

2013 WORK PLAN PROGRESS - ACS

1. Create a successful transition for the shift in funding and policy governing the long-term support system for adults that ensures LTS populations have effective and continuous care.

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1.a	DD managers will communicate through words and actions a "new narrative" that emphasizes integrated employment, strengthening partnerships with family and community members both inside and outside of the DD system while acknowledging the reality of shrinking public dollars available for residential services	<ul style="list-style-type: none"> Presented "new narrative" Power Point to LTS committee broker and Taste of Dane Shared "new narrative" with families at 3-part parent listening session in May/June 2012 and disseminated written summary. Hosted "capacity building" event in Dec 2012 with providers, families and community organizations and disseminated written summary. 	<ul style="list-style-type: none"> Focus "new narrative" message on high school students, young adults leaving the schools and their families Stronger employer and community partnerships consistent with recommendations from parent listening sessions and community capacity event. 	<ul style="list-style-type: none"> Share "Living the New Narrative" presentation with Waisman Center Outreach and Family Support and Resource Center staff. Develop new job tasks for SDS coordinator and intake social workers that promote capacity building and community building during high school transition years as well as for people on waiver waiting list. 	<ul style="list-style-type: none"> Presentations for Waisman Center and Family Support and Resource Center are completed. SDS coordinator has facilitated an interactive, capacity and community-building event for young adults leaving high school and their families by end of first quarter 2013. Intake workers will have met face to face with 67 waiting list families by 12-31-13 and attempted to make at least 1 community connection on their behalf. 15 individuals with developmental disabilities will report their life has been enhanced through the community building approaches of intake worker. 	Monica Bear with assistance from Doug Hunt, Eric Miller, Angela Radloff and Sue Werner December 2013	<ul style="list-style-type: none"> New Narrative presentation to Family Support and Resource Center in Feb 2013; Waisman presentation October 2013. "New Narrative" is now part of all discussions with consumers and their families. 3 part parent transition network informational series completed between January-June 2013 with families, County and MMSD staff as co-presenters. Intake workers or designated POS staff met with 67 wait list families, offering to facilitate community connection. During 2013, 61 people were connected to the Capacity Building Initiative, Lov-Dane, Timebank or other community resource.

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1.b	"Capacity Building Initiative" funds in the 2013 adopted budget.	<ul style="list-style-type: none"> • There is \$230,000 in 2013 budget appropriated for new initiative to increase support to people on the waiting list and adults living at home with their parents. • We need to develop and implement a plan for disseminating the funds in 2013. 	<ul style="list-style-type: none"> • 15 individuals on the waiting list will hire a support broker and receive an SDS rate of approximately \$3,000/person • 45 adults living at home with their parents will receive support to increase their community participation while offering relief to their family caretakers. 	<ul style="list-style-type: none"> • Meet individuals on waiting list in order of their enrollment on waiting list to identify 15 interested participants. • Invite adults, their families, DD providers and community members to 1st quarter capacity building event. • Develop a summary of promising practices most likely to build community capacity consistent with new narrative. • Invite people with disabilities, families and other stakeholders to collaborate with each other to develop capacity building proposals. • Evaluate and fund capacity building proposals that benefit 45 individuals who currently have no publically funded supported living services 	<ul style="list-style-type: none"> • 15 people on waiting list have hired brokers and developed low cost plans that meet their needs • 45 individuals who currently have no publicly funded supported living services will participate in a capacity building project that enhances their community participation and provides relief to their family caretakers for an average cost of \$3,000 person. • Written summary of promising practices is prepared by 12-31-13. 	Monica Bear with assistance from Doug Hunt, Eric Miller, Angela Radloff and Sue Werner December 2013	<ul style="list-style-type: none"> • 15 people from the waiting list hired a broker and developed a low cost plan with an average SDS rate of \$3,000. • 63 Individuals with no publically funded residential support participated in one of four Capacity Building initiatives at an average cost of less than \$3,000/person. • Received quarterly updates from 4 Capacity Building team leaders. Promising Practice paper currently being written by John O'Brien with expected completion 2-28-14. Annual project summaries from project leads due 2-28-14. • One Year celebration held 2-11-14.
1.c	Maintain individuals with difficult behaviors and dementia care needs in their current home-like settings (CBRFs)	<ul style="list-style-type: none"> • Some CBRFs are not well trained or have sufficient staff to serve this population. Many do not provide a specialized care plan to fit the needs of individuals with dementia. • Three CBRFs registered for the Dementia Center for Excellency training held September 2012. Seventy staff members attended the trainings. 	Improve support services to consumers with dementia and the facility care providers, continuing efforts with the three CBRFs that participated in 2012.	<ul style="list-style-type: none"> • Individualized dementia care plans are offered to COP/MA Waiver consumers and other individuals who agree to participate in the county funded Dementia Center for Excellency. • The 3 facilities participating in the trainings have made significant changes in their operations and hands on care procedures. • During the 3rd quarter evaluate the progress made by the 3 facilities and make changes if necessary. 	<ul style="list-style-type: none"> • 25% of 2012's 70 facility staff successfully completes the hands-on care training. • Individualized care plans developed for at least 3 COP consumers living in their respective facilities. • Present the Center for Excellency award to all facilities that make substantial, appropriate changes in operations and hands on care. 	Theresa Sanders, Alzheimer's and Dementia Alliance and South Madison Coalition.	<ul style="list-style-type: none"> • 70 staff from 2 CBRFs and one (1) licensed Adult Family Home attended the Dementia Care training. Pine View and Sienna Meadows received mentoring visits and had their care plans for COP consumers reviewed. • The Center of Excellency award was presented to Sienna Meadows in April 2013. Secretary of WI Dept. of Health Services, Kitty Rhoads, and State DQA staff were present. • By end of 2013, turnover in direct care and facility management staff were a larger than anticipated barrier.

