HERE FOR YOU

through integrated health care

2013 OUTCOMES REPORT

NORTHWESTERN COUNSELING & SUPPORT SERVICES

www.ncssinc.org

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Letter from Executive Director

Northwestern Counseling & Support Services, Inc. (NCSS) is pleased to share our outcomes report for 2013 that covers our three service divisions, Behavioral Health; Children, Youth & Families; and Developmental Services. We began incorporating Results Based Accountability (RBA) to measure outcomes over 12 years ago.

With the changes in State and health care reform the focus on outcomes has become more predominant than ever. NCSS collaborates with community partners with the goal of improving the health and well-being of the population of Franklin and Grand Isle Counties.

Our Integrated Health initiative continues to move at a fast pace with positive initial results. Social Workers on the Blueprint Community Health Team are in most of the primary care practices. Plus, we began our contract with the NOTCH to provide behavioral health services in their primary care practices as well.

Our commitment to quality is a direct result of our dedicated staff, our passion for collaboration, and our belief in the importance of education and training. These efforts are exemplified by the fact that NCSS is recognized with the highest level of accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF).

NCSS has distinguished itself as a quality organization by the commitment to our mission… to ensure that the residents of Franklin and Grand Isle Counties have access to high quality services, which promote healthy living and emotional well-being.

As you review this report you'll see how our efforts have had a positive impact in our community during the past year. We hope that if you or someone you know needs services, you will come to us knowing that ***WE'RE HERE FOR YOU*** through integrated health care.

Ted Mable, Ed.D.
Executive Director

BALANCED SCORECARD

The Balanced Scorecard is a management system that enables our Agency to clarify our vision and strategy and translate them into action. It provides feedback around internal business processes and external outcomes in order to continuously improve strategic performance and results. The Balanced Scorecard provides a clear prescription as to what our Agency should measure in order to "balance" the financial perspective with other very important outcome perspectives.

"Alive because of NCSS. What a gift!"

~ 2013 Consumer Satisfaction Survey

Client Satisfaction and Staff Engagement data is based on a 7-point scale.

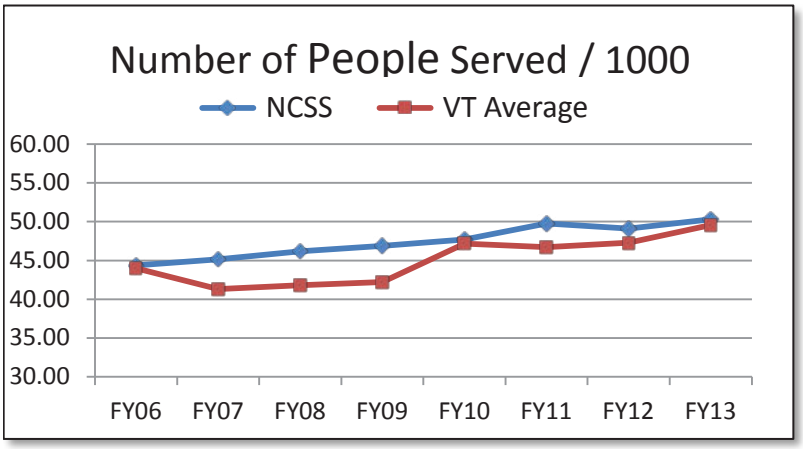
NCSS Clients Served

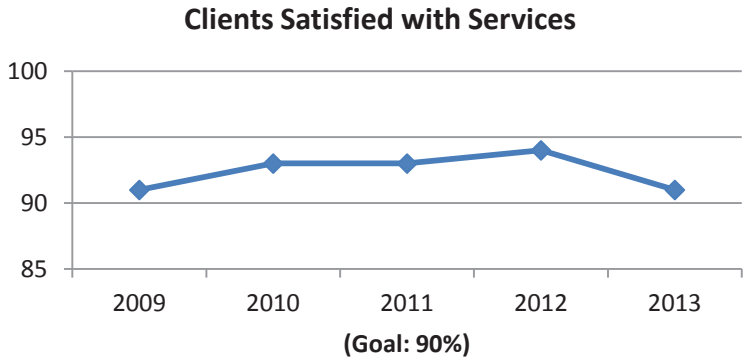
Served in 2013 4026

Program Outcome Statement: Clients of NCSS will be satisfied with services that they received

Program Indicator: Residence of Franklin and Grand isle counties will have access to high quality services

Headline Measures:





Story Behind the Baseline Performance:

Our mission is to ensure that the residents of Franklin and Grand Isle Counties have access to high quality services, which promote healthy living and emotional well-being. Our goal is to make sure that the high quality services meet individual needs, make a different in their lives and that each client is satisfied with their overall care and experience.

As a Designated Agency, NCSS is required to perform an annual client satisfaction survey and over the years the survey has evolved. In 2013 we designed one agency satisfaction survey that had ten core questions and was administered with the same process across all three divisions. In addition to the process changes, the 2013 survey replaced the 5-point scale to a 7-point scale giving a more accurate picture. This year's survey had one of the highest return rates with 559 surveys returned, however the 2013 results were slightly lower than 2012. This can be attributed to the change in the survey scale.

"Thank you for everything you guys do. I really appreciate all of the services we received and I am forever grateful to you for giving me my daughter back, the progress she has made is beyond what I ever imagined."

