ROCK COUNTY BEHAVIORAL HEALTH SYSTEM INTEGRATION REDESIGN
Behavioral Health – Adult/Juvenile Justice – Human Services Partnership

STRATEGIC PLAN NARRATIVE

Prepared by ZiaPartners, Inc. – September, 2013

Overview

The purpose of the strategic plan is to provide a framework for system transformation and integration for the Rock County Behavioral Health Redesign Steering Committee (BHRSC), which represents an operating partnership among Rock County Human Services Department (Behavioral Health, Juvenile Justice, and Child Protective Services), Rock-County-based criminal justice services (jail, detention, parole, local public safety), mental health and AODA providers in Rock County, other partners (school-based services, health centers, faith-based community), and consumers/families. The strategic plan is designed to assist the BHRSC to operationalize a vision of a welcoming, recovery-oriented, trauma-informed, complexity-capable, culturally competent system of care for adults and children/families throughout the county, in order to improve outcomes for Rock County citizens, within available resources. A particular focus is reducing utilization of—and recidivism in—high-end services, particularly within the criminal justice system (e.g., jail and detention), but also in other arenas: reducing hospitalizations, AODA treatment recidivism, and residential placement for youth.

Note that this strategic plan narrative and the incorporated SMART goals are intended to be used together with the charter document. Please reference the attached diagram (Appendix 1).

Organization of the Strategic Plan

The Strategic Plan provides guidance for organizing system redesign as a county-wide quality improvement partnership and process. In this partnership process, improvement will take place in multiple arenas simultaneously. These multiple arenas include:

- **Systemwide improvement (Goals #1 and #2)**: Systemwide framework for adoption of—and improvement in—welcoming, recovery-oriented, trauma-informed, co-occurring capable/complexity-capable, culturally competent practice, within each program in the partnership, and in the system as a whole.

- **Subsystem improvements**: Specific steps to improve performance and outcomes within the following subsystems in Rock County:
  - Services for Cultural and Linguistic Minorities (Goal #2)
  - Children's System of Care (Goal #3)
  - Adult MH System of Care (Goal #4)
  - AODA Continuum of Care (Goal #5)
  - Crisis System Redesign (Goal #7)
  - Psychopharmacology Prescriber Network (Goal #9)
  - Behavioral Health – Criminal Justice Collaboration (Goal #10)
- **Program and Practice improvements (Goals #1, 2, 3)**: Specific steps for each program to take to improve welcoming, recovery-oriented, trauma-informed, co-occurring capable/complexity-capable, culturally competent policies, procedures, and practices, including competency development for all staff providing help.
- **Improvement in Consumer/Family Empowerment (Goal #8)**: Specific steps to more effectively empower the voice of consumers and families in the design, development and improvement of the service system, and to expand the availability of peer recovery support throughout the service network.
- **Progress Reporting and Continuous Improvement (Goal #6)**: Development of a process within the BHRSC for continuous improvement tracking, and strategically using performance improvement data to measure progress and continuously update goals, objectives, strategies and activities from year to year.

SMART Goals

The core of the Strategic Plan is defined within the SMART Goals. The SMART Goals outline specific goals, measurable objectives and time frames, strategies, and responsible teams and individuals for each of the areas above. The first SMART Goal describes the framework for systemwide improvement, and provides guidance for the partnership within which all programs will make progress. The first SMART Goal also makes reference to a Charter Document, which is also part of the Strategic Plan, and which is described in the next paragraph. The Charter Document provides guidance for the specific activities each provider and program in the partnership agrees to engage in to improve their respective capacities in the direction of the shared vision. Each of the remaining SMART Goals references progress in specific subsystem activities listed above, except for one SMART Goal which is focused on progress in consumer empowerment and peer support expansion.

Charter Document

The Charter Document is provided as a road map for the systemwide progress that is outlined in the first SMART Goal; it also simultaneously supports the structures within which progress on the other SMART Goals takes place. It is a mechanism for each participating partner to sign on to a consensus that incorporates the following:

- Agreement on a shared vision.
- Agreement on a framework for operationalizing the vision (Comprehensive Continuous Integrated System of Care [CCISC]).
- Commitment by each partner regarding steps to take to support systemwide progress:
  - Commitment by Rock County Human Services Department to organize the process across the county as a whole, and within each of the subsystems, in accordance with the structures and steps described in the SMART Goals.
  - Commitment by each provider/program to organize and participate in the quality improvement process, identify change agents, utilize recommended tools for baseline self assessment, and make measurable progress in its own work in the direction of the vision, as described in the SMART Goals.

Collective Impact

The whole process of redesign utilizes a system quality improvement model called *Collective Impact*. In this process, progress in the Strategic Plan to achieve the vision happens in multiple areas at the same time. The responsibility for each area of improvement is assigned to a different entity within the system (e.g., BHRSC, specific subsystem workgroups, individual providers/programs). Each entity makes small steps of progress, using specific tactics and strategies to achieve its measurable objectives in the direction of its goals, in relation to the overall vision, as defined and outlined in the SMART Goals. Even though the overall process is complex, each entity is only responsible for its own small and achievable steps. However, because those small steps are occurring at many places at once, the whole system makes considerable progress. The entire process is coordinated by the BHRSC.

Motto: Progress not perfection. Slow and steady wins the race.

Within the quality improvement process for system change, the BHRSC can provide important guidance by making sure that each participating partner or workgroup recognizes the importance of small steps of measurable progress, gets a round of applause for its accomplishments, and is supported to slow down if it starts to feel overwhelmed by its tasks.

Review of the SMART Goals

This section of the narrative briefly reviews each SMART Goal, and provides some guidance for implementation and organization of the change process defined by that SMART Goal. SMART Goals #1-6 relate to systemwide or large subsystem improvements in various areas; SMART Goal #7 relates to crisis system improvement specifically. SMART Goals #8 and #9 relate to targeted practice areas of peer support and psychopharmacology, and SMART Goal #10 focuses on the intersystem partnership between behavioral health and criminal justice.

