and strengths of each family. One-on-one services can include, but are not limited to, help with parenting skills, budgeting, and managing finances, and improving cleanliness and physical safety within the home environment. The Family Development Workers, in conjunction with the case managers, review a visit expectation form with the families, and all parties sign the form indicating they have read and understood what is being asked of them during their time with their children. The expectations are both general and tailored to specific families and may include things such as bringing age-appropriate activities, meals, and engaging respectfully with workers and foster parents during transition times.

Jefferson County Human Services has a visitation room designed to be as comfortable as possible for children and parents who are unable to visit one another at home or in the community. This room is equipped with video/audio recording equipment which allows staff to record visitation if needed. This allows staff to review sessions and continue to fine-tune our approach. Staff, in conjunction with a therapist, have been able to use this equipment to provide Parent-Child Interaction Therapy (PCIT). PCIT is used to improve the quality of parent-child relationships by changing parent-child interactions. At times, family development workers and case managers partner with legal professionals and psychologists who complete our parenting assessments, as well as other Jefferson County Human Services professionals, such as mental health workers, to put together individualized parenting recommendations for clients. This process involves a therapist watching the parent and child through a one-way mirror and coaching that parent using a microphone and earpiece. The room is continually updated using child abuse prevention funds to make the space more inviting, as well as ensuring that parents have essentials if they are unable to provide them. The room has a couch and table and there are calming paint colors, as well as artwork. A bookcase was added, along with other toys, pillows, and activities for the children and parents to use while in the room. The room also has diapers, wipes, and other snacks and supplies in case a parent does not provide or cannot afford these items.

Family interaction requirements vary from case to case due to each parent's specific needs, learning styles, and mindset for taking direction. Sometimes staff will take a more hands-on approach by modeling and giving on-the-spot suggestions or prompts throughout a visit, other times staff will take a more passive, observation-only role during the visit and provide feedback afterward if necessary. The feedback can be given verbally or by completing a written form which is then provided to parents to review, process, and discuss later. Additionally, to make visits occur, family development staff frequently provide transportation for the children and/or parents. When possible, visits take place in a family's home environment. If that is not possible, visits take place somewhere in the community or in the visitation room at the Human Services building.

Every year the CHIPS team takes part in initiatives aimed at improving our practice and improving outcomes for children and families involved in the child welfare system. One of the ongoing initiatives, Motivational Interviewing (MI), is a collaborative, person centered form of guiding to elicit and strengthen motivation to make meaningful change. The fidelity to this collaborative form of communication is important to the team because as we continue to move forward, we use the transfer of learning exercises during team meetings and make MI a focus on every case during worker supervision. MI has become an integral part of the environment in Jefferson County and to further strengthen skills, staff continue to attend training and learning labs each

year. Jefferson County took the time to train qualified internal staff to in turn train new employees and to enhance current practices throughout the year. Each team has at least one MI coach, which will ensure the fidelity to this initiative for years to come. The CHIPS team has two coaches, the supervisor, and a case manager, who take part in providing feedback to other team members as well as assisting in learning labs and other training provided throughout the agency.

In 2019 Jefferson County received additional funding as part of the 2019/2020 biennium budget in the form of an increase to the Child and Family Allocation from DCF. One of the ways in which we chose to utilize that funding was to hire a psychotherapist specifically attached to the CHIPS team, for both parents and children. The aim and goal of this position was to decrease wait times for CHIPS families to receive treatment, as well as allow a therapist to become folded into the CHIPS team, focusing on this at-risk and neglected population. The therapist meets with the CHIPS team monthly to "staff" the consumers as well as consult about potential new referrals. This has led to services being offered to consumers timelier, streamlining the process for them to receive said services, and keeping the lines of communication between the CHIPS case managers and therapists open to better serve the families. This position continues to be an invaluable asset to the CHIPS team and families with whom we work.

In 2023, Jefferson County took part in a Tailored Dispositional Order collaborative, partnering with Special Prosecutor Henry Plum, Corporation Counsel, participants from the CCIP, Parents Supporting Parents representatives, and several other legal parties, including Guardian ad Litems and counsel appointed to parents. The Intake and Ongoing CPS units, as well as PSP staff at JCHS, took up rewriting the Court Ordered Conditions to make them easier to understand and less intimidating to parents. We fully implemented these conditions in court orders in 2024. Since the inception of the Tailored Dispositional Orders there seems to be a clearer sense of what is expected of parents and the court orders are less daunting.

Every April, to promote Child Abuse Awareness month, the CHIPS team puts together activities and displays and raises funds to use throughout the year for the families we serve. The planning for the events and activities starts months in advance and takes the efforts of everyone on the team to be successful. There are clothing and other item sales, fundraising through Jefferson County businesses, and general donations. The funds are used to support families throughout the year in various creative ways, such as updating the car seats the CHIPS team uses to transport children, purchasing graduation gifts for youth, sponsoring children with sports gear or participation fees, and keeping the visitation room stocked with diapers and wipes, among many other needs. CAPs month proves to be a fun, though busy month, every year with the hard work paying off through smiles and gratitude of the families we serve throughout the year. Below are some pictures from Child Abuse prevention month activities in April of 2024, including the Children's Share and Care Fair, one of several pinwheel displays throughout the county, and at BINGO at Rock Bottom in Jefferson.

Looking Forward

The challenges we look forward to in 2024 include maintaining the fidelity of former training and initiatives and continuing to modify our practice as new challenges and evidence-based practices arise. We look forward to maintaining a fully staffed team so that each case manager can focus on, and target, a lower number of families per caseload. This will help families stay focused, feel more supported, and build upon and enjoy their successes. Case manager practice modification will require increased transfer of learning exercises and more targeted supervision on each case. The CHIPS team includes staff new to CPS work, and staff with a great deal of expertise and experience. Several members of the team are key contributors or actual trainers in Motivational Interviewing, Incredible Years Parenting, Strengthening Family Systems (formerly known as Trauma Informed Parenting), the Diversity Committee, and other collaborations with the State. Having these resources available to the entire CHIPS team on an ongoing basis will ensure that the team can embrace new challenges in 2025.

Review of 2024 Goals:

Key Outcome Indicator: **Case managers and the Family Teaming Coordinator will offer and schedule Family Team Meetings with parents on all out-of-home cases quarterly, post Disposition.** In 2024 the CPS team held 20 family team meetings, in which 18 of these successfully occurred but two did not occur due to the parents not appearing. Overall, the team felt these were a success and it is hoped that with the hiring of the Family Teaming Worker in 2025 more meetings will be facilitated and attended. ***This indicator was met.***

1. The CPS team will have, and document, contact with non-custodial parents monthly and use the contact form for such purposes in each individual case. ***This goal was attained.*** Throughout 2024 the CPS team kept records of contacts with non-custodial parents and the form helped streamline these efforts to maintain communication and open lines of contact.
2. The CPS team will schedule and organize quarterly Safety Roundtable staffing sessions with the Intake Unit to ensure that cases are moving forward and are the safest and least intrusive to the families with whom we work. ***This goal is in process.*** Due to scheduling conflicts between the two teams, this goal was partially met. This will be a continuing goal for 2025.
3. The CPS team will hold internal Permanency Roundtable sessions to boost progress toward safe and timely permanence for children in out-of-home care. These sessions will be held prior to permanency plans, starting with children who have been placed out-of-home longest. Other Children and Families Division Supervisors will be invited, in hopes of eliciting more expansive dialogue. ***This goal was attained.*** There were seven of these sessions held throughout the year, with a great collaboration of diverse staff at the table, and case movement occurred.
4. To ensure that the CPS team is making progress toward proficiency in Motivational Interviewing skills, each team member will submit a recording for a coaching opportunity. Additionally, CPS team members will participate in any agency wide professional development activities. ***This goal was attained.*** All CPS team members participated in MI professional development activities and recordings in 2024.

Goals for 2025:

Key Outcome Indicator: **Case managers and the Family Teaming Worker will offer and schedule Family Team Meetings (FTM's) with parents on all new out-of-home cases quarterly, post Disposition. Additionally, FTM's will be offered to all current families with children placed in out-of-home care at least 60 days prior to each Permanency Plan Hearing.**

1. The CPS team will schedule and organize quarterly Safety Roundtable staffing sessions to ensure that cases are moving forward and are the safest and least intrusive to the families with whom we work.
2. The CPS team will host Roundtable sessions with the Parents Supporting Parents program. These sessions will give both teams the ability to gain insight and understanding of how to best serve the families we work with while being able to ask questions of one another in a safe space. There will be a minimum of spring and fall sessions.
3. To ensure that the CPS team is making progress toward proficiency in Motivational Interviewing skills, each team member will submit a recording which will be coded during our team meeting and coached during

their 1:1 supervision. Additionally, CPS team members will participate in any agency wide professional development activities.

4. The CPS team will make a concerted effort to do community outreach in 2025, focusing on medical partnerships. This will include having new pamphlets made and distributed during face-to-face contacts with clinics and hospitals within our service area.

Children's Long-Term Support Waiver Program

"Helping families support their children with disabilities in their own home."

CLTS Waiver Vision Statement

Every life has value and purpose within their family and community. When families have the resources and services, they are able to function at their best, they can better meet the needs of the child. The CLTS Waiver team is devoted to being champions for children and families of Jefferson County.

Overview of the CLTS Waiver Program:

The Children's Long Term Support (CLTS) Waiver Program provides a structure within which Medicaid funding is available to support children and youth, also known as the participant, who live at home or in the community and have substantial limitations in multiple daily activities as a result of one or more of the following:

- Intellectual and/or developmental disabilities
- Physical disabilities
- Mental health disabilities

This program is one of Wisconsin's Home and Community-Based Services (HCBS) Medicaid Waiver programs, federally authorized under § 1915(c) of the Social Security Act. These HCBS waiver programs were authorized by Congress in 1981 and implemented in Wisconsin in 1983. HCBS waivers are called "waivers" because they permit certain federal Medicaid regulations to be waived, and Medicaid funding to be used, in a home and community setting rather than an institutional setting.

Primary values of the CLTS Waiver Program include:

- Supporting individual choice
- Enhancing relationships
- Building accessible, flexible service systems
- Achieving optimum physical and mental health for the participant
- Promoting presence, participation, optimal social functioning, and inclusion in the community

Eligibility and Enrollment:

A child may be eligible for CLTS if he or she has a significant disability that's expected to last more than one year and is living at home or a foster care setting. Eligibility is based on a child's functional limitations which can be physical, developmental or emotional and restrict their ability to carry out daily-living activities like dressing or eating, or may impact their learning, communicating or mobility.
To participate in CLTS, a child must:

- be under the age of 22
- be a United States citizen
- be a Wisconsin resident
- have significant care needs: A child must need a high level of care throughout his or her day. The CLTS Waiver Program defines this as an institutional level of care, in cases where care is typically provided in a hospital, nursing home or facility for people with developmental disabilities.

Following a referral, the CLTS Access and Eligibility Specialist will meet with the child and family to determine program eligibility. This must be done within 45 days of the initial referral. During that visit, a screening tool, called a **Functional Screen**, is used to assess the child's level of care needs and functional limitations. The Functional Screen is a functional eligibility tool that collects information on the child's health, need for support and how the child interacts with others**. This includes parents input on their child's limitations, care needs and challenges.** Once program eligibility is determined, an SSC is assigned to work with the family. Continuous enrollment is a process that helps children join the CLTS Waiver Program faster as there are no longer waiting lists.

How families are supported by CLTS:

This program supports Medicaid-eligible families of children with disabilities by providing funding and resources to enable parents to meet the needs of their child and participate in their communities.

The program's 'Deciding Together' framework emphasizes a collaborative team model. This team, comprising of the child, family members, and designated support members, are central to all decision-making. Supports and services are unique to every family and services funded through the CLTS Waiver Program are based on the child's needs and goals.

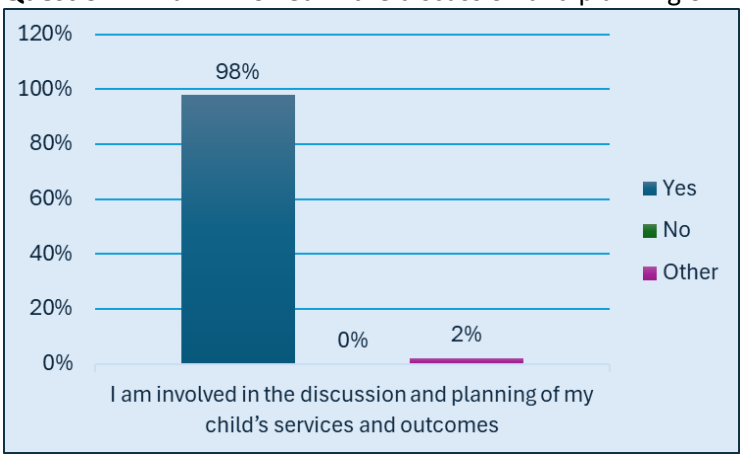
What the CLTS Waiver Program can provide:

- **Support Services:**
  - Respite Care
  - Personal support
  - Childcare
  - Day services
  - Community competitive/integrated employment
  - Discovery and career planning
  - Participant and family-directed goods and services
  - Transportation
- **Management and coordination**
  - Community integration services
  - Financial management services
  - Participant and family-direction broker services
- **Housing related**
  - Home modifications
  - Housing support services
  - Relocation services
  - Adult family home
  - Children's foster care
- **Teaching and Skills Development:**
  - Counseling and therapeutic services
  - Daily living skills training
  - Empowerment and self-determination support
  - Family/unpaid caregiver supports and services
  - Grief and bereavement counseling
  - Health and wellness
  - Mentoring
  - Safety planning and prevention
- **Physical aids**
  - Assistive technology
  - Communication assistance for community inclusion
  - Personal emergency response system
  - Specialized medical and therapeutic supplies
  - Vehicle modifications
  - Virtual equipment and supports

How we are doing:

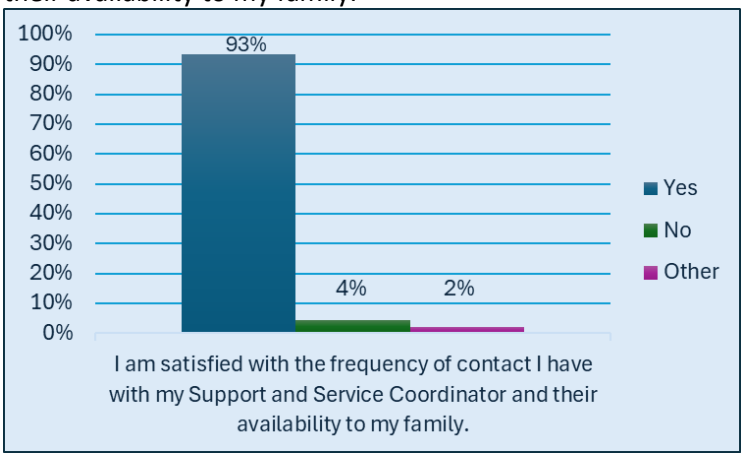
To ensure the ongoing delivery of high-quality, impactful services, the CLTS Waiver Program conducted a comprehensive family survey in January 2025. This initiative is aimed at identifying program strengths and opportunities for enhancement. To determine the program's strong suits and any areas in need, the survey resulted in a return of 46 surveys, which is 10.4% participation. The following indicates the survey results.

Question 1. I am involved in the discussion and planning of my child's services and outcomes.



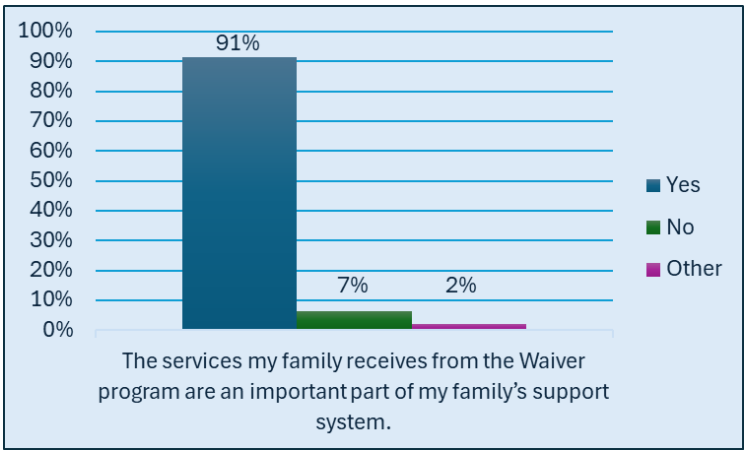
~98% of families agree they are involved in the discussion and planning of their child's services and outcomes.

Question 2. I am satisfied with the frequency of contact I have with my Support and Service Coordinator and their availability to my family.



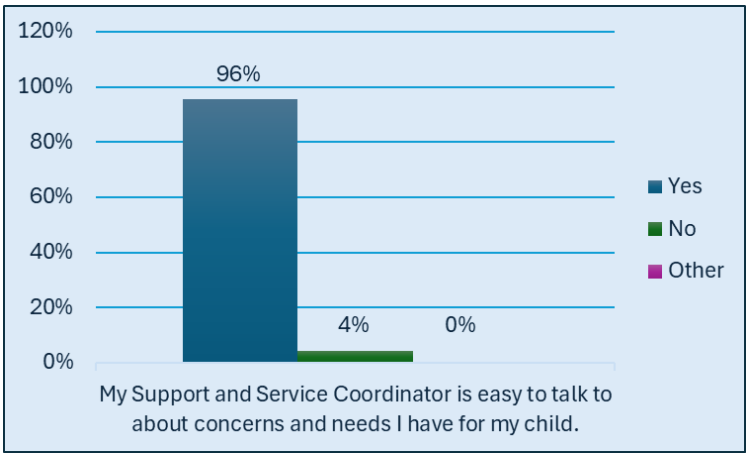
~93% of families agree they are satisfied with the frequency of contact they have with their Support and Service Coordinator and their availability.

Question 3. The services my family receives from the Waiver program are an important part of my family's support system.



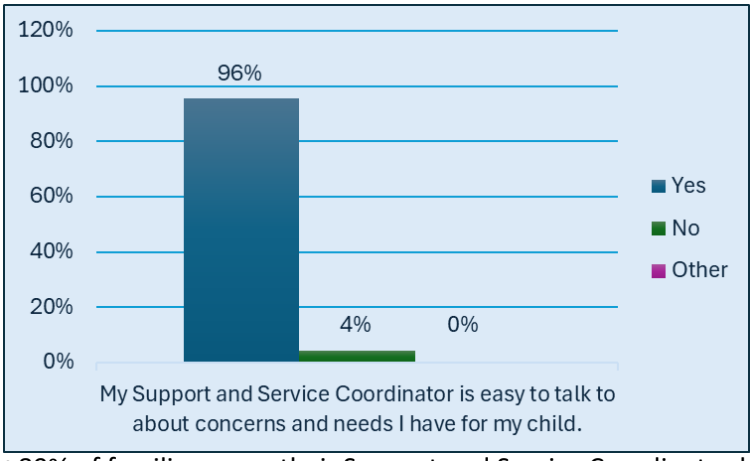
~91% of families agree the services their family receives from the CLTS Waiver Program are an important part of their family's support system.

Question 4. My Support and Service Coordinator is easy to talk to about concerns and needs I have for my child.



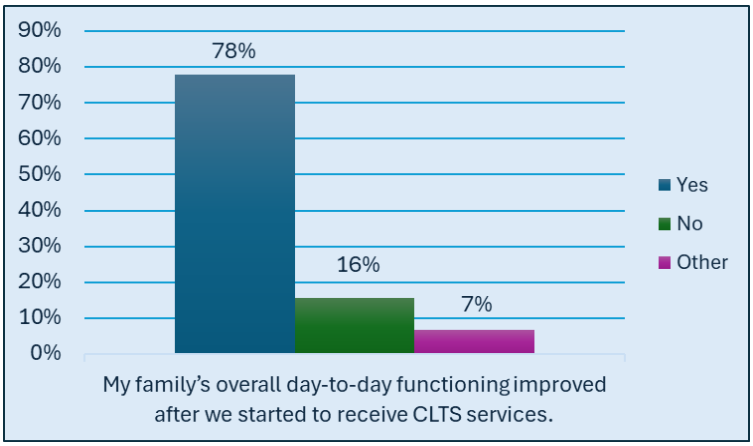
~96% of families agree their Support and Service Coordinator is easy to talk to.

Question 5. My Support and Service Coordinator helps advocate for my child's health, safety, and community inclusion.



~89% of families agree their Support and Service Coordinator helps advocate for their child's health, safety, and community inclusion.

Question 6. My family's overall day-to-day functioning improved after we started to receive CLTS services.

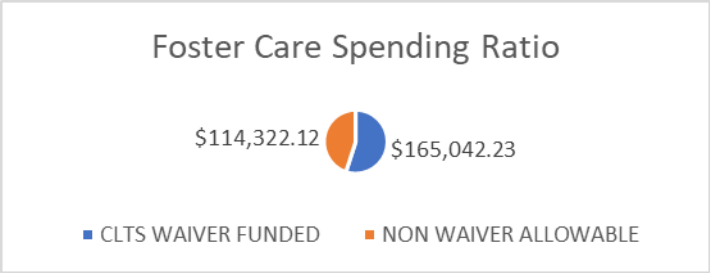


~78% of families agree their family's overall day-to-day functioning improved after they began to receive CLTS services. This percentage reflects the impact experienced by families when there is a narrow field of available CLTS funded service providers.

