Behavioral Health Redesign Steering Committee (BHRSC)
September 19, 2013

Call to Order. Chair Flanagan called the meeting of the Behavioral Health Redesign Steering Committee to order at 12:02 P.M. in the Courthouse Conference Center, second floor, Rock County Courthouse-East.

Committee Members Present: Supervisor Billy Bob Grahn, Tim Perry, Lance Horozewski, Cmdr. Erik Chellevold, Kate Flanagan, Neil Deupree, Brian Gies, Faith Mattison, Pastor Mike Jackson, Tom Gubbin, Linda Scott-Hoag, Denny Luster, Lisa Usgaard, Julie Lenzendorf, Linda Garrett, and Greg Ammon.

Committee Members Absent: Judge James Daley, Cindy Zaharias, Kim Kempken, Lynn Larsen, Jean Randles, Yolanda Cargile, and Deputy Chief John Olsen.

Staff Members Present: Elizabeth Pohlman McQuillen, Criminal Justice System Planner/Analyst; Cpt. Craig Strouse, Sheriff's Office; and Melissa Meboe, Crisis Supervisor, HSD.

Others Present: Supervisor Steve Howland.

Approval of the Agenda. Supervisor Grahn moved approval of the agenda as presented, second by Mr. Deupree. ADOPTED.

Approval of the Minutes of August 15, 2013. Mr. Luster moved approval of the minutes as presented, second by Mr. Deupree. ADOPTED.

Workgroup Updates.

Data Workgroup: Ms. Pohlman McQuillen said she would be having a follow-up call with Mr. Zahniser after the Zia visit.

AODA Workgroup: Chair Flanagan said this group continues to meet and will be working with Dr. Minkoff on September 24th specifically on AODA issues, system mapping, identifying strengths, needs, and gaps, as well as including the prevention coalitions in the work.

CCRG: Ms. Meboe said the group reviewed the Smart Goals and agreed with them.

Prescribers: Mr. Ammon and Ms. Usgaard said there are a lot of prescribers in the county and they intend to hold a meeting during the fourth quarter to talk about the Smart Goals and allow the prescribers to identify their top issues.

Kids Continuum of Care: Mr. Horozewski said the CST Coordinating Committee met and talked about the Smart Goals. He said they wanted to include additional stakeholders in their meetings.

Adult Continuum of Care: Chair Flanagan said this is still the HSD mental health supervisory team, but they are working to make it broader.

Consumer/Family: Chair Flanagan said she is still at a standstill with the Grassroots Empowerment Project due to staff turnover.

Cultural Competency: Mr. Deupree said he and Ms. Garrett met and tweaked the Smart Goals and they hoped to have some time to talk with Zia when they are here for the site visit.

Review of Draft Smart Goals and Discussion of Feedback to Smart Goals. Chair Flanagan said the small group had a meeting and provided the feedback to Zia Partners to incorporate into the latest draft of the Smart Goals. Chair Flanagan went over the latest draft of the Smart Goals. She said the group would be going over the latest draft when Zia was on-site. Chair Flanagan also went over a draft of the Narrative document which, along with the Smart Goals, is the strategic plan and what will be used to move things along in the future.

Final Preparation for Zia Site Visit. Chair Flanagan went over the schedule for the site visit. The group agreed that Mr. Deupree and Ms. Garrett should meet with Zia after the BHRSC meeting and before the first breakout group.

Follow-up on COMPASS-EZ & SOCAT Training. Chair Flanagan said a handful of BHRSC members participated in the phone trainings.

Discussion and Support for Justice and Mental Health Collaboration Grant. Ms. Pohlman McQuillen said she was notified Rock County was awarded the Planning and Implementation grant.

Supervisor Grahn moved that the BHRSC support and provide oversight to the grant activities. Second by Ms. Scott-Hoag. APPROVED UNANIMOUSLY.

Report on Human Services Department Reorganization. Chair Flanagan said the Human Services Department is undergoing a reorganization process. She said it would impact several people in the department and that the reorganization is related to the work the BHRSC has undertaken. She said the key changes are as follows: Child Protective Services and Juvenile Justice are merging and there will be one division manager and new program managers, clinical services with move to the Mental Health/AODA Division and child and family services will be added to her division; the TQM Division is moving under Administrative Services; and there will be additional positions in the kids' area. Mr. Luster asked if the BHRSC could get an organizational chart when the process is complete.

Discussion regarding Next Steps. Nothing additional discussed.

Citizen Participation and Announcements. Ms. Lenzendorf said RVCP is opening a mental health outpatient clinic, which will be open to the public, and not just correctional clients.

Time and Date for Future Meetings. Zia Site Visit, Monday, September 23, 2013, at 8:00 a.m., Courthouse Conferences Center, Second Floor, Courthouse East. Next regular meeting, Thursday, October 17, 2013, at Noon, N1-N2, Fifth Floor, Courthouse East.