~ 2013 Consumer Satisfaction survey

Proposal to Improve Performance:

- Continue with the 7 point scale and have consistent survey questions from previous surveys
- Increase client support with filling out the survey

Action Plan:

- Have the surveys documented by program to be able to produce different levels of survey results
- To work with the Vermont Council with having a standard survey questions and process throughout the Designated Agencies in Vermont

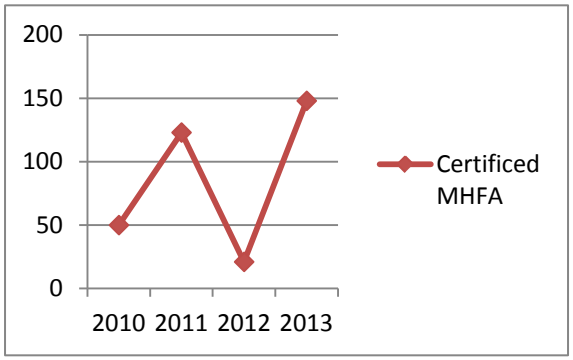
Mental Health First Aid

Program Outcome Statement: People will be certified and reduce stigma around mental health conditions

Program Indicator: Neighbors, professionals and families will be given the tools and knowledge of supporting a person experiencing a mental health crisis

Headline Measures: Is anyone better off?

Certified Aiders in Franklin and Grand Isle County

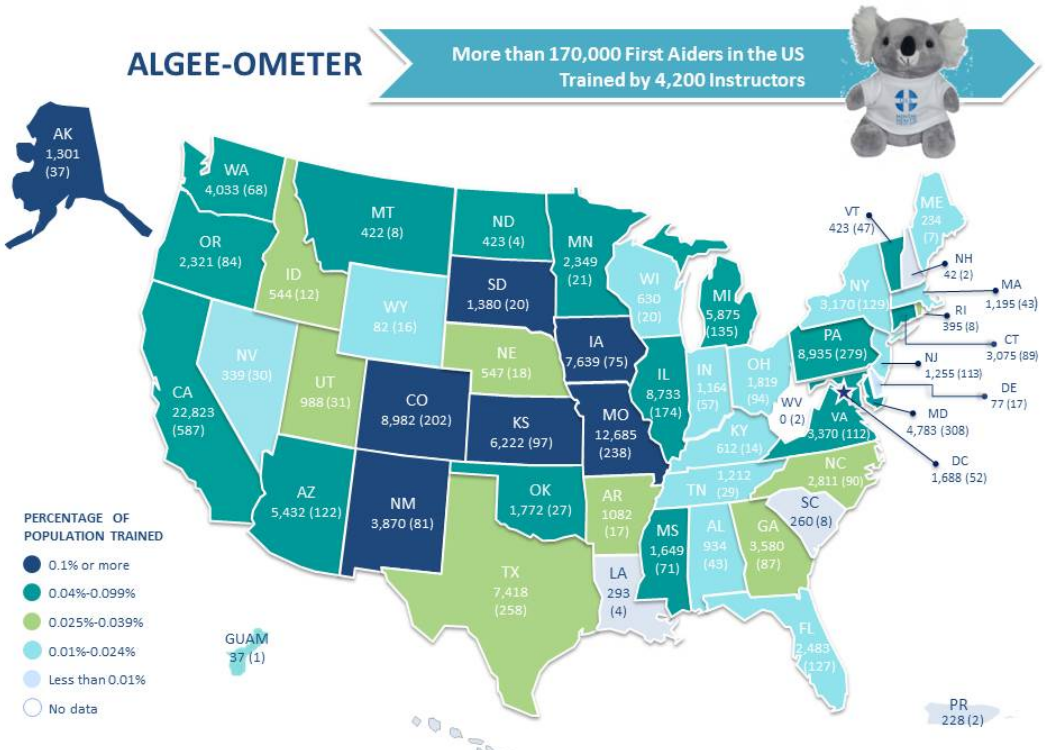


Story Behind the Baseline Performance:

In the State of Vermont there are 423 people certified in MHFA and of that number NCSS trained 342 of them. In 2013 we had an increase in trainings that included the Developmental Services Division. What the numbers do not show is that in the fall of 2013, we sent four of our trainers to be certified in Youth Mental Health First Aid and we have had two pilot trainings.

What Works:

Our trainings have helped bring awareness of mental illness, have built strong working relationships with community partners and has helped the community understand local issues.



Community Partners:

- Community Neighbors
- NOTCH - Healthcare Practice
- The Abenaki Community
- VAL & Reach Up
- State Police, Swanton Police, St. Albans Police, Rutland Police and Milton Police Departments

Proposal to Improve Performance:

- Train more trainers for the Veterans curriculum
- Continue to provide the adult version of Mental Health First Aid Adult on an annual basis

Action Plan:

- Have 2-4 Youth Mental Health First Aid courses for the community
- Expand the Youth Mental Health First Aid for schools and DCF foster homes

TRAUMA INFORMED CARE

PROGRAM OUTCOME STATEMENT: TRANSFORM ORGANIZATIONAL CULTURE THROUGH TRAUMA INFORMED CARE IMPLEMENTATION PROCESS DEVELOPED BY THE NATIONAL COUNCIL FOR BEHAVIORAL HEALTH

PROGRAM INDICATOR: DEMONSTRATE INCREASED TRAUMA INFORMED CARE BY IMPROVING SCORES IN ORGANIZATIONAL SELF-ASSESSMENT DOMAINS

Headline Measures – How much are we doing?

Organizational Self-Assessment Scores ~ Baseline Score on 4 point scale~	
Domain 1 –Screening/Assessment	2.77
Domain 2 – Consider Driven	2.68
Domain 3 – Workforce Development	2.26
Domain 4 – Best Practices	2.75
Domain 5 – Safety/Environment	2.84
Domain 6 – Community Outreach	2.70

Story Behind the Baseline Performance:

NCSS will be participating in a yearlong demonstration project with assistance from the National Council for Behavioral Health to implement a process for improving trauma informed care. While there are "pockets" of strengths in certain programs or with staff, there is not a strong trauma informed presence or a process for training new staff to increase awareness, competence and outcomes for persons served.