Thoughts and stories shared by CLTS families and SSCs:

- "Our anxiety and stress levels have tremendously decreased. We're able to find things that help our child with anxiety and stress. We're able to get a break away from our child every now and then."
- CLTS came into our lives in an extremely trying time for our family. We were experiencing deregulated behavior, unsafe body control, and low school attendance. It was a challenge to say the least. When the opportunity to join came to us, I was unsure of what kind of support would really be offered. Quickly after, we were surrounded by a caring and supportive staff who assisted in developing plans and goals for both of my autistic kids. Including in the emotional support offered, CLTS assisted in finding doctors, therapists, and provided safety and regulation devices (examples: alarms for windows and doors, noise cancelling headphones, hygiene products, sensory items, weighted blankets, task charts and more.) This past fall CLTS even connected us with a company to have a fence installed to help enclose my runner from the dangers of nearby ponds, road and railroad tracks. Our team works closely with all our providers and even school to ensure we are all connected in strategizing and have the same goals. I can't begin to voice what being part of this program has truly meant for my family and how much progress I've seen in my kiddos these past two years. We are in a place I never dreamt possible and my gratitude is endless. As a parent having not one, but two children struggling feels overwhelming at times but I never feel alone."
- "We have come a long way from the beginning. The CLTS IT'S JUST AN AMAZING PROGRAM."
- This young girl and her family began working with the CLTS Waiver Program in 2021. At that time, their daughter's mobility was significantly impacted by a Neuromuscular Disorder and she struggled to be physically active even with use of her leg braces. Parents and their SSC collaborated to support her goals. Several items were funded through the CLTS Waiver Program to support her goal to be physically active and more involved in school life. Now at age 11, through the support of the CLTS Wavier Program and hard work by this young girl, she no longer needed one of her leg braces to be active and has joined the school Cheerleading team. This is truly a success story for this family!"
- "I know that my daughter's health conditions are difficult and as a family it has affected us in the economy, emotional state and uncertainty, but by receiving the help and guidance of the team, we are moving forward day by day. Yes, things are still difficult for my daughter but we continue working on it."
- "They have helped open doors to receive support for our daughter."

Foster Care Spending Ratio



Twenty (20) children residing in foster care throughout 2024 received Children's Long Term Support (CLTS) services. As shown in the graph above, the total annual cost for these 20 children in out-of-home placement amounted to $279,364.35. Of this total, the Children's Long Term Support Waiver Program covered $165,042.23. The remaining $114,322.12 is considered non-waiver allowable. Children in foster care who qualify for CLTS services help reduce costs in the alternate care budget. More importantly, foster parents receive the additional support and services needed to maintain the child in a home environment.

A Year in Review for 2024

The CLTS Waiver Program enrolled **130** new children in 2024, providing support and services to a total of **579** children and their families throughout the year. This total includes families that may have moved out of Jefferson County, or disenrolled from the program.

The chart below shows the growth for the program over the past 3 years. The total served column reflects the total number of children served throughout the entire year.

Year	Enrolled	Total served during year
2022	142	445
2023	114	522
2024	130	579

As the need for CLTS Waiver services continued to grow, so did the CLTS Waiver team! Throughout 2024, additional staff and positions were added. By the end of 2024, our team consisted of two program supervisors, an Administrative Specialist, an Administrative Assistant, and 18 Support and Service Coordinators (SSC).

Review of 2024 Goals:

***Key Outcome Indicator*:** CLTS program will meet enrollment timeframes (DHS Activity Timeline) 86% of the time. All children are considered in enrollable status when determined functionally eligible and when entered in PPS. Enrollment into CLTS must occur within 45 calendar days. The Support and Service Coordinator has a maximum of 45 days to:

- Meet all CLTS eligibility criteria
- Place an end date in the participant's record in PPS
- Enroll participants in EES

Based on an internal audit our CLTS team met the DHS Activity Timeline expectation for 2024. ***This indicator was met.***

1. CLTS program staff will achieve 86% or higher in Incident Reports were Completed Timely as evidenced by the 2024 audit conducted through internal audit. Incident reports are required for identified incidents that occur at any location and with any provider: home, school, paid or unpaid. Incident reports are completed for actual or alleged abuse, neglect or exploitation, medication error-based hospitalization, psychiatric hospitalization, law enforcement contact or investigation involving the participant, unapproved use of restrictive measure, or death of the participant. Incident reporting is a dual process for the CLTS Support and Service Coordinator requiring an initial report to be completed within 3 business days of notification of incident and report completion within 30 calendar days of incident notification. Both deadlines are evaluated for this two-part goal. ***This two-part goal was attained***. Our internal audit revealed excellent performance in incident reporting. We achieved an 88.24% success rate for the initial Department of Health Services (DHS) notification within the three-day timeframe and a 95.59% success rate for full incident report submission within the required 30-day requirement.

2. CLTS program staff will provide in-person visits with the participant and parents or guardians for bi-annual service plan reviews at 86% or higher as evidenced by the 2024 audit conducted through internal audit. ***This goal was attained.*** The internal audit confirmed that this goal was surpassed at 96.22%, validating our team's efforts.

3. The CLTS program strives to be a resource for the families they serve. To better address free and low-cost disability-related community resources available in Jefferson County and the surrounding areas, the CLTS team will research and compile a resource guide to be shared with the CLTS families. ***This goal was attained.*** A creative approach was taken by the CLTS Waiver team to ensure up-to-date resources were provided to families and community partners on a monthly basis. Our monthly CLTS newsletter includes community resources, local family friendly events as well as disability-related educational opportunities.

4. To continue building community partnerships and awareness goals for 2024, the CLTS program will connect with local educators and medical providers to promote the CLTS services and program. ***This goal was attained.*** This was truly a team effort. CLTS program supervisors collaborated with Jefferson County school administrators and teaching staff, as well as Jefferson County Health Department and WIC programs, to share program information. Written materials were provided to medical clinics, Rock River Community Clinic and Anytime Fitness. Support and Service Coordinators (SSC) have an active role as well. By partnering with local

schools and medical providers, SSC's create natural opportunities to program education and awareness. The CLTS team participated in local community outreach events to promote the CLTS Waiver program and provide general information.

5. An ongoing goal for the CLTS program staff is to continue building their Motivational Interviewing (MI) skills, through submission of a MI recording for coding and coaching prior to their annual performance review. The CLTS team will engage in MI skill building activities quarterly during CLTS team meetings. ***This goal was attained.*** As the CLTS program expands, we're ensuring new Support and Service Coordinators receive training in Motivational Interviewing (MI). All experienced Support and Services Coordinators submitted a recording for coding and coaching support. Additionally, CLTS focused Motivational Interviewing training was provided to the CLTS team.

Goals for 2025:

Key Outcome Indicator: CLTS program will meet enrollment timeframes (DHS Activity Timeline) 86% of the time. All children are considered in enrollable status when determined functionally eligible and when entered in PPS. Enrollment into CLTS must occur within 45 calendar days. The Support and Service Coordinator has a maximum of 45 days to:

- Meet all CLTS eligibility criteria.
- Place an end date in the participant's record in PPS.
- Enroll participants in EES.

1. In 2025, the CLTS program will further develop community partnerships and expand program awareness. This will involve partnering with a network of providers who service CLTS enrolled children, including Autism treatment providers and other community-based organizations, to promote CLTS services and ensure families are informed.

2. As measured by the 2025 internal audit, the CLTS program staff will achieve 86% or higher score that Functional Screens were completed timely. Wisconsin's Functional Screen system is a web-based application used to collect information about a consumer's functional status, health, and need for assistance for various programs that serve people who have intellectual, developmental, or physical disabilities, or have mental health and substance use disorders. CLTS program staff receive extensive training and become certified screeners to access and administer the exam.

3. CLTS program staff will demonstrate an achievement of 86% or higher performance rating for the timely completion of the CLTS Child and Family Needs Assessment as evidenced by the 2025 internal audit. This assessment provides the foundation for developing a consumer's outcomes, or goals, the services and supports to address those outcomes, and response plans and/or backup plans to minimize risks to the participant's health and well-being.

4. An ongoing goal for the CLTS program staff is to continue building their Motivational Interviewing (MI) skills. Prior to their annual performance review, each team member will submit a recording of their consumer interaction for coding and coaching. The CLTS team will engage in MI skill building activities as available through the agency.

COORDINATED SERVICES TEAM/WRAPAROUND

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

Program Description and Updates

Jefferson County's Coordinated Services Team (CST) is an intervention and support model that is overseen by the Department of Health Services and offers participants a team-centered, strengths-based assessment and planning process. CST is also referred to as Wraparound, or the Wraparound program. The terms are synonymous and either can be used when referring to the program. For the purposes of the annual report, the term most used will be CST.

The vision of CST is to implement practice changes and system transformation. This occurs by developing a strengths-based system of care driven by a shared set of core values, which is reflected and measured by the way CST providers interact and deliver support and services to families involved in multiple systems of care such as child welfare, youth justice, mental health, special education, and substance use. In 2024, CST provided care coordination to 30 youth and had 45 new referrals, which is 25 more referrals than we received in 2023. When screening the family for CST services it may be determined that the child and family may require intensive mental health services not offered through the CST process. When this occurs, these referrals are staffed internally; and depending on the service needs of the family, they may be referred to programs such as Children's Long-Term Support, Comprehensive Community Services, Community Support Program, or the Mental Health Clinic due to the higher level of mental health need.

The CST team is comprised of two care coordinators, one community outreach worker and is supervised by the Youth and Family Services Supervisor. Each youth and family have a plan of care tailored to their unique needs and use their strengths to build up their areas of need. The youth participate in activities throughout the year to demonstrate and practice utilizing the skills that the team is building upon and teaching. The team has the ability make these activities fun and in conjunction with other youth in the program. The CST program is funded by the Wisconsin Department of Health Services and through Targeted Case Management billing.

COORDINATED SERVICES TEAMS CORE VALUES:

- FAMILY CENTERED
- CONSUMER INVOLVEMENT
- BUILDS ON NATURAL AND COMMUNITY SUPPORTS
- STRENGTH BASED, UNCONDITIONAL CARE
- COLLABORATION ACROSS SYSTEMS
- TEAM APPROACH ACROSS SYSTEMS
- CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES
- ENSURING SAFETY
- GENDER/AGE CULTURALLY RESPNOSIVE TREATMENT
- SELF SUFFICIENCY
- EDUCATION AND WORK FOCUS
- BELIEVE IN GROWTH, LEARNING AND RECOVERY
- OUTCOME ORIENTED

Fun CST Activities in 2024

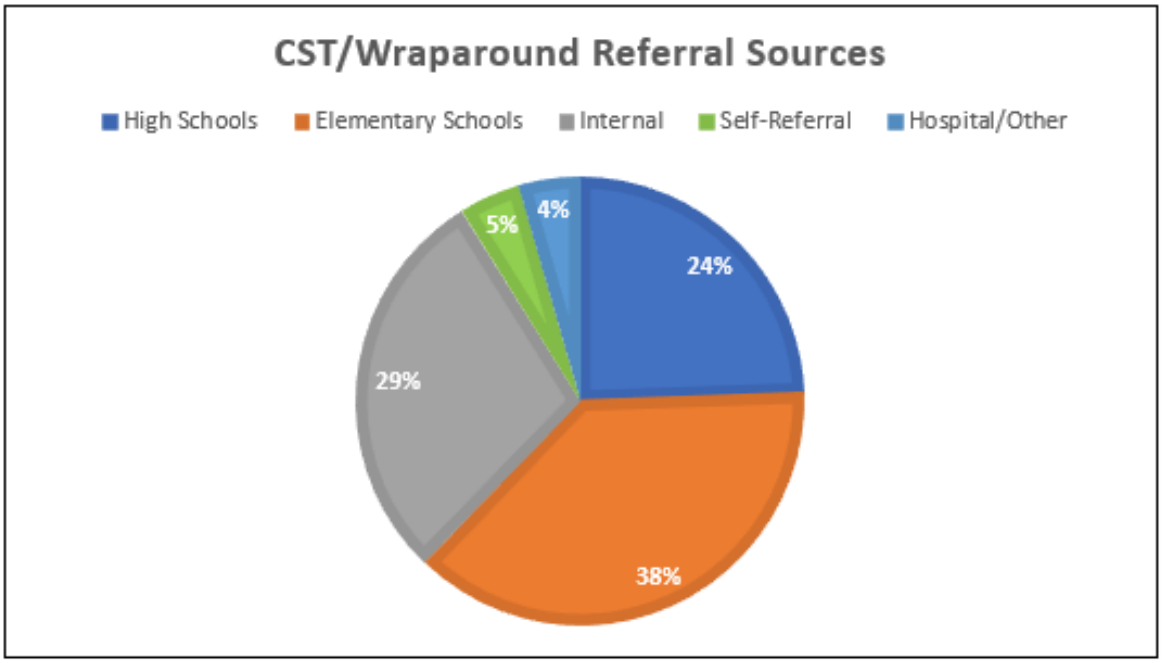
The CST program is dedicated to creating opportunities to support families with children with specialized needs. In 2024, the team provided two Family Fun Nights in two different communities for families to come together for fun, food and friendship. The events were funded by additional financial resources offered by DHS and were a huge hit. Kids, parents and CST team members alike had a blast playing games, getting to know each other and making crafts and cookies. In addition to the many positive outcomes experienced by the families who attended, the CST was able to discuss the Wraparound Coordinating Committee to generate possible interest in joining the committee by attending meetings and providing parent voice to the program, something we value and would be grateful to have as part of the group.

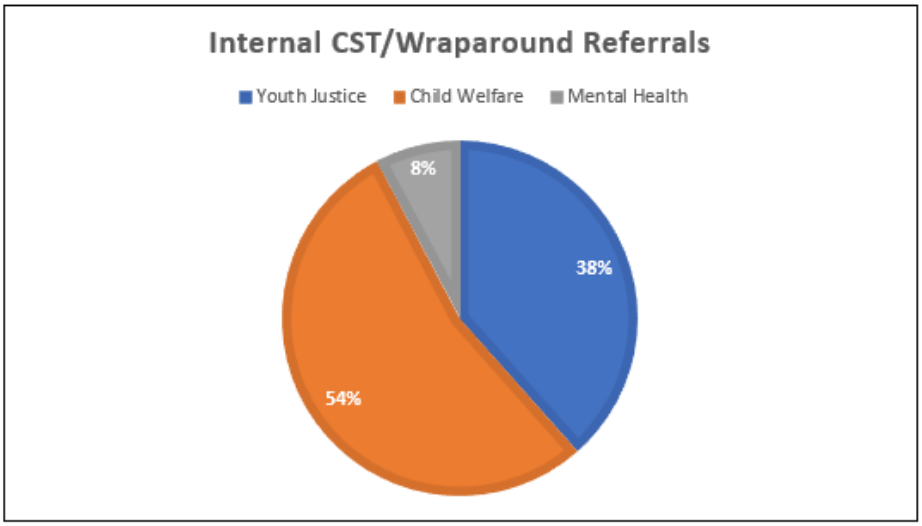
Jefferson County CST members also provided a new evidence-based social skills curriculum called “Strong Kids” to elementary aged children in Jefferson County. Workers taught the first group in July, delivering the curriculum to three youths from the CST program who live in Lake Mills. The second group was held at Jefferson County Human Services and began in September. That group included five youths from CST and Children’s Long Term Support programs.

There were many other skill building activities that CST delivered to the children and youth who were part of the program in 2024. All three team members provided community outreach activities to the kids. Some examples of these activities included teaching kids how to cook, budget, manage emotions, spending free time productively, choosing good friends, completing job applications and performing other independent living skills. Workers also helped parents develop daily routines, meal plans, reward systems and find creative ways to spend time as a family when time is limited, and stress is high.

Referral Sources

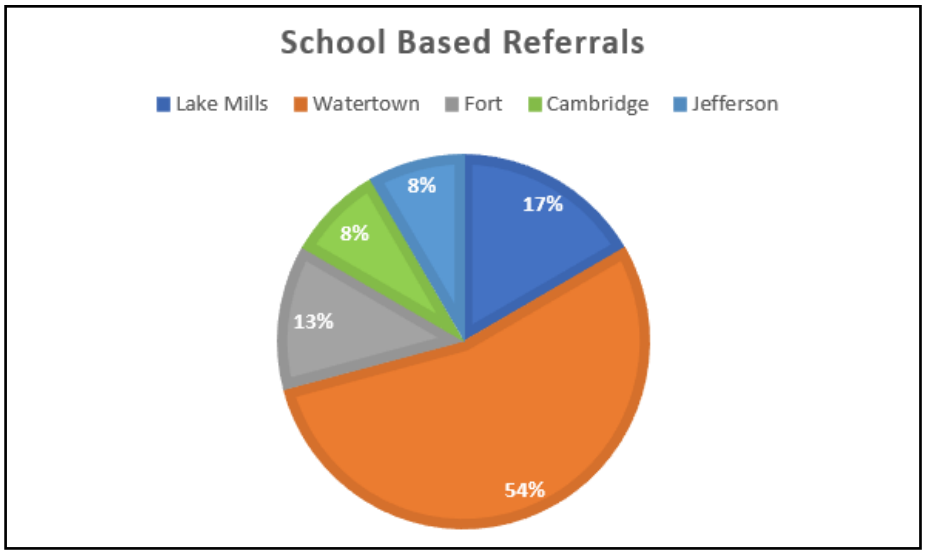
Referrals are received from internal programs and external sources. As you can see from the graph below, more than half our referrals came from our local schools, mostly elementary and high schools. Additionally, a little more than 1/3 of our referrals came from internal programs at Jefferson County, such as Youth Justice and the Community Response Program. We did receive one referral from a hospital and two referrals directly from the parent or caregiver. This year we received referrals from five different school districts throughout the county: Watertown, Fort Atkinson, Jefferson, Lake Mills and Cambridge. This is one more district than last year, showing that our outreach efforts are making a difference. All referrals are received and screened utilizing a Family Centered approach that relies on parent participation. The CST/Wraparound team is dedicated to delivering the program message of hope and help to different members of the community and is committed to increasing the number of community-based referrals moving forward, meaning originating from outside of Human Services.





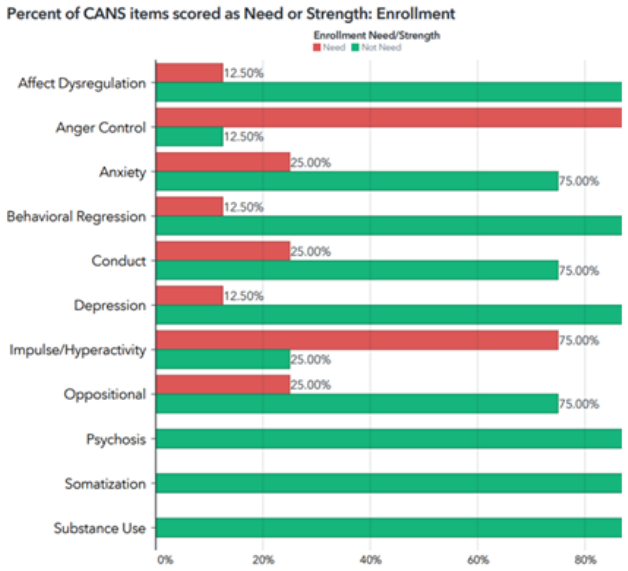
The graph on the top left shows where internal referrals are typically received. Most of our internal referrals are diversionary in nature, meaning, they are meant to keep families out of formal systems, such as Child Protective Services or Youth Justice.

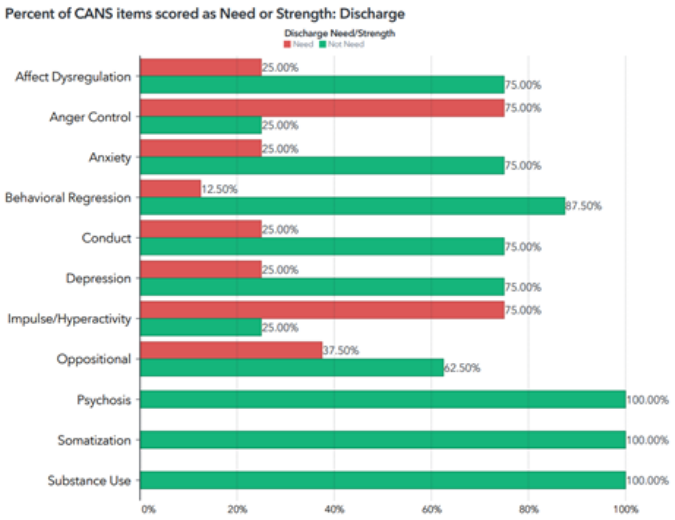
The graph directly underneath breaks down which school districts in Jefferson County referred families to the CST program in 2024. All these districts have great participation in the Wraparound Coordinating Committee.



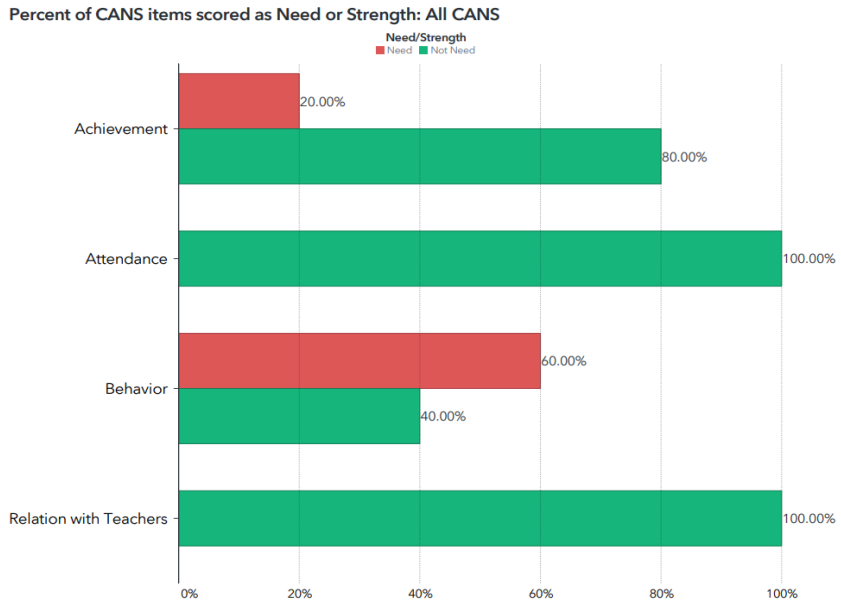
Jefferson County Coordinated Services Team CANS Assessment Outcomes for 2024

Youth and families are assessed with a comprehensive tool called the Child and Adolescent Needs and Strengths (CANS) tool and this data is reported to the State DHS at enrollment and disenrollment to monitor their progress. Youth and families are rated on a 4-point scale as to the severity of their needs or level of their strengths. Information gathered from the 2024 CANS administered on youth who were enrolled and served in the program can be found on the next two pages. The graphs highlight needs and strength areas at enrollment versus case closure of those youth who were discharged in 2024. Additionally, the graphs on the next two pages give a picture of the needs and strengths of the youth served in the program in 2024.