Adjournment. The meeting adjourned at 1:00 p.m. by acclamation.

Respectfully submitted,
Elizabeth Pohlman McQuillen
Criminal Justice System Planner/Analyst

NOT OFFICIAL UNTIL APPROVED BY COMMITTEE.

Appendix 1

Behavioral Health Redesign Steering Committee Data Work Group

Jim Zahniser, Ph.D., TriWest Group

Overview

The Behavioral Health Redesign Steering Committee (BHRSC) established a Data Workgroup to examine the extent and nature of the overlapping involvement that people experiencing behavioral health problems have with the criminal justice and behavioral health services systems. Building on accomplishments from the first phase of the BHRSC's work, in 2013 the Data Work Group completed two studies:

1) A high-level summary of the overlap in systems for over 4,000 people who had at least one booking into the Rock County Jail in 2012; and

2) A focused study of 270 people from Study 1 who were identified by Rock County Jail staff as having behavioral health problems and as representing significant behavioral management challenges. Data Work Group members from Rock County Human Services Department (Rock County HSD) and from participating behavioral health provider agencies used their data sets to calculate the number and percentage of those 270 people who had received services from their agencies (or through agencies with whom they contract, in the case of Rock County HSD), from 2008 through 2012.

Given the emerging success of the 2013 study and the availability of a new grant procured by Rock County, Zia Partners and TriWest Group are proposing that the Data Work Group continue its work in 2014 (and the remainder of 2013) by focusing on ways that its learning from the two past successes in sharing and examining data can be applied to the new grant received recently by Rock County, which will focus on re-entry and aftercare planning for people with behavioral health problems leaving jail. This appendix summarizes the data yielded by the 2013 studies (with a focus on the second, more focused study) and provides recommendations for the Data Work Group's activities going forward.

Data Work Group Membership

Key leaders from both criminal justice and behavioral health systems who volunteered to participate with the Data Work Group consisted of those listed in the table below. Zia Partners and TriWest Group recommend that the same members continue with the group going forward this year and through 2014. In addition, we recommend that one leader representing the criminal justice system and one leader representing the behavioral health system co-chair the Data Work Group October 2013 forward.

Member	Agency/Organization
Erik Chellevold	Rock County Sheriff's Office
Craig Strouse	
Tom Gubbin	Department of Corrections
Dara Mosley	Rock County
Kate Flanagan	Rock County Human Services
Patrick Singer	Rock County Human Services
Lisa Moore-Kelty	Rock County Human Services
Julie Lenzendorf	Rock Valley Community Programs
Tim Perry	Crossroads Counseling Center
Greg Ammon	Beloit Memorial Hospital
Mary Cefalu	
Elizabeth Pohlman McQuillen	Rock County Criminal Justice Planner/Analyst
Jim Zahniser	TriWest Group
Tonya Aultman-Bettridge	TriWest Group

Data Work Group 2013 Study of People with BH Problems In Jail

Background – Study 1

A preliminary study was conducted in late 2012 and early 2013 with a large sample of all people who had at least one booking into Rock County Jail in 2012. This data set, produced by Dara Mosely, identified 4,579 unique persons with at least one booking in 2012. Nearly one-quarter of those people (1,111; 45%) had two or more bookings in 2012, and 45 people had five (5) or more bookings (slightly less than 1%).

Patrick Singer and his staff at Rocky County HSD analyzed the number and percentage of the sample from the above-mentioned data set who had ever received services through Rock County HSD contracted providers. Below is a tabular summary of the findings.

	Rock County HSD Program	2012 Inmates with Program Involvement History	% of Total 2012 Inmates
Mental Health Services	Outpatient Mental Health Clinics	134	2.93%
	Community Support Program	7	0.15%
	Crisis Intervention	126	2.75%
	Inpatient Residential	60	1.31%
AODA Services	Intoxicated Driver Program / AODA	147	3.21%
	Crisis Detoxification Services	65	1.42%
Juvenile Justice Services	Juvenile Supervision and Diversion Services	199	4.35%
	Secure Detention	116	2.53%
	Shelter Care	116	2.53%

Methods for the 2013 Study of People with BH Problems in Jail

Commander Erik Chellevold and his staff agreed to conduct a thorough analysis of the people who were in Jail in 2012, using the data set produced by Dara Mosely for the Data Work Group's initial study of the entire sample of people with jail bookings in 2012. The analysis would identify people, using information on behavioral health issues in Geo Management software used by the Jail, as well as incident reports to identify people who were experiencing significant behavioral health problems in the jail setting, and who had either evidenced significant distress or represented behavior management challenges for the jail staff.

The resulting sample identified by Commander Chellevold and his staff consisted of 270 people. The table below shows the demographics of the sample; the number who had committed a felony, a violent crime, or an alcohol/drug related crime; the number with either diagnosed or self-reported (or observed) mental illness; self-reported substance abuse problems; and the number who had contact with the Jail Social Worker. Data are presented in the table at the top of the next page. It should be noted that the rates of substance abuse probably represent a "floor" in that they only indicate the number and percentage of people who self-reported a problem in that area. It is highly likely that the actual rates are higher.