SMART Goal #1: Welcoming, Recovery-oriented, Trauma-informed, Integrated System of Care

This goal defines the strategies and objectives for making universal progress in quality improvement, using the CCISC model. Each partner has already agreed (in the "homework" poll) to engage in the activities described in the Charter Document. Training in the tools has been provided. The next step is for individual programs to get organized in creating their CQI teams, identify change agents to attend an introductory change agent training, and perform their self-assessments using the appropriate tool(s). Following the self-assessment, each program should identify a few areas for improvement (action plan). Progress gets reported back to the BHRSC, where small steps are applauded, next steps are coordinated, and system barriers can be identified and addressed at the policy level.

Once change agents are identified and oriented, they should make a plan to meet regularly, with support from the BHRSC. The change agents should solicit "peer support" from Milwaukee's change agent team (MC3). The change agents will share their own progress in each program with each other, and work to become a collective, boundary-spanning team at the frontline care level. Representatives of the change agent team might be invited to join the BHRSC to provide a formal connection as well.

As each program makes progress in this process, even though initial steps may be small, the system culture as a whole starts to shift, and there is more empowerment and partnership at multiple levels in the change process. This in turn informs the work of the subcommittees and workgroups, and helps "subsystems" to make more progress with more creative solutions.

Sharing stories and experiences of "real people" with complex needs is one method for sharing and demonstrating improvement in both culture and outcomes. These experiences can illustrate progress at all levels of the system in welcoming and engaging individuals and families with complexity, and illustrate areas of improvement opportunity where each partner can take a small step to create a better experience for people coming to the door.

The process of change outlined for each program continues over a period of many years. The BHRSC can update the SMART Goals and the Charter Document annually as indicated, to identify next steps of progress on this SMART Goal once the initial targets have been achieved. Progress involves improvement in more targeted clinical practices such as assessment, treatment planning, cross-consultation and collaboration, programmatic content in skills training, and core staff competencies.

SMART Goal #2: Cultural Competency/Cultural Intelligence

Rock County deserves a round of applause for putting this important but challenging issue into the Strategic Plan at the outset. Note that the early targets of this Goal are simply to engage partners representing diverse population, and organize them into an empowered team that has a place at the table. The next set of steps is to identify a mechanism for collecting baseline data on the diversity of the population served and on the "cultural intelligence" for each provider. Although this process is starting later in the sequence than the processes for improving trauma-informed care and co-occurring-capable care, the process of improving cultural competency/cultural intelligence can and should build on the same framework that is put together for universal improvement in SMART Goal #1—each program can use the same CQI team, the same change agent team, and the same process of self-assessment and action planning. In this way, Rock County is using this Strategic Plan to build a quality improvement partnership structure within which all types of change activities can be inserted over time.

SMART Goal #3: Children's System of Care

This SMART Goal provides a fairly concrete set of steps that allows for progress within the CSOC partnership to improve trauma-informed co-occurring capability in order to improve outcomes for youth and families with complex challenges. Four key components of this SMART Goal reflect strategic alignment:

- Alignment of the internal change processes with the goals and objectives of Human Services Department reorganization of children's services.
- Elevation of the CSTCC to be an overarching CSOC partnership under the umbrella of the BHRSC, rather than focusing in isolation on the CST as one program.
- Alignment of the change process in CSOC with the overarching CCISC process, by utilizing the CCISC system of care tool (SOCAT™) to engage "non-clinical" partners, while also utilizing COMPASS-EZ™ by partners that provide clinical services.

- Incorporating formal processes and metrics for improving the engagement and availability of parent partners in alignment with the expansion of peer support generally, described in SMART Goal #8.

SMART Goal #4: Adult System of Care

The focus of this SMART Goal is on utilizing the whole strategic planning process to make progress in welcoming, access, engagement, and effective/efficient service provision for adults with complex needs who may be entering the door of mental health services, commonly with co-occurring AODA issues, and often coming in from crisis settings and/or jail.

When operationalizing the strategies and objectives in this Goal, it is important to keep in mind:

- The system has been historically "mis-designed" into rigid boxes that do not match what clients need. Those boxes often inadvertently produce poorer outcomes and higher costs by making it harder to gain access, placing clients in higher levels of service for longer periods than needed without flexibility to adapt, and interfering with creating flexible "team models" of care for high-volume complex populations. The purpose of this process is to use this improvement framework slowly and steadily to redesign the adult system of care to be better matched to the needs and hopes of the clients coming to the door.
- Responsibility for change must be collectively held. County-operated services have room to improve, but the BHRSC represents a county-wide partnership. If all partners take a small step in the direction of shared ownership of the total population, realizing that there is more to be gained *in* the partnership than by standing outside of it, the whole system will make progress.
- Within that partnership, each partner must be viewed as a priority client of the other partners, so that each program that steps forward knows that other programs will be there to be helpful and welcoming.
- Within all of this activity, CCS must be viewed as a helpful funding stream that facilitates systemic improvement, rather than a separate funding silo. Consequently, CCS planning should be "integrated" within the BHRSC process, either using the BHRSC as a whole—or the Adult Continuum of Care workgroup—as the CCS planning committee, within which specific workgroups can break off to accomplish concrete tasks, but held within the larger redesign process. However, steps of progress in access and engagement can be developed (see next bullet) within any funding stream.

- All the partners must be challenged to think creatively about access and engagement. Examples include models of "open or same day access" (where teams come together to engage people who drop in, either for initial or continuing care); flexible teamwork to provide brief but intensive crisis intervention, recognizing that for many individuals continuing therapy or case management is *not* required; flexible transitions out of CSP into intermediate levels of service; and development of better team structures so that prescribers can work more effectively with more organized support. Remember: progress not perfection. To be an effective partner may involve taking *one* more client in crisis than currently is the case—if that's the best way for that partner to proceed.
- This goal aligns with Goal #9 (Psychopharmacology) and Goal #10 (Criminal Justice Partnership). Note the importance of collecting data on the current baseline of access (e.g., currently, how long is the waiting list?) so that it is easier to demonstrate progress.