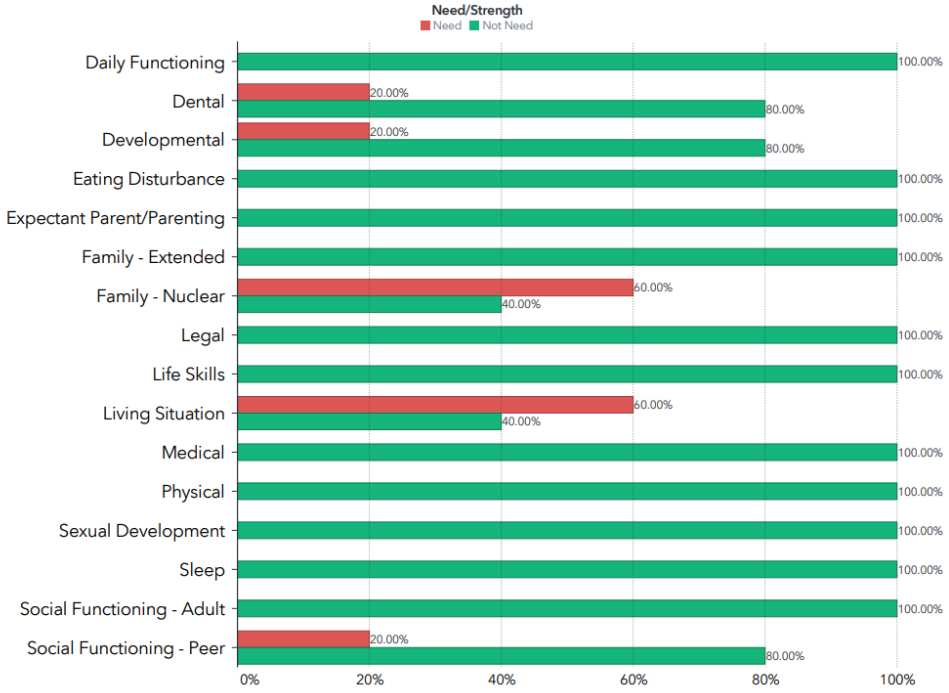


The graphs above display the CANS areas of strengths and needs upon enrollment and again at discharge from CST. Though there was not a lot of movement in the youth who were discharged from the program in 2024, the graphs do show a decrease in risk in anger control and an increase in strength in this area. There was slight increase in risk in oppositional behaviors with a decrease in strength in this area.

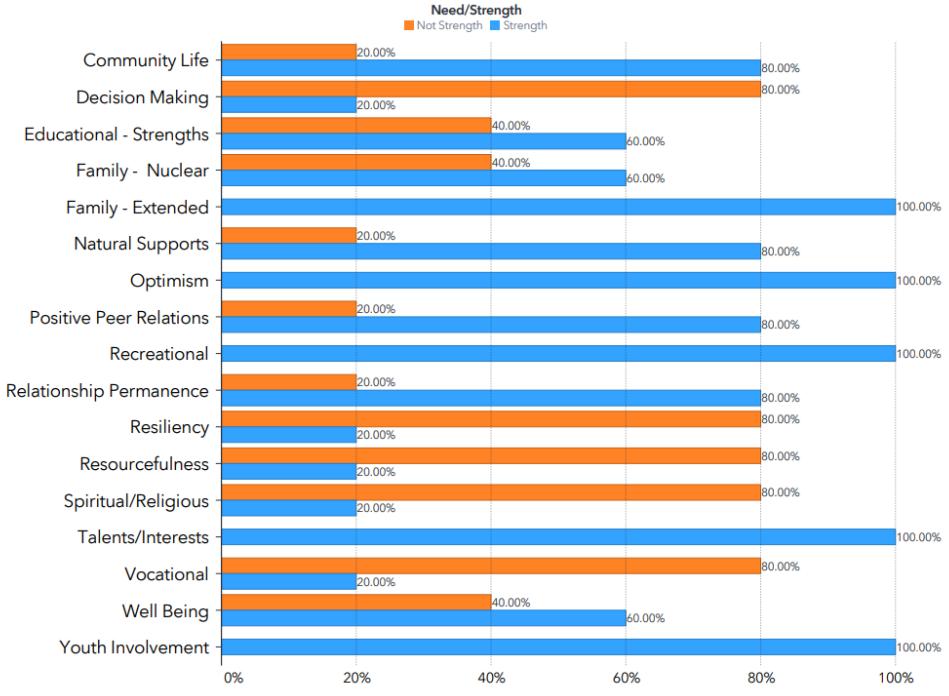


The graph to the left depicts what the children and youth served in the CST/Wraparound program struggle with as well as where their strengths lie, according to the CANS tool. These are common areas of life that lead to a CST/Wraparound referral.
As demonstrated, a small percentage of youth faced challenges with academic achievement, while more than half of the program participants showed needs in the area of behavior.

Percent of CANS items scored as Need or Strength: All CANS



Percent of CANS items scored as Need or Strength: All CANS



The chart to the left shows the needs and strengths of the children and youth served in the program in 2024. Though there are many strength areas, there are also areas of need, including in the areas of dental, developmental, nuclear family support, living situation and peer functioning in a social situation. It is noted that multiple program participants experienced unstable housing in 2024, something for which CST/Wraparound provides assistance.

The CANS tool contains a specific section in which youth strengths are measured. The second graph shown in blue and orange depicts areas where strengths are identified in the 2024 program participants. As you can see, Community Life, Optimism, Recreational, Talents and Interests and Youth Involvement are all high strengths areas; and these are skills the workers in the program focus on by offering community events and social skills groups.

Review of 2024 Goals:

Key Outcome Indicator: **To enhance knowledge of the program and increase community-based referrals, the CST team will share information regarding wraparound services to a minimum of one community partner agency each month.** The team shared information regarding the CST program to 16 different community agencies/organizations. This was profound, as it led to a 46% increase in total referrals received in 2024 (compared to 2023). ***This indicator was met.***

1. The Coordinated Services Team will host at least 2 Family Fun Nights throughout the year to provide an opportunity for youth and their families to spend quality time together as well as to increase parent engagement in the CST process. ***This goal was attained.*** The CST hosted an event for families being served in the CST program in August in Lake Mills and again in December at Jefferson County Human Services. These events were well attended, and the feedback was incredibly positive.
2. The Coordinated Services Team will teach an evidenced-based Strong Kids curriculum to improve the social emotional learning of CST youth of the appropriate age as evidenced by an average score of 80% on the final knowledge test. ***This goal was attained.*** The first Strong Kids group began in in July and included three youth from the Wraparound program. The second group began in September and included five youth from Wraparound and CLTS programs. The average score of the groups was 82.5%.
3. To increase youth voice in programming, the Coordinated Services Team will acquire youth feedback on a variety of topics and integrate at least three ideas to continue to create an environment where youth feel valued and heard. ***This goal was attained.*** The team solicited feedback from some of our youth at a focus group session as well as at various outreach and social skills events. They did provide feedback for our Family Fun Night events, and those suggestions were considered and/or included in those.
4. 75% of eligible youth will complete a program satisfaction survey by October 31, 2024. ***This goal was not attained***. 52% of eligible youth completed a program satisfaction survey by October 31, 2024.
5. To keep Diversity, Equity and Inclusion and Belonging as a priority and ensure it is infused in programming, the Coordinated Services Team members will take turns delivering transfer of learning activities at least monthly to each other in team meetings and share learning experiences at quarterly Coordination Committee meetings, which will be reflected in the meeting minutes. ***This goal was attained.*** The team shared Diversity topic transfer of learning activities 6 out of 12 months during team meetings and shared information on a diversity topic to the Wraparound Coordinating Committee, which all members of the CST attended, five additional months of the year. There was only one month out of 12 that did not feature a shared Diversity transfer of learning activity.
6. To ensure that the Coordinated Services Team is making progress toward proficiency in Motivational Interviewing (MI) skills, each team member will submit a recording for a coaching opportunity. Additionally, CST team members will participate in any agency-wide professional development activities. ***This goal was attained.*** All team members completed this goal.

Goals for 2025:

Key Outcome Indicators**: The Coordinated Services Team will coordinate a monthly service activity in 2025 that integrates children and/or their families into the community. The Community Response Program will perform an activity each month that is designed to deliver information about local prevention resources to families or organizations that work with families not at the Child Protective Service level.**

1. To guide and grow the new CYF Prevention Services unit, team members will create a program vision statement by March 31, 2025.
2. To better define the strengths and needs of the families in Jefferson County, the CYF Prevention Services unit will complete a gaps and strengths analysis on community resources by June 30, 2025.
3. To guide and grow the new CYF Prevention Services unit, the team will work together to identify the steps to begin building a 5-year strategic plan by June 30, 2025.
4. To message the new CYF Prevention Service unit's vision, philosophies and service array, team members will create a marketing plan with activities, steps, costs and funding proposals and present it to leadership by September 30, 2025.

5. To enhance opportunities for families who utilize the Prevention Services programs, unit team members will brainstorm ideas and develop a fundraising plan by September 30, 2025.
6. To ensure the current Wraparound plan of care is easy for families and team members to understand and navigate, team members will solicit feedback about the current document and suggestions for improvements from stakeholders by September 1, 2025.
7. To create a smoother transition for youth moving from CST to another program, Wraparound team members will collaborate with other teams in the agency to provide education on wraparound principles and practices, facilitate discussions about how that could benefit their consumers and subsequently pilot a program that maintains enrollment for families in CST who are referred to CCS or CLTS on a case-by-case basis and wish to continue in Wraparound.
8. Each team member will continue to work toward achieving proficiency in Motivational Interviewing, as evidenced by the submission of a tape or tapes that are coded to proficiency or demonstrate improvement.

INCREDIBLE YEARS

Incredible Years Parenting Series Program and Incredible Years Social Skills Group

Incredible Years Parenting Class and Program Description

The Incredible Years (IY) Parenting Series Program and Incredible Years Social Skills Group provide evidence-based interventions designed to support parents, children, and educators. These programs focus on addressing behavioral challenges while fostering the social, emotional, and academic growth of children. Backed by over 40 years of research, the program is inclusive of all cultural and economic backgrounds. In Jefferson County, the initiative offers eight tailored parenting classes that span various age groups and topics, ensuring that the diverse needs of the community are met.

Additionally, Social Skills classes (using Incredible Years social skill companion curriculum) are available to children receiving limited services through Jefferson County Human Services, as well as in select elementary schools. The CST/Wraparound staff coordinates both the parenting and social skills classes, ensuring these vital resources are accessible to community members, those referred through the court system, those receiving services at JCHSD and to parents and children that are at risk of further interventions. To remove barriers to participation, such as childcare, transportation, and meals, the program collaborates closely with other Human Services staff, interns and volunteers. Moreover, partnerships with community stakeholders are integral to the program's success, providing vital support in the form of venue arrangements, financial contributions, and other resources, making the program more accessible and effective for all participants.

Incredible Years Parenting Series

The parenting classes, led by the CST/Wraparound staff in collaboration with Community Response Programming (CRP) staff, are designed to cater to various age groups, from infants (0 years) to children over 12. These classes also offer specialized sessions focusing on autism, advanced parenting (with an emphasis on co-parenting and communication strategies), and supporting children's educational journeys. Typically spanning 10 to 18 weeks, each session lasts two hours and provides valuable, in-depth guidance for parents. The Incredible Years Program collaborates closely with the CRP program to ensure parents have access to valuable parenting information. One of the services provided by the CRP Parent Coach focuses on parenting support. This support may include individualized one-on-one IY parenting sessions in-home, which can serve as a temporary solution until parents can attend the formal class, or as an alternative for parents who are unable to participate in the class for various reasons or for maintenance after the class is completed. This service is especially beneficial for parents who require extra help and struggle with learning through traditional methods. It offers the opportunity to engage with the curriculum both individually and in a group setting, helping parents better process and apply the information while receiving additional support from other parents.

Regardless of the way a parent receives IY, throughout the course they will be equipped with practical, positive parenting techniques to strengthen family dynamics and decrease the need for formal interventions. These include fostering bonding and attachment, honing communication and social/emotional coaching skills, setting clear boundaries, establishing routines, and addressing misbehavior. By instilling these tools, the program empowers parents to confidently create a nurturing home environment, reduce the reliance on harsh discipline and promote healthier, more constructive relationships. Ultimately, the goal is to decrease the need for more intensive interventions while supporting positive outcomes for families and their children.

In 2023, one of the CST staff began the process for certification in the Incredible Years. This process can take years to complete to meet and full fill all the criteria. In early 2024, the staff was awarded the facilitation certification in IY. This is the only Incredible Year facilitation certification currently in Wisconsin.

Overview of IY Parenting Classes offered in 2024

In 2024, five IY parenting classes were provided for 92 parents, which is one class less than in 2023. This reduction occurred because no classes were held in partnership with Watertown Family Connections, as there was no identified need for baby classes this year, unlike the previous two years. The availability of classes is determined by factors such as demand, the number of referrals, and parent interest. Additional considerations include the time of year, school breaks and activities, weather, the need for childcare, and the locations of parents when scheduling and offering classes.

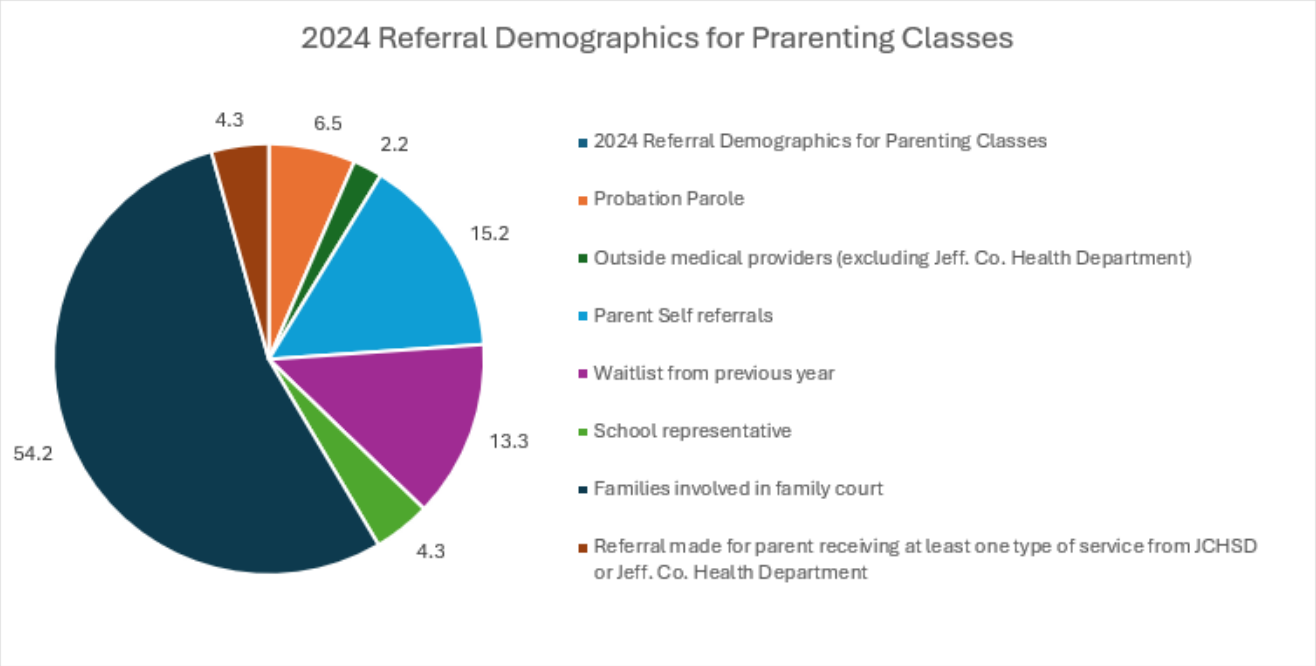
Incredible Years 2024:

When classes were held	What classes were offered	Demographics of classes held
February	1-3 Years Toddler Class	15 parents offered the class 10 parents registered to attend the class 8 parents attended at least one class 6 parents attended 50% or more of the classes
February	6-12 Years School Age Class	22 parents offered the small group 11 parents registered to attend 8 parents attended at least 1 class 6 parents attended at least 50% of the class
July	3-6 Years Pre-School Age Class	16 parents were offered the class 12 parents registered to attend the class 12 parents who registered attended at least one class 6 parents attended at least 50% the class
August	1-3 Years Toddler Class	18 parents were offered the class 10 parents registered to participate in the class 10 parents registered attended at least 1 class 8 parents attended at least 50% the class
November (still going due to holiday break)	6-12 Years School Age Class	31 parents were offered the class 13 parents registered to take the class (2 of these parents were previously referred 2024) 6 parents registered and are actively participating in the class

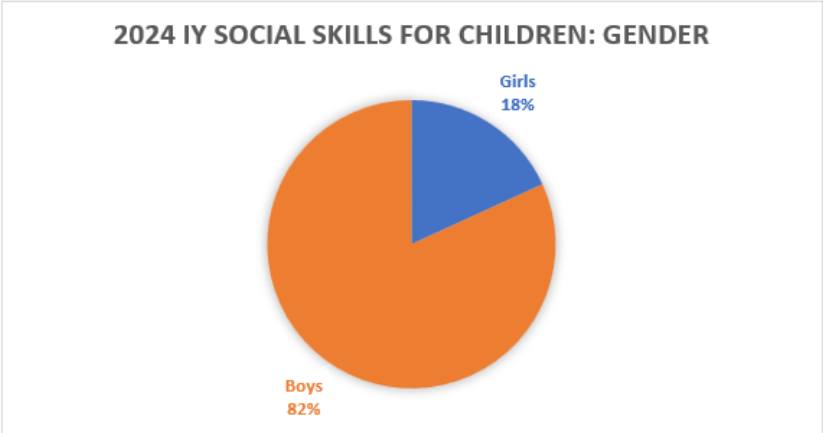
~Classes encourage parents to connect with other parents and enhance parenting skills ~

It is noted that 92 parents were offered an Incredible Years class in 2024, which is an increase of 10 more parents than 2023. Of those 92, 41 of those parents registered to attend a class in 2024 and 45% of parents who registered attended at least one class session in 2024. Additionally, in-home parenting sessions were provided for 14 parents using the Incredible Years curriculum. A total of 14 parents participated in one or more individual, in-home parenting sessions in 2024. Of those 14 parents, two participated in the IY Baby series, five participated in the IY 1-3 Years Toddler series, three participated in the IY 3-6 Preschool series, and four participated in the IY 6-12 Years School Age series. Parents who wish for additional support or instruction, or require accommodations to the traditional class, are provided instruction in this format.

Referrals for Incredible Years Parenting Class come from various sources, as the graph below shows:



Incredible Years Social Skills Group:



The Incredible Years Children's Social Skills group is a comprehensive, interactive, video-based curriculum provided in a small group setting. In a group, children learn social skills, problem-solving, and develop strategies to manage emotions in a healthy way. This enables children to have reduced behavioral issues, a decrease in the need for interventions, and enables them to become emotionally competent. Group leaders communicate weekly with each student's parents, teacher, and school social worker, to promote the transfer of learning both at home and in their classroom. The group is designed to meet weekly for 2 hours over a period of 18-22 weeks. When the group is facilitated in a school setting, the curriculum is modified so that it can better align with the students' academic day. The class is therefore taught weekly for 40 minutes over a period of eight weeks. The topics that are covered are based on the particular needs of the students in the group. In 2024, IY Social Skills group was taught to a total of six 1st graders in Lake Mills Elementary School and five 3rd grade students at West Elementary School in Jefferson. The graph to the right breaks down some of those demographics.

Review of 2024 Goals:

1. Incredible Years facilitators will teach two modified eight-week sessions of Social Skills for Children in Jefferson County school districts. ***This goal was attained.*** Incredible Years facilitators were able to teach two modified eight-week sessions of the social skills curriculum at two different Jefferson County schools in 2024. Both sessions took place between April- June 2024. One class was taught at Lake Mills Elementary in Lake Mills, WI. This class was comprised of six first grade students. Four of those students were male

and two of those students were female. The second class was taught at Jefferson West Elementary in Jefferson, WI. This class was comprised of five male students in third grade.

2. IY parenting facilitators will host at least one class in the community. ***This goal was not attained***. After this was explored, the decision to continue hosting all classes at Human Services was made due to its central location for parents who were referred to the classes. This location also facilitated easier childcare support for participants. As a result, no classes were held directly in the community, but the overarching program's intent of accessibility was addressed through the building's location, use of gas cards and ability to provide childcare.
3. IY parenting coordinator will reach out to at least one new community organization to explore one new alternative option for childcare support. ***This goal was attained.*** The coordinator did reach out to community organizations, and while this did not result in new childcare support options, this effort led to other positive outcomes that included new parent referrals, the posting of the class flyer, and the possibility of hosting a class in a new venue. While the primary goal related to childcare wasn't fulfilled, there were indirect benefits that contributed to program growth and visibility.

2025 Goals:

1. IY facilitators will offer one IY Class in Spanish.
2. IY facilitators will host at least five classes with at least one being held in the community.

THE INTAKE UNIT

Who We Are

The Intake Unit is comprised of one Access Worker, five Initial Assessment Workers, one Juvenile Court Intake Worker, one Youth Justice Prevention Worker, one Family Advocate, one Parent Coach, and the Intake Unit Supervisor.