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5. Improve the availability of evidence-based programming to address high need individuals and those with challenging behaviors in need of long-term care and children and youth whose needs are met in both the long-term support system and in the child protective service or the juvenile justice systems.

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5.a	Adapt Alternative Sanction programs to be more available as tools that incorporate alcohol and other drug concerns into criminal case disposition whenever appropriate.	Admission to dispositional alternative sanction treatment programs (Drug Court, TAP, and Pathfinder) occurs well after an individual's arrest. Trade literature suggests program admission close to the time an individual is arrested increases the likelihood of successful outcomes.	Eligible participants are identified early and promptly placed in alternative sanction programs. (Key Component #3 of Problem Solving Courts)	<ul style="list-style-type: none"> Hold discussions with partners in the criminal justice system on the importance of achieving this reduction and problem-solve ways to bring reduction about. Adjustments will be made to enable participants' more prompt admission to alternative sanction programs. Use DART as an early entry point for many would-be eligible participants to enter treatment and to be supervised 	<ul style="list-style-type: none"> Each dispositional alternative sanction program will achieve a 25% reduction in the time between an individual's arrest and program admission. Baseline data is gathered so the current time between arrest and program admission for Drug Court, TAP, and Pathfinder is known. 	Todd Campbell, Circuit Courts, Court Commissioners, District Attorney's Office, State Public Defenders Office, Sheriff.	A report by retired Judge Sarah O'Brien and several meetings with criminal justice partners has resulted in a redesign of the alternative sanction programs. There is agreement and a plan in place to reach a goal that would have participants admitted within 60 days after the date of their arrest. Implementation will start in January 2014.

7. Improve alternatives to in-patient care for adults, including those who pose a risk to themselves or others and those with dementia.