Commander Chellevold made the list of people available to the Data Work Group members who had agreed to examine their data bases in order to count the number of people who had received services, across an array of mental health and substance abuse treatment services in Rock County,

sometime in the past five years. The Data Work Group decided to include a five year period in order to identify a maximum number and percentage of people who had received services.

Demographic Characteristics, Criminal History, and Behavioral Health Information of the 270 People Identified by Jail Staff as Requiring Significant Behavioral Management

Demographic, Criminal and Behavioral Health Variables	Males	Females	Total
Gender	192 (71%)	78 (29%)	270 (100%)
Diagnosed or Self Reported Mental Illness	162 (84%)	64 (82%)	226 (84%)
Self-Report Substance Abuse	84 (44%)	39 (50%)	123 (46%)
Violent Crime, Felony, or Alcohol/Drug Related Crime	184 (96%)	66 (85%)	250 (93%)
Contact with the Jail Social Worker	122 (64%)	47 (60%)	169 (62%)

Summary of Key Findings from the 2013 Study of High-Challenge People with BH Problems in Jail

Because the agencies represented in the Data Work Group have not yet worked out the types of formal data sharing agreements that would enable them to share person-identified personal health information, due to HIPAA laws, the Work Group was not able to determine the exact number and percentage of unique/unduplicated individuals who had received behavioral health services. However, as can be seen in the table on the next page, a fairly high percentage of people had been served sometime in the five-year period of 2008 through 2012. Over three-quarters of them (77%) had received services through agencies that provide services funded through ad/or monitored by Rock County Human Services Department, and it is possible that some of the other people served through other agencies, such as Beloit Memorial Hospital, Mercy Hospital, and Crossroads Counseling Center, were not captured in the Rock County HSD data.

On the other hand, there are several reasons to suggest the data should raise concerns about the extent to which people with behavioral health needs are accessing the levels and types of care they need.

First, more of those served through providers associated with Rock County HSD were served through Crisis and Inpatient Residential services (combined) than through Outpatient Mental Health Clinics and the Community Support Program. Only a small subset (4%) were served through the CSP program, which could, in part, reflect the *success* of that program in helping keep people out of jail, but which also might indicate the fact that some people in need of CSP services are not receiving them prior to entering jail. (Recall that the sample of 270 people identified includes people with obvious or apparent behavioral health problems who represent significant behavioral management challenges to jail staff.)

Second, there was a very small percentage of people receiving AODA treatment, and those who did receive such treatment tended to receive it through the Intoxicated Driver Program and through Crisis Detoxification Services. While the study is not definitive in showing that a much smaller percentage of people received outpatient substance abuse treatments, which would probably be the set of services most needed by our sample of 270, the data do suggest the need to examine this potential gap in care very closely.

It should be noted that data from Tom Gubbin at DOC recently has been submitted to the group for inclusion in the summary provided on the next page. It is recommended that the Data Work Group add this data to the data summary and update the discussion of findings provided above

Percentages Receiving Behavioral Health Services Among a Sample of People with 2012 Jail Bookings and Identified Behavioral Health Needs

		Rock Co Human Services Dept	DOC - Probation	Beloit Memorial[1]	Mercy	Crossroads
	Levels/Types of Service	% Served	% Served	% Served	% Served	% Served
Mental Health Services	Outpatient Mental Health Clinics	42%				
	General Outpatient - Adult			7%	20%[2]	7%
	General Outpatient - Children/Youth			1%		4%
	Community Support Program	4%				
	Crisis Intervention	46%				
	Inpatient Residential	27%			8%	
	Psych. Testing/ Assessment - Adult			8%	13%	3%
	Psych. Testing- Children/Youth			1%		0.4%
AODA Services	Intoxicated Driver Program / AODA	26%				
	Crisis Detoxification Services	24%				
	General AODA - Adult			3%	11%[3]	4%
	General AODA - Children/Youth			0.5%		0.3%
	Intensive Outpatient			1.1%		
	AODA Day Treatment - Children/Youth					0.7%
Juvenile Justice Services	Juvenile Supervision and Diversion Services	32%				
	Secure Detention	27%				
	Shelter Care	26%				
	DOC Probation (Adults)		71%			
	Total	**77%**	**71%**	**12%**	**N/A[4]**	**18%**

[1] Four (4) of 32 people served were children/youth
[2] Includes 29 receiving therapy/counseling and 25 receiving medicaiton (not necessarily unduplicated)
[3] Includes 21 receiving therapy/counseling and 9 receiving medication (not necessarily unduplicated)
[4] Do not have unduplicated count

Recommendations

We recommend that the Data Work Group continue meeting and working together to use data in examining the overlap between criminal justice and behavioral health systems and in informing plans for increased coordination and collaboration. Ultimately, the Work Group has the opportunity to increase access to needed services and reduce some of the pressures on the criminal justice system that result from less than ideal access to and coordination of care.