What Works:

NCSS has a strong team development model across all divisions and we will be capitalizing on this through a cross divisional implementation team, composed of representatives from all three service divisions, administration, and individual with lived experience (peers).

The trauma informed care implementation process has demonstrated effectiveness through monthly webinars, technical assistance calls from National Council Faculty, and measures of performance in domain areas & Performance Monitoring Tool.

Community Partners:

- Cross Division Implementation Team
- Department of Mental Health, Department of Aging and Independent Living
- Primary Care Providers
- Northwestern Medical Center

Proposal to Improve Performance:

- Increase Trauma Informed Care domain scores in all areas, which should result in improved screening & assessment, consumer driven or peer services, systematic approach for workforce development, broader application of evidenced based practices across programs, safer work settings, increased outreach to the community, and trauma specific evaluation data for measuring success.

Action Plan:

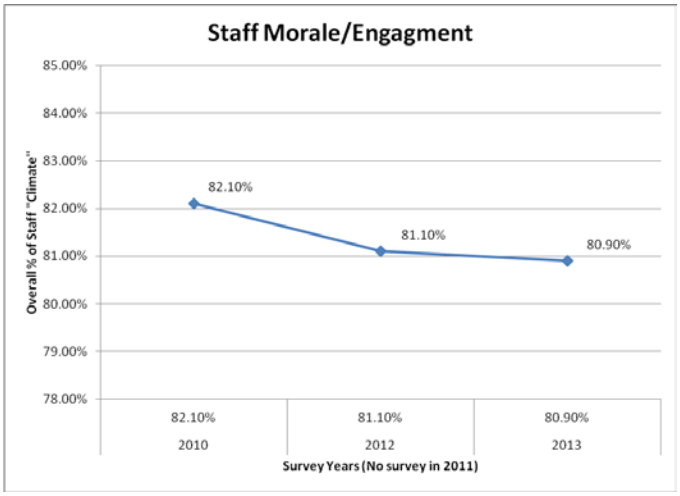
- Form Core Implementation Team with a common vision
- Assess baselines performance in Trauma Informed Care Domains through Organization Self-Assessment and Client Surveys (see baseline scores above)
- Implement action plans in priority domain areas
- Collect data related to each goal by developing a Performance Monitoring Tool

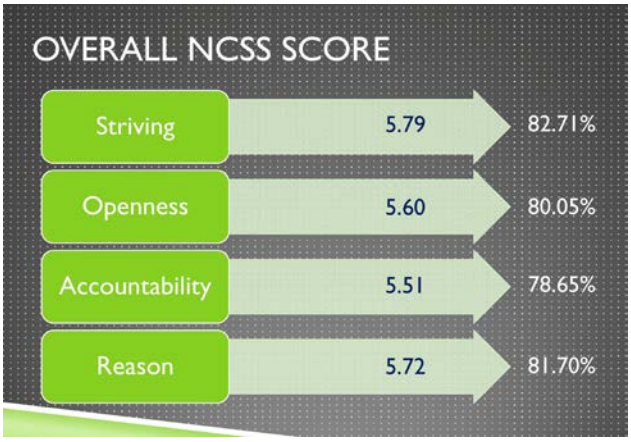
Staff Climate and Engagement – Human Resources

Program Outcome Statement: Engaged staff believe they perform meaningful, important and interesting work, and are committed to NCSS

Program Indicator: Staff fully embracing the agency's mission will breed enthusiasm and positive energy, giving rise to survey scores!

Headline Measures: Is anyone better off?





Story Behind the Baseline Performance:

After years of administering a 12 question climate "satisfaction" survey scored on a 5 point scale, we enhanced the survey to gather a more in-depth understanding of employee engagement; moving to a 7 point scale and 92 questions. We fine-tuned the focus by dividing the survey into 4 sections; using the acronym S.O.A.R. The data indicates morale and staff engagement continues to be consistently high.

What Works:

The HR Department recognizes that staff morale is an important factor in the delivery of high quality client care. We know that happy staffs tend to be motivated, engaged and productive employees. NCSS plays a critical role in the lives of clients and staff alike; it's important that employees are truly engaged in their jobs, therefore, must be shown support and appreciation for their hard work. This will yield committed and engaged employees!

The Agency administers an annual staff climate survey to take the organizational temperature. Our annual surveys probe employee satisfaction regarding working conditions, individual supports, professional growth opportunities, leadership satisfaction, pay, benefits, and our overall company culture.

In addition to our ongoing pay and benefits efforts, we regularly invest in staff morale boosters, both on the individual employee level and through all staff activities such as tuition assistance, BBQ's, exercise classes, fun contests and much more!

Community Partners:

- Local gym facilities
- Unicare EAP
- Wellness instructors
- Center for Health & Wellness
- BCBS
- Fidelity Investments
- Aflac
- Educational Assistance

Proposal to Improve Performance:

- We are in the process of reviewing our organizational structure to ensure alignment with the future of healthcare; making sure we have the right staff, with the right skills, knowledge and attitudes in the right roles. We are working on developing a tiered career ladder to encourage employee growth and development, which we believe will have a positive impact on employee engagement.

Action Plan:

- Review survey results with leadership and teams looking for areas of strength, so we can build upon them.
- Identify areas of employee interest that may further inspire staff to give their best effort at work.
- Decide if we will return to the 12 question survey annually, but continuing with the 7 point scale.