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7.a	Identify hospital units for admitting elders with dual medical care needs, dementia and significant health issues.	Elders with dementia experiencing significant medical care needs are being admitted to Mendota via the county's emergency Crisis Unit. Most of the elders are not known to the county's long-term care system and their physical care needs have not been sufficiently reported to or treated by the medical professionals.	Improve results for individuals with significant health care needs and dementia by identifying hospitals that do a good job of coordinating care plans between the medical doctor and the hospital psychiatrist.	<ul style="list-style-type: none"> Work with Journey's Crisis Unit and hospitals to better understand the criteria for admitting individuals with significant medical needs and experiencing difficult dementia behavior. Establish a working relationship with Stoughton Hospital for better utilization of their in-patient geriatric teams. 	<ul style="list-style-type: none"> 40% of the calls made to the Crisis Unit are diverted to hospitals rather than Mendota 80% of the admissions have stays of less than 90 days of stay. Identify additional indicators to measure effectiveness. 	Theresa Sanders, South Madison Coalition and Alzheimer's and Dementia Alliance.	<ul style="list-style-type: none"> In consultation with the Community Services Manager for Mental Health the collection of data on the number of elderly diverted to hospitals would not be available until later in year 2014. Goal achieved. GTU stays through December 551 days or an average of 39.4 days. No other indicators were identified.

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7.b	Reduce adult, non-geriatric and developmental disability inpatient hospitalizations at MMHI, WMHI, local hospitals and Trempealeau County Health Care Center (TCHCC)	<ul style="list-style-type: none"> Inpatient costs have steadily risen due to growth in utilization and cost of care per day. For younger adults at Mendota and Winnebago, we funded 3425 days in 2010; 2183 days in 2011; 2918 in 2012. Expenses at the Institutes have been over budget for five of the last seven years (2006-2012). The number of days funded at the local hospitals was 316 in 2012 and 317 in 2011. Three people were placed at high cost (\$300/day GPR) out of county facilities for extended lengths of time (962 days projected total) which increased our costs in 2012. 	<ul style="list-style-type: none"> Maximize use of the Care Centers. Reduce the number of days of adult non-geriatric care compared to historical averages. Capture MA crisis stabilization revenue, which is essential to covering costs of the Care Centers and other alternatives to hospitalization. Reduce placements at facilities that have a high GPR cost. 	<ul style="list-style-type: none"> A new position was added to Journey Mental Health Center, Crisis Unit, for the sole purpose of monitoring the hospitalizations, treatment course and discharge planning. Monitor institute, local hospital and out of county placements. Monitor Care Center usage with providers. DCDHS and MHCDC ESU staff will discuss all admissions at least twice weekly to explore community alternatives and flow through the system. Encourage and monitor use of other inpatient alternatives such as the Care Centers, Recovery House, Crisis Homes and Badger Prairie Health Care Center. Implement a level of care guidelines process across the system to better communicate what constitutes appropriate use of hospitalizations and community alternatives. Educate the service system regarding County contracted services, budget priorities and responsibilities. 	<ul style="list-style-type: none"> 2013 inpatient costs are within budget. 80% or more of Care Center capacity is utilized. Earn \$1,170,000 in MA Crisis revenue in the Care Centers. Minimize the use of out of county GPR funded facilities to no more than 500 days. 	Mary Grabot, Carrie Simon	<ul style="list-style-type: none"> 2013 costs exceeded the budget for all local Hospitals and Institutes. Hospitals: Adopted budget: \$400,800. Actual: \$621,406. Institutes: Adopted Budget: \$1,839,625. Actual: \$1,912,132. Out of County placements came in under budget. Adopted budget: \$196,125. Actual: \$159,574. Bayside was utilized 81% of contract. Dane County Care Center reached 74% of its contracted bed days. MA Crisis earnings in the care centers totaled \$1,239,844. Out of County inpatient settings were used for a total of 562 days. (Two people were at Clearview and three at Trempeleau).