Data Work Group Mission Statement

The following is the recommended Data Work Group Mission Statement. The Data Work Group approved this statement in 2013.

"To develop a complete baseline assessment and a method for ongoing tracking of the needs of the jail/criminal justice system population and the overlap between the behavioral health and jail/criminal justice systems"

Data Work Group Goals for 2014

We recommend that the Data Work Group's goals for 2014 focus on two primary and complementary endeavors: a) building on the studies completed to date; and b) supporting the new grant that will be focusing on community re-entry of people leaving jail and coordination of follow-along behavioral health services.

Specific recommended goals aimed at supporting the two primary endeavors outlined above include the following:

1. Complete the high utilizers study and, estimating the level of met and unmet need for behavioral health services in the sample, complete a "system map" which shows where needs of the population of people with both behavioral health needs and criminal justice system involvement are being met, and where there are gaps.
2. Develop a method for better integration and/or sharing of data on BH needs and system involvement across systems, including across providers within the county and use this method to track people leaving jail who have need for behavioral health services, documenting whether people receive services, where they receive them, and what types and levels of care they receive.
3. Build on the already-strong participation of data leaders from both criminal justice and behavioral health systems and solicit involvement of all remaining key providers, including, for example, other hospital providers not currently involved in the Data Work Group.

Rock County Strategic Plan SMART[1] Goals: 2013 – 2014 (Third Draft – September, 2013)

Overview: Rock County DHS is joining in a partnership with Stakeholders of all types from across Rock County to create a redesigned/transformed system of care with the following vision and mission:

VISION: Rock County envisions a system of care that supports independence, hope and healthy lives by making accessible MH and AODA services that are responsive, integrated, compassionate, and respectful.

MISSION: The mission of Rock County's behavioral health system is to provide—in partnership with consumers, families, staff, the justice systems, and community-based agencies—welcoming, integrated services for mental health, substance abuse, criminal justice involvement, health, and other needs, promoting wellness, recovery, and resiliency while respecting the complexity and diversity of those served.

CONSENSUS FRAMEWORK: A consensus has emerged that recognizes the need to create a broad systems approach with universal application for all prevention, early intervention, justice services and treatment programs and people providing service, in order to create an INTEGRATED system that is welcoming, accessible, strength-based, person- and family-centered, prevention, recovery- and resiliency-oriented, trauma-informed, culturally competent, and complexity capable.

Timeframes: Redesign is about designing a system that promotes life and hope for people in Rock County with behavioral health needs, and shifting over time to a more fully community-based system of care. Therefore, Redesign must be viewed as a **multi-year (5-year minimum) project** with ambitious targets. However, initial SMART Goal implementation targets and timeframes need to be focused on measuring current baselines and identifying strategic, **attainable, and measurable** goals/objectives **that can be achieved within the next 12-18 months**. There will then be **Annual Updates of the SMART Goals** to define measurable progress toward the highest possible standards for all services.

Scope: The scope of Redesign efforts relates to the public sector **behavioral health (MH *and* AODA)** needs of citizens (adults, children, and families) of Rock County as a whole, not just those individuals specifically served within county-funded or county-operated settings. Consequently, SMART Goal targets apply to the Rock County public (uninsured, Medicaid) BH population, unless otherwise specified. In addition, because the Redesign process emerged from the efforts of the Rock County Criminal Justice Coordinating Committee (CJCC) to reduce adult and juvenile justice involvement for individuals with behavioral health needs, the population at risk for involvement in the justice system will be a particular focus, regardless of payor source.

Best Practices: SMART Goals are designed with the expectation that Redesign involves efforts to implement the widest possible variety of evidence-based and promising practices into all areas of the system.

Glossary of abbreviations: MH = Mental Health; AODA = Alcohol and other drug abuse; BHRSC = Behavioral Health Redesign Steering Committee; CJCC = Criminal Justice Coordinating Committee

#	SMART Goal 2013-2014	Performance Target Date	Tactical Objectives[2]	Assigned Responsibility[3]	Implementation Partners[4]	RCHS Staff Assistance

[1] **SMART**: Specific, Measurable, Attainable, Realistic, and Time-bound
[2] **Tactical objectives**: Examples of intermediate attainable measurable objectives in the direction of achieving the SMART Goal. Time frames for these objectives (and others) will be developed by each Action Team or workgroup.
[3] **Assigned responsibility**: The identified Action Teams and other workgroups that are responsible for defining, specifying, and implementing or recommending the implementation of the attainable measurable objectives above. Each Action Team or workgroup operates within—and is supported by—the larger system partnership that is accountable to Rock County DHS and to the BH Redesign Task Force as a whole.
[4] **Implementation partners**: Implementation of objectives to achieve the SMART Goals requires collaboration of multiple partners. Implementation partners will be represented on the Action Teams and other relevant workgroups.