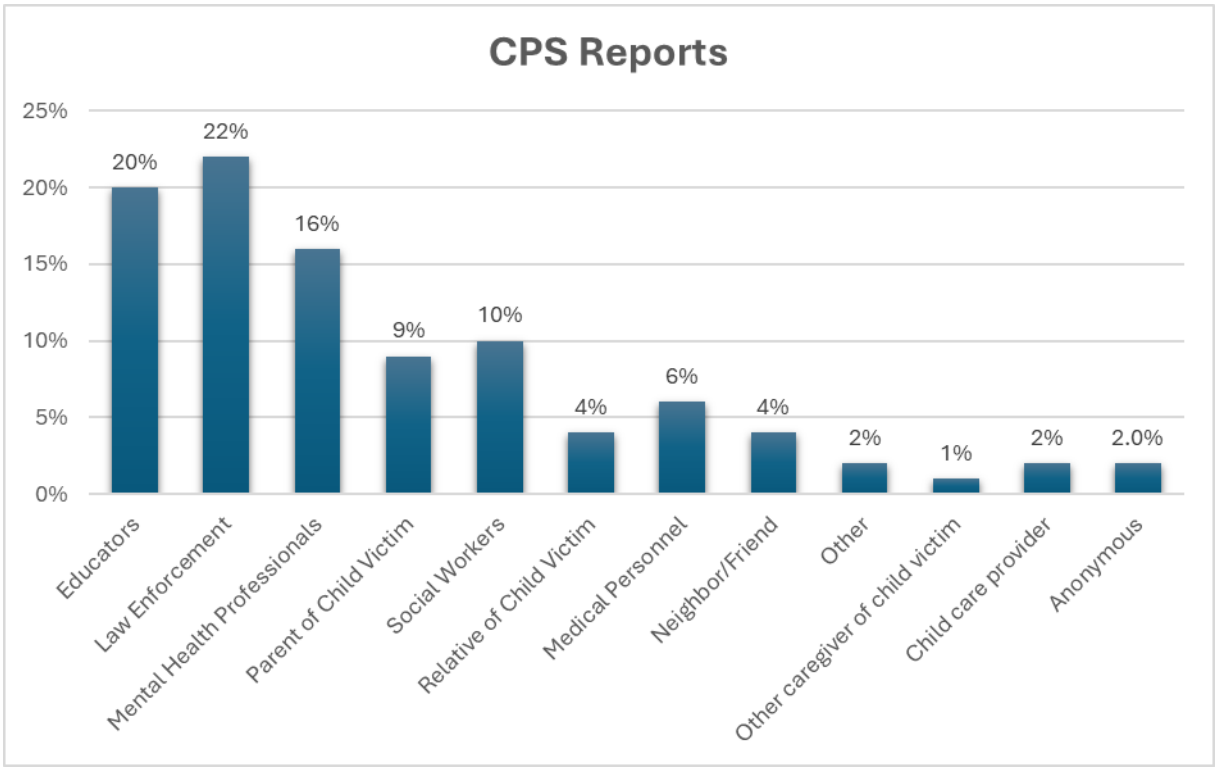
What We Do

The Intake Unit is the point of access for interventions and services for children, youth, and families in Jefferson County. The Intake Unit carries out many responsibilities, including:

- Receiving Access Reports
- Conducting Initial Assessments
- Processing Truancy and Youth Justice Referrals
- Carrying out Youth Justice prevention efforts
- Carrying out Community Response Programming
- Conducting multi-disciplinary team meetings and mandated reporter training in the community

An Overview of an Access Report

The Intake Unit is responsible for receiving and screening Access Reports, which are also known as CPS Reports. A report can be made by anyone at any time, and can be made by phone, letter, fax, email, or in person. The following graph shows the ratio of reports received in Jefferson County in 2024 by both mandated and non-mandated reporters. As the graph shows, most reports received are made by mandated reporters, with reports by law enforcement and school personnel consistently being the highest. This is encouraging as it demonstrates that our Children in Crisis Response Guide and ongoing collaboration with community partners continues to promote awareness and prevention efforts for the safety and wellbeing of children in Jefferson County.



The following outlines the total number of CPS Reports made to our Intake Unit for the past five years, as well as how many were screened in for Initial Assessment. As the data shows in the last two years in 2023 and 2024, there has been a decrease in Screen in CPS Reports. Specifically in 2024, there was a 10% decrease in CPS Reports made. Statewide there was a 3% decrease in CPS Reports made. It should be noted that there were 179 Child Welfare Reports combined with Community Response Program as well as Initial Assessment to move forward prevention efforts with families. Along with this there was a shift in 2024 for educators to Mandated Supporting of families instead of Mandated Reporting. This was done to try to align the need to the family first and get them services prior to making a CPS Report. All these efforts one could conclude are reasons for the decrease in the number of CPS Reports made.

	2020	2021	2022	2023	2024	Jefferson County	State of WI
Screened In CPS Reports	265	279	233	196	167	25%	28%
Screened Out CPS Reports	551	564	522	537	492	75%	72%
Total CPS Reports Made	816	843	755	733	658	100%	100%

One might question why approximately only a fourth of CPS Reports made are screened in for CPS intervention. It is important to know that families have the right to parent their children as they choose so if the reported allegations, even if true, would not meet the statutory definition of abuse or neglect, then CPS intervention cannot occur. If it is determined that the report does not meet the legal standards of child maltreatment or threatened maltreatment to warrant CPS intervention, voluntary outreach to a family may still be attempted by way of a Services Report or a referral to our Community Response Programming.

An Overview of an Initial Assessment

An Initial Assessment is typically known as a CPS investigation. As mentioned, an Initial Assessment can only be conducted when allegations rise to a level of maltreatment or threatened maltreatment as defined in Wisconsin State Statutes and CPS Standards. The purpose of this intervention is to ensure child safety while also partnering with families to meet their needs to enhance parental protective capacities and improve family functioning.

Allegations of neglect continue to be the most reported, and the most investigated, type of maltreatment. Of the 167 screened in CPS Report, 104 screened in reports had allegations of neglect. Approximately one-third of Initial Assessments completed involve allegations of drug or alcohol abuse by a parent and/or exposure to controlled substances by a parent, and drug and alcohol use by parents is the primary cause of neglect and unsafe findings for their children.

Jefferson County established the Children in Crisis Response Guide in 2019. This Guide helps ensure early intervention, coordinated investigation, assessment of safety, and the provision of supportive services to victims and their families. The Initial Assessment Workers work the closest with the Drug Task Force on these cases and this strong partnership has also been instrumental in not only providing awareness and training on the Guide, but also in providing awareness and education on drug trends in Jefferson County. The following data represents the drug seizures (in grams/dosage units) conducted by Jefferson County Drug Task Force over the past seven years. It should be noted that many of the seizures are down for 2024, however, this was explained by the Drug Task Force that they have been working with another entity on a complex case, as well as, in the years past they had one or two significantly high amounts of cocaine, and marijuana found in homes.

In 2024, Multidisciplinary Team Meetings continued to be held on a quarterly basis, focusing on case reviews and providing further education on topics such as Domestic Violence and Sex Trafficking. The two co-chairs for the Children in Crisis continue to provide community awareness to mandated reporting. In 2024, the Intake Unit completed a total of 9 Mandated Reporter Trainings. The trainings included 5 Jefferson County School Districts, 3 for all of Jefferson County Sheriff's Department Patrol, and 1 to hospital staff in Jefferson County.

The two co-chairs collaborated with Human Services staff to create a Resource Guide for Mandated Supporters. The two co-chairs distribute these handouts during their mandated reporter presentations.

DRUG TYPE	2018	2019	2020	2021	2022	2023	2024
CRACK COCAINE	3.71	99.37	137.22	26.44	43.11	107.38	106.83
POWDER COCAINE	504.67	2341.74	366.48	225.04	170.27	9,266.58	878.75
HEROIN	1.63	9.87	12.34	143.66	1.05	0	0
FENTANYL	0.03	0.69	1081.23	2011.39	43.93	169.707	63.2
METHAMPHETAMINE	15.65	31.13	1402.65	351.86	107.28	377.21	187.66
LSD	0	81.72	93.04	49.71	27.03	0	12
MARIJUANA	8175.38	1157.61	8346.57	31,813.04	11,469.43	11,802.2	2009.67

It is important to note that even when a child is assessed as being unsafe in their home environment, this does not automatically mean the child needs to be removed from the home. In many cases, children can safely remain in their homes with the support of both formal and informal services, resources, and support systems. Research indicates that families are more likely to be successful when children can remain in the home. While a third of Initial Assessments completed involve allegations of drug use, alcohol use, and/or exposure to controlled substances by a parent, most of these do not require placement of children outside their homes**.** A significant reason for this is Jefferson County's use of Targeted Safety Support Funding (TSSF) which continues to support the implementation of concentrated in-home safety plans that control danger threats to child safety that would otherwise potentially require the removal of children from their homes.

The graph below shows our use of this programming for the past five years, which includes how many families have been referred, how many out-of-home placements of children were prevented, and the savings in alternate care costs. Notably, there was a significant decrease in out-of-home placements prevented, which dropped by nearly 50%, resulting in a 55% decrease in savings. One could conclude that the reason for the decrease in families served is due to the decrease in screened in CPS Reports for 2024 by 15%. Along with this, there were a total of 227 children served through screened in CPS reports in 2024, compared to 282 children served through screened in reports in 2023. This is another example of how prevention efforts are positively affecting overall numbers in Jefferson County.

	2020	2021	2022	2023	2024
Families Enrolled In IHSS/TSSF	26	29	35	66	40
Out-Of-Home Placements Prevented	50	62	64	97	58
Savings In Alternate Care Costs	$330,000	$484,344	$768,000	$1,047,600	$481,760

Our Intake Unit always goes above and beyond in meeting timelines and standards, as well as carrying out the best practice for the consumers we serve. The following shows that over the past year Jefferson County was only one of eight counties in Wisconsin that was above 95% in completing timely face-to-face contacts on Initial Assessments, and we were only one of 25 counties that was above 95% in completing Initial Assessments within the required 60-day timeline. In 2024, Jefferson County was one of only three counties in the State of Wisconsin to achieve 100% in completing face-to face contacts on Initial Assessments. In addition, in 2024, Jefferson County was one of only 12 counties to achieve 100% completion of Initial Assessments within the required 60-day timeline. This is a tremendous achievement that reflects the dedication and commitment of the Intake Unit staff to the children, youth, and families we serve.

Timely Initial Contact	Jefferson County	State Average	County Comparison < 95%
2019	97%	80%	1 of 9
2020	97%	80%	1 of 6
2021	97%	80%	1 of 9
2022	98%	79%	1 of 9
2023	99%	79%	1 of 10
2024	100%	82%	1 of 8

Timely IA Completion	Jefferson County	State Average	County Comparison < 95%
2019	100%	68%	1 of 20
2020	100%	73%	1 of 18
2021	100%	75%	1 of 22
2022	100%	73%	1 of 25
2023	100%	75%	1 of 27
2024	100%	82%	1 of 25

An Overview of Delinquency and Truancy Referrals

The Intake Unit is also responsible for processing Truancy Referrals and Youth Justice Referrals, which are generated by schools and law enforcement. Our child welfare and youth justice systems have many parallels and data shows that over 79% of youth referred to Juvenile Court Intake have been involved in the child welfare system. Traditional wisdom would suggest that a punitive and probationary approach is necessary in addressing truancy and delinquent behavior; however, research suggests that a strength-based, family-focused, and trauma-informed approach has better outcomes for youth and their families. Approximately 80% of the youth referred for 2024 in Jefferson County are identified as low to moderate risk to reoffend, and research shows that involving these youth in the formal Juvenile Court system may actually increase their potential to commit further crimes. Only approximately 25% of the referrals processed by our Juvenile Court Intake are referred for ongoing case management, and approximately half of these are under Deferred Prosecution Agreements, which do not require court involvement.

The Intake Unit is also responsible for processing Truancy Referrals and Youth Justice Referrals. Truancy Referrals are made by schools when youth have been habitually truant from school, as defined by Wisconsin State Statute. Delinquency referrals are generated by law enforcement when youth commit criminal offenses, as defined by Chapter 938. Traditional wisdom would suggest that a punitive and probationary approach is necessary in addressing truancy and delinquent behavior; however, evidence-based research suggests that a strength-based, family focused, and trauma-informed approach has better outcomes for youth and their families.

As illustrated in the data below, the number of Delinquency Referrals decreased by 32% this past year while the number of Truancy Referrals received decreased by 68%. The decrease in Delinquency Referrals and Truancy Referrals is notable. In 2024, the Intake Unit worked with our community stakeholders including legal parties, schools, law enforcement, and judges on the Tailored Dispositional Court Orders. During this process, community partners were educated regarding the YASI Assessment Tool and how Court involvement impacts our youth. The Intake Unit along with community stakeholders worked together to identify the underlying reasons for delinquency acts and connect them with appropriate services and resources in the hopes court intervention will not be necessary.

The Intake Unit began our truancy intervention programming and partnerships with schools and families in 2020. In 2024, the Intake Unit and the Youth Justice prevention designee took it a step further and started a Truancy Pilot with Jefferson High School. The Youth Justice prevention designee identified Jefferson High School as a school that had a higher rate of formal Truancy Referrals. This Truancy Pilot focused on high-risk youth identified by the school, and utilizing the WARNS which is an evidence-based assessment tool for Truancy. Our Youth Justice prevention designee helped develop and implement this Pilot. The Youth Justice prevention designee was trained in Check and Connect, which is an evidence-based model that has shown positive results for children with Truancy concerns. The Youth Justice prevention designee has worked with several youths in the last year and has seen significant success with youth that have engaged in the Pilot and Check and Connect. In 2024, there were 9 referrals to the Truancy Pilot Program, and 6 of those youth,

engaged in programming and are having successful outcomes. The Truancy Pilot grant money will continue until June 2025 and will expand to Jefferson Middle School.

It should be noted that even when Truancy Referrals are made, as part of the Intake process, we strive to work with schools and families. Whether under preventative intervention or through the Intake process, such services and resources could include referrals to Diversionary Programming, mental health services, Wraparound programming, or Community Response Programming.

	2020	2021	2022	2023	2024
Delinquency Referrals	196	238	282	230	157
Truancy Referrals	15	36	20	22	7
Total Referrals	211	274	302	252	164

An Overview of Community Response Programming

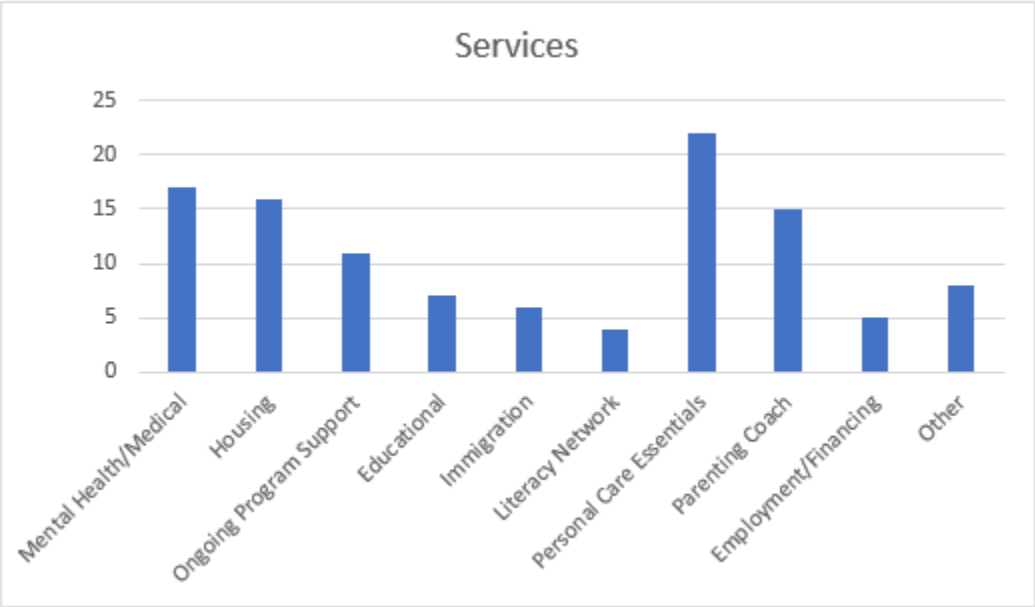
The Intake Unit established its own Community Response Programming in the fall of 2018 and provides voluntary support to families who have screened out CPS Reports or that have been referred to CRP at the close of an Initial Assessment. The overall goal of Community Response Programming is to strengthen families, prevent child abuse and neglect, and prevent families from having re-referrals to CPS. This Programming is vital in prevention, targeting, and engaging these families in services designed to reduce risk factors and promote family strengths associated with child safety and wellbeing. It should be noted that our Community Response Program is one of the few in Wisconsin that is housed within its Human Services Department, which ensures continuity of care and sustainability.

Our Family Advocate and Parent Coach have strong community partnerships and offer direct service or referrals in the areas of domestic violence, vocational assistance, family medical needs, financial support, household or family needs, housing, mental health services, parent education and child development, as well as substance abuse services. It should be noted that our Parent Coach is trained in the evidence based Incredible Years (IY) Parenting Program and provides this in both a group setting, as well as individually with the families she works with. The Parent Coach helped facilitate five Incredible Years Parenting classes in 2024 and provided these classes to 92 parents.

It should be noted that the data reflects numbers for 2024, however, from approximately October 2024 through December 2024, CRP did not accept any new referrals as we had a change in the Family Advocate position and had to go through the hiring process. Despite the brief pause in referrals, there was a large increase in CRP referrals made. There was also an increase in the number of families that accepted services in 2024. Approximately 60% of families referred to our Program do not respond to our outreach. Schools are a large source of referrals to our Program, so we continue to forge our partnerships with school staff who can then assist with introductions with families, which in turn makes families more open to engage in services. Our Family Advocate and Youth Justice Prevention Worker are conducting monthly meetings with almost every school district in Jefferson County to discuss at-risk youth and families, with the hopes of collaborating and providing services at an earlier point to prevent crisis.

	2019	2020	2021	2022	2023	2024
Referrals Made To CRP	109	162	134	132	87	126
Families Who Accepted Programming	40	69	49	60	39	49
Need For CPS Intervention During/After CRP Participation	3	18	2	6	3	1
Need For Formal Court Involvement During/After CRP Participation	0	5	0	0	0	0

The chart below shows the trends in 2024 for services offered to families and the reason for referrals. It should be noted that 15 families were offered home parenting classes with our Parenting Coach. These referrals are Community Response Program families as well as CPS Ongoing families. Along with this, the parenting coach continued to take the lead in the Incredible Years Parenting class. The Parent Coach helped facilitate five Incredible Years Parenting classes in 2024 and provided these classes to 92 parents. The highest service needs for 2024 were housing and medical/mental health services. Housing has been a significant barrier for many families in Jefferson County. In 2024, the Family Advocate collaborated with Community Action Coalition and the Homeless Coalition of Jefferson County to help advocate for these families.



Review of 2024 Goals:

Key Outcome Indicator: **Meet 100% of CPS and Juvenile Justice mandated timelines.** According to DCF reporting, the Intake Unit completed 167 Initial Assessments in 2024. Our performance scorecard for completing Initial Assessments within the mandated 60-day timeline was 100%, whereas the state average was 81.6%. The Intake Unit performance scorecard for successfully completing initial face-to-face contact on Initial Assessments within the screened in response time was 100%, whereas the state average was 81.6%. Data compiled internally indicates that 100% of Juvenile and Truancy Referrals were processed within the mandated 40-day timeline. These indicators ranked among the highest performance in the state. ***This indicator was met.***

1. A continuing goal for the Intake Unit is to maintain compliance with all CPS and Juvenile Justice State and Federal Standards and timelines. ***This goal was attained.*** As previously stated, the Intake Unit completed 100% initial Assessments in 2024 within the mandated 60-day timeline. Along with this, the initial face-to-face contacts on Initial Assessments within the screened in response time was 100%. Juvenile and Truancy Referrals were also 100% processed within the mandated 40-day timeline. The Intake Unit screened 99.54% of calls within 24 hours of the call received, whereas the state average is 93.75%. All Intake standards are looked at when screening Access calls as well as completing Initial Assessments. This is ensured to be completed as there are check boxes with every case that is screened in to ensure that all Federal and State Standards are being met regarding content of Initial Assessments. Juvenile Justice is continuing to practice with YASI Assessment Tool as a guide. All YASI pre-screens are completed at the Intake level as a guide for how to best proceed with a case and utilize the Tailored Disposition Conditions.
2. The Community Response Programming will continue their efforts in strategic planning, outreach, and implementation. Specifically in the areas of conducting and collaborating with school districts for monthly meetings. As part of outreach efforts, the Community Response Program will connect with community networking to discuss what Community Response Program can offer to families. Along with this, the Family

Advocate will continue to gather information about new resources available in the community. Community Response Programming will utilize Targeted Safety Services Funding when applicable in their programming as a source of funding. Community Response Programing Parenting Coach will continue to teach and offer Incredible Years Parenting Classes in the community. ***This goal was attained.*** Our Family Advocate and Youth Justice Prevention Worker are continuing to provide prevention, awareness, and direct work with youth and families. They continue to have monthly meetings with multiple school districts to discuss at-risk youth and families, with the hopes of collaborating and providing services at an earlier point to prevent crisis. Along with this, in 2024 the Family Advocate attended Homeless Coalition meetings as well as had meetings with the Community Action Coalition to collaborate efforts. The Parent Coach continues to take a lead in the Incredible Years Parenting Class. The Parent Coach helped facilitate five Incredible Years Parenting classes in 2024 and provided these classes to 92 parents. Along with this, the Parent Coach continues to do in-home parenting with CRP families as well as CPS Ongoing families. The Parent Coach did utilize Targeted Safety Services Funding when applicable in the parenting classes for families she worked with in 2024.