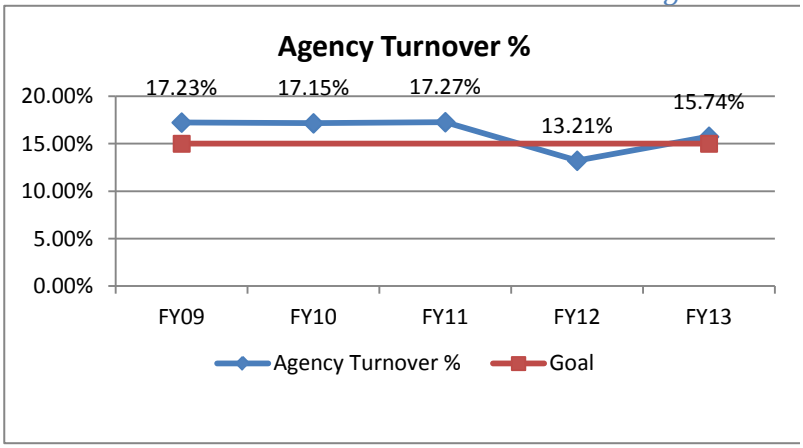
Staff Turnover – Human Resources

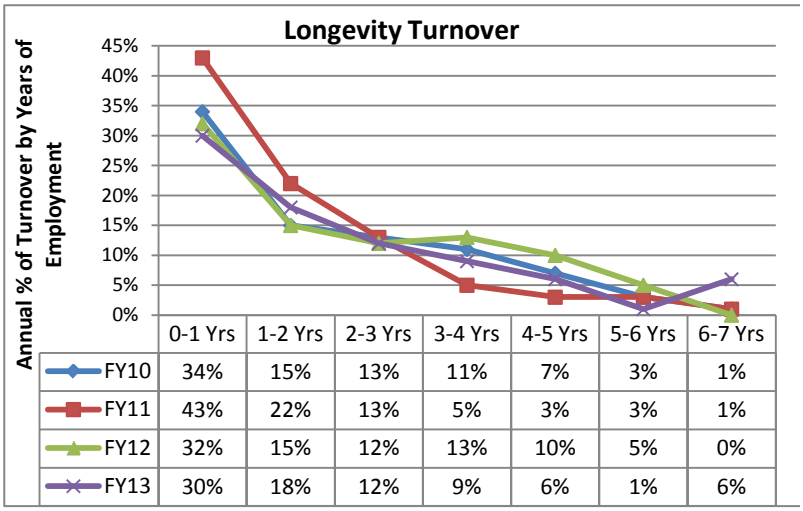
Employed in 2013 485

Program Outcome Statement: Our goal is to be welcoming, competent and helpful to all staff, knowing our interaction sends a vital message about our organization.

Program Indicator: Create a captivating experience for all employees, which attributes to a healthy turnover rate

Headline Measures – How much are we doing?





	0-1 Yrs	1-2 Yrs	2-3 Yrs	3-4 Yrs	4-5 Yrs	5-6 Yrs	6-7 Yrs
FY10	34%	15%	13%	11%	7%	3%	1%
FY11	43%	22%	13%	5%	3%	3%	1%
FY12	32%	15%	12%	13%	10%	5%	0%
FY13	30%	18%	12%	9%	6%	1%	6%

Story Behind the Baseline Performance:

Once beyond the third year of employment turnover stabilizes at a healthy annual rate of 3-4%. Our focus over the past few years has been to create an environment where employee engagement happens in the first 12-months. Many successful initiatives towards this end have been implemented starting with a "hire hard" philosophy, implementing a wrap around support approach with a big focus on training including new employee orientation, assignment of a mentor, and online learning opportunities to enhance an employee's assimilation; in return they deliver higher quality services to clients.

What Works:

We know that on average 34% of staff turnover happens in the first twelve months of employment. Several factors can be attributed to this 12 month period; including - new graduates trying out the field for the first time, determining if there is a job and culture fit, deciding if the pay scale is for them, and successful completion of the Agency's introductory period.

Community Partners:

- Social media
- Employee referrals & Internal promotions
- Career fairs
- Websites (NCSS & external)
- Direct Mailing
- Newspapers
- Radio

Proposal to Improve Performance:

- We continue to focus on hiring practices to ensure we are hiring people that not only have a strong skill set, but also have the right attitude. We believe in the philosophy of Appreciative Inquiry and as we identify what is working for the teams with low turnover, we can do more of "it", to increase retention!

Action Plan:

- Develop a tool that objectively measures *attitude* of potential hires in addition to core job competencies. Further evaluate our recruiting strategies to more effectively hire and retain star employees that fit our culture.

Behavioral Health

The Behavioral Health Division serves children, adolescents, adults and families. Psychiatry and Nursing services operate out of this Division and also serves the Children's, Youth & Family Services and Developmental Services Divisions. Services within the Behavioral Health Division include Crisis Services, Outpatient, and services for adults with severe and persistent mental illness (Community Rehabilitation and Treatment Program). The sudden closing of the Vermont State Hospital has created a demand for a higher level of acute care services, which we have addressed through the development of a mobile outreach team and enhancement of services to improve access. Health Care reform has created an opportunity to be a partner with primary care through the Blueprint initiative where providers work in primary care settings. We are in a continuing process of modifying the services we provide to meet community needs. The process of evaluating the impact of our services is also an ongoing process and one we are excited about describing to you in this report.