#	SMART Goal 2013-2014	Performance Target Date	Tactical Objectives[2]	Assigned Responsibility[3]	Implementation Partners[4]	RCHS Staff Assistance
IMPROVEMENT AREA 1: System of Care: Creating a collaborative system of care that is welcoming, person-centered, recovery/resiliency-oriented, trauma-informed, integrated, and culturally competent, for all programs and persons providing care to individuals and families with behavioral health needs.						
1	**Person/Family-centered, Recovery-oriented, Trauma-informed, Culturally Competent, Integrated System:** Improve the experience of welcoming, hope, and engagement for individuals and families with complex needs by: a. Progress in systemwide implementation of improvements in welcoming, person/family-centered, recovery-oriented, trauma-informed, culturally competent, co-occurring capability. b. Increased percentage of individuals and families with behavioral health needs experiencing a crisis being engaged in hopeful, trauma-informed continuing relationships that prevent hospitalization and incarceration. c. Improvement in utilization of data from person-centered "stories" to inform system improvement efforts in the BHRSC.	By March 2014 (a-c): a. 80% of BHRSC partner programs and services will have demonstrated measurable progress in welcoming hopeful engagement, person-centered care, trauma-informed interventions, and/or co-occurring capability. b. By December, 2013, Rock County will have an identified team of frontline change agents representing 80% of partner programs and consumer/family advocacy organizations; the team will have monthly meetings scheduled in 2014. c. 10% increase over current baseline in the number of individuals and families who have crisis contact or adult/juvenile justice involvement who are engaged successfully in continuing care that is hopeful and trauma informed. d. 80% of BHRSC meetings will share in an organized manner examples of one or more stories and experiences of individuals/ families in service in order to both inspire and inform the quality improvement process in Redesign.	**Note: In this section only, strategies are matched to each measurable objective.** 1) Identify gaps in BHRSC participation, and take steps to engage those partner agencies in the process. Establish partnership values in the BHRSC that emphasize mutual support for the partners in sharing the population, so all the partners can "win" by participation. 2) Have each program identify change agents and have initial training with ZiaPartners in September; schedule regular meetings with the group to share passion and compare notes re change efforts in each program; receive consultation and assistance from Milwaukee County change agents re content of meetings. 3) Create a "charter document" (based on 9/13 draft) that defines those values and identifies consensus steps for each partner to take in defining its own improvement actions to make progress in welcoming, person/family-centered, recovery-oriented, trauma-informed, culturally competent, co-occurring capability. 4) Provide training in use of COMPASS and SOCAT tools by September 30. 5) Initiate a change agent team with an initial training event by Sept 30. 6) Identify a workgroup to develop a	BHRSC	• Persons with lived experience • Rock County Human Services • And other partners: adult/child MH/AODA providers, public safety/criminal justice agencies, etc. • Data Workgroup	Kate and Lance

#	SMART Goal 2013-2014	Performance Target Date	Tactical Objectives[2]	Assigned Responsibility[3]	Implementation Partners[4]	RCHS Staff Assistance
			simple form to track participation and progress by the partners. 7) Ask Data Workgroup to develop a baseline estimate of how many people in crisis/justice involvement get connected to care, and use that baseline estimate to measure or estimate progress after 6 months.			
2	**Cultural Competency/Cultural Intelligence** By 2014, Initiate organized improvement in cultural intelligence, competency, and responsiveness in the Rock County BH system, by: a. Formalizing a partnership of diverse community representation into a Cultural Intelligence workgroup. b. Identifying initial steps in a Rock County BH Cultural Competency improvement plan that is adopted by the BHRSC partners.	a. By January, 2014, the Cultural Intelligence Workgroup of the BHRSC will have its first meeting, with representation from communities of diversity in the county. b. By April, 2014, the Cultural Intelligence Workgroup will provide an outline for a Cultural Competency plan for review by BHRSC. c. By July, 2014, the outline and initial objectives are adopted by the BHRSC, with a commitment by the partners to take initial steps toward those objectives.	1) Identify community advocacy groups, including faith-based organizations interested in behavioral health needs of diverse populations (e.g., African-Americans, Hispanic Americans, immigrants/refugees, LGBT, etc.). 2) Survey current efforts by participants to measure and achieve cultural competency (tools, training, consultation, in-service education, peer support, etc.). 3) Share data (however collected) on the prevalence of individuals with diversity needs in the current service population of the BHRSC partners. 4) Convene initial workgroup meeting. 5) Review Cultural Intelligence plans and objectives from other counties (e.g., Milwaukee) as well as from other state and federal documents in order to develop initial draft ideas.	BHRSC with Cultural Competency Workgroup development subcommittee chaired by Neil Deupree and Linda Garrett	• Persons with lived experience • Rock County Human Services and all the BHRSC partners • Faith-based organizations • Diverse community advocacy organizations • Tribal organizations	?
3	**Children's System of Care (CSOC):** Within the context of the overall BHRSC mission, vision, and strategic plan, develop a children's system of care in which we work in partnership with each other and with the children and families we serve to improve the ability of	a. By Dec 2013, the CSTCC will have a consensus document adopted by all partners, including parent partners, that commits to the BHRSC redesign, and the specific implementation of a family-	1) Establish regular CSTCC meetings and participation of HSD and community partners. 2) Redefine CSTCC as CSOC community stakeholders of major entities (parents, police, community orgns.)	Coordinated Services Team Coordinating Committee **(CSTCC)**	• Persons/families with lived experience • Rock County Human Services and BHRSC partners	Lance, Tara