SMART Goal #5: AODA Continuum of Recovery-oriented Services

This Goal focuses on expanding flexible use of limited resources within the AODA continuum, in a strategic improvement process that mirrors the activity in SMART Goal #4. Progress is aligned with concepts of universal welcoming and co-occurring capability, development of a recovery-oriented system of care with gradually increasing emphasis on continuing "disease management" and recovery coaching than on front-loaded high-intensity treatment episodes, expansion of sober living options, and establishment of a quality improvement partnership where providers who step forward to be creative problem-solvers within the AODA continuum (and within the larger system change as a whole) are supported and rewarded.

In addition, a key element of the work of the AODA Continuum involves engaging prevention networks and prevention providers to partner with treatment in addressing population needs, in partnering with multiple types of prevention (AODA, MH, domestic violence, school dropout) to have a systemic, trauma-informed, holistic prevention approach, and to begin to collaborate to promote early detection and early intervention with individuals and families at risk.

Key elements to keep in mind in operationalizing this Goal:

- A small pot of flexible funding is available for Rock County to receive consultation and training in the AODA continuum. Because the system redesign involves universal improvement in co-occurring capability (which is part of the strategy of better leveraging all available resources to support appropriately matched and integrated interventions for AODA issues) that flexible funding pot can be used to support broader system activities such as change agent training and program technical assistance regarding co-occurring capability.

- The COMPASS-Prevention™ is a specific COMPASS™ tool for prevention programs.
- The same strategies of facilitating flexibility and access that were described above in Goal #4 also apply in this Goal. AODA services have also been traditionally designed into rigid and expensive care boxes, rather than emphasizing flexible access, person-centered/trauma-informed assessment and intervention, and ongoing recovery support partnerships over intensive and expensive brief episodes of care. Each program can begin to take small steps to facilitate access and low-threshold retention to improve the ability to serve more individuals for longer periods within limited resources.
- In the CCISC process and partnership, more individuals should receive services in a single door, rather than duplicate or parallel services. Therefore, mental health and AODA providers should become priority partners for one another, through provision of consultation and in-reach, not only through referral.
- Expansion of peer support and recovery coaching allows extension of services utilizing less costly service providers more effectively and efficiently.
- AODA services should *not* be designed on the assumption that individuals are discharged for use. Providing continuing care for individuals who are either in early stages of change or who relapse while in treatment is an essential component of a recovery-oriented, trauma-informed, co-occurring-capable continuum. Working in ongoing partnerships with complex clients to help them gradually learn the skills they need to succeed is a more cost-effective long-term approach to managing the chronic disease of addiction.
- Expansion of sober housing and recovery homes provides an inexpensive grassroots community investment in the startup of small houses that are eventually self-supporting and can collaborate with outpatient services to provide a functional residential level of care at much lower cost. Rock County is fortunate to have a knowledgeable sober home operator in a key position to help make this happen.
- Finally, as in the previous Goal, it is important to gather simple baseline data on access and retention in order to make it easier to demonstrate improvement toward the achievement of the measurable objectives in this SMART Goal.

SMART Goal #6: Progress Reporting

This Goal basically defines the BHRSC as the locus of data collection for evaluation and continuing improvement, and defines the role of the Data Workgroup or similar workgroup to engage in a process to develop a simple set of metrics and dashboards to track progress.

To keep it simple, there are three things to plan for:

- A dashboard that tracks progress by each workgroup on its SMART Goals and Objectives.
- A simple checklist by which each individual partner can track progress on its activities in the Charter Document and on the COMPASS-EZ™ and SOCAT™.
- A mechanism for creating an annual report of progress for key stakeholders, including the County Board of Supervisors, and for updating the SMART Goals approximately once a year.

SMART Goal#7: Crisis System Redesign

The framework of this SMART Goal is to provide guidance for the CCRG on areas of strategic prioritization within the larger redesign process, to help go beyond monitoring and improving the current MOUs. The mobile crisis team implementation has made dramatic impact on the system, as has the opening of the Crisis Stabilization Unit at Rock Valley. Now there is an opportunity to take this one step further, as follows:

- Expansion of voluntary access to crisis response involves beginning to map and coordinate *all* the places in the county that provide any level of crisis response, so those services operate as a continuum, rather than as disconnected. The goal of CCRG then becomes the provision of the "glue" that holds it all together and mobile crisis becomes a means to "hold the back" of existing crisis capability as much as possible.
- Part of the crisis partnership involves the transition from a crisis evaluation to some form of continuing crisis care. Any improvement in this capacity by any of the partners takes pressure off the need to find the "right disposition" after a single crisis contact, and is likely to result in less pressure on high-end services.
- Finally, as part of the larger improvement process, the goal for the crisis continuum is to become more integrated. This means more organized collaboration between mental health crisis and AODA access, improvement in welcoming of individuals with active substance use in crisis programming at all levels, and in general, less reliance on sequential or parallel service delivery. All partners working on co-occurring capability take steps to become more welcoming of individuals who are in mental health crisis with active substance use issues, thereby steadily reducing utilization of 51-45 commitments, which are commonly costly and duplicative, as a sequential intervention prior to receiving mental health crisis care.
- Again, as with the other goals, it is important to identify and measure the baseline related to the SMART Goal objectives, in order to more easily demonstrate incremental progress in the appropriate time frames.

SMART Goal #8: Consumer/Family Empowerment/Peer Support Specialist Expansion

This Goal allows for measurable progress in a key component of recovery-oriented system development, in alignment with all the other SMART Goals. Rock County is just getting started in these areas, but the framework of the SMART Goal objectives allows for a focus on achievable targets and measurable success.

Key elements include:

- Strategic alignment of the Grassroots Empowerment Project funded by DHS with the larger Redesign activity. It is recommended that the GEP identify metrics for progress that might be appended over time to the objectives for this SMART Goal.
- Recognition of the importance of taking measurable small steps in getting consumers and families organized, so that collectively they can be more effectively represented at the various tables, including the BHRSC.
- Recognition of proceeding slowly with peer support specialist implementation, in order to help partners who are concerned about risk and liability make progress in a way that feels manageable, and helps the involved peers be successful.
- Utilizing peers from other counties (e.g., peer support specialists participating in MC3 in Milwaukee) as "mentors" for local peer development activities, so as to use resources efficiently and not reinvent the wheel.
- Once again, measuring the baseline at the beginning (even though it is very low) is important to be able to document progress in the SMART Goals.