~ Steve Broer, Director of Behavioral Health Services

Amada Story*:

Amada* struggled transitioning into adulthood. She developed a severe and persistent mental illness known as Bipolar disorder, which involved periods of extreme "highs" & "lows" and required multiple inpatient psychiatric hospitalizations. At that time, her only involvement with NCSS was through our crisis services. A community based plan was ultimately developed through the Community Rehabilitation & Treatment (CRT) program. Initially, her individualized plan of care involved a range of services: psychiatry, housing supports, case management, employment, development of a Wellness Recovery Action Plan (WRAP). Over time as her illness became more manageable for her, services were adapted to meet her needs. Eventually, she did not require the supports offered through the CRT program and ultimately she worked with her providers in modifying her plan of care to include: psychiatry, outpatient therapy and periodic support from crisis services. Amanda found meaningful work, has been able to maintain her own apartment, engage in a trusting relationship with a significant other, and contribute to the Behavioral Health division's standing committee.

** Name has been changed for confidentiality purposes.

"Thank you for your help! I'm happy I did decide to get help from NCSS. I'm doing a lot better."

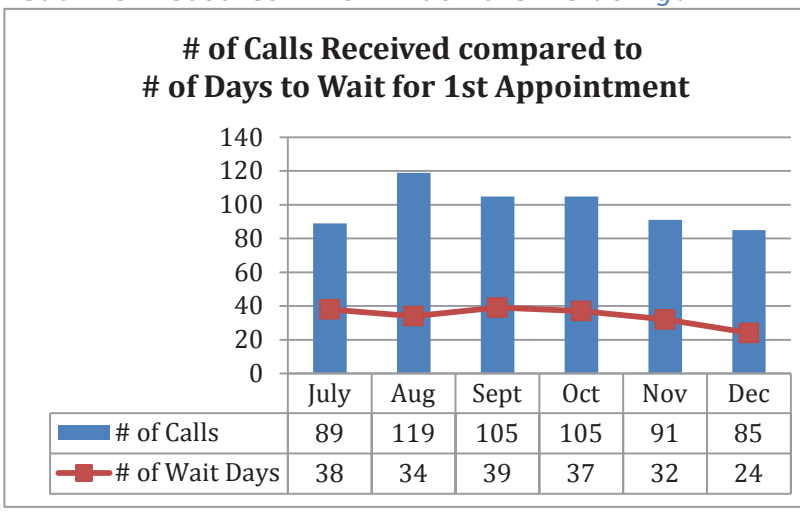
~ 2013 Client Satisfaction Survey

Outpatient Access to Services – Behavioral Health Services

Program Outcome Statement: Increase access to outpatient services within a high demands environment

Program Indicator: track number of calls for service leading to scheduled appointments & compare to decrease in number of days to first appointment

Headline Measures – How much are we doing?



	July	Aug	Sept	Oct	Nov	Dec
# of Calls	89	119	105	105	91	85
# of Wait Days	38	34	39	37	32	24

Story Behind the Baseline Performance:

Outpatient service has experienced a steady demand with no significant drop in demand throughout the year. This is a steady trend over the years. Implementation of a centralized communication role (Access Coordinator) and a same day access option for non-emergencies have demonstrated an improvement in access time from initial call to first date of service. Data demonstrates reduction in number of days (high of 39 days) to a (low of 24 days). Calculation of days includes weekend days. Preliminary data for 2014 is even more encouraging with implementation of other steps to improve access.

What Works:

- Maintain same day access for individuals in crisis
- Maintaining new client admission expectation for Outpatient service
- Implement same day access option for brief treatment for individuals not in crisis
- Centralizing communication through Access Coordinator role
- Expand groups to address common treatment needs
- Implementing wider range of brief treatment options
- Regular tracking of demand for services and number of days till first appointment

Community Partners:

- Direct referrals from persons seeking services
- Referrals from Primary Care and other providers
- Referrals from Crisis and other NCSS providers

Proposal to Improve Performance:

Continue to identify process improvement strategies to decrease the amount of days till first appointment

Action Plan:

- Expand same day access option by adding another therapist skilled in brief treatment
- Expand group options
- Develop case management options to serve more individuals who need this service more than therapy
- Continue to measure access and other factors which may contribute to improving access

Supported Employment (SE) – Behavioral Health

Program Outcome Statement: To decrease psychiatric hospitalization rate by offering community-based supports and resources to increase symptom management and independent living

Program Indicator: Increase number of individuals gainfully employed through the Supported Employment program

Headline Measures – How much are we doing?

Employment Rate	
State Expectation	18%
Program Performance	17%
VR Closures	
State Expectation	11
Program Performance	11
Average Wages	
State Expectation	$1,800
Program Performance	$2,100
# of Service Hours for All Employment Codes	
2082 Hours	

Story Behind the Baseline Performance:

The Supported Employment (SE) Team serves individuals enrolled in the CRT program. SE supports include job search support, job development with local employers, on-site supports, benefits counseling, and treatment team involvement. The program goals are to increase the number of individuals working, increase the number of new jobs starts, and increase the number of individuals working 90 days successfully. The team has met each one of these goals for the past two years. However, the team is under pressure to reach a contract imposed increase target numbers year after year in a challenging job market with a limited number of employers due to the rural area.

What Works:

The SE team continues to utilize the Individual Placement and Support Model (IPS), an Evidence-Based Practice. Each client identifies their own employment goal which allows for the individual to feel a sense of belonging and purpose. Collaboration with Vocational Rehabilitation (VR) has made it possible to reach expectations in several priority areas.

Community Partners:

- Vocational Rehabilitation
- Champlain Valley Office of Economic Opportunity
- Department of Labor
- Department of Mental Health
- Area Businesses
- Chamber of Commerce

Proposal to Improve Performance:

- While the program has demonstrated strong performance in several domain areas, there continues to be a significant challenge in meeting the overall employment rate goal. In fact, contract requirements will increase employment expectations in the coming year. This poses a serious challenge which requires a range of creative an innovative action steps.