#	SMART Goal 2013-2014	Performance Target Date	Tactical Objectives[2]	Assigned Responsibility[3]	Implementation Partners[4]	RCHS Staff Assistance
	children and families with complex behavioral health and human service needs to safe and successful at home, school, and in the community, by: a. Implementation of an organized collaborative with consensus values based on trauma-informed, family-centered, strength-based care partnerships. b. Establishing the empowered involvement of families, parent partners, and youth peers at all levels of CSOC implementation. c. Within that collaborative, improving the child/family experience working with each partner in the collaborative—both separately and as a team. d. Reorganization of the Rock County Human Services Department, with consolidation of Juvenile Justice and Child Protective Divisions in order to better coordinate services for complex families within a CSOC framework. e. Improvement of engagement of children and families with Behavioral Health/Juvenile Justice/Child Protective crises in helpful partnerships that promote success.	centered trauma-informed CSOC. b. By Jan 2014, CSTCC partners will have performed a self-assessment using the SOCAT and developed individual and collective improvement targets. c. By March, 2014, 80% of the CSTCC partners will have improvement in welcoming, trauma-informed, family-centered care. d. By March, 2014, as a result of CSOC development and Human Services reorganization, 10% improvement in engagement of youth and families in crisis over baseline, with reduction of high-end placements. e. By Jan 2014, 80% of service programs in CSTCC partnership will have parent partners at the table in planning improvements.	3) Develop a plan for drafting and adoption of consensus document. Ensure alignment with the BHRSC Charter document (a supplemental charter specifically for CSTCC). 4) Use the SOCAT to help each partner understand its role and its next steps. 5) Ensure child/family agency and parent partner participation in Change Agts. 6) Provide introductory training in trauma-informed care for all partners, and for Change Agents. 7) Assist all partners with engagement of parent partners or other parent/ youth advocates in their improvement activities. 8) Develop early and attainable success metrics for improvement in Trauma Informed Care (TIC) for youth and families (e.g., data on prevalence of trauma; improving processes that contribute to retraumatization; using strength-based language in all case discussions).		• Child protective services • Community school system reps	
4	**Adult System of Care (SOC): Accessible and Flexible Community Continuum of Recovery Support:** By 2014, develop and sustain a continuum of services and programs (both county-operated and operated by system partners) for adults with mental illness—including those with co-occurring substance use disorders and other complex needs—that is welcoming, flexible, and prioritizes early intervention. There will be improvements in the flexible availability and continuity of	By March, 2014: a. Rock County will implement Comprehensive Community Services program. b. Improve the intake/access function in the Human Services Department BH Division to be welcoming, flexible, and responsive, with standardized processes to facilitate access at multiple entry points for adults	1) Develop CCS implementation plan through partnership with neighboring counties in the region. 2) Redesign access to county MH Services by creating more of an open access model. 3) Develop a collaboration with other county providers to set up an access system with collaborative coordination for priority clients. 4) Continue working on universal	Adult Continuum of Care workgroup (including county and other adult providers)	• Persons with lived experience • BHRSC members • Prescriber's Workgroup • Data Workgroup	Kate (Kent, Amy, Sue)