SMART Goal #9: Improving Psychiatric and Prescribing Practice Quality, Access and Responsiveness for Individuals and Families with Complex Needs

The overarching purpose of this SMART Goal is to create a structure by which Rock County prescribers can become more organized system partners with one another, and collectively be empowered partners in the redesign process. It is important to remember that small steps of progress in this area are a very big deal, because currently the providers are so disconnected, which leads to unnecessary tension and struggle in a small county where everyone has the potential to provide mutual support.

Key elements include:

- Rounds of applause for having regular meetings of the Psychiatric Prescribers Workgroup.

- Over time, establish and empower the role of a system Medical Director, and have that person assume the leadership of the Workgroup and have a seat on the BHRSC.
- Recognize that any improvement steps taken by the Prescribers Workgroup might initially be small. Examples include better communication regarding clients moving through the system; adoption of simple practice guidelines for access and retention of individuals with complex needs; identification of one improvement area for peer discussion (e.g., suicidal behavior; crisis assessments). Pressure to take on too much makes things harder.
- Most important, recognize the importance of psychiatrists, nurse prescribers, and other prescribers being on teams with other clinicians in as many venues as possible. Teamwork does not have to only look like CSP. Medication clinics can be team exercises where all the team's clients are scheduled to appear on a particular day/time where everyone is present to take care of whatever is needed, providing more efficient engagement and lots of ready-made support for the prescriber.

SMART Goal #10: Behavioral Health-Criminal Justice Linkage and Data Sharing

Note that the previous work of the Rock County CJCC, the progress on the current data-sharing project by the Data Workgroup (see summary in Appendix 2 by Dr. Zahniser), and the considerable progress in the development of specialty treatment court services in the county are all strong steps to build upon in the system redesign. This SMART Goal outlines several areas of opportunity, as follows:

- Include the specialty court programs in the broad system partnership to sign on to the Charter Document, use the COMPASS-EZ™, and so on. Note that it is helpful to expand representation directly from the Specialty Court staff on the BHRSC. It will be important for each Specialty Court to have specific structure to regularly meet as a team for continuous improvement of program policies, procedures, and practice, to more successfully incorporate co-occurring capability and therapeutic justice principles into routine work.
- Begin the conversation with the Specialty Courts about applying what they have learned about therapeutic justice in routine dockets, even proceeding in small measurable steps. Co-occurring behavioral health needs are an expectation throughout the "regular" courts, and any measurable step forward is a round of applause per the SMART Goal objective.
- The current high-utilizer project provides an opportunity to identify a subset of the high-utilizer population that can potentially be better managed by improved coordination and "team membership" between designated probation officers and designated treatment

providers. The motto of *progress not perfection* starts with the places where these team structures make sense because high utilizers are already present to support the investment of resources. Based on what might be learned from improvement with these individuals, further improvement can be planned and measured in accordance with the SMART Goal.

- Consider the brand new re-entry grant as a transitional step to develop more routine procedures for pre- and post-booking diversion into rapid access crisis case management, and for more routine procedures for transitional case management for jail re-entry, as well as movement toward assigning probation officers to be regular partners to treatment teams that share their caseload of individuals with behavioral health needs.
- Keep in mind that co-occurring is an expectation. As much as possible, individuals with criminal justice involvement will do better receiving integrated care (rather than parallel care in two settings) because they tend to have a hard time making a single connection, let alone two connections. Thus, progress in universal co-occurring capability is linked to progress in this SMART Goal as well.
- Finally, it is important to measure the current baseline regarding the SMART Goal objectives, in order to be able to more easily demonstrate progress.

Next Steps

This Strategic Plan incorporates activities and objectives through the middle of 2014. Remember that if the timeframes seem too ambitious, the BHRSC can decide to lengthen time frames or adjust targets as needed, in order to support successful progress.

Once the bulk of the initial objectives are achieved, the BHRSC should prepare a formal report and review of the Strategic Plan and the SMART Goals, with input from the various workgroups, individual providers, and other constituencies (change agents, consumers, families, etc.).

At this point, two sets of decisions need to be made:

- Each workgroup should be responsible for updating its own SMART Goal, measurable objectives, time frames, strategies, and partners. Updates should reflect measurable and achievable next steps in the direction of the overall goal. Each workgroup should submit a draft to the BHRSC for collective review; the BHRSC designates an individual to collate the updates into an updated plan.
- The Charter Document should be reviewed and updated at the same time. The Charter Document includes measurable and achievable next steps for *each* program. These may

include further progress in implementing core practices in alignment with the vision: integrated screening, assessment, recovery/treatment planning, etc.