Action Plan:

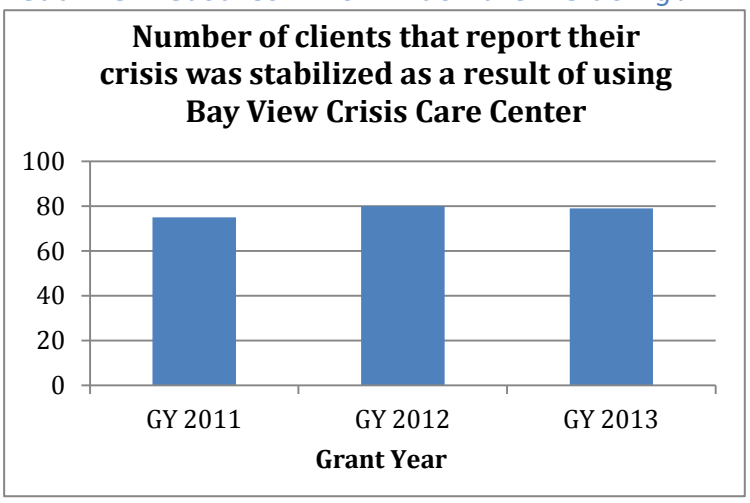
- Follow recommendations in 2013 Fidelity Review conducted by DMH/Dartmouth, which include strategies to enhance job development, increase field supervision, and provide a forum for SE clients to share positive stories about work (such as Adult Behavioral Health Standing Committee).
- Provide trainings to CRT staff that will enhance their knowledge regarding benefits and the importance of being gainfully employed.

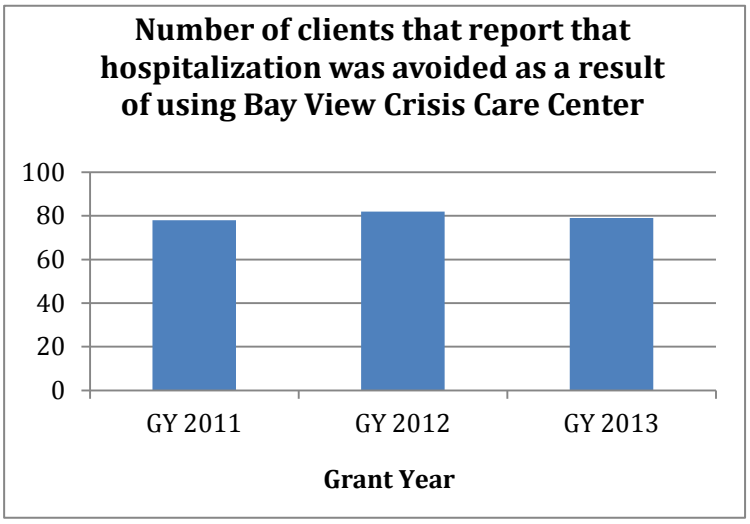
Bay View Crisis Care Center – Behavioral health

Program Outcome Statement: To decrease psychiatric hospitalization rate by offering community based supports and resources to increase symptom management and independent living.

Indicator: Community Crisis stabilization through The Bay View Crisis Care Center

Headline Measures – How much are we doing?





Community Partners:

- Local Primary Care Physicians and medical providers
- Local mental health private practices
- Hospitals
- Other Designated Agencies

Story Behind the Baseline Performance:

The Bay View Crisis Care Center is a community recovery resource designed to prevent inpatient psychiatric hospitalization for adults who may be experiencing acute stress or a serious mental illness. Bay View provides a safe setting with comprehensive crisis stabilization supports. The program is also a resource to reduce the cost of hospitalization by serving as a step down discharge option for those who are not ready for entry into the community without intensive support. During each stay, a LOCUS and Brief Symptom Inventory (BSI) are performed and upon discharge, people are asked to complete a satisfaction survey. This data has been tracked since the program's inception and highlights the program's effectiveness in 7 key areas: Average LOCUS at Admission and Discharge; # of Clients Served; Average decrease in LOCUS from Admission to Discharge; Client and Stakeholder Satisfaction of Services Rendered; Average # of Days in Program; Rate of Re-admission as a percentage; # of Clients Served from Outside of Franklin & Grand Isle Counties.

What Works:

Bay View had 239 admissions in grant year 2013 and has been an important resource in the community for individuals who experiencing a mental health crisis. 79% of people who used Bay View reported that they felt Bay View stabilized their crisis at the time. Bay View is continually developing programs to support the statewide goal of reducing the hospitalization rate and promotion of community options for those in crisis.

Proposal to Improve Performance

To demonstrate that individuals are better off as result of their experience at the Bay View Crisis Care Center, data on symptom reduction through the Brief Symptom Inventory will be analyzed in addition to a functional improvement measure (the LOCUS).

Action Plan:

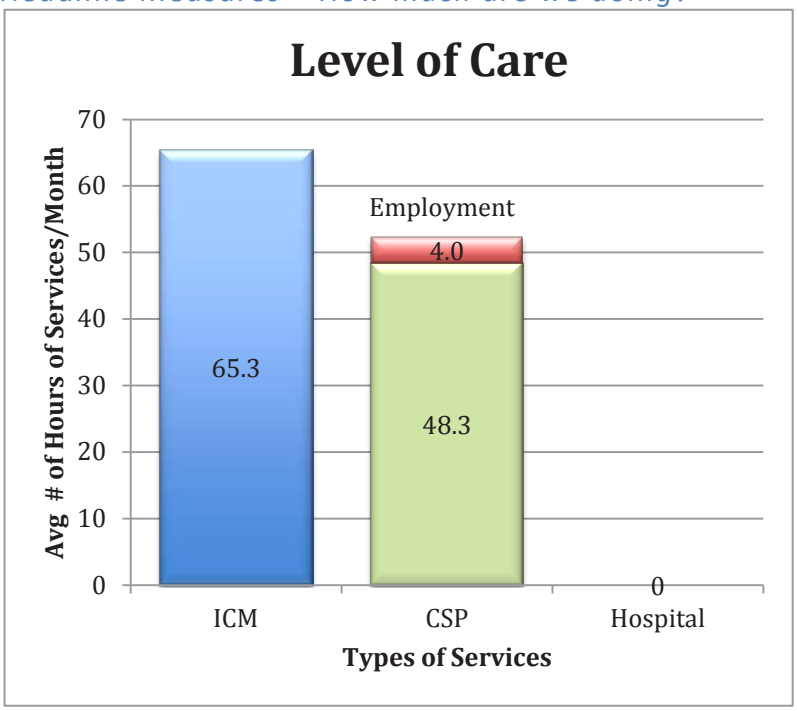
Develop a process to systematically train staff on administration of the BSI and LOCUS to maintain reliability and fidelity to scoring. Enhance clinical program offerings to directly address crisis stabilization needs.