#	SMART Goal 2013-2014	Performance Target Date	Tactical Objectives[2]	Assigned Responsibility[3]	Implementation Partners[4]	RCHS Staff Assistance
	community-based recovery supports resulting in: a. Improved access to community-based assessment, treatment, medication, and recovery supports for individuals/ families with behavioral health needs. b. Improvement in flexibility of maintaining continuity of service/support/treatment relationships when service intensity needs change.	and children. c. Through the redesigned access process, access to MH services for adults in crisis or coming out of jail will be improved by reducing wait times by 25% (or 75% of individuals seeking continuing services after crisis/jail will be connected within 14 days). d. 25% of current clients in CSP will be able to transition to less intensive services while maintaining some continuity of treatment relationship. e. *Increase psychiatric prescriber capacity by adding an additional prescriber resource (see below).* f. *Improve targeted outreach and access for those re-entering the community from jail (see below).*	welcoming, and co-occurring capability (per Goal 1). 5) Utilize flexible funding models to design person-centered service packages that can flex with clients as their needs change. 6) Encourage existing county clinic staff to organize more flexibly in each location to facilitate managing complex populations, including a range of service intensities from intermediate crisis intervention all the way to CSP. 7) Collaborate with Prescriber's Workgroup to improve MD/RN access. 8) Collaborate with data workgroup re outreach to jail release and probation.			
5	**AODA Recovery-oriented System of Care Continuum** To create a welcoming, recovery-oriented integrated system of care where individuals can access care as needed, move through the continuum as appropriate with flexible lengths of stay, and have co-occurring mental health and trauma issues addressed throughout.	By March, 2014: a. There will be a procedure for clients to move through levels of care based on readiness rather than on fixed length of stay. b. 20% of all clients will demonstrate flexible lengths of stay using this procedure. c. The AODA continuum will make progress on co-occurring capability in partnership with MH (see Goal 1). d. There will be a process by which 50% of clients move quickly (within 14 days) into a treatment	1) Continue work on universal COD capability per Goal 1. 2) Develop a working partnership with all AODA providers to establish flexible procedures through performance improvement and client-centered approaches. 3) Improve access to less intensive services like sober housing, recovery coaching and peer support, so that people with addiction and co-occurring conditions can have more ongoing support within limited resources.	AODA Steering Committee	• Persons with lived experience • AODA treatment providers • Detox • Sober housing providers • Probation • Juvenile Justice • AODA Treatment Courts	Rebecca

#	SMART Goal 2013-2014	Performance Target Date	Tactical Objectives[2]	Assigned Responsibility[3]	Implementation Partners[4]	RCHS Staff Assistance
		setting after initial access appointment.				
6	**Overarching Structure for Continuing Rock County BH System Improvement and Oversight (Progress Reporting):** Produce and maintain a mechanism to publicly chart system quality indicators that reflect progress on Redesign SMART Goals, and use the data in those indicators to inform continuing strategic planning and data-driven improvement steps.	By January, 2014: Develop/draft the first annual Rock County BH System Dashboard and Community Progress Report to chart progress on Redesign SMART Goals.	1) Establish public/private system quality indicators aligned with the overall system vision. 2) Identify and coordinate existing data sets and data sources. 3) Determine how to include "data" on consumer/family experiences in the improvement process. 4) Identify how improvement targets in SMART Goals will be measured and reported. 5) Create information-sharing agreements.	Redesign Task Force Possibly with Data workgroup or a new Evaluation or Quality workgroup	• Persons with lived experience • BHRSC members	Kate, Lance, and ?
IMPROVEMENT AREA 2: Crisis System Redesign: Creating and sustaining a community-based continuum of crisis services to reduce involuntary commitments and undue reliance on acute inpatient care.						
7	**Welcoming Integrated Crisis Continuum:** To provide a coordinated, integrated response to mental health and AODA emergencies that is focused on individual and family needs; to promote understanding and acceptance of each collaborative partner's role in emergency response through continuous improvement, training and collaboration. By 2014, improve crisis access and response to reduce Emergency Detentions (Chapter 51, Involuntary Commitment for Treatment) and improve continuity of care following crisis.	By Mar 2014: a. The number of 51-45 involuntary commitments for addiction will be reduced by 25%, and replaced by a more welcoming, integrated crisis response. b. The number of Crisis Intervention (CIT) trained officers in Rock County will increase by 20%. c. Consumer satisfaction surveys will demonstrate a 10% improvement in satisfaction with welcoming, person-centered crisis response. d. The percentage of voluntary crisis interventions (compared to involuntary) will increase by 10%.	1) Continue to review and enhance the Community Crisis Response Group (CCRG) MOU. 2) Case reviews to compare actual practice with Memoranda of Understanding. 3) Increase availability of Crisis Intervention (CIT) training, and engagement of officers in the training. 4) Expansion of role and availability of mobile crisis. 5) Addressing protocols that facilitate engagement in crisis intervention of individuals who are using substances. 6) Improving welcoming crisis response so more individuals and families ask for help sooner, before involuntary intervention is needed. 7) Increasing development of protocols	Community Crisis Response Group as a subgroup of the Adult Continuum of Care workgroup	• Persons with lived experience • Crisis Director • Community crisis service and inpatient providers (e.g., Rock Valley, Mercy, Beloit Hospital) • Local public safety • Hospital Emergency Rooms • AODA director • Crisis AODA providers • MH and AODA providers	Melissa