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7.c	Reconfigure mental health services targeting seniors.	<ul style="list-style-type: none"> In 2008, the MOST program at JMHC was transferred from the Long Term Support Unit to the Mental Health Services Unit. Historically, the program has responded primarily to aging and mental health needs. Our intent is to change the focus of the program from serving seniors with long term support needs who also have some mental health needs to serving people over the age of 60 who primarily have mental health needs. We will continue to provide consultation support to the focal points. The MOST program has also been providing information and assistance. With the implementation of the Aging and Disability Resource Center, (ADRC), it is time to clarify roles and responsibilities between these two programs getting MOST out of the I&A business. The MOST programs should focus on direct service. MOST is primarily GPR funded, earning very little third party revenue. This is not sustainable. 	<ul style="list-style-type: none"> Increase access to MOST for the mental health system. The community will look to the ADRC for information and assistance rather than the MOST program. Work with the Aging system regarding older individuals at high risk of psychiatric hospitalization for psychiatric reasons not related to dementia. Maximize third party billing for those served within MOST. 	<ul style="list-style-type: none"> County will monitor who receives service within the MOST program, providing more oversight. Caseloads will be examined and acceptable staff to client ratios established. MOST will develop a connection with the mental health case management service system. MOST and the system will utilize each others expertise to better serve aging mental health individuals. A senior CSP will be created which will focus on high need individuals in MOST and other mental health system case management programs. Facilitate ongoing discussions with the ADRC and County MH system. Create guidelines explaining use of ADRC and MOST and communicate these across the systems and community. County and JMHC will prioritize any and all third party revenue for those served in MOST. 	<ul style="list-style-type: none"> MOST's target service group will be those who are 60+ years of age and have a serious and persistent mental illness. MOST services/expertise will become accessible for aging mental health individuals. Caseloads will be established for case management and prescriber services. For those who meet level of need, MOST will transfer individuals to CSP and will focus on providing an appropriate level of case management services. Referrals to the MOST program will come from the Adult Mental Health System. The primary characteristic for individuals is serious and persistent mental illness. MOST will increase its earned third party revenue by \$50,000. 	Mary Grabot, Carrie Simon	<ul style="list-style-type: none"> MOST redefined its service target and age group to meet contract expectations. Information sessions were held to inform service providers about its parameters. MOST relocated to a location with a CSP to better access service transition, continuity and appropriate level of care. MOST still receives the majority of its referrals from the community at large. MOST began earning MA crisis funding in May. Earned \$45,386 from May through December 2013.

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7.d	Monitor the transition of the court ordered evaluation program from JMHC to Community Partnerships and contain costs.	<ul style="list-style-type: none"> • Court ordered evaluations (COEs) have increased in volume and have been significantly over budget for the past several years. Dane County increased the rate that evaluators were reimbursed in 2012. The program was put out for RFP in 2012 and was awarded to a different agency, Community Partnerships, with a start up date of 12-17-12. • Additionally, we developed a commitment extension process that was aimed at reducing evaluations when a consumer was stipulating to the extension. 	<ul style="list-style-type: none"> • Reduce the volume of COEs • Reduce the cost of needed evaluations • Maintain a qualified and available pool of evaluators • Develop a business contract with each evaluator 	<ul style="list-style-type: none"> • Coordinate with the public defender and Corporation Counsel to establish a timeframe wherein decisions can be made regarding the necessity of 51 extension evaluations. • Instruct the pool as to what technologies can be utilized for evaluations outside of Dane County. • Explore using evaluators located in other cities and counties to reduce costs. • Create a set pool of evaluators with the expertise needed and use consistent contract rates. • County and POS staff meet regularly to discuss possible program efficiencies and quality improvements. • County presents a Level of Care Guideline to the system in an effort to prevent unnecessary emergency detentions and returns, as well as increase the number of stipulations. • DCHS meet with Community Partnerships monthly to review transition. Meet with Judge and with Corp Counsel to make transition as smooth as possible. Conduct training for all evaluators doing 54/55 evaluations. 	<ul style="list-style-type: none"> • Stay within budget for 2013 • Reduce the volume of 51 extension evaluations by at least 25% • Implement the use of process improvements, such as stipulating to extensions, specialized pool of evaluators and use of technology. 	Mary Grabot, Marykay Wills	<ul style="list-style-type: none"> • Number of COEs increased in 2013. In 2012, 917 evaluations were completed for Chapter 51 civil commitments. In 2013, 1,241 were completed. • In 2012, there were 465 extensions under 51. In 2013, 689 of the evaluations were 51 extensions, which reflects almost a 30% increase. • Stipulations in 2012 totaled 33; in 2013, the total was 52, with the fourth quarter of the year showing a sharp decline (17, 22, 11 and 2 per quarter). • Marketed for new evaluators. Added 5 to pool. • Implemented video-conferencing, which was used 69 times.