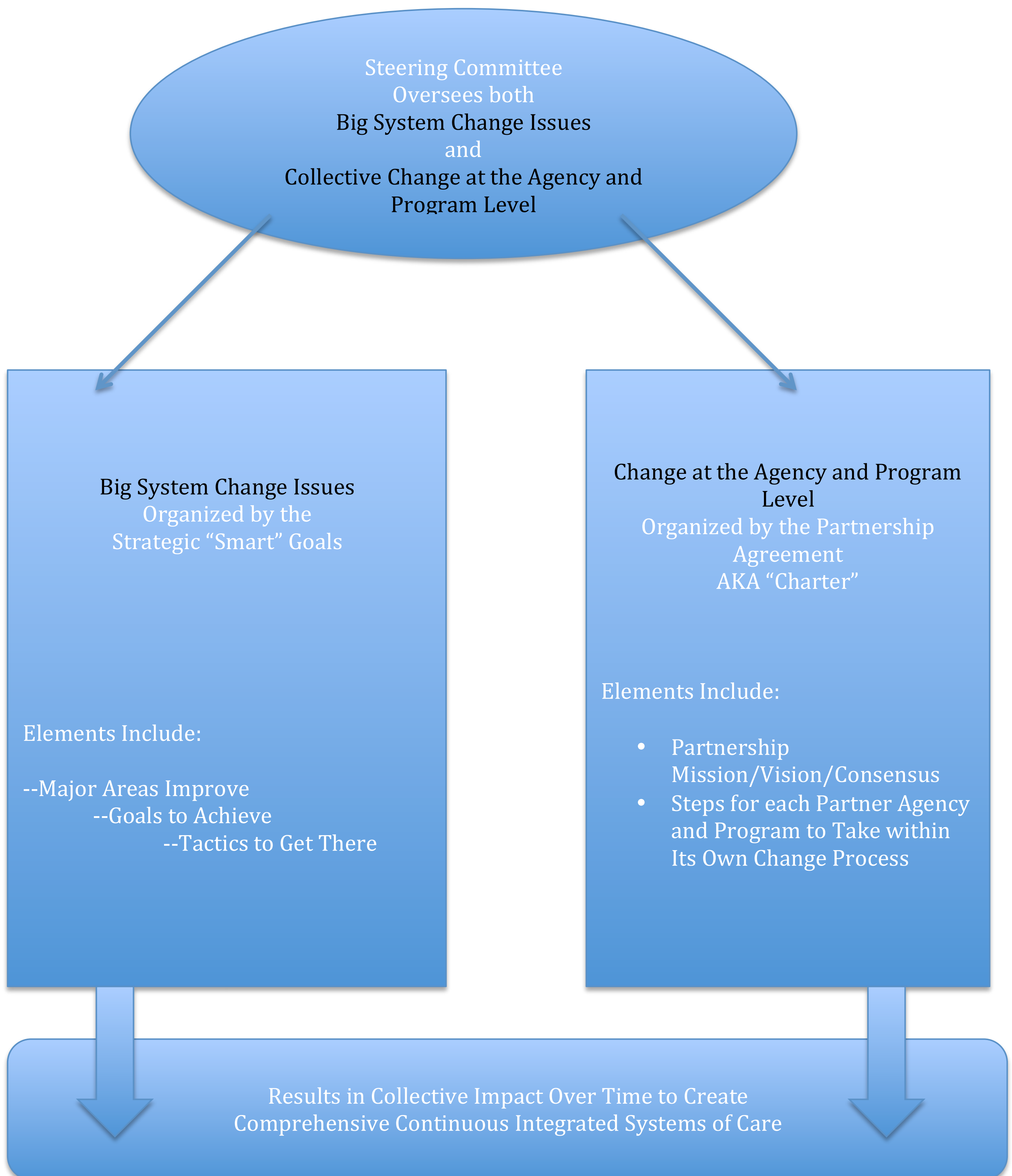
- Based on the importance of relevant issues and the availability of individuals/groups to take them on, BHRSC should review whether additional SMART Goals and workgroups should be initiated. One important issue to address might be housing/homelessness for individuals with behavioral health needs, including those involved with the criminal justice system. This activity might be built on the existing county coalition to address homelessness, or similar group. Another important improvement area will be primary health/behavioral health integration, and implementation of the Affordable Care Act within the county.

Conclusion

This Strategic Plan will help the Rock County BHRSC partnership to get started in making measurable progress toward implementing the system vision, and to have a framework for continuing measurement and updates over time. Ultimately, the BHRSC and the system as a whole can use this process to create an enduring partnership within which continued transformation and improvement toward having an inspired system can take place over many years, and can anchor the partnership in place in an enduring way.

Appendix 1

How Strategic Planning Tools Work Together for Rock County



Appendix 2

Behavioral Health Redesign Steering Committee Data Work Group

Prepared by 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.
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 the 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, ZiaPartners and TriWest Group propose 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 are listed in the table below. ZiaPartners 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 from 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 1 booking in 2012. Nearly one-quarter of those people (1,111; 45%) had 2 or more bookings in 2012, and 45 people had 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 programs	7	0.15%
	Crisis interventions	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 use 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 on 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 databases 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 Behavioral Health 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 page 6, 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 and/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 (CSP). 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 that some people in need of CSP services were 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, a very small percentage of people received 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 was recently 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

		% Served				
	Levels/Types of Service	**Rock County Human Services Dept**	**DOC - Probation**	**Beloit Memorial**	**Mercy**	**Crossroads**
Mental Health Services	Outpatient Mental Health Clinics	42%				
	General Outpatient - Adult			7%	20%[1]	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%[2]	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[3]	18%

[1] Includes 29 receiving therapy/counseling and 25 receiving medication (not necessarily unduplicated)
[2] Includes 21 receiving therapy/counseling and 9 receiving medication (not necessarily unduplicated)
[3] 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:

- Building on the studies completed to date.
- 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 behavioral health 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 (Final submission by ZiaPartners – September 29, 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

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[1] **SMART**: Specific, Measurable, Attainable, Realistic, and Time-bound

#	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. 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	**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 "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.	BHRSC	• Persons with lived experience • Rock County Human Services • And other partners: adult/child MH/AODA providers, public safety/criminal justice agencies, etc. • Prevention networks • Data Workgroup	Kate and Lance

[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
		experiences of individuals/ families in service in order to both inspire and inform the quality improvement process in Redesign.	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 Dec 30. 6) Identify a workgroup to develop a simple form to track participation and progress by the partners in co-occurring capability development. 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 Competency 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 participants' current efforts to measure/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) and from other state and federal documents in order to develop initial draft ideas. 6) Identify a program self-assessment tool for cultural competency.	BHRSC with Cultural Competency Workgroup development team 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 • Prevention networks • Tribal organizations	?

#	SMART Goal 2013-2014	Performance Target Date	Tactical Objectives[2]	Assigned Responsibility[3]	Implementation Partners[4]	RCHS Staff Assistance
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 children and families with complex behavioral health and human service needs to be 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.	a. By Feb, 2014, 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-centered, trauma-informed CSOC. b. By Apr 2014, CSTCC partners will have performed a self-assessment using the SOCAT and developed individual and collective improvement targets. c. By Jun, 2014, 80% of the CSTCC partners will have improvement in welcoming, trauma-informed, family-centered care. d. By Jun 2014, 80% of service programs in CSTCC partnership will have parent partners at the table in planning improvements. e. By Jun, 2014, 10% improvement over current baseline in engagement of youth and families who are in crisis in helpful partnerships that promote success and reduction of high-end placements.	1) Establish regular monthly CSTCC meetings and participation of HSD and community partners. 2) Redefine CSTCC as CSOC community stakeholders of major entities (parents, police, community orgns.) 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) Adopt Functional Family Therapy engagement strategies for families in contact with Juvenile Justice and Child Protective Services 8) Assist all partners with engagement of parent partners or other parent/ youth advocates in their improvement activities. 9) 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). 10) Develop metrics and measure baseline for each performance target.	Coordinated Services Team Coordinating Committee (**CSTCC**)	• Persons/families with lived experience • Rock County Human Services and BHRSC partners • Child protective services • Community school system reps • Prevention networks	Lance, Tara