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			for crisis followup		• Faith-based services • CIT trainers	
IMPROVEMENT AREA 3: Continuum of Community-based Services: Creating and sustaining an integrated and accessible continuum of recovery-oriented community-based behavioral health services, including psychopharmacology, to support recovery in the least restrictive settings.						
8	**Consumer/Family Empowerment, plus Peer Specialist and Peer-Operated Services Expansion:** To develop and sustain a legitimate mechanism for integrating organized consumer/family voice into the BHRSC strategic planning and RCHSD operations AND to expand the availability of peer/family support and recovery coaching services in the Rock County system of care.	By March, 2014: a. Identify a formal group of MH and AODA consumers and family members to meet regularly and have a role in the BHRSC process. b. Provide training for 10 individuals interested in being certified peer specialists. c. Recruit 5 individuals in peer specialist roles in MH and/or AODA services.	1) Implement the Participatory Decision-making Model Process via the GEP/DHS initiative. 2) Engage peer specialists from other systems to meet with key leaders in BHRSC and RCHSD to help identify curricula, provide mentorship, and define roles for peer specialists. 3) Create partnerships between MH peers, AODA peers, youth peers and family-to-family peers. 4) Seek DHS support for initial CPS training. 5) Identify BHRSC agency partners to initiate peer specialist activities. 6) Create policy to allow peer specialist roles within existing service models.	Consumer/Family Workgroup	• Persons with lived experience • Grassroots Empowerment Project (GEP) • WI Department of Human Services (DHS) • Peer Support leaders • National Alliance for the Mentally Ill (NAMI) • Sober support organizations • Parent partners • BHRSC providers • Faith-based organizations	Kate Flanagan and Maggie Keneen
9	**Psychiatry and Psychopharmacology Access and Quality:** To empower psychiatrists and NPs across the county to work as partners to improve access and quality of psychopharmacologic practice, through reviewing and improving clinical and policy barriers, and identifying/recommending improvements to the BHRSC.	By March 2014: a. The Prescriber's Workgroup will have three meetings, and identify MD/NP (nurse practitioner) leadership. b. The Prescriber's Workgroup will identify one psychopharm practice guideline or policy and recommend improvement.	1) Provide admin support to help the MDs have time and resources to organize. 2) Implement a defined Medical Director role for the Rock County systems of care, to provide necessary leadership in this area. 3) Validate the need for collaboration among MDs and NPs as cost-effective	Prescriber's Workgroup chaired by Greg Ammon and Lisa Usgaard Consultation from Ron Diamond	• Persons/families with lived experience • All BHRSC community providers with prescriber capacity (including NPs)	Rock County Human Services Dept Medical Director for BH

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		c. There will be a discussion of consensus psychopharm practice guidelines for individuals with co-occurring disorders. d. There will be a proposal for collaborative methods for problem solving or medical review of complex cases in the county.	approach to improving quality. 4) Review existing practice guidelines. 5) Identify medical leadership roles for adults and children within the county. 6) Develop mechanisms by which prescribers can more easily collaborate and communicate across boundaries to improve care.			
IMPROVEMENT AREA 4: Integrated Multi-system Partnerships: Create welcoming partnerships between behavioral health stakeholders and other community systems to maximize access to services that promote recovery and health.						
10	**Criminal Justice – BH Linkage and Data Sharing:** By 2014, improve criminal justice behavioral health collaboration to reduce inappropriate incarceration of people with behavioral health needs, through: a. Establishment of data link between the Rock County criminal justice system and Rock County BHD that respects privacy and confidentiality requirements and helps prevent inappropriate incarceration of persons with mental illness and AODA conditions. b. Development of a baseline assessment of the behavioral health needs of the criminal justice populations. c. Creation of a mechanism for ongoing tracking and service improvement for high-need individuals with CJ-BH needs. d. Progress in implementation of an integrated continuum of Rock County criminal justice diversion and reentry services, based on application of therapeutic justice principles for persons with behavioral health needs.	By Oct 2013: a. Complete the high-utilizer study with a report on resource utilization, system mapping of service provision, and potential for improvement. b. Identify an initial target group for intervention based on overlap of recidivism, probation involvement, and treatment attachment. By Jan 2014: c. Initiate two pilot projects with teamwork between probation and service sites to demonstrate the potential value of improved teamwork in reducing recidivism. d. Create a protocol to improve more routine data sharing and data tracking across the system going forward for individuals with criminal justice involvement, in order to promote collaboration to reduce recidivism.	1) Collaboration between CJCC, Adult Continuum of Care Workgroup, and Data Workgroup. 2) Initiation of more routine BH screening at jail/probation entry. 3) Setting up a process for routine data collection and tracking of high-risk individuals going forward. 4) Develop proactive release of information protocols for BHRSC member agencies. 5) Initiate a training in therapeutic justice and co-occurring disorder principles for all court personnel, and develop a workgroup to apply these principles systemwide.	Adult Continuum of Care Group with support of Data Workgroup and CJCC	• Persons with lived experience • Rock County Criminal Justice Coordinating Committee (CJCC) • BHRSC and its partners • Criminal justice system behavioral health providers (including specialty court and jail-based services) • Judges, prosecutors, defense bar • Adult and Juvenile probation and parole • Jail medical staff • Detention staff	

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		e. Develop a shared framework for how all the specialty court services will collaborate to introduce therapeutic justice principles into the "usual" court proceedings for individuals with behavioral health needs.				