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10. Improve the department's ability to protect and strengthen the services it is mandated to provide

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10.a	Disability Benefit Specialist (DBS) Services at the ADRC	The State's ADRC contract requires counties to provide DBS services. Although there is a benefits program which targets MH consumers, there currently is no DBS service available for people with disabilities. 2013 Adopted Budget includes 4.0 FTE DBS. It is anticipated that there will be high demand for this service.	By the end of 2013, the DBS program is fully functional, busy serving consumers, and the individuals served report a high level of satisfaction.	<ul style="list-style-type: none"> • Proceed as quickly as possible with hiring and training staff. • Develop and implement plan to inform the community regarding the availability of DBS services by 05/31/13. • By June 30, develop a method to solicit feedback from individuals who use the service. 	<ul style="list-style-type: none"> • 4.0 FTEs hired by 04/30/13. • Each staff person completes 60 hours of training within six months of hire. • Supervisor reports that DBS caseloads are at least 80% full by October 1, 2013. • Reports on consumer satisfaction / feedback are prepared for 3rd and 4th qtrs (by 10/31/13 and 01/31/14) 	Jennifer Fischer and Deb Solis of the ADRC	<ul style="list-style-type: none"> • Hiring to fill the ADRC DBS positions took longer than planned. Three DBS workers started the end of April and the fourth started July 1, 2013. Training was completed. • In 2013, DBS staff opened 191 cases and DBS staff opened 241 information only contacts. • Fiscal Impact of all closed DBS cases through December 31 2013: \$564,249. • Survey of walk-in clients was completed in the third quarter of 2013 and a survey was sent by mail to all fourth quarter DBS consumers.
10.b	Marketing the ADRC	The State's ADRC contract requires counties to market ADRC services. Melissa Mulliken Consulting was selected via RFP in 2012 to work on marketing. 2013 ATT Yellow Pages will have two ADRC ¼ page ads. A marketing plan is currently being developed. Our goal is to market the ADRC throughout 2013. 2013 Adopted Budget includes funds for ADRC marketing.	<ul style="list-style-type: none"> • The ADRC will have a written, multi-faceted marketing plan for each month during 2013. • The ADRC will be able to document a variety of marketing efforts that took place. • Data will indicate steady growth in the number of individuals served each month over the course of 2013. 	The ADRC will undertake a variety of outreach efforts including, but not limited to: media interviews, booths at health fairs and community events, presentations to professional and community groups, newsletter articles, open houses, and paid and earned media.	<ul style="list-style-type: none"> • The ADRC will have at least 52 separate outreach events during 2013. • The number of individuals served each month over the course of 2013 will steadily increase. • During 4th quarter of 2013, the ADRC will serve an average of 500 unduplicated individuals per month. 	Jennifer Fischer and ADRC management staff, Fran Genter, M. Mulliken Consulting	<ul style="list-style-type: none"> • In 2013 the ADRC completed over 90 outreach events. • The ADRC consistently increased its call volume each month. • The 3rd and 4th quarter 2013 data of unduplicated individuals is as follows: July - 601 August - 623 September - 689 October - 645 November - 590 December - 545