3. The Youth Justice prevention designee will continue their efforts in strategic planning, outreach, and implementation. Specifically in the areas of conducting at-risk youth school meetings and collaborating with school districts for monthly meetings. The Youth Diversionary Programming will continue to support the Truancy Pilot with Jefferson High School throughout the next year. ***This goal was attained.*** As stated above, the Youth Justice Prevention Worker continues to provide prevention, awareness, and direct work with youth and families. The Youth Justice Prevention Worker has continued to have monthly meetings with multiple school districts to discuss at-risk youth and families. In 2024, there was a Truancy Pilot that was rolled out with Jefferson High School, that has proven to be very successful with youth that engage in programming and Check and Connect. In 2024, there were 9 referrals to the Truancy Program, and 6 of those youth engaged in programming and are having successful outcomes.
4. The Intake Unit will continue its program development and implementation of the Jefferson County Children in Crisis Response Guide through quarterly Multidisciplinary Team Meetings, ongoing outreach, and technical assistance. The Intake Unit will focus on continuing to organize and collaborate with law enforcement and community partners in Mandated Reporter trainings to educate community partners regarding the Children and Crisis Guide. ***This goal was attained.*** Multidisciplinary Team Meetings continued to be conducted on a quarterly basis in 2024, which included case reviews, as well as further education on topics such as Domestic Violence and Sex Trafficking. The two co-chairs of the Children in Crisis Response Guide conducted mandated supporter presentations for law enforcement jurisdictions, school districts, and other community partners within Jefferson County throughout the year. The two co-chairs collaborated with Human Services staff to create a Resource Guide for Mandated Supporters. The two co-chairs distribute these handouts during their mandated supporter presentations.
5. The Intake Unit will continue its support of the Jefferson County Diversity Committee through the implementation of the Strategic Plan, participation in training opportunities, as well as every team member sharing an education transfer of learning at team meetings. ***This goal was attained.*** Throughout 2024, the Intake Unit has had multiple members of the Diversity Committee and for a short period of time, one person of the Intake team was taking more of a lead role on that committee. There is currently one member of the Intake Unit on the Diversity Committee. During 2024, each member of the Intake Unit led a transfer of learning activity at a team meeting each month that focused on diversity, cultural humility, and inclusion. This transfer of learnings promoted safe group discussions on all these areas to better improve our practice with families.
6. An ongoing goal for the Intake Unit is to continue building upon our skillset and proficiency in Motivational Interviewing (MI) through implementation of the tools and skills in our daily practice, as well as monthly reviews of each other's MI recording samples. ***This goal was attained.*** The Intake Unit is engaging with families daily, whether that is written communication, phone, or in-person. Throughout 2024, Motivational Interviewing was done daily to help engage families and meet families where they are at. Consistent with previous years, each of the ten Intake Workers submitted sample recordings that the team peer reviewed

and provided coding and feedback for each individual staff. It should be noted that one of the Intake Staff is also an MI Coach. In 2024, the MI Coach created folders to reference when working with families and works to set MI goals for each individual Intake Worker.

Goals for 2025:

Key Outcome Indicator: Meet 100% of CPS and Juvenile Justice mandated timelines**.**

1. A continuing goal for the Intake Unit is to maintain compliance with all CPS and Juvenile Justice State and Federal Standards and timelines.
2. The Intake Unit staff that are trained in Forensic Interviewing will complete Forensic Interviews according to the Forensic Interview guidelines for not only Child Protective Services cases, but also for our community partners when applicable. To ensure that best practice is followed, peer reviews will be completed with all staff trained in Forensic Interviewing.
3. The Youth Justice prevention designee will improve the effectiveness of prevention services by systematically gathering and analyzing data to identify risk factors, service gaps, and intervention opportunities.
4. The Intake Unit will continue its implementation program of the Jefferson County Children in Crisis Response Guide through quarterly Multidisciplinary Team Meetings. Part of the Multidisciplinary Team Meetings will be devoted to working towards the revision of the Children in Crisis Response Guide and re-signing ceremony. The Intake Unit will focus on continuing to organize and collaborate with law enforcement and community partners who have ongoing child interactions, including medical clinics, schools, and daycare providers for Mandated Reporter Trainings. The materials created in collaboration with the Citizen Review Panel for Mandated Reporter Trainings will be distributed during these trainings.
5. The Intake Unit will enhance their skills, knowledge, and professional development through trainings pertaining to child safety, as well as strengthening protective factors.
6. The Intake Unit will continue its support of the Jefferson County Diversity Committee through the implementation of the Strategic Plan, participation in training opportunities, as well as every team member sharing an educational transfer of learning at team meetings.
7. An ongoing goal for the Intake Unit is to continue building upon our skillset and proficiency in Motivational Interviewing (MI) through implementation of the tools and skills in our daily practice, as well as monthly reviews of each other's MI recording samples.

PARENTS SUPPORTING PARENTS

~ Parent voices are elevated and supported as key partners in the child welfare process and towards systems improvement efforts in order to promote resilient and thriving Wisconsin families, communities and systems. ~

PSP Mission Statement: Parents Supporting Parents cultivates the leadership of Wisconsin parents who have lived experience in the child welfare system to serve as models of hope and sources of support for parents experiencing public child welfare and to shape services and systems that promote child safety, permanency and family well-being.

Parents Supporting Parents (PSP) is an evidence-based model aimed at empowering parents with lived CPS experience as mentors to parents currently involved in the system, while integrating the voice of lived experience into the Wisconsin child welfare system.

What is a Parent Partner Program?

A parent partner program is recognized as a vital approach for supporting parents in navigating the complex child welfare system. This program hires or contracts with 'parent partners' who are parents who have previously experienced the child welfare system and wish to support parents who are newly involved with the system. The goal of a parent partner program is to engage parents more fully in their case planning, provide needed information to help navigate the child welfare system and support parents in working to reunify with their children. Parent partners work collaboratively with case workers to help ensure parents have access to a wide range of services that are respectful of cultural, ethnic and other community characteristics.

The PSP Program in Jefferson County operates at the local level within the county health and human services agency. The program is comprised of three main roles:

- Coordinator, who manages and supervises the team.
- Parent Partners, who mentor families involved in the system
- Clinical Support, a licensed mental health provider who facilitates monthly support for the local team of Parent Partners.

What do Parent Partners do?

Parent Partners support families by:

- Working closely with birth parents to encourage active participation in the case plan
- Attending team meetings, court hearings, and other discussions
- Helping maintain connections between parents and their children
- Assisting in the pursuit of reunification or an appropriate permanency goal
- Providing hope and inspiration
- Collaborating with the team supporting the family

The Parent Partner works as part of a team and receives a lot of training, support, supervision and ongoing opportunities for professional development. During their first year of employment, Parent Partners engage in extensive training which includes a 24-hour Building a Better Future training and 13 other core trainings on the following topics: mandated reporting, confidentiality, ethics and boundaries, CPS 101/Permanency, family interaction, domestic violence, mental health, family team meetings, implicit bias, cultural competency, substance use, trauma, and self-care and resiliency. The Parent Partners also participate in Motivational Interviewing training sessions and the Strengthening Families and Systems class offered through Human Services and they access numerous webinars to increase their knowledge about the child welfare system, trauma-informed care and other topics relevant to their work. As part of their training process, Parent Partners also spend time shadowing CPS Intake and Ongoing staff to learn about the child welfare and court

process and to learn skills related to parent engagement. As the Parent Partner develops and grows in their role, they have the opportunity to participate in local and statewide meetings, committees, trainings and collaboration. The Parent Partners are supported in their work via weekly supervision, monthly clinical support sessions (and individual sessions as needed), and weekly Community of Practice sessions with the Parent Partners from other PSP sites.

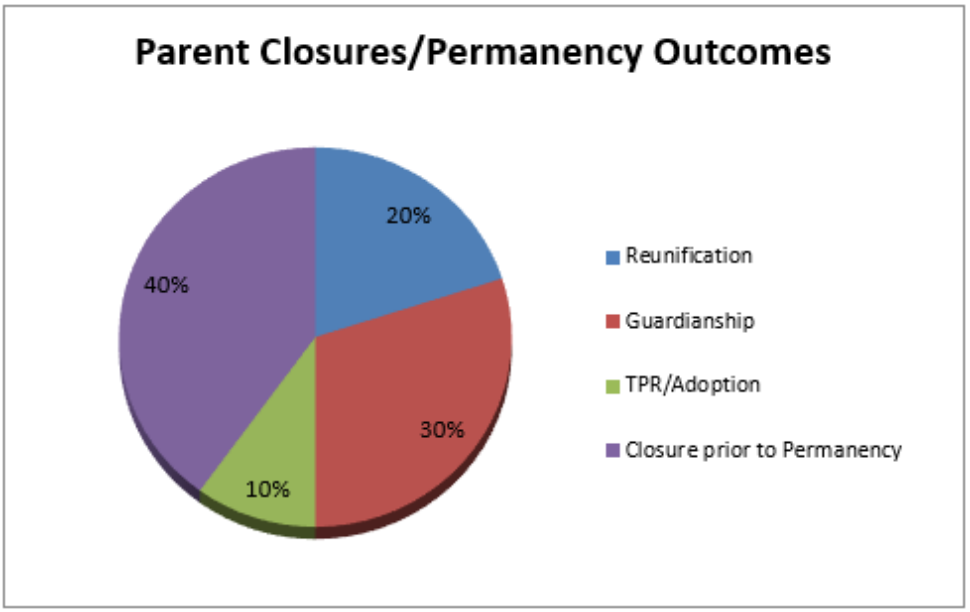
Jefferson County hired its first Parent Partners in February 2021. The PSP Program currently employs three full-time Parent Partners. A full-time Parent Partner can work with up to 12 parents; a part-time Parent Partner is able to work with up to 6 parents.

HOW DOES IT WORK?

Direct Service

Parent Partners provide peer-to-peer support for parents who are currently involved in the child welfare system. A parent is eligible for PSP services if they currently have a child placed in out-of-home care under a juvenile court order. Parents can also be referred if they have an in-home safety plan with a high risk of out-of-home placement and identified need for peer support. Participation in PSP is voluntary, and the program strives to have parents referred within the first 60 days of an out-of-home placement.

The PSP program in Jefferson County began accepting parent referrals in mid-September 2021. At the close of 2024, a total of 33 Jefferson County parents had been enrolled. Of those enrolled parents, 27 have been mothers and 6 have been fathers. Parents are closed to the program once permanency for their child(ren) has been achieved (either via reunification, guardianship or TPR/adoption) or if they request closure or are not engaging in the program before then. The program has closed 20 parents with the closure reasons and outcome rates as represented in this pie chart:



The PSP program operates in four other sites in Wisconsin (Rock County, WellPoint in Milwaukee County, Eau Claire County and Jackson County). The Department of Children and Families oversees all five sites and put out the following data statistics as of September 2024:

- Since 2021, Parents Supporting Parents has served **96** parents, **84** families and **250** children.
- The average length of PSP enrollment is **11.4** months.
- **56** children have exited from PSP with permanency achieved.
- **81%** of parents post-PSP enrollment have not had another screened-in CPS Report.
- **34%** of the children in out-of-home placement reached permanency during their parent's time with PSP. And of that **34%, 95%** of them were reunified with their parent(s) or primary caretaker.
- In the first two years of serving parents (2021 and 2022), Parent Partners spent **756** hours directly serving parents.
- This direct service included **331** face-to-face visits, **182** virtual visits, **94** team meetings, **111** court hearings, and assistance accessing services 80 times.

Local Level

Each PSP site has a Local Advisory Council that promotes outreach and education, and systems change at the local level. The Jefferson County PSP Local Advisory Council was established in Fall 2020. Programs or services that routinely interface with the PSP Program and children and families are represented, including the legal community, schools, community service providers (mental health, AODA, domestic violence, early care and education) and foster care. Council members serve as a liaison between the PSP Program and the agency or program they represent. The Council meets quarterly each year.

The Parent Partners interact regularly with agency CPS staff to discuss parent progress and case status for the parents that they support and have been able to advocate for parent needs and practice considerations during those interactions. The Parent Partners also participate in the Judicial Engagement Team (JET) to lend their voice to court practice improvement efforts and collaboration with child welfare and other system partners.

In 2024, the Parent Partners shared information about the PSP program at community outreach events in Fort Atkinson and Watertown, shared their personal stories and "destructive decisions"-related experiences with the Fort Atkinson High School junior classes, presented to a group of law enforcement officers as part of the Crisis Intervention Training group, and shared their personal stories and participated on a panel about shared parenting at a local foster parent training/conference.

State Level

The PSP Program has a State Advisory Council that guides PSP Program policy, implementation, sustainability, evaluation and key programmatic decisions at the state level. The State Advisory Council members include representatives from each PSP site including Parent Partners, members from the state team, DCF leadership and other system stakeholders. The State Advisory Council meets six times per year. An achieved goal for 2024 was to expand the PSP program to include support to parents on a more preventative basis; specifically, to get a Parent Partner involved when there is an in-home safety plan to provide peer support to parents in a way that will help them mitigate the identified safety threats and prevent their child(ren) from going into out-of-home care.

In 2024, a group of Parent Partners from all PSP sites in Wisconsin presented at the Public Child Welfare Conference and the Peer Recovery Conference, and several Parent Partners lent their lived experience voice to the 2024 Strengthening Families: Exploration of Elements for Successful In-Home Safety Planning Learning Collaborative, a monthly discussion hosted by DCF for child welfare professionals across the state.

These impact staements were collected from those who have experienced Parents Supporting Parents in Wisconsin:

From parents…

"Those first few days when your children are taken from you you're scared you're confused you don't know the first step to make, I'll never forget that first meeting with [the Parent Partner] it really helped set the stage and clear my mind that's where I found my first footing."

"She has been there for me during struggles and obstacles that have came up in my life while in the reunification process. The empathy and hope that she has shared with me has pushed me to keep a positive mindset."

"The Parents Supporting Parents Program has helped make an unbearable situation one of success and positivity. I greatly appreciate all this program and [the Parent Partner] have done for my family and I."

From CPS professionals…

"In my position as an ongoing worker, I've found parent partners to be helpful in bridging the gap between myself and the families that I work with. Not only is it helpful having them at the table when meeting with parents, but working with them behind the scenes to improve my engagement with them as well."

"I appreciate that PSP gives parents an advocate who not only knows the system, but who relates to their story – the emotions, challenges, and changes. Not only does it help parents know that reunification is possible, it an help parents know that sobriety is possible, parenting through difficult behaviors is possible, or being in healthy relationships is possible."

From legal system partners…

"The Parents Supporting Parents program is a valuable resource to families here in Jefferson County. The Parent Supporting Parent advocates often appear in my courtroom. They provide assurance and support to the parents who are facing difficult challenges. The parent advocates are always willing and able to step in where needed when a parent needs assistance, emotional support or someone to answer their questions. When parents feel supported within the system, it helps them advocate for themselves and their families. We are lucky to have such a wonderful program here in Jefferson County."

Judge, Jefferson County Circuit Court

"I have seen the PSP program have a positive effect in Jefferson County. First, the impact this program has had on our Parent Partners is phenomenal! …I have witnessed them present to various groups and share their stories in a way that I never could. Their lives have forever been changed for the better by working in this field. …Second, I know that I personally and professionally have benefitted from this program. I have also seen the benefits county wide of having the perspective of the Parent Partners when setting policy and moving cases forward. …Lastly, I have seen that cases that have a Partner or Partners on board, and where the parents engage with the Partners, resolve more quickly. Most often with a return of the children to their parents but some with TPRs. Watching the Partners support the parents through a TPR is truly moving. Our Partners are so supportive and caring the parent is made aware that they are not alone in the process. Of all the initiatives, this one truly makes a positive impact in the lives of all involved and our system."

Attorney, Jefferson County

Review of 2024 Goals:

Key Outcome Indicator: **At least 50% of CPS cases that involve a child placed in out-of-home care in 2024 will have at least one parent being served by the PSP program.** Monthly data shows that this indicator was met for only 6 out of the 12 months for 2024. The service rates for out-of-home care cases being served by PSP were between 52-53% for the months of January, February, March, September, October, and December. The other months had a service rate between 41-49%. ***This indicator was partially met.***

1. PSP Program staff will work collaboratively with the Department of Children and Families and the Statewide Advisory Council to develop and implement a process to serve parents in in-home, high-risk situations in an effort to prevent children from being placed in out-of-home care. ***This goal was attained.*** The Statewide Advisory Council group met three times in the first half of 2024 to thoughtfully discuss and develop the process and guidelines for in-home referrals. The in-home referral process and service guidelines were finalized in July 2024.
2. The PSP Program will increase the number of PSP referrals for adjudicated fathers who have a child placed in out-of-home care and have more fathers served by the program. ***This goal was attained.*** The PSP program received three referrals for fathers in 2024 and each were opened to the program. This is an increase over the one father that was referred and opened in 2023 and the two fathers referred and opened in 2022.
3. The PSP Program will participate in all required data reporting for the evaluation and overall implementation monitoring, as outlined in the program handbook and model fidelity guidelines. ***This goal was attained.*** The PSP program supervisor enters monthly activity tracking data and completes an agency archival records report every six months as requested by the Department of Children and Families. All data reports were submitted to DCF for 2024.
4. To ensure that the PSP team is making progress toward proficiency in Motivational Interviewing (MI) skills, each team member will submit a recording for a coaching opportunity and identify a professional development goal related to MI to be documented on their performance review. ***This goal was partially attained.*** All PSP staff have completed Levels I and II of Motivational Interviewing training and they participated in team sessions with an MI trainer in 2024 to discuss their use of MI in the field and increase their MI skills. Each staff member has a professional development goal related to MI documented on their 2024 performance review. Not all staff submitted a recording for a coaching opportunity in 2024.

Goals for 2025:

Key Outcome Indicator: **At least 50% of CPS cases that involve a child placed in out-of-home care in 2025 will have at least one parent being served by the PSP program.**

1. There will be an increase in the number of referrals for a Parent Partner for parents involved with in-home safety services CPS cases, with the goal of preventing children from being placed in out-of-home care.
2. The PSP team will participate in Roundtable sessions with the Ongoing CHIPS team, the goal of which to give both teams the ability to gain insight and understanding of how to best serve the families we work with while being able to ask questions of one another in a safe space. There will be a minimum of a Spring and a Fall session.
3. Parent Partners will be utilized as a resource within the agency beyond direct service parent assignments.
4. The PSP Program will participate in all required data reporting for the evaluation and overall implementation monitoring, as outlined in the program handbook and model fidelity guidelines.

5. To ensure that the PSP team is making progress toward proficiency in Motivational Interviewing (MI) skills, each team member will have completed Levels 1 and 2 of Motivational Interviewing training and will identify a professional development goal related to MI to be documented on their performance review.

YOUTH JUSTICE SERVICES

"The Youth Justice Team works collaboratively to provide our families with evidence-based, meaningful, innovative and relationally focused services, that increase positive outcomes, behavioral change and protective factors, while decreasing recidivism and dynamic risk factors."

The Jefferson County Youth Justice Team provides innovative services to at-risk youth in Jefferson County. In addition to our family-based, relationally focused case management services offered to families who are referred through the Juvenile Court System, we also provide programming to families, children, and youth in the community who are at risk of becoming involved in the Youth Justice System. The work we do with our consumers is trauma-informed, treatment-focused, and collaborative with families and other system partners. The Youth Justice Team is a part of the Children, Youth and Families Division and is comprised of the CYF Division Manager, Youth and Family Services Supervisor and seven ongoing family case managers who serve moderate to high-risk youth, diversion youth and students with school attendance issues. The Youth Justice Team recognizes the dignity of each youth and family.

Who We Serve

Juveniles Alleged to be Delinquent* - Includes any person over the age of 10 who is alleged to have violated any state or federal criminal law. Under 1995 Wisconsin Act 77, the general jurisdiction of the juvenile court was lowered from age 17 to age 16. 17-year-olds do not fall under the original jurisdiction of juvenile courts in Wisconsin. More information can be found in Wis. Stats. sec. 938.12.

Juveniles in Need of Protection or Services (JIPS)* - Youth may be alleged to require protection or services if certain conditions apply: JIPS Non-Truancy conditions include a parent or guardian unable or needing assistance to control a young person; a youth who runs away from home; or a youth who commits a delinquent act before age 10. JIPS Truancy conditions include habitual truancy from school. Youth adjudicated JIPS may be referred to for a variety of services, but they cannot be sent to a correctional facility or a secure residential care center. More information on JIPS jurisdiction can be found in Wis. Stats. sec. 938.13.

Youth at risk of being involved in the criminal justice system – Our diversion programming serves families that include one or more youth in a family exhibiting signs that they are at risk of becoming involved in the youth justice system, either through a formal delinquency referral or a JIPS referral. Referrals can come from a variety of sources, including schools, law enforcement, parents, or other providers.

Youth who display school avoidance behaviors or have chronic attendance issues – Our Attendance Improvement Program uses multiple assessment tools to try to find the root cause of chronic attendance issues. Designed to keep students out of the formal JIPS/Court system, the program serves families on a voluntary basis using the Functional Family Case Management model and services designed to meet the needs of this unique population of adolescents.

*(adopted from the DCF Youth Justice data report)

2024 Accomplishments

The Jefferson County Youth Justice team was awarded another Department of Children and Families a Youth Innovation Continuation grant in 2024 to further the work we started in 2022 and 2023 matching services to the needs of youth and families in our program.

2024 Grant Updates

Jefferson County Youth Justice was awarded the final year of the *DCF Innovations Grant* to continue and complete the program enhancements we proposed as part of the original grant we received in 2022. With an emphasis on filling the two remaining identified service gaps of offering more resources for parents and trying new and innovative services to improve outcomes for students with school attendance issues, the team focused their efforts on launching the *CONNECT Attachment-Based Parenting group*, an evidence-based, parenting program that targets families who struggle with how to most effectively parent their adolescent child who exhibits oppositional, antisocial, and difficult to manage behaviors, and the *Attendance Improvement Program*, an innovative approach to addressing school avoidance and refusal that includes an array of service delivery backed by research in what works in truancy service delivery.

- **CONNECT Attachment-Based Parenting Class Launched**

Utilizing funds from the DCF Innovations grant, Jefferson County individuals who were trained in the CONNECT Parenting curriculum met regularly as a group and with the national consultant throughout the first half of 2024 to plan and implement the first group. This included messaging this new program to the various teams who work with parents at Human Services, visiting team meetings and delivering informational sessions to help folks understand what CONNECT is and how to explain it to parents. All that effort paid off, as the first CONNECT class launched in June 2024 at Jefferson County Human Services. Over the course of ten weeks, a group of six parents came together to learn about the principles of attachment-based parenting and how to successfully improve their attachment and connection with their adolescent child. The parents were great participants and made the group so meaningful. The feedback collected after the group was incredibly positive. 100% of group participants found learning about attachment to be very helpful or helpful and 100% of participants felt either somewhat or a great deal more confident in their ability to parent their child as a result of completing the group. The plan for sustainability is to train more workers across the agency to teach this curriculum and eventually send some of the group facilitators to a "train the trainer" session.