INTENSIVE CASE MANAGEMENT PROGRAM – BEHAVIORAL HEALTH

PROGRAM OUTCOME STATEMENT: TO DECREASE PSYCHIATRIC HOSPITALIZATION RATE BY OFFERING COMMUNITY BASED SUPPORTS AND RESOURCES TO INCREASE SYMPTOM MANAGEMENT AND INDEPENDENT LIVING.

PROGRAM INDICATOR: DEMONSTRATE IMPROVEMENT THROUGH TRANSFERS TO A LOWER LEVEL OF CARE AND REDUCE COSTS

Headline Measures – How much are we doing?



Six clients started FY13 with ICM Level of Service (65.3 hours) and were transferred to the Community Support Program (48.3 hours) once stabilized. These six clients received decreased level of services in addition to recovery based programs, such as employment (4.0 hours). This demonstrates a cost savings to the program, while meeting the service needs of the client; ultimately, resulting in zero hospitalizations of these six individuals.

Story Behind the Baseline Performance:

The Intensive Case Management Program (ICM) within CRT offers medication delivery to ensure medication compliance, frequent case management supports and a team based approach to help maintain individual's independence in the community. Individuals receiving ICM have benefited from this support and have a decreased hospitalization rate. One of the challenges is the nature of severe and persistent mental illness can be debilitating, and those individuals often have complex medical needs, which impact the overall wellbeing of individuals. Ultimately, the goal is to increase education and employment levels, increase medication compliance, increase connection to resources and natural supports so individuals served are able to maintain their independence with a lower level of care (Community Support Program) or eventually be dis-enrolled due to goal completion.

What Works:

Intensive Case Management plays a valuable role in reducing psychiatric hospitalization by offering individualized support, medication delivery, collaboration with medical providers and other resources to ensure persons served manage their symptoms and maintain independent living. When clients are able to achieve this, the individual is able to transfer to a lower level of care, the Community Support Program (CSP).

Community Partners:

- Local Primary Care Physicians and other medical providers
- Home Health Services
- Care Partners
- Champlain Valley Office of Economic Opportunity
- Vocation Rehabilitation
- Designated Psychiatric Hospitals

Proposal to Improve Performance

Prioritize interventions to increase transfer of clients to a lower level of care within the CRT program to reduce costs and provide resources to care for others. Implement Evidenced Based Practices and other treatment approaches to facilitate these performance improvements.

Action Plan:

Increase capacity of both the Intensive Case Management & Community Support Teams to implement Illness Self-Management and other treatment approaches which focus on symptom self management and improved functioning.

CRISIS PROGRAM – BEHAVIORAL HEALTH

PROGRAM OUTCOME STATEMENT: SUPPORT COMMUNITY OPTIONS FOR PERSONS EXPERIENCING CRISIS

PROGRAM INDICATOR: INCREASE IN LAW ENFORCEMENT CONTACT AND DECREASE IN CLIENTS COMING TO EMERGENCY ROOM

Headline Measures – How much are we doing?

Face to Face Contacts	
Year	# of People Served
2012	1,177
2013	1,408
Police Involvement	
2012	14%
2013	14%
Police Involvement On Scene	
2012	36%
2013	20%
Police Brought Client in to be Seen	
2012	62%
2013	66%
Avoided ER Visit	
2012	46%
2013	33%
Avoided Hospitalization	
2012	56%
2013	51%

Story Behind the Baseline Performance:

In 2012 when the Vermont State Hospital was closed due to a devastating flood, we competed for increase funding to support the goal of community options of individuals in crisis rather than inpatient hospitalizations. Some individuals in crisis can be triggered when the police are involved and this can escalate a situation. With crisis staff support, these types of situations can be de-escalated before the client needs to be taken to the emergency room or possibly incarcerated. We believe there are many interventions, which can prevent unnecessary use of our local medical center's Emergency Department, unnecessary arrests and incarcerations and inpatient psychiatric hospitalizations

What Works:

- Working closely with local law enforcement and building on relationships.
- Offering to be on scene for police wellness checks.
- Debriefing about situations that didn't go as planned, or as well as we would have hoped.
- MHFA class for law enforcement to support intervention strategies.
- Support law enforcements understanding of assisting persons with mental illness.

Community Partners:

- Vermont State Police
- St. Albans City Police
- Swanton Police Franklin & Grand Isle County Sheriff
- Lamoille County Sheriffs for non-intrusive transports
- Homeland Security

Proposal to Improve Performance:

- Decrease over utilization of medical center's Emergency Department for non-emergent/life threatening conditions that we could see in a community setting

Action Plan:

- Working closely with law enforcement and community partners to bring clients to alternate locations vs. ER if it is not warranted.
- Hire specific person to navigate the law enforcement world and be implanted in multiple office to improve relationships and continue to provide education around mental illness.
- Monthly meeting with local Emergency Department leadership.