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10.c	Adult Protective Services	There are three Elder Abuse (EA) social workers, three Adult Guardianship Protective (AGP) services social workers, two Adults at Risk (AAR) staff, and one Victims of Crime Act (VOCA) staff. Each are experts in their respective roles and services. Each group has worked in separate locations and their responsibilities have not overlapped. An Adult Protective Services Unit was formed in December 2012. Staff are now co-located at NPO and have the same supervisor.	Staff are cross-trained and are able to perform a broader range of duties within adult protective services.	<ul style="list-style-type: none"> • Training in WI Statutes Chap 46. 90, 54, and 55 is provided to all staff. • Staff shadow and observe each other work on active cases. • EA staff learn how to assess AGP referrals, file AGP petitions and participate in court hearings. • AGP staff learn how to handle EA and AAR intake, assess risks, conduct home visits and offer relevant services. 	<ul style="list-style-type: none"> • By 12/31/13, each EA social worker will have been assigned three AGP cases. • By 12/31/13, each AGP social worker will have been assigned three EA or AAR cases. 	Shari Gray-Dorn, APS Supervisor, and APS Unit staff members.	<ul style="list-style-type: none"> • Asst. Corporation Counsel provided training on Statutes. EA and AGP social workers participated in joint home visits and court hearings to better understand each other's responsibilities. • 1 EA worker was assigned 2 AGP cases. • The three AGP workers were assigned 2 or more EA cases • New standards were developed. For example, EA workers shall make face-to-face contact with an alleged victim within 5 days of case assignment. This standardizes and improves service delivery.
10.d	DCHS DD Children's Unit will start to work with the eWISACWIS program. This program will allow case managers to document detailed information about children that are placed out of home. This will allow the DD until to collaborate with other departments within Dane County.	Currently the DD Unit is not using eWISACWIS. The documentation for children that are out of home is done on paper. DCHS has met with the Department of Children and Families to discuss how eWISACWIS is being used and how it will help with recording and bring the program into compliance.	<ul style="list-style-type: none"> • To be in compliance with our paperwork and documentation with DCF. • Case managers have access to systems to have ongoing information about children and families. 	The DD Unit will start to document information in eWISACWIS by the end of first quarter 2013. To be better prepared the DD Unit will be provided a technical training on the eWISACWIS program so that case managers are trained on how to complete the information. We will also identify support staff within the county to help with ongoing support. The DD Unit will collaborate with the CYF Department to share resources and have ongoing assistance.	<ul style="list-style-type: none"> • A training date will be identified and all DD children's case managers will attend. • Yearly meeting with DCF to make sure that we are in compliance with the system and information that is provided. 	Angela Radloff, DD Children's Manager. March 2013	<ul style="list-style-type: none"> • This initiative was not acted upon due to staff turnover at DFS and within the DCHS IT Department and Children's Unit. • In 2014 CYF will identify a social worker with eWISACWIS access to act as a resource to DD Children's case managers. • DD case managers will be trained in eWISACWIS by December 2014.

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10.e	Develop cost effective 2013 grad employment outcomes for transition age youth with significant barriers to work.	Currently, the capacity of school staff to job develop varies from school to school and lacks coordinated strategies to achieve cost effective outcomes.	Pilot a Coaching/Training model with grads at East HS, Memorial HS, Middleton HS, and Oregon HS. This will be a partnership between DCDHS, DVR, and the local school districts identified.	Kim Kessler will lead the coaching/training effort at these high schools and lead a 6 session training series on job development topics for school and POS vocational agency staff.	Employment data on exiting 2013 grads (hours of work, wages, etc.) and data on the cost of supports related to 2013 grad employment will show improved work outcomes for 2013 grads when compared with data from the last five years.	Doug Hunt December 2013	<ul style="list-style-type: none"> • With a grant from DHS, Kim Kessler provided over 1000 hours of mentoring to Dane Co. high school staff and vocational providers. Kim also led 6 trainings on job development attended by 20 to 30 vocational agency and school staff at each session. • Outcomes for the 62 2013 grads: An average of 15.3 hours of work/week and earnings of \$488 per month. Both average hours of work and wages were higher than in previous two years. • Median annual cost/grad in 2013: \$18,074/year. This is lower than the median cost per grad in '09,'10, and '11.
10.f	Strengthen Friends and Family support broker model	We have issued a new RFP for this model of brokering and the RFP window for submission has closed. RFP scoring is scheduled for late January.	Brokers employed through the Friends and Family model are more engaged and connected with Dane County's developmental disability community and provider network to better promote outcomes of the "New Narrative".	A committee of county staff and community members will review proposals in January 2013 with preference given to the provider who best articulates how to support friends and family interested in brokering to promote the new narrative and meet Medicaid waiver requirements.	<ul style="list-style-type: none"> • Award new RFP by 3-1-13 • Have new broker agency operating by 4-1-13 	Eric Linn-Miller Monica Bear April 2013 December 2013	<ul style="list-style-type: none"> • The RFP was awarded to Support Broker Consultants in March and they began operations in April.