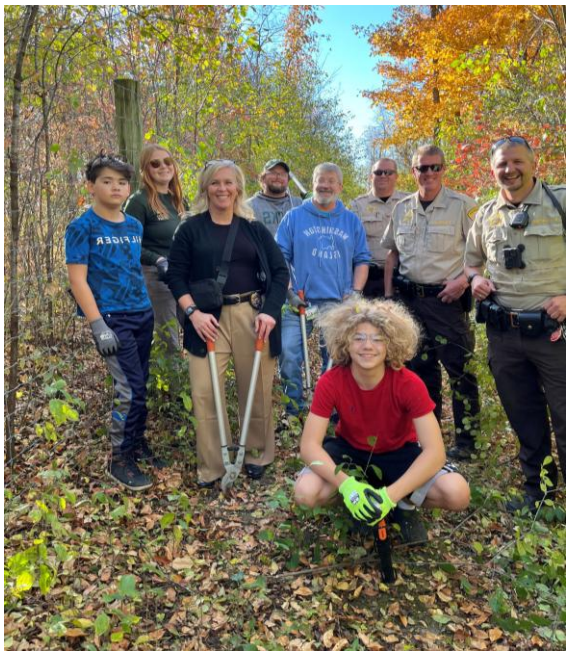
- **Attendance Improvement Program Launched**

Jefferson County combined the Department of Justice year two grant for diversionary programming with part of the DCF year three Innovation grant to launch the Attendance Improvement Pilot program for students who struggle with school avoidance or refusal tendencies. Using a validated assessment tool to determine risk for future school avoidant behaviors, along with additional assessment tools to find the driver of the behaviors and services to enhance the skills of these young people, the goal is to help students get back to school and improve their educational outcomes. The Attendance Improvement Program (AIP) uses a tiered approach to service delivery based on risk level. The ongoing Youth Justice Team has one dedicated worker who specializes in truancy and provides the ongoing services for high-risk students in the AIP. This case manager uses various approaches to address the root cause of chronic absenteeism, including Functional Family Case Management, a family-based, relational model of service delivery to increase hope and decrease negativity and blame in the family system. Incentives to encourage positive steps to improved attendance are also offered, as well as Check *and Connect* mentoring, tutoring and connecting students and family members to needed resources to build critical skills and address mental health and trauma related symptoms that can often lead to school avoidance.

One student in the program improved their attendance rate by 5.2%. Another student raised their attendance rate by 17.4%. These students also improved their credit earning rates from the previous year. A trend we have seen thus far when providing service to high-risk students in the AIP is that there is often mental health issues, complex family struggles, such as homelessness and significant lack of basic resources, and students who require special education services or an alternative educational program that fits their learning style better.

Kickball/Community Partnership Events

A key value of the Jefferson County Youth Justice team is to promote and enhance opportunities for our youth and families to find connections with their communities. Many youth come to us with limited ties to their communities and at times a mistrust of government systems, such as Human Services and Law Enforcement. To encourage positive community ties and relationships with positive adults, the team held multiple events in 2024 designed to build skills and a sense of belonging for our youth. In August, with the generous financial backing of the Jefferson County Citizen Review Panel, the team hosted a fun kickball event for our youth and families in Jefferson that included various Human Services workers from the Youth Justice Team, Children, Youth and Families Division and Parents Supporting Parents program. Additionally, law enforcement officers from Jefferson, Fort Atkinson, Watertown and the Sherrif's Department joined us, as did municipal and circuit court Judges and one of our Assistant District Attorneys. Approximately 15 youth and a few parents came together with all of us for a friendly game of kickball, lunch and a shared sense of community. It was a truly amazing day, enjoyed and appreciated by all. We hope to offer this event annually and expand it even further.



The team also partnered with the Jefferson County Parks Department and law enforcement officers from Watertown and the Jefferson County Sheriff's Department in the fall to clean up sticks and other debris at the dog park. The group removed saplings and other overgrowth along approximately 200 yards of park fences. The youth who attended were afforded a great experience of spending positive time with their case managers and local police officers while giving back to their community by ensuring the dog park, used by many citizens in Jefferson County was in good shape for the dogs to run freely through the park. Afterward, the youth were gifted pumpkins from a local farm and enjoyed some pizza from one of local establishments in Jefferson to enjoy each other's company and build their friendship skills. It was a great experience for all involved, and as with the kickball event, the intention is to offer more of these opportunities moving forward.

Youth Justice Action Month

October is Youth Justice Month (YJAM), a time to spread awareness about the impact of the justice system on children, the history of the youth justice system, the improvements that we have made in the field and the best ways to deliver services to rehabilitate young people who commit crimes. We also take the opportunity in October to raise funds to subsidize positive activities and experiences, such as sports or music camps, equipment for an activity, driver's education classes and fees, birth certificate fees to obtain employment, and others. In October 2024 the team once again offered the "Snack Attack Cart" and singing telegrams to employees around the agency. We also provided the agency with weekly emails that highlighted some element of the principles of YJAM. To the right is an example of one of these emails on the journey of the language we use and why.

The Progressive Era was a time of social and political reform in the **late 19th** and **early 20th** centuries. It had a **huge** impact on kids since, in **1899**, the first ***juvenile court*** was established in Chicago. Its purpose was aimed to rehabilitate youth and protect them from punishment, providing individual treatment and to act as an alternative to adult prison. This era saw a shift in defining childhood to ***include adolescents***, with the state being seen as a **protector of children**. Other Progressive Era reforms included: compulsory school attendance, child labor laws, kindergarten, school lunches, and vocational education!

The Due-Process Era took place in the **1960s** and **1970s**, when the Supreme Court began to extend due-process rights to juveniles. This was a response to the belief that the juvenile justice system was still failing to rehabilitate young offenders. Juveniles now also had the right to legal counsel – including for those who couldn't afford an attorney. They were also given the right to be notified of the charges against them, to confront witnesses, and the Juvenile courts required to prove guilt beyond a reasonable doubt, rather than by a preponderance of the evidence. These great strides opened up even more opportunity for youth-centered programs and services.

The Get-Tough-On-Crime Era was what most understand now as an overcorrection rather than progress. It was a period from the **1980s** to the **1990s** when state lawmakers, driven by a public perception that juvenile crime was increasing and the system too lenient, ***shifted policies*** to focus on punishment over rehabilitation. Incarceration increased as states passed laws making it easier to transfer youth offenders to adult court and correctional facilities. Certain crimes now had mandatory sentences and the use of pretrial detention for juvenile offenders increased. Youth correctional facilities became overcrowded with poor conditions, and there was a ***disproportionate impact*** of this era on ***minority youths***. However, research began to show that interventions like boot camps, increased sentence lengths, and simple incarceration tended to **increase recidivism**, not reduce it. Those studies continue to be reconfirmed to this day!

The Kids-Are-Different Era is where we now find ourselves. The U.S. Supreme Court has recognized that children are different from adults and have different ***needs*** than adults. Several rulings have further protected youth from harsh punishments and once again encouraged rehabilitation over incarceration. The juvenile justice system's current goal is to hold youth accountable for their actions ***while rehabilitating them***, rather than punishing them in the adult criminal justice system. A considerable amount of **new scientific research** has shown that most brains are not fully developed until a person's mid-20s, and that youth are more likely to be impulsive, emotional, and risk-taking. Such discoveries have had a tremendous impact on how the juvenile courts see and respond to kids' needs.

The Youth Justice Team poses for a picture in the YJAM sweatshirts they sold to raise money for youth activities after performing a singing telegram on Boss' Day 2024.

Youth Justice Diversion Programming

The Youth Justice Diversion program is a key piece of our overall programming, as it provides much needed intervention to those lower risk youth who need services and have committed a crime or have been identified as at-risk for system involvement; but to put them through the formal system could increase their risk of further system involvement. Youth Justice Programs across the country have seen similar trends in the youth and families that come into this system. This program offers family-based services, including an assessment of needs and strengths and a case plan designed with the input of the youth and parents. Below is a description of two examples of services offered through the Diversion Program, depending on the needs of the youth. This program does not use the Youth Assessment Screening Instrument, as these youths' participation is voluntary and outside of the formal Youth Justice System.

1. Intensive Collaborative Services

One piece of Diversion Programming is to deliver services quickly to youth who have more intensive needs. The arm of the Diversion Program is designed for youth with a high level of needs, whose behaviors related to complex trauma, mental health, or developmental disabilities present as delinquent acts. Assessment and intensive case management to connect youth and families to much needed community resources are offered to these families to stabilize these youth and prevent further system involvement.

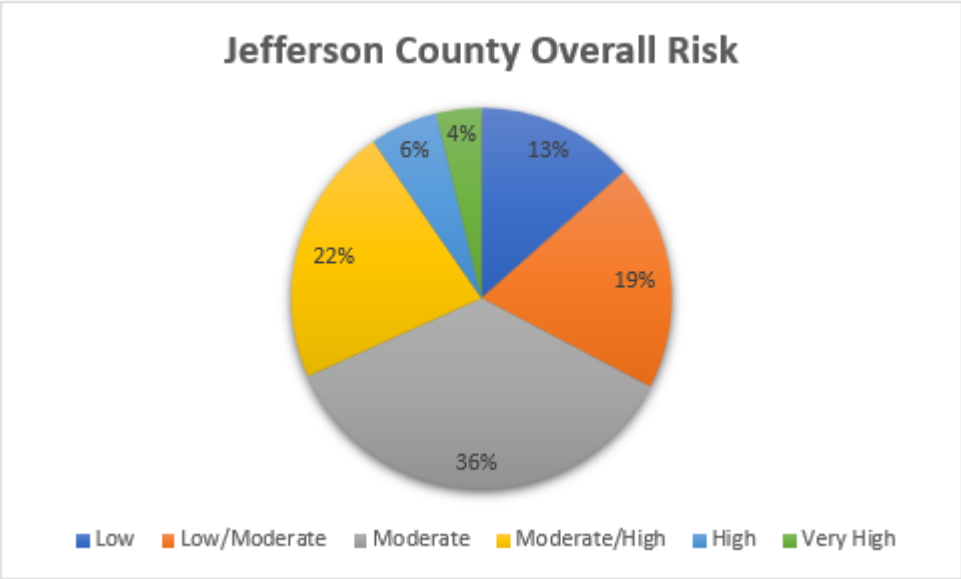
2. Juvenile Court Diversion

Youth who would benefit from restorative practice for accountability and skill building may receive this as a part of the Diversion Program. Services such as apology letter exercises, individual skill enhancement sessions, and Restorative Circles are offered.

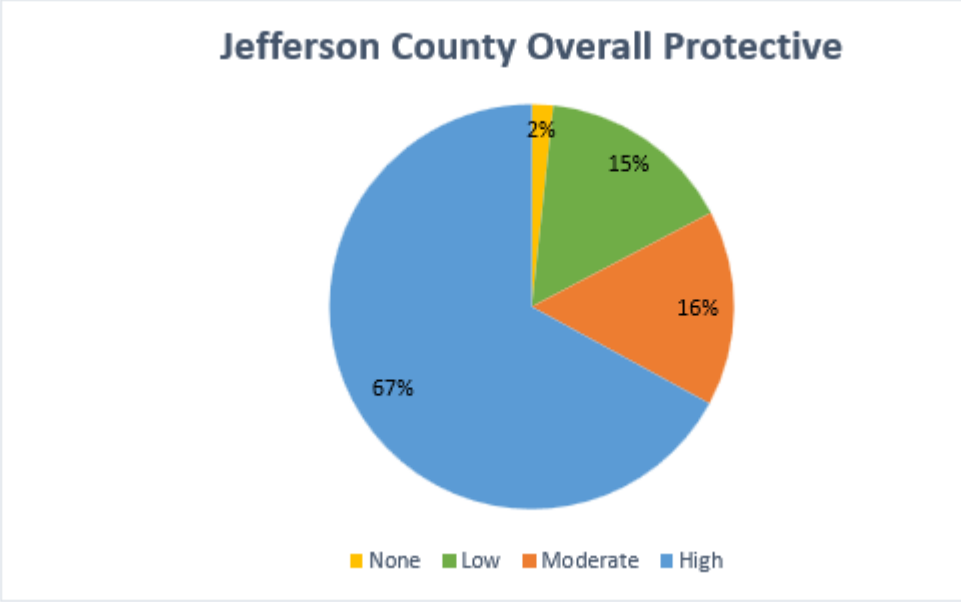
Youth Assessment Screening Instrument (YASI)

The Jefferson County Youth Justice team has a rich history of providing innovative services, supported by research, and in line with best practices. We know it is crucial not to overserve our referred youth who have a low risk to re-offend and high protective factors – and overserving those youth in the criminal justice system can increase their risk of recidivism. At the other end of the spectrum, it is imperative to serve youth who are high risk to re-offend and have low protective factors with services designed to address the target behaviors, beliefs, and domains that have led them to commit crimes.

Our team utilizes the YASI to inform decisions regarding how best to serve the youth who enter the Youth Justice system. The risk and protective levels indicate the dosage of ongoing intervention and progress of the youth at the six-month mark. The treatment modality is gleaned from the YASI assessment as well, as this assessment maps out the thoughts and actions that reach the core of criminal behaviors. Case Managers reassess the youth every six months to determine if the interventions are decreasing their overall dynamic risk factors as well as increasing their protective factors. The graphs below indicate the risk and protective levels of the youth who were served by the ongoing Youth Justice Team in 2024.



Of the youth who were administered full assessments by ongoing YJ workers in 2024, 32% were low or low/moderate risk to reoffend, a little more than ½ of the youth were moderate or moderate/high and just 10% were high/very high risk to reoffend. Though this is a little higher number than we like to see in the low and low/moderate category, the moderate and high categories align better. Risk level is one indicator of "dosage" of interaction and interventions delivered to the consumer. Youth served by the ongoing team in the low or low moderate risk categories most likely receive a lesser dosage of interventions.



The protective factors graph compiles information from the initial full assessments and the reassessments of the youth we served in 2024. This graph reflects that 17% of youth we served in 2024 on the ongoing team had either no or low protective factors. These youth may have been referred to the ongoing team with a low or low/moderate risk factor score. Conversely, 67% of our youth scored as high protective factors. These youth may have been referred to us due to a high-risk score, or, they may have raised their protective factor score through the course of supervision. Though not reflected in the graphs, the ongoing team also uses YASI full assessment information to determine the top target behaviors and uses that information to work with the family to build the case plan. The services offered to the youth and families are designed to address the highest domains.

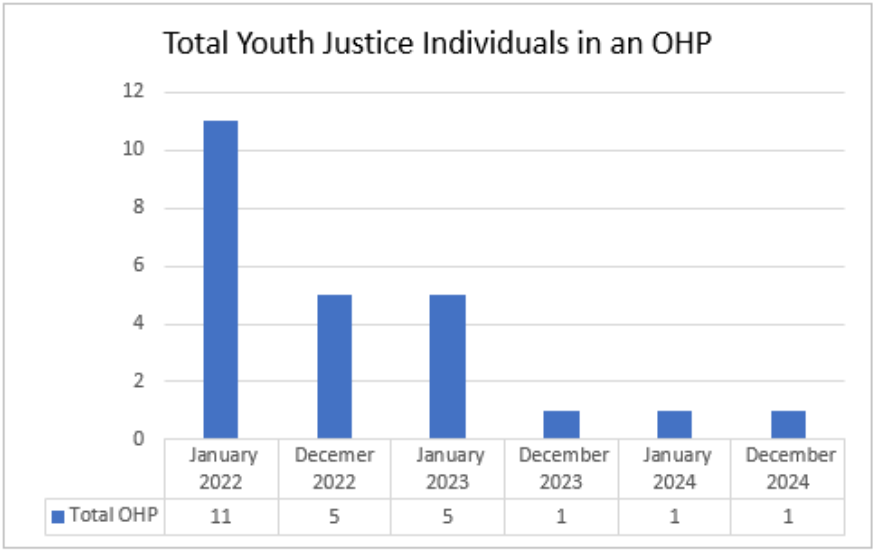
Ongoing Service Model – *Fostering Resilient Families Program*

Jefferson County provides an innovative family approach to working with youth either at risk of or involved in the justice system. *Fostering Resilient Families,* (FRF) is the family relationship-centered program we offer each of our youth justice families. *Fostering Resilient Families* is trauma-informed and works off the premise that improving family outcomes reduces the risk of further involvement in the criminal justice system. Case Managers engage with the whole family to maximize opportunities for change. The Functional Family Case Management (FFCM) model is the centerpiece of the FRF program. FFCM goals are to engage families, reduce negativity and blame, motivate families to make positive changes within the family context, and provide services to all family members who need them, ensuring that each person in the family receives services and treatment to address their needs in such areas as educational, employment, mental health, and AODA. We use the YASI full assessment as a tool to match

evidenced based services to the youth and family and monitor the services through regular contact with the family and collaterals and adjust services, as necessary. The model is strength-based, and workers integrate a relational focus into every visit with the families. Our goal is to help families healthily find hope and function without our intervention and presence in their lives.

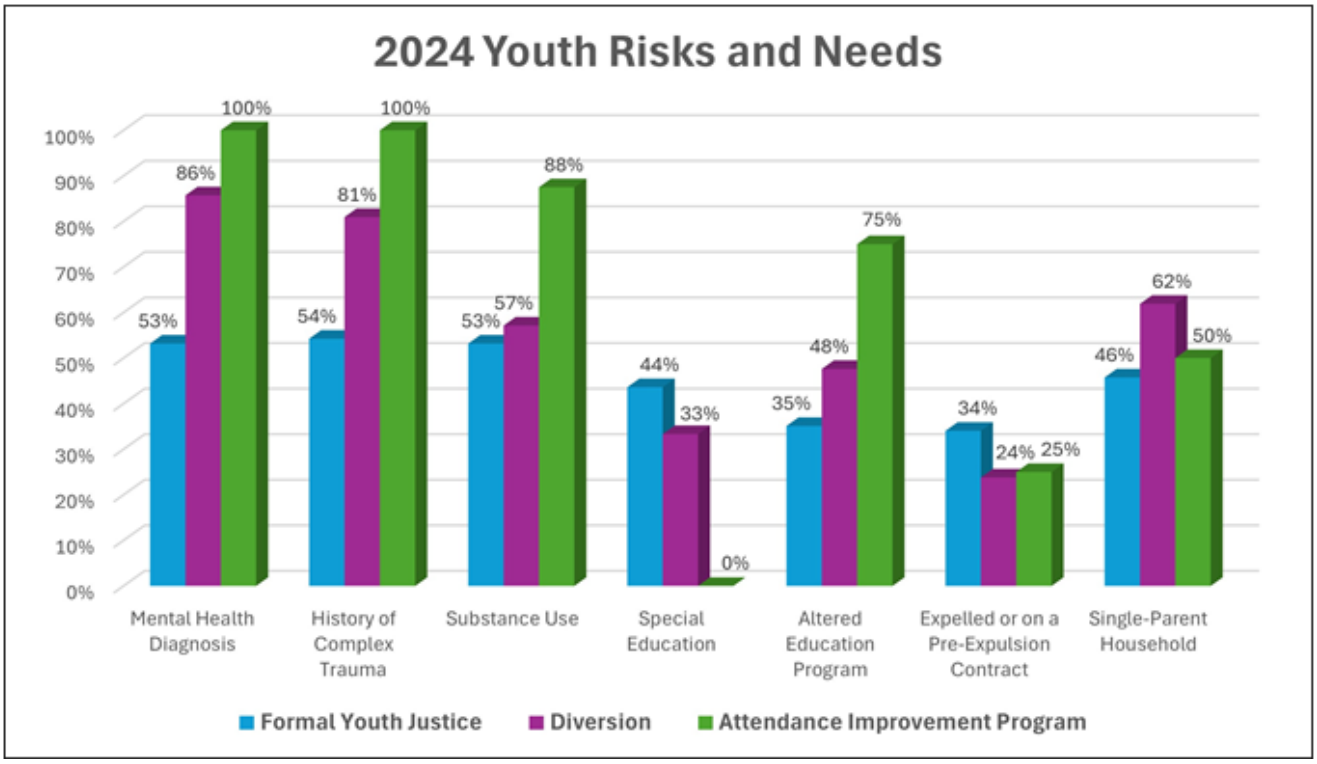
Based on what the research tells us about how beneficial incentives and rewards can be to motivate people to make sustainable changes, incentives are a component to the *Fostering Resilient Families* program as well. Each family member is allowed to earn incentives for making positive contributions to the functioning of his/her family. Each family designs an individualized goal plan that includes positive behaviors that contribute to the happiness of the whole family. For example, kids in the family can earn points for getting themselves up and out the door, doing their homework, being respectful to family members, doing chores, attending therapy, taking medications, etc. Parents can earn points for completing a family routine, following said routine, participating in a trauma parenting group, looking for a job, taking steps to go back to school, trying new parenting techniques, etc. Members of the household can also earn family points by meeting family goals. The points equate to a plethora of choices of incentives, ranging from options that do not cost anything, to gift cards and tangible items. Some families decline incentives, but many have taken advantage of this innovative practice and have seen great success in reaching their goals. The Jefferson County Youth Justice team is highly respected around the state, and we are incredibly proud of our efforts to earn that reputation. We are committed to innovative practice and will continue to push ourselves to keep growing and doing what is best for our families.