#	SMART Goal 2013-2014	Performance Target Date	Tactical Objectives[2]	Assigned Responsibility[3]	Implementation Partners[4]	RCHS Staff Assistance
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, continuity, and collaboration of 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. c. Improved partnership within Adult MH programs, so that all programs collaborate in sharing responsibility for the population in Rock County with public MH needs d. Improved partnerships between MH and AODA providers, so that each program is a priority partner of the other system, for access/consultation/in-reach/support.	By July, 2014: a. Rock County will implement the Comprehensive Community Services Medicaid Waiver program. By March, 2014: b. RCHSD will improve intake/access function in the Human Services Department BH Division (for adults, children, and families) to be welcoming, flexible, integrated and responsive, with standardized processes to facilitate access at multiple entry points for adults and children. c. RCHSD will develop an access policy establishing that the purpose of Access is to welcome people into service and connect to the right resource (in the county as a whole), not screen out. d. 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). e. RCHSD adult MH providers (and possibly other partners) formally adopt an understanding that they are partners sharing responsibility for managing the adult MH population in need in the county.	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) Integrate the various county MH and AODA access processes (including child) into a functional team 4) Collaborate with other county providers to set up an access system with collaborative coordination for priority clients. 5) Continue working on universal welcoming, and co-occurring capability (per Goal 1). 6) Utilize flexible funding models to design person-centered service packages that can flex with clients as their needs change. 7) 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. 8) County programs practice working with partners to facilitate entry for new clients in crisis, and step-down for others who are more stable. 9) Develop metrics and measure baseline for each performance target. 10) Collaborate with Prescriber's Workgroup to improve MD/RN access.	Adult Continuum of Care workgroup (including county and other adult providers)	• Persons with lived experience • BHRSC members • Prescriber's Workgroup • Data Workgroup	Kate (Amy, Sue)

#	SMART Goal 2013-2014	Performance Target Date	Tactical Objectives[2]	Assigned Responsibility[3]	Implementation Partners[4]	RCHS Staff Assistance
		f. Increase psychiatric prescriber capacity by adding an additional prescriber resource (see below). g. Improve targeted outreach and access for those re-entering the community from jail (see below).	11) Collaborate with data workgroup re outreach to jail release and probation.			
5	**AODA Recovery-oriented System of Care Continuum for Prevention, Early Intervention, and Treatment** a. 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. b. To create a holistic, integrated county-wide prevention partnership that works collaboratively to strategically implement best-practice systemic prevention approaches to reach the widest possible population at risk. c. To develop a collaborative partnership between prevention and treatment in the continuum. d. Improved partnerships between AODA and MH providers, so that each program is a priority partner of the other system, for access/consultation/in-reach/ support.	By Dec. 2013: a. The AODA Steering Committee will have a written vision, mission, and charge, regular membership representing 80% of providers, and a framework for change. By March, 2014: b. There will be a pilot process for clients to move through levels of care based on readiness rather than on fixed length of stay, and for providers to partner to facilitate that movement. c. The AODA continuum membership will make progress on co-occurring capability in partnership with MH (see Goal 1). d. There will be a process by which 50% of high-risk clients move quickly (within 14 days) into a treatment setting after initial access appointment. e. There will be a map of the current service array, including current accessibility/ability to provide co-occurring-capable services, and opportunities to fill the gap based on applying person-centered, co-occurring capable principles within existing resources.	1) Continue work on universal COD capability per Goal 1. 2) Develop a working partnership with all AODA prevention and treatment providers to address vision-driven system improvement through the AODA Steering Committee. 3) Establish flexible procedures for facilitating access, particularly for individuals with high need or stepping down from high-end services, through performance improvement and client-centered approaches. 4) Improve access to less intensive services like sober housing, recovery coaching and peer support, so people with addiction and co-occurring conditions can have more ongoing support within limited resources. 5) Develop prevention partnerships across all prevention providers. 6) Participation of prevention in Children's System of Care activity. 7) Development of a countywide holistic prevention strategic plan. 8) Develop metrics and measure baseline for each performance target. 9) Incorporate shared values and commitment to partnership in contract language for 2014.	AODA Steering Committee	• Persons with lived experience • AODA treatment providers • Detox • Sober housing providers • Probation • Juvenile Justice • AODA Treatment Courts • Prevention Networks and Providers	Rebecca

#	SMART Goal 2013-2014	Performance Target Date	Tactical Objectives[2]	Assigned Responsibility[3]	Implementation Partners[4]	RCHS Staff Assistance
		f. There will be an initial meeting of a holistic prevention coalition representing all county prevention efforts. By June 2014, g. There will be a plan for universal welcoming, trauma-informed, integrated screening for individuals and families at risk in multiple settings (schools, CPS).				
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:** Provide coordinated, integrated response to MH/ AODA emergencies that is focused on individual/ family needs; to promote understanding/ 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. Consumer satisfaction surveys will demonstrate a 10% improvement in satisfaction with welcoming, person-centered crisis response. c. The percentage of	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) Measure baseline for each performance target.	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	Melissa

#	SMART Goal 2013-2014	Performance Target Date	Tactical Objectives[2]	Assigned Responsibility[3]	Implementation Partners[4]	RCHS Staff Assistance
		individuals/families requesting voluntary crisis interventions (compared to involuntary) will increase by 10% By Sep, 2014 d. The number of Crisis Intervention (CIT) trained officers in Rock County will increase by 10%. e. The percentage of individuals with emergency detentions who are able to be treated closer to home and families will increase by 10% over baseline.	5) Expand structured partnering between crisis and AODA access, and crisis and MH access process. 6) Address protocols that facilitate engagement in crisis intervention and crisis diversion programs of individuals who are using substances. 7) Improve welcoming crisis response so more individuals and families ask for help sooner, before involuntary intervention is needed. 8) Marketing plan for the county on how individuals can ask for help directly without involving police. 9) Increasing development of protocols for crisis follow-up.		• AODA director • Crisis AODA providers • MH and AODA providers • 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 voices 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