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10.g	Continue the successful Rural Renal Dialysis Transportation Project.	In 2012, DHS received a small grant from the National Center for Senior Transportation to pilot Time Banking as a solution to providing transportation assistance to non-Medicaid dialysis patients. Funding for this pilot ends March 31, 2013. The pilot was successful and the program will be extended through the end of this calendar year.	To have a continued option of transportation provided by Time Bank (TB) volunteer drivers.	Continued use of the Time Bank Dialysis service option for TB members.	Fifteen unduplicated persons in 2013 will receive transportation provided by Time Bank members.	Norah Cashin; Jane Betzig December 2013	The program served 16 unduplicated clients between April - December. Utilization grew during 2013. As of March 2013, there were 45 rides per month. By the end of 2013, rides averaged 70 - 80 per month.
10.h	Increase utilization of county-funded rural senior transportation	These popular and very cost-effective routes providing transportation to senior center programs, grocery and general shopping have had a stable ridership of older adults but have not been utilized by newly-eligible seniors and younger persons with disabilities. Calls to the DHS One-Stop Transportation Information Center indicate low awareness of available services by targeted populations.	To increase utilization of group trips by newly-eligible seniors and persons with disabilities.	<ul style="list-style-type: none"> • North/Eastside Senior Coalition intern will prepare materials. Printing will be done by Dane County Human Services. • Area focal points will distribute materials • Targeted outreach to seniors in rural communities. Brochures and posters will be distributed in eligible communities. 	<ul style="list-style-type: none"> • Seven area-specific brochures and posters will be prepared. • We will experience an increase in ridership. 	Norah Cashin December 2013	<ul style="list-style-type: none"> • Ten area-specific posters and one comprehensive brochure were printed. • Ridership increased on existing routes in 4 communities. Underutilized routes in 2 communities were consolidated. Overall ridership numbers did not increase but efficiency of the transportation services improved.

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#	Initiative Area	Current Status (Where are we now?)	Chosen Target (Where do we want to be?)	Tactics to Close the Gap (How do we get there?)	Measures of Success (How will we know we're there?)	Lead Staff Responsible (Who? By When?)	Progress December 2013
10.i	Increase transportation for veterans and veterans' families not eligible for VA transportation services.	In 2012, Dane County purchased four used accessible vehicles at low cost through a State capital assistance program. Three of these vehicles were leased to a local veterans' services organization. In addition, RSVP secured funding for a Vets-Helping-Vets transportation initiative, which has been quite successful.	To increase transportation to veterans and veterans' families.	Develop a working partnership between the Department's One-Stop Transportation Information Center, RSVP, and Dryhooch of America to coordinate volunteer-driven conventional and accessible rides.	Increased utilization of the Veterans Transportation resources. Our goal is to provide 1,000 rides in 2013.	Norah Cashin, Jane Betzig December 2013	<ul style="list-style-type: none"> • Coordination activities of the organizations (VA, Dane County, RSVP) increased utilization of transportation services by veterans. • Over 1,500 rides were provided in vehicles purchased by Dane County, of which approximately 50% were medical or medically-related.
10.j	Increase transportation options for low-income workers in rural areas of Dane County.	<p>The most frequently-requested transportation assistance at the DHS One-Stop Transportation Information Center for which no assistance is currently available is employment transportation for non-disabled low-income adults in rural areas.</p> <p>We intend to create a revolving auto loan program. This program is a replication of a successful program in several state Community Action Programs. Other programs have reported being able to provide 20 loans per year exclusively out of the repaid loan fund within 5 years.</p>	<ul style="list-style-type: none"> • Create a revolving automobile loan program, which will be tied to fiscal literacy programs and community ride-sharing. • Will provide transportation to low-income families and credit repair upon successful repayment of the loan. 	Provide no-interest loans to low-income working families in 2013. The initial investment will become part of a revolving fund as payments are received.	<ul style="list-style-type: none"> • Provide four loans in 2013. • At least 15% of rides will be shared rides. 	Norah Cashin December 2013	<ul style="list-style-type: none"> • Five loans were provided in 2013 and repayments are up-to-date. • Data is not available on shared rides.