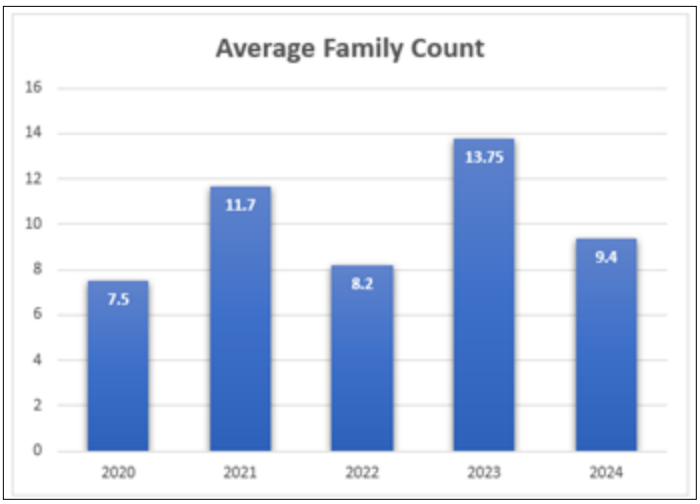
2024 YJ Ongoing Youth Justice Year at a Glance



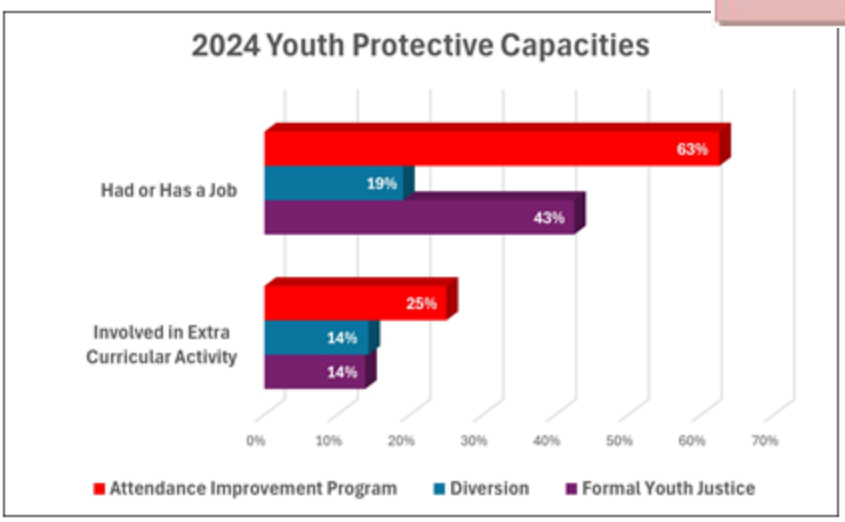
We have been providing the Fostering Resilient Families program, which marries a family/relational based case management model with structured incentives for certain families, since 2018. This graph represents our commitment to keeping families together whenever possible with safety plans and additional services to avoid an out of home placement. We have worked hard to reduce our out of home placement (OHP) numbers, reducing the number of youths who experience an out of home placement on a youth justice order by 90% since January 2022. When an out of home placement is necessary, we strive to make that happen in a family setting, such as a relative, like kin or foster care setting. Congregate care, shelter care and detention settings are used rarely, and only when the youth is a danger to the community without that level of supervision and services and cannot be managed safely in the community.

The chart on the next page reflects the high number of youths who struggle with mental health, substance use, complex trauma, educational difficulties and from homes of single parents. This graph shows data from all three subsets of programs within the Youth Justice Team: Formal Youth Justice consumers, Diversion consumers and Attendance Improvement Program participants.

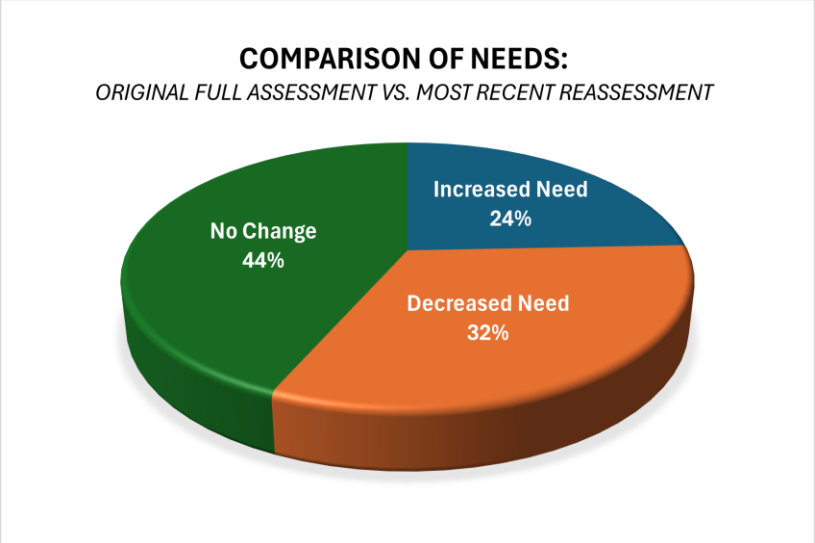


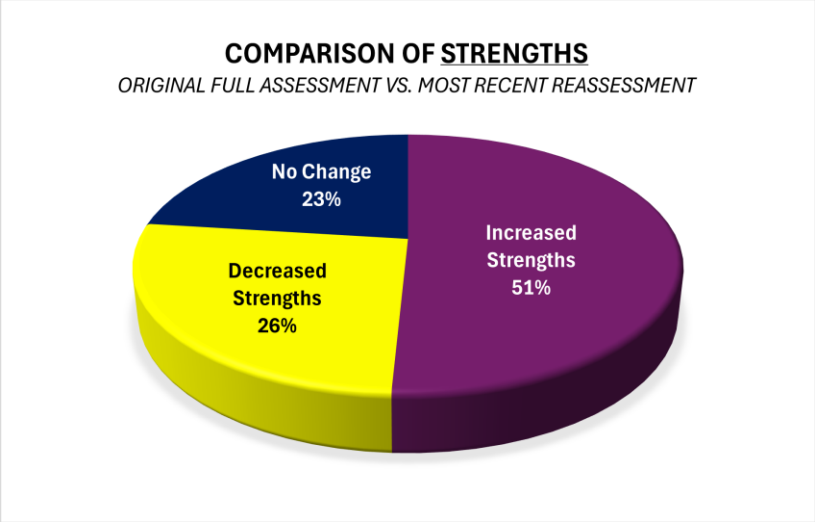


The average caseload size in 2024 decreased to just under ten cases per case manager. Though this number may seem somewhat low, it is noted that our YJ case managers provide several direct intervention services, and high family caseloads can hinder that valuable part of the work. Additionally, FFT, Inc. recommends caseloads no higher than 12 to maintain fidelity to the model. This number allows us to provide FFCM to fidelity, coupled with direct services and case management, to reduce recidivism.



The graph to the left highlights two key protective factors in the youth we served in the three subsets of the Youth Justice Program in 2024. Youth who come to us with one or both of these factors may be diverted completely from the system, and youth who gain experience a job and/or become involved in an extra-curricular activity may be eligible for an early release from supervision.





MOVING THE NEEDLE

The graphs to the left measure change in the overall risk and protective factor scores of the youth served in 2024 using the original full assessment compared to the most recent reassessment. The results indicated that service matching and the work we are doing with the youth, and families decreased the risk in about 1/3 of the youth we served. Though we would like those percentages to be higher, it is promising that 51% of youth increased their strengths/protective factors. This can happen when a youth finds employment, raises grades, joins an extra-curricular activity or changes to a more law-abiding peer group. These are all areas we work on with youth and families, and it shows in the lower graph, directly to the left.

Other Trends of 2024

- *High number of students with educational instability*– A number of youth we served in 2024 in the Fostering Resilient Families program were on expulsion contracts (they need to follow certain conditions to remain in school and avoid expulsion) or actually expelled. Additionally, several young people we served in 2024 signed agreements with their schools agreeing to withdraw from the district to avoid expulsion so they could be eligible and attractive to other districts outside of their home community. Multiple students also withdrew from school programming altogether in lieu of homeschooling, and though it may have looked like a good solution, some of these students didn't follow through with home instruction and essentially became dropouts.
- *Continuation of Housing Insecurity and Homelessness Issues* - Many of the families we serve in the Youth Justice system live below the poverty line and struggle to meet all the financial demands of raising a family. Due to several factors, housing issues are common for our families; and 2024 was no exception. At times, families are evicted for their child or adolescent's behaviors as well as for affordability reasons and inability to keep up with rising rent costs. This can make consistent care a challenge and lead to greater instances of truancy and untreated mental health issues.
- *Youth Employment* – A positive trend in 2024 was related to youth employment. Obtaining a job is a strong protective factor in youth and decreases the risk of repeating a similar crime, and higher levels of young people we serve held employment at some point during the course of the year than in previous years.

Review of 2024 Goals:

Key Outcome Indicator: **90% of youth who receive Youth Justice services will be placed in a home, in a relative's home or in the home of a "like kin" caregiver.** The Youth Justice team met this KOI 100% of the time in 2024. ***This indicator was met.***

1. To enhance worker and supervisor skills and proficiency in the Functional Family Case Management (FFCM) model, we will use the rating format during weekly FFCM consultations 100% of the time in 2024. ***This goal was attained.*** However, it is noted that in June of 2024 our team pivoted from a model of staffing a case each week to a more global approach to improving knowledge and skill of FFCM. Each worker took a monthly topic and presented the materials that were structured each week by: overview of the concept, practice activity, followed by two weeks of staffing cases using the skill/topic. This model of practice was very well received by all team members, and we plan to continue highlighting new topics/skills in 2025.
2. To increase awareness of gang related issues and trends and other community violence concerns, the team will seek additional training and guidance from local law enforcement agencies, webinars and other training venues throughout 2024. ***This goal was attained***. A Detective from one of our local police departments provided training in March 2024 that included guidance on what constitutes a gang, what to look for and what to do if we suspect gang involvement in our community.
3. To ensure we are offering services that match the core issues that lead to Youth Justice involvement, the team will conduct a gap analysis of our services and create a plan to address the deficits in service array by June 30, 2024. ***This goal was partially attained.*** On November 20, 2024, the team conducted a gap and strengths analysis on the steps and process of assessing, interpreting the assessment results, providing feedback to the family and developing a case plan that matches services effectively. This is a large part of what we do in our work with families, and we are working on developing solutions to the gaps we identified in this exercise.
4. To improve outcomes for youth who struggle with school avoidance and/or refusal, the team will implement a new truancy pilot in partnership with the intake team, Jefferson High School and Professional Services Group by December 31, 2024. ***This goal was attained.*** The team launched the Attendance Improvement Program in March 2024. More information about this program can be found in this section.
5. To increase awareness of the cultures and ethnic norms of the families we serve, the team will seek educational opportunities to provide Human Services community members in 2024. ***This goal was attained.*** The team provided educational information each week in October to the agency as part of Youth Justice Action Month and coordinated multiple events where community partners and our youth/families came together in a positive manner.
6. To improve our commitment to diversity, equity and inclusion, each team member will create an individual goal related to this area and post in the Youth Justice work region by March 1, 2024. ***This goal was attained.*** These goals were posted in the Youth Justice Region to state our commitment to improve ourselves in this area and let others know how we will do this.
7. To improve data driven Youth Justice services, the team will use YASI initial and closure assessment findings as a measure of successful case closure throughout 2024. ***This goal was attained.*** Data findings are included above in the Youth Justice narrative.
8. To improve youth voice and programming, the Jefferson County Youth Justice Team will develop and effectuate a plan to launch a local youth advisory group by June 1, 2024. ***This goal was partially attained and will continue into 2025.*** The team lead on this project secured funding and met with 3 schools in the district to host monthly Youth Leadership meetings during an all-school no-class period. Unfortunately, there were not enough referrals to launch the group in those schools. The Youth Advisory Group committee reconvened and developed a new plan that would join youth from all the schools in the county, and that is set to launch in February 2025.
9. Each team member will continue to work toward achieving proficiency in Motivational Interviewing, as evidenced by the submission of a tape or tapes that are coded to proficiency or demonstrate improvement. ***This goal was attained.*** In addition to formal coaching in Motivational Interviewing occurs

formally through a tape submission, workers also get ongoing, more informal coaching during weekly supervision.

Goals for 2025:

Key Outcome Indicator: **95% of youth who receive Youth Justice services will be placed in a home, in a relative's home or in the home of a "like kin" caregiver.**

1. In an effort to increase mentors and respite providers in Jefferson County, the Youth Justice Team will reach out to a minimum of three community partner members or organizations to provide information and education about the needs of Jefferson County at-risk youth throughout 2025.
2. To increase confidence in the use and efficacy of our graduated responses tool, the Youth Justice Team will update services included in the grid and adjust responses to align with our current philosophy, if necessary, by June 30, 2025.
3. To increase youth voice in our programming, the Youth Justice Team will launch the YJ Youth Advisory Board in 2025.
4. To improve educational outcomes for youth, the Youth Justice Team will research and identify a minimum of three community tutoring options and develop a plan to identify funding for that service by December 1, 2025.
5. To provide improved quality services to families with language barriers, the team will explore creative ways and ideas (in addition to current interpreter options) to enhance and improve Youth Justice services for those families and create a plan to test the implementation of at least one of the ideas by September 1, 2025.
6. To expand our knowledge and potential use of a variety of therapy modalities, the Youth Justice Team will research options and deliver information on innovative, high level treatment modalities to leadership and mental health providers by December 1, 2025.
7. Each team member will continue to work toward achieving proficiency in Motivational Interviewing, as evidenced by the submission of a tape or tapes that are coded to proficiency or demonstrate improvement.

ECONOMIC SUPPORT DIVISION

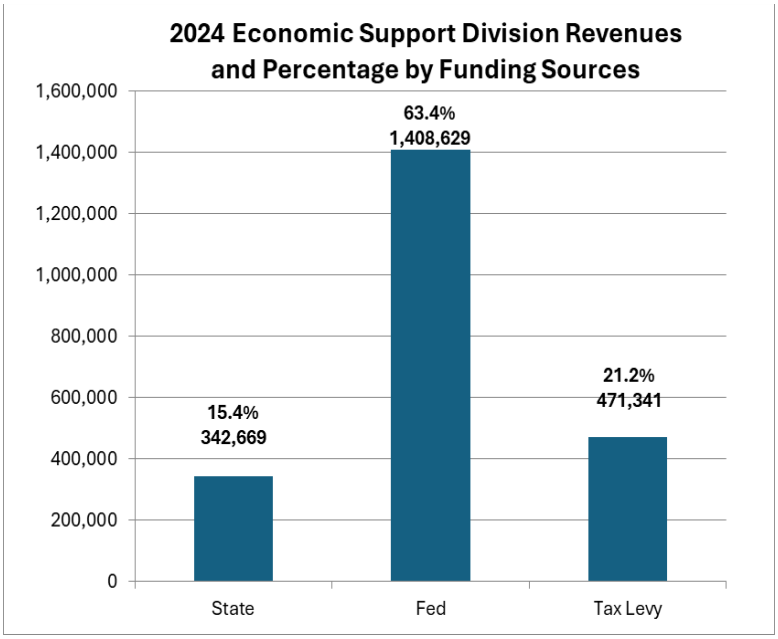
~Providing benefits and coordinating resources to strengthen our community's Individuals and families~

The Economic Support Programs for Jefferson County are administered 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 Division of Vocational Rehabilitation (DVR), the WORKSMART Program and New Beginnings. Our community partnerships continue to result in effective service coordination. Our partners include Community Action Coalition (CAC), Goodwill Industries, Salvation Army, Forward Services, local food pantries, St. Vincent de Paul, and 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, job fairs, labor market data, and resources available to meet your workforce needs, the websites of www.jobcenterofwisconsin.com and www.worksmartnetwork.org are the key sites. The unemployment rate for Jefferson County, as of December 2024, was at 2.6%, which is consistent with 2.5% in December of 2023 per the Local Area Unemployment Statistics (LAUS) information found per website https://jobcenterofwisconsin.com/wisconomy/pub/laus.

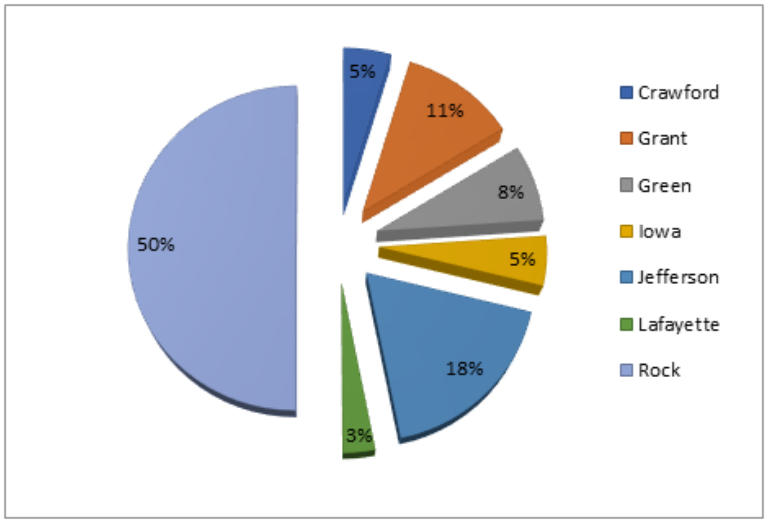
The Economic Support Division of Jefferson County Human Services facilitates customer access to financial assistance programs. The case managers assist the customers in applying for benefits, they also determine eligibility, update changes, explain program requirements, assess for possible fraud, and coordinate referrals to other resources. All Economic Support staff process Healthcare and FoodShare benefits, and select staff specialize in reviewing and authorizing WI Shares Child Care and Long Term Care services. Jefferson County is a member of the seven-county Southern Consortium which includes Crawford, Grant, Green, Iowa, Jefferson, Lafayette, and Rock counties. The Southern Consortium's monthly caseload for December 2024 was 46,544 households, which is 6.47% of the statewide Wisconsin caseload. Jefferson County comprises 18.13% of the Southern Consortium caseload. As a consortium, we coordinate job functions, manage the entire workload, determine program eligibility, and implement consortium-wide policies to increase efficiency. The Consortium also operates the Southern Consortium Call Center (SCC) at 1-888-794-5780. Contacting the SCC connects the customer to an Economic Support Case Manager located within any of the seven counties. Each Case Manager has access to their case specifics and is readily available to assist with an array of services including completing applications, renewals for ongoing eligibility, changes, answering questions, and more.

Jefferson County has twenty-two Economic Support staff including 19 case managers (two of which are lead workers with a greater knowledge and skillset, and three who are bilingual to serve our Spanish speaking population), one administrative staff, a supervisor, and a manager.

The Division's revenue comes from federal, state, and county funds and is reflected in the graph to the right. The contract funding is directed to the lead county (Rock) and then disbursed to each county based upon their caseload percentage.



Division of Caseload per County: Southern Consortium



The Division's overall goal is to enhance and maintain a successful Income Maintenance Consortium and meet mandated performance standards. The key indicators of our success are measured by our ability to meet timeliness, accuracy, and customer satisfaction standards established by the State of Wisconsin. Daily workload dashboards in coordination with quarterly, monthly, and weekly reports specifically address each aspect of these key indicators and are reviewed and monitored continuously. Based upon the data obtained and consortium staff training, procedural changes are developed to ensure we consistently meet these standards.

ECONOMIC SUPPORT

The Economic Support Division determines household eligibility for programs designed to improve financial stability and healthcare access. Often our programs are necessary to meet emergency needs such as job loss, medical concerns, or homelessness. Each program serves a specific population and incorporates different income guidelines and requirements.

Jefferson Caseloads - December Point in Time

2024 – 8,440 households 2023 – 8,930 households 2022 – 9,712 households

Requests for program benefits can be initiated by contacting the Southern Consortium Call Center at 1-888-794-5780, applying online at www.ACCESS.wisconsin.gov., contacting the Economic Support Division at 920-674-7500 to set an appointment or request an application by mail, or by coming into the agency and speaking with a lobby services case manager. The customer may also use the MyACCESS mobile application where they can check benefits, get reminders, submit required documents, and even complete some case actions such as FoodShare six-month report forms.

SOUTHERN CONSORTIUM CALL CENTER (SCC) – There are 10 consortiums in the State of Wisconsin, and our call center (Southern Consortium) is comprised of Economic Support Case Managers from seven counties: Crawford, Green, Grant, Iowa, Jefferson, Lafayette, and Rock Counties. The call center is the focal point for the customers' questions, change reporting, and completion of applications and renewals. In 2024, the Southern Consortium Call Center agents answered and helped 137,381 callers, which was a increase of 8,435 calls from 2023. The Southern Consortium uses a "One Touch" model in an effort to reduce the number of incoming calls, to resolve customers interactions in one call rather than reaching out multiple times for applications, phone renewals, change reporting, or checking the status of their case. Whenever possible, a caller will remain on the line while their documents are processed, eliminating a follow up call to request status later. The addition of technology, such as the online resources through the ACCESS website (www.ACCESS.WI.gov)

and the MyAccess mobile App, also reduces calls as clients can report changes, make updates, review the status of their case, and review the needed verification items online or through the Mobile App.

Implementation of an updated version of our call center platform increased our average speed to answer calls as the callback feature previously offered was disable for several months. Also, reports were not available to correctly report the number of calls taken by Jefferson agents until October of 2024. Based on averages from the available months, Jefferson County staff answered a monthly average of 17.7% of all calls taken by our consortium (or roughly 24,316 calls). The Southern Consortium accomplished this call volume with an average speed to answer of 4.49 minutes (2.67 minutes in 2023) and a call average answer rate of 94.48% (96.14% in 2023). Incoming calls must be answered within 10 minutes of arriving in the queue, and the Southern Consortium has an outstanding average speed to answer incoming calls within the state of Wisconsin. The Southern Consortium carries top ratings in answer rate, average speed to answer, and average handle time compared to consortiums throughout the state. The chart below shows a monthly breakdown of the Southern Call Center statistics for 2024.

January 2024 through December 2024:

Statistics

SCC Statistics (previous 12 months)

Month	Calls Offered	Calls Answered	Answer Rate	Average Speed of Answer/Mins	Average Talk Time/Mins	Average Handle Time	Longest Waiting Call /Mins
January	13,532	12,759	94.29%	4.68	11.06	11.38	59.58
February	126,36	12,081	95.61%	3.75	11.03	11.36	56.53
March	11,412	11,031	96.66%	2.91	10.87	112.1	61.95
April	12,292	11,091	96.82%	2.73	11.12	11.45	67.02
May	11,783	11,273	95.67%	3.38	11.38	11.09	40.60
June	11,671	11,212	96.07%	3.13	10.97	11.27	54.22
July	12,950	12,454	96.17%	3.39	10.71	10.99	55.73
August	12,841	12,103	94.25%	5.0	10.69	10.99	59.03
September	11,792	10,843	91.95%	6.20	11.12	11.75	54.60
October	13,066	12,110	92.68%	5.52	10.63	17.70	73.75
November	10880	10147	93.26%	5.46	9.96	21.39	39.90
December	11379	10277	90.32%	7.73	9.82	19.89	85.56

MEDICAL ASSISTANCE: MA is a State and Federally funded program that provides low-income customers with comprehensive and affordable healthcare. Numerous individual programs are included under the umbrella of Medical Assistance: BadgerCare, Medicaid Purchase Plan (MAPP), Family Planning Only Services (FPOS), Medicare Savings Program (MSP), Family Care, and Long-Term Care programs. Each program has individual financial and non-financial criteria for eligibility. The Forward Health card verifies coverage, however most Medical Assistance customers also participate in a Health Management Organization (HMO). On the Medicaid website http://www.dhs.wisconsin.gov/health-care-coverage you can access information on the individual program benefits and requirements.