#	SMART Goal 2013-2014	Performance Target Date	Tactical Objectives[2]	Assigned Responsibility[3]	Implementation Partners[4]	RCHS Staff Assistance
9	**Psychiatry and Psychopharmacology Access and Quality:** To empower psychiatrists, NPs and other prescribers across the county to work as partners to improve access, quality of practice and responsiveness to individuals and families with complex needs 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 leadership. b. The Workgroup will identify one practice or policy improvement opportunity impacting service to people with co-occurring issues and make improvement recommendations to BHRSC. c. There will be a discussion of psychopharm practice guidelines for individuals with co-occurring disorders. d. There will be a proposal for collaborative methods of problem solving or medical review of complex cases in the county.	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) Improve collaboration among MDs and NPs as cost-effective approach to improving quality and access to care. 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.	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	Rock County Human Services Dept Medical Director for BH Kate Flanagan
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.	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 BH needs. By Nov, 2014: c. Each Treatment Court will have scheduled team meetings for the purpose of improving co-occurring capability, per Goal 1.	1) Collaboration among CJCC, Adult Continuum of Care Workgroup, and Data Workgroup. 2) Initiation of more routine BH screening at jail/probation entry, beginning with post-booking diversion, and then introducing pre-booking diversion. 3) Set up a process for routine data collection and tracking of high-risk individuals going forward, at each point of sequential intercept model. 4) Develop proactive release of information protocols for BHRSC member agencies.	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 BH providers (including specialty court and jail-based services) • Judges, prosecutors, defense bar • Adult and Juvenile probation and parole	Elizabeth

#	SMART Goal 2013-2014	Performance Target Date	Tactical Objectives[2]	Assigned Responsibility[3]	Implementation Partners[4]	RCHS Staff Assistance
	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.	d. Initiation of the Re-entry grant program will have taken place, to provide case management for high-risk individuals with BH needs released from jail. By Jun 2014: e. Initiate two pilot projects with team structure of regular probation officer participating with a service team that shares his/her clients to demonstrate the potential value of improved teamwork in reducing recidivism. f. 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. g. Develop a shared framework in the court system to introduce BH and therapeutic justice principles into "usual" court proceedings.	5) Identify criminal justice behavioral health programs as a "priority client" for the County BH system. 6) Have each treatment court be responsible for continuous quality improvement for complexity capability for its own program 7) Initiate training in therapeutic justice and co-occurring disorder principles for all court personnel, and develop a workgroup to apply these principles systemwide.		• Jail medical staff • Detention staff	

Working Draft

SHORT VERSION

Charter Document for
System Integration and Transformation in Rock County
September, 2013

This is a living planning tool that will be continually modified based on stakeholder input. The Behavioral Health Redesign Steering Committee is the vehicle to gather and coordinate this input….Glossary can be added….ultimately the Charter process should be unifying and organizing. One consideration in developing it is should it be signed, and if so, by whom?

Rock County Human Services Department is joining in a partnership with Stakeholders of all types from across Rock County to create a 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.***

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 of care that is **welcoming, accessible, strength-based, person- and family-centered, prevention, recovery- and resiliency-oriented, trauma-informed, culturally competent, and complexity capable**.

In order to accomplish this goal, **Rock County** has identified the **Comprehensive, Continuous, Integrated System of Care (CCISC) model** as a framework for quality-improvement-oriented integrated system design and implementation.

The basic framework and principles of CCISC, as described by Minkoff and Cline (2004, 2005), **are listed in Appendix A**.

This charter document outlines initial agreed-upon action steps for Rock County BHRSC, in partnership with provider leadership (including hospitals, primary health centers), program managers, frontline staff, consumers and families, and other stakeholders to organize the implementation of the vision. These action steps are aligned as well with the Rock County BHRSC Strategic Plan and its incorporated SMART Goals.

This version of the charter is a draft working document that outlines action steps for each level of the Rock County system during the coming year to make progress within SMART Goal #1 (System-wide

welcoming, recovery-oriented, trauma-informed, co-occurring capability). It also outlines commitments by Rock County HSD and the BHRSC to support the structures and processes needed for implementation of the other SMART Goals in the Strategic Plan.

Action Steps for Rock County BHRSC as a whole, and each organizational partner (Rock County Human Services, including Adult MH, Child MH, and AODA, Juvenile Justice, and Child Protective Services; Adult Probation and Parole; Sheriff's Department and Jail; Court Services and Specialty Courts; Hospital and community-based behavioral health providers; local police; School Districts; Consumers and Family Advocacy Organizations.)*:*

1. **Say it out loud.** Adopt this charter document, and the vision and mission in the charter, as an official statement, and disseminate officially to all stakeholders.
2. **Quality improvement partnership.** Work in a quality improvement partnership with other county agencies, with providers and with stakeholders.
3. **BH Redesign Steering Committee.** Support and provide representation in an empowered representative **BHRSC** that reflects the partnership throughout the system, to steer or coordinate the implementation of the BH Redesign quality improvement process.
4. **Change Agents.** Support development and empowerment of a cadre of change agents representing the frontline voice of county staff, provider agency staff, and consumers/families/other shareholders, and ensure empowered representation of the Change Agents at the BHRSC.
5. **Vision/Mission Development.** Develop a process to work with system partners to finalize the Vision and Mission Statement.
6. **Charter Development.** Organize a process for implementation and formal adoption of this charter document over the course of the next 3 months of this process.
7. **Project Management and Direction.** Identify a formal leadership structure (Co-chairs) for the Steering Committee, as well as a project coordinator (Elizabeth Pohlman). Create vehicles for regular communication such as a newsletter or website.
8. **Strategic Plan Utilization.** Organize representative participation the implementation activities outlined in the Strategic Plan and **SMART Goals**, as listed below.
9. **Systemwide Trauma-informed Co-occurring Capability Development:** Organize the systemwide CQI partnership within which ALL programs make progress toward welcoming, recovery/resiliency-oriented, trauma-informed, complexity capability. Organize use of the COMPASS-EZ and SOCAT for trauma-informed co-occurring capability development, all workgroup activities are coordinated, and there is a mechanism for tracking progress and updating objectives **(SMART Goal #6)**.
10. **Redesign Infrastructure Development.** The BHRSC will identify quality improvement **Workgroups** to address particular improvement targets, metrics, and objectives related to the direction and vision of a recovery/resiliency-oriented integrated system of care, as outline in the **SMART Goals**. Each workgroup will have defined membership, leadership, and charge, and will provide opportunities to include county staff and community partners other than those on the BHRSC. Some workgroups may be ongoing, and others time-limited.
11. **Workgroups.** The following is a list of workgroups and related SMART Goal assigned. The **SMART Goals** should be referenced for the specific goals, objectives, strategies and leadership assigned for each workgroup.