BADGERCARE: BadgerCare is a State and Federally funded program for low-income adults, pregnant women, and children. Eligibility for BadgerCare is determined using IRS tax filing guidelines and household information which are aligned with the guidelines used for the Federal Marketplace. Applications completed through the

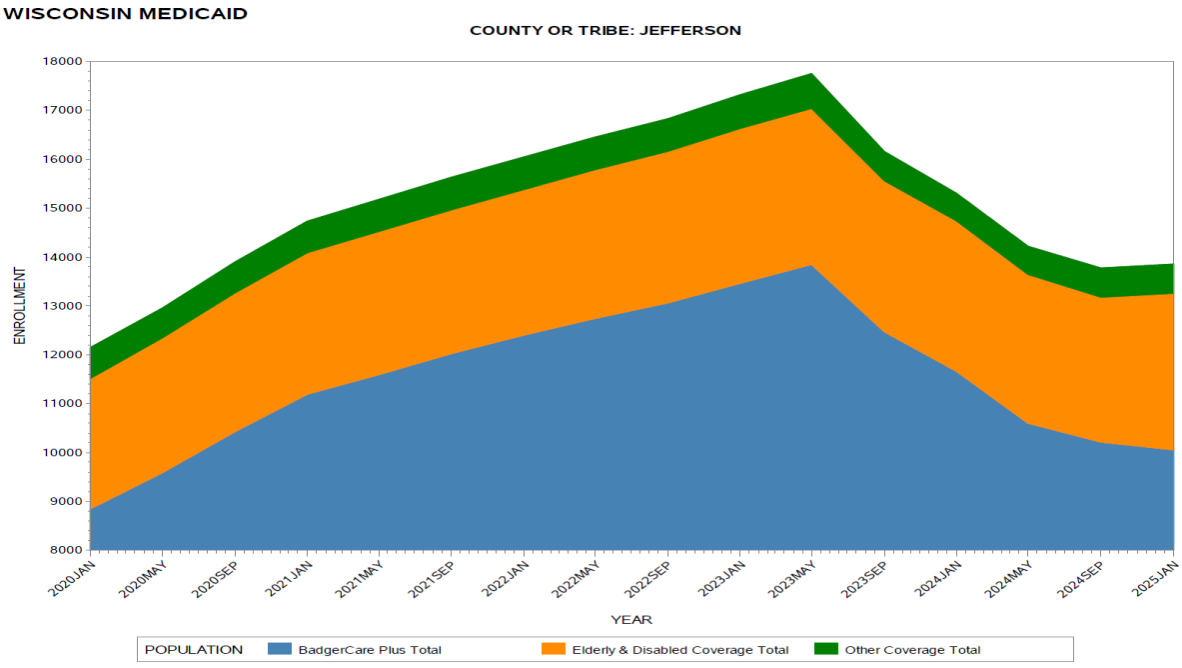
online ACCESS system will provide the customer with an immediate eligibility determination if all required verifications can be done using existing data exchanges. The site is https://access.wisconsin.gov.

The following chart displays the AVERAGE number of individual customers receiving benefits from specific Medicaid categories in Jefferson County from 2018 to 2024. In 2023, the most recent data available, the amount paid to medical providers for Jefferson County Residents was $164,138,284.70. Although the order to maintain healthcare eligibility throughout the Federal COVID Emergency has ended, enrollment and eligibility have remained elevated. While there was a steep climb in enrollment seen during the health emergency, the number of eligible individuals and families has remained higher than pre-COVID averages, however we are just now starting to see a decrease in numbers official ending of the health emergency and completed "unwinding" period. During the "unwinding" period all healthcare recipients were required to complete the review process once again, in which all financial and non-financial criteria was evaluated to determine ongoing eligibility for Medicaid healthcare programs. *Additional (past) years have been added back onto the following table to reflect pre-COVID, COVID, and post-COVID enrollment information to help show the trend throughout the duration of the Public Health Emergency (PHE) to current.*

Recipients of Medical Assistance - 2018 to 2024

Average Monthly Caseload	Families	Nursing Home	Elderly Disabled	Totals
2018	9,394	137	2,689	12,220
2019	9,343	117	2,741	12,201
2020	10,311	118	2,846	13,275
2021	12,264	98	2,994	15,356
2022	13,384	99	3,119	16,602
2023	13,569	98	3,183	16,850
2024	11,341	94	3,125	14,560

The graph displays the number of certified Medicaid individuals for Jefferson County, showing an increase in eligible members during COVID, and the decrease in enrollment after May of 2023 when the "unwinding" period ended:



FOODSHARE-(SNAP): The Supplemental Nutrition Assistance Program (SNAP), also known as FoodShare in Wisconsin, is a Federal Program funded by the USDA that provides a monthly allotment to low-income households to purchase food. Eligibility is based upon income, household composition, shelter expenses, and other criteria. The eligible customer receives a QUEST debit card to purchase food which they are able to make purchases both in store or online food purchases from community businesses such as Walmart and Amazon. Depending on the location, some FoodShare consumers can have their grocery items delivered from Walmart and Amazon to their residence in order to better serve those who may be homebound. The use of their EBT card continues to help support our local economy as well by being able to use their benefits at the local farmers markets. Some of the local markets run programs including a *Double Dollars Food Program* with matches FoodShare shoppers' purchases up to $20 per market day, which in turn supports local farmers and vendors. For the past several years, the number of FoodShare households receiving benefits increased steadily due to COVID, and even with the end of the Public Health Emergency, benefits continue to hold steady with only a slight decrease in the average number of monthly participants in Jefferson County. Beginning in April of 2020, households received additional emergency FoodShare benefits each month, up to the maximum allowed per household size, and this continued through 2022, with the final month of additional FoodShare allotments issued in February 2023. Additional years have been added to the chart below to provide an overview of the average number of recipients (both individuals and assistance groups) receiving this benefit, as well as the Average Monthly Total Issuance of FoodShare dollars issued to Jefferson County residents. While Jefferson County experienced a significant decrease in issuance of FoodShare benefits between 2023 and 2024 due to the end of the Public Health Emergency, the number of individuals and groups in need has not returned to pre-COVID levels. As a result, average FoodShare distributions remain elevated. For more information, the FoodShare website is available at: https://www.dhs.wisconsin.gov/foodshare/rsdata.htm

FoodShare Year	Average Monthly Recipients	Average Monthly Groups	Average Monthly Total Issuance
2018	6,428	3,233	$631,137
2019	6,126	3,102	$610,733
2020	6,839	3,548	$1,089,572
2021	7,795	4,105	$1,763,617
2022	7,068	3,728	$1,749,103
2023	7,127	3,737	$1,196,066
2024	6,966	3,684	$1,048,330

WISCONSIN SHARES CHILD CARE: Wisconsin Shares 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. Specialized child care staff establishes authorizations for each child and the customer receives a MyWIChildcare debit card containing their monthly subsidy. The customer makes their subsidy payment directly to the provider and is responsible for any remaining balance above the subsidy amount issued to the card. Jefferson County contracts our child care certification program to 4C (Community Coordinated Child Care) as they have access to extensive resources including a resource library and connections to their food program. Specific child care eligibility criteria and program information is located at https://www.dcf.wisconsin.gov. Following is the recipient data for the Jefferson County Wisconsin Shares program for 2022, 2023, and 2024.

***2022** – 185 families received authorizations for 309 unduplicated children. **The average yearly payment per child was $4,330.13.** Payments were made to 67 child care providers of $1,338,010.08. There were 165 children under the age of six and 104 children over the age of six served.

***2023** – 163 families received authorizations for 262 unduplicated children. **The average yearly payment per child was $4,892.82**. Payments were made to 54 childcare providers of $1,281,920.08. There were 205 children under the age of six and 82 children over the age of six served.

***2024** – 202 families received authorizations for 325 unduplicated children. **The average yearly payment per child was $4,777.85**. Payments were made to 53 childcare providers of $1,562,358.27. There were 270 children under the age of six and 99 children over the age of six served.

THE JEFFERSON ST. VINCENT DE PAUL SOCIETY - provides our division access to local funding for the customer's emergency needs when living in the Jefferson School District. These include rent, hotel vouchers, utilities, emergency expenses unmet by other programs, clothing, and necessary home furnishings. St. Vincent de Paul graciously provides $500 in a 2-year period, to provide much needed assistance and relief, especially to those needing immediate temporary lodging at local hotel/motels.

Following is the data for households served through St. Vincent de Paul in 2022, 2023, and 2024:

****2022**- 104 households received $14,238.85. This amount included $1,800.00 for rent, $8,120.00 for local hotel vouchers, $2,242.08 for utilities and $2,076.77 for other needs.

****2023**- 130 households received $14,501.91. This amount included $6,420.00 for rent, $3,870 for local hotel vouchers, $2,127.72 for utilities and $1,984.19 for other needs.

****2024**- 131 households received $18,537.92. This amount included $7,626.00 for rent, $6,135.00 for local hotel vouchers, $2,484.00 for utilities and $2,292.92 for other needs.

THE SALVATION ARMY – The Salvation Army has been assisting the Jefferson County Economic Support division by providing funds for a small pantry at the Workforce Development Center for many years. Through this pantry we have been able to assist individuals and families within Jefferson County providing grocery items for a variety of reasons including homelessness, temporary lodging with no access to food, and for the short time between being approved to receive FoodShare and when the FoodShare (Quest) card is received by the household.

Jefferson County also works with The Salvation Army to provide vouchers allowing us to assist the entire Jefferson County community as well as all of Watertown, WI. When residents in our radius call or come to our office, we will review the need and, if they meet the qualifications, provide a voucher that is funded by The Salvation Army. This assistance covers several types of needs including **Shelter**: Motel, Rent (past due or eviction, 1st month for a new residence) and Mortgage (past due). **Heat & Utilities**: Utilities – to avoid disconnect, Heating Fuel (wood, propane, oil, etc.), and Water. **Food:** Groceries, Food Pantry Supplement. **Clothing** (as needed): Winter outerwear, general clothing and shoes, work boots, safety shoes for work, etc. **Transportation:** Gasoline for vehicle, auto repair or parts.

For Fiscal Year 2024 Jefferson County Salvation Army provided:

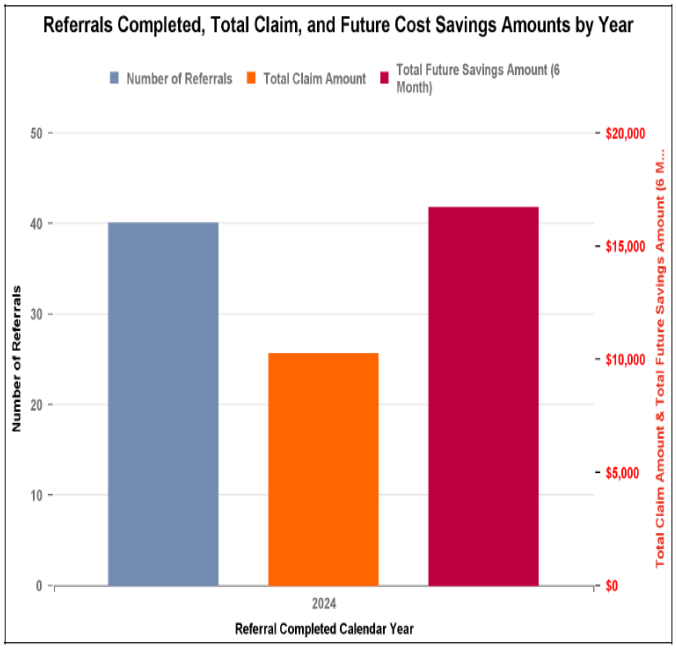
Emergency Lodging:	$49,439.29 - 173 Singles & 53 Families (333 Total people given shelter)
Rental Assistance:	$24,214.50 - 47 Singles & 25 Families (128 Total people helped)
Utility Assistance:	$6,804.04 - 10 Singles & 16 Families (70 Total people helped)
Transportation:	$877.26 (65 Total people helped)
Food:	$913.53 (1605 people helped)
GRAND TOTAL:	**$82,248.62 / 756 PEOPLE HELPED**

FRONT END VERIFICATION AND FRAUD - Jefferson County continues to implement mandated strategies to investigate potential fraud and reduce the abuse of taxpayer dollars. Jefferson County and the Southern Consortium utilize an Error-Prone Profile to dictate specific circumstances when the case managers are

required to complete enhanced verification or additional investigations to determine if accurate benefits are being issued. The Economic Support division previously received an average of 800-1000 discrepancy matches per quarter from the State Wage Income Collection Agency (SWICA) and other income discrepancy reports, however post COVID these matches only returned roughly 150-200 quarterly SWICA matches once reinstated. This decrease in SWICA matches was due to guidelines put in place specifically to reduce the number of unnecessary matches based on updated policies, however, they have since averaged out to return roughly between 500-600 matches per quarter. These matches are reviewed for unreported income and/or increases in income that may have caused benefit overpayments. An employment discrepancy is reviewed by the case manager who gathers the wage information from the customer and/or employer and compares the household income to reporting requirements and previously reported wages. If a benefit overpayment exists, a claim is established, and recoupment is initiated from ongoing benefits. Individuals who are no longer receiving benefits are required to make monthly payments or are referred to for IRS recovery. SWICA reports were suspended in 2020 due to the COVID Emergency Order, however the reinstatement of SWICA discrepancies began the first quarter of 2022. There continue to be numerous ongoing changes to the policies and the procedures of benefit recovery which have caused a decrease in the overpayments we create and collect. Effective April 1, 2023, policy was updated, and overpayment claims are no longer created for any health care program regardless of why the overpayment occurred. At this time health care overpayment collections are much lower than they were prior to COVID. Additionally, FoodShare overpayment policies have also been adjusted only allowing a FoodShare overpayment to be created/collected when the overpayment will be $500 or greater. With the many policy changes during the Public Health Emergency (PHE), and new guidance post-PHE, we have seen a notable decrease in the benefit recovery amounts for Economic Support Income Maintenance agencies.

The Benefit Recovery Tracking System (BRITS) is a state web-based system that tracks our investigation referrals for customers. The system reduces workload, creates efficiencies in data collection, increases program integrity and facilitates overpayments or potential prosecutions. Fraud Investigator Training is provided to have staff understand the benefit recovery process in its entirety. Staff training includes fraud prevention, completing desk investigations, proving intent, preparing for administrative hearings, writing comprehensive reports and all aspects of the overpayment calculation process.

In 2024, Jefferson County initiated 40 investigations that resulted in $11,375.00 in overpayment claims, but because ongoing information on these cases was updated with correct and accurate information, an estimated $16,710 in future savings was generated. In 2024, 18 external investigations were completed. External referrals included 7 completed by the Office of the Inspector General (OIG) at the State level and 11 completed by Central States Investigations (CSI), our consortium contracted investigative agency. The above statistics include investigations completed by all agencies, and the overpayment claim, and cost savings data reflect and incorporate SWICA discrepancy resolutions. For reference, in 2023, Jefferson County initiated 50 investigations that resulted in $3,522.00 in overpayment claims and $21,384.00 in future savings. In 2023, 24 external investigations were completed. External referrals included 14 completed by the Office of the Inspector General (OIG) at the State level and 10 completed by Central States Investigations (CSI), our consortium contracted investigative agency. In 2022, Jefferson County initiated 251 investigations that resulted in $90,779.42 in overpayment claims and $25,008 in



future savings. In 2022, 20 external investigations were completed. External referrals included 7 completed by the Office of the Inspector General (OIG) at the State level and 13 completed by Central States Investigations (CSI). The above statistics include investigations completed by all their agencies and the overpayment claim and cost savings data reflect and incorporate SWICA discrepancy resolutions.

To avoid overpayments that we may not be able to recoup going forward, staff are more closely monitoring benefit issuance for accuracy with an increased focus on preventing future overpayments. Staff also continued to review individual eligibility for Intentional Program Violations (IPV), which is a penalty that prohibits the customer from receiving future benefits for a minimum of one year.

2024 GOALS: TO MEET MANDATED PERFORMANCE STANDARDS AND FACILITATE PROGRAMS ACCESS

1. **Key Outcome Indicator: To determine eligibility on applications/reviews within 30 days of receipt. Mandated Performance Standard 95%.** The Southern Consortium processed applications at an average monthly rate of 99.60%
   - The Southern Consortium processed reviews at an average monthly rate of 99.48%
   - The Southern Consortium processed priority service FoodShare applications at an average monthly rate of 99.64%.
   - Jefferson County processed priority service FoodShare applications at an average monthly rate of 99.62%.
   - Monthly summary reports show that Jefferson County achieved application processing timeliness above 99% for all months, including 4 months at 100%.
2. **Key Outcome Indicator: The Southern Consortium Call Center (SCC) (including Jefferson County) will answer 100% of the incoming calls within 10 minutes. Mandated performance Standards 95%.**
   - The Southern Consortium (SCC) took 137,381 calls in 2024, an increase of 8,435 calls from 2023.
   - The average number of calls taken per month was 10,746, also a slight increase from 2023.
   - The SCC average monthly answer rate was 94.47%, a decrease from 96.14% in 2023.
   - The SCC average speed to answer was 4.49 minutes.
   - The Southern Consortium average talk time was 10.78 minutes, consistent with 2023.
3. **Key Outcome Indicator: Staff will strive for 100% accuracy in eligibility processing**
   - Consortium FoodShare Average Active Error Rate was 2.83% (FY2024) State 4.4%
   - Consortium FoodShare CAPER (denials/procedural) Error Rate was 16.67% (down from 18.64% in 2023).
4. **Key Outcome Indicator: To resolve and complete all discrepancies received quarterly from DHS within mandated 45 days of receipt.**
   - 100% of the matches were processed timely and resolved within the 45 day processing timeframe.
   - Each team is responsible for their discrepancies, requesting actual income, comparing actual to reported income, reviewing notices and timeframes to determine potential overpayment in benefits
   - Detailed spreadsheets were completed to gather and track all discrepancies received, which the lead workers distributed to the teams quickly so teams could process them timely.
   - Supervisor enhanced monitoring and mentoring of staff completing overpayment calculations
   - Staff completed training on past overpayment calculations, increased usage of BRITS data entries, and tracking and worked directly under supervision to learn the process.

OUR 2025 GOALS: TO MEET MANDATED PERFORMANCE STANDARDS AND FACILITATE PROGRAM ACCESS

1. **Key Outcome Indicator: To determine eligibility on applications/reviews within 30 days of receipt. Mandated Performance Standard 95%.**
   - 100% of program requests will be processed within 30 days.
   - 100% of FoodShare expedited benefits will be processed timely within seven days.
   - FoodShare on Demand applications processed within 48 hours.
   - Staff will monitor team dashboard daily, assign and fully complete tasks.
   - Continuing development of internal efficiencies, review of division processes, ongoing training.

2. **Key Outcome Indicator: The Southern Consortium Call Center (SCC) and Jefferson County will answer 100% of the incoming calls within 10 minutes. Mandated performance Standards 95%**
   - 100% of calls will be answered timely as monitored by daily DHS SCC statistics and call center.
   - Maintain monthly team calendars of call center assignments and plans to meet emergency needs.
   - Reinforce the "one touch" model to ensure timeliness, having all documents and requests for benefits processed during initial customer contact when possible.
   - Provide quality customer service verified by customer self-reporting and satisfaction surveys.
3. **Key Outcome Indicator: Staff will strive for 100% accuracy in eligibility processing**
   - Lead workers maintain responsibilities for specific monthly reports
   - Discussion and monthly review of Second Party and Quality Control Errors
   - Bi-weekly training by Consortium trainer. Discussions at agency staff meetings and small group team meetings to ensure full understanding of the updated process and procedure
   - Reinstate quarterly on-site visits from consortium trainer for staff refresher training
   - Completion of mandated trainings and refresher trainings on DHS/DCF Training site
   - Staff will participate in refresher training and micro-learning to be prepared as suspended eligibility rules are reinstated
4. **Key Outcome Indicator: To complete and resolve discrepancies received quarterly from DHS within the mandated 45 days of receipt.**
   - Team members will consistently and timely resolve discrepancies by collecting wage information and updating benefits.
   - Staff will consistently and actively explain reporting requirements to customers.
   - New staff will be fully trained in correct handling and processing of State Wage Matches and the overpayment process.
   - Supervisory staff will monitor completion of discrepancies, BRITS referrals, overpayments and assign fair hearings.
   - Designated staff attendance at Office of Inspector General training.
   - Overpayment liaison designated for Jefferson County overpayment calls/questions to the call center for proper direction of questions and timely responses to customers.
5. **Jefferson County / Southern Consortium Goals for 2024:**
   - **Training Goal** – To use the same resources consortium wide for uniformity among the Economic Support workers for assessment of knowledge and skills. Resources/tools may include:
     - FoodShare and BadgerCare quizzes developed by lead county (Rock County), call reviews for new workers, inviting all consortium workers to the trainings held by the lead county, additional shadowing for workers struggling in call center.
     - Quarterly refresher trainings will be required for all staff. These will be recorded and saved on the Southern Consortium website for future viewing.
     - Completing all annual training requirements, no later than November 2024 so all information may be submitted to the appropriate monitoring departments in December, without delay.

"Far and away the best prize that life has to offer is the chance to work hard at work worth doing." ― Theodore Roosevelt

INFORMATION & ACKNOWLEDGEMENTS

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

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Fax Number: 920-674-6113
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AGING & DISABILITY RESOURCE DIVISION
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Phone Number: 920-674-8734
Toll Free: 1-866-740-2372

ECONOMIC ASSISTANCE
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