a. **Coordinated Service Team Coordinating Committee (CSTCC) – SMART Goal #3 – Children's System of Care**
b. **Cultural Competency Workgroup – SMART Goal #2 – Cultural Competency/Cultural Intelligence**
c. **Adult Continuum of Care Workgroup – SMART Goal #4 – Adult System of Care**
d. **AODA Steering Committee – SMART Goal #5 – AODA Recovery Oriented System**
e. **Community Crisis Response Group (CCRG): SMART Goal #7 – Crisis Redesign**
f. **Consumer/Family Workgroup: SMART Goal #8 – Consumer/Family Empowerment and Peer Support Expansion**
g. **Prescribers Workgroup: SMART Goal #9 – Psychopharmacology**
h. **Data Workgroup and CJCC: SMART Goal #10 – Behavioral Health – Criminal Justice Collaboration and Data Linkage**

12. **Workforce Development.** Support progress toward defining universal recovery/resiliency-oriented, trauma-informed, complexity competency in systemwide workforce development efforts and plans, addressing all categories of staff.
13. **Welcoming Access Policy.** Develop county-wide policy and procedures for measurably improving welcoming access for individuals and families at risk for and/or experiencing complex conditions in all portals of the Rock County behavioral health, housing, child protection, and criminal justice systems. Included in this policy will be a vision for how each component of the system is a welcomed priority partner with the other components. (Reference improvement measures in the SMART Goals.)
14. **Integrated Stage-matched Strength-based Assessment and Recovery Planning Guidelines.** Engage the Change Agents to support the development over time (during 2014) of sample guidelines and instructions for how to document integrated recovery/resiliency-oriented trauma-informed screening, assessment and recovery/treatment/service planning in a manner that meets funding guidelines.
15. **CCS Implementation and Flexibility in Funding Policies.** As part of CCS implementation, work over time (during 2014) toward providing clearer instructions about how to bill for services to complex priority clients with multiple issues within each program and funding stream, and how to use each funding stream in the most efficient and flexible manner to support progress toward the vision.
16. **Technical Assistance.** Arrange for provision of consultation, training and technical assistance for the system and for each provider to be able to make progress.

Action Steps for County Programs, Contracted Providers and other service partners (where applicable)*:* Timeline: 1 Year.

There will be a "tracking process" for how each agency/program is making progress through their steps. (SMART Goal #6)

1. **Commitment to the process.** Formally agree to participate in the BHRSC, relevant Workgroups, charter activities, and provide information to all staff and involved consumers/families regarding the Rock County redesign integration process and the principles of the CCISC model.

2. **Say it out loud.** Agency- AND program-level formal commitment to welcoming, recovery/resiliency-oriented, trauma-informed, cultural competence and co-occurring capability as a formal goal, disseminated to everyone officially by the director or designee.
3. **CQI Team.** Identify a representative (from all programs) CQI team of leadership, supervisors, frontline staff, and consumers who are interested in creating welcoming, trauma-informed co-occurring-capable services The team is empowered and meets regularly.
4. **Change Agents.** Identify an adequate number of representative change agents to support internal change and to participate regularly in the countywide Change Agent Team, with representation from all types of services, including all the age-based services.
5. **COMPASS-EZ.** For providers of behavioral health services, conduct an annual self-survey **for each program** using the COMPASS-EZ. Begin within 3 months of adoption of this charter.
6. **SOCAT.** For participants in the Children's System of Care, participate in utilizing the **SOCAT** for baseline assessment of children's system of collaboration, within 3 months of adoption of this charter.
7. **Cultural Competency Self-assessment:** Perform a program self-assessment using the tool identified by BHRSC.
8. **Action Plan.** Based on the program self-survey(s), develop a program-specific QI action plan outlining measurable changes to move toward trauma-informed co-occurring capability and cultural competence. Monitor the progress of the action plan at six-month intervals.
9. **Welcoming and access.** Program action plans will work on improvement of welcoming, engagement, hope, and access for individuals and families at risk for and/or experiencing complex needs, including cultural and linguistic barriers.
10. **Screening and Identification.** Program action plans will work on improvement of routine integrated screening and enhancing data collection and information sharing related to identifying individuals with co-occurring mental health (including trauma) and substance use conditions, including criminal justice involvement and diversity.
11. **Integrated Strength-based Assessment.** Program action plans will work on improvement of developing integrated, hopeful, strength based program-specific assessment processes for all individuals and families
12. **Integrated Stage-matched Recovery Planning.** Program action plans will work on improving inclusion of hopeful, stage-matched integrated interventions for individuals and families with complex conditions (including trauma), within integrated person-centered and family-centered service/recovery planning, as appropriate for the mission of the program.
13. **Workforce Competency.** Program action plans will include progress in adoption and implementation of the goal of welcoming, trauma-informed, cultural competence and co-occurring competency for all staff, regardless of whether they are licensed or certified, as part of the agency's long-range workforce development plan.
14. **Inter-program Partnerships.** Program action plans will include working on developing and/or enhancing existing partnership relationships with complementary mental health and substance abuse prevention, treatment, or advocacy programs, along with other health, human services, and criminal justice partners to build mutual collaboration in developing trauma-informed co-occurring or complexity capability.

SIGNATURES (Optional)