Crisis Program – Behavioral Health

Program Outcome Statement: support community options for persons experiencing crisis

Program Indicator: Reduce inpatient psychiatric hospitalization through increased access and services and increase in more support to clients who would not normally be eligible

Headline Measures – How much are we doing?

Inpatient Admissions	
2012	9%
2013	7%
Voluntary Admissions	
2012	7%
2013	5%
Involuntary Admissions	
2012	2%
2013	2%
Went Home after a Crisis Intervention	
2013	78%
Non-Categorical Case Management	
2013	282

Story Behind the Baseline Performance:

In 2012 the Vermont State Hospital was destroyed due to a devastating flood leaving it to the Designated Agency System to provide services for individuals who might otherwise be hospitalized. Act 79 increased funding to enhance our capacity to reduce inpatient psychiatric admissions and provide access to a wider range of services to maintain community living for those in crisis. One of the services developed, non categorical case management provides specific support in the community to address a range of immediate needs which may contribute to risks of hospitalization.

What Works:

Providing short and longer term case management to clients who need support and have goals that need an additional level of support and advocacy; same day access to therapy;increasing short term treatment options;reaching out to clients recently hospitalized to prevent re hospitalization and to assist in stabilization

Community Partners:

- Economic Services
- Department of Children & Families
- Department of Vermont Health Access
- Community Action
- Champlain Valley Agency on Aging
- Hospitals
- Primary Care Providers
- Department of Corrections
- Blueprint team

Proposal to Improve Performance:

Reducing inpatient psychiatric hospitalization by increased access to a range of community based services known to improve outcomes for individuals in crisis.

Action Plan:

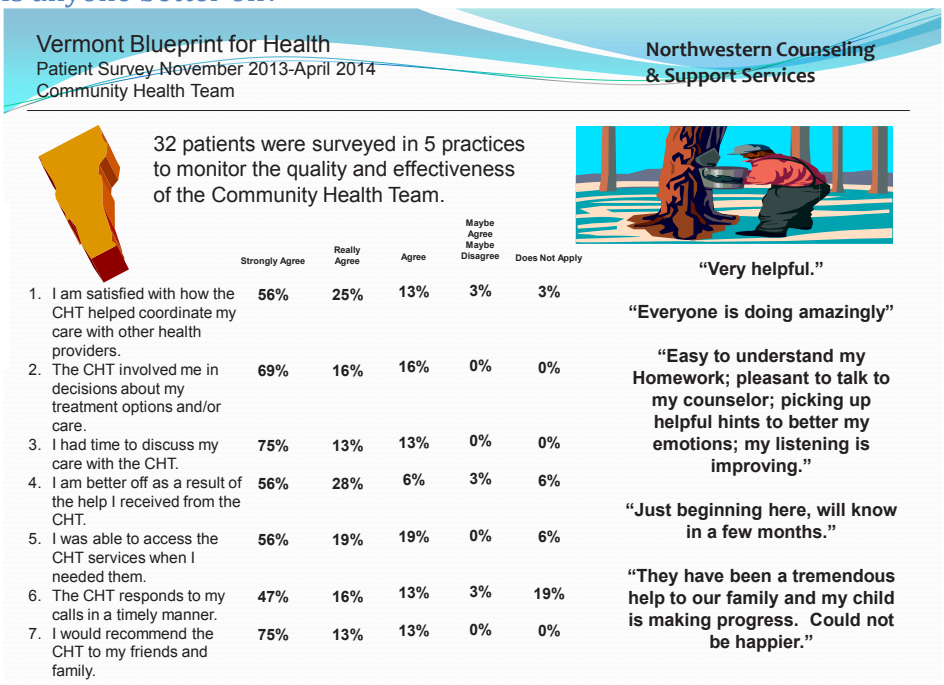
- Decrease inpatient hospitalization through more responsive case management services
- Decrease inpatient hospitalization through proactive outreach to individuals upon discharge from a hospital
- Increase access through centralized screening and referral process
- Increase access through same day access for non-emergency situations with a range of services

BLUEPRINT COMMUNITY HEALTH TEAM – BEHAVIORAL HEALTH

PROGRAM OUTCOME STATEMENT: WORK IN COLLABORATION WITH OTHER COMMUNITY HEALTH TEAM PARTNERS IN SUPPORTING AN INTEGRATED SYSTEM OF HEALTH CARE FOR PATIENTS SERVED.

Headline Measures: Is anyone better off?

Patient Satisfaction Results from November 2013-April 2014



Story Behind the Baseline Performance:

The Community Health Team integrates with patient-centered medical homes to deliver enhanced care coordination, self-management support and/or brief therapy to patients referred by their care team at no cost regardless of insurance.

Often patient's needs can all be met within the same four walls and no specialty referral is needed as a result of the intervention.

Integration is always a challenge but ultimately we envision being seen as another provider within each office both by the practice itself and by the population we serve.

What Works:

Patients are overwhelmingly satisfied with our services. Providers thus far have expressed satisfaction with our services. At most sites access to services is immediate. Serve any patient at an NCQA scored Patient Centered Medical Home (PCMH) Serve top 5% (most complex patients) of patient panel at PCMH. Serve providers at the PCMH.

Community Partners:

- NMC (team members; leadership; project manager)
- NOTCH
- Primary Care Providers (PCP) offices (Patient-Centered Medical Homes)
- Vermont Chronic Care Initiative (VCCI)
- PCP offices that are not yet Patient Centered Medical Homes

Proposal to Improve Performance:

Continue to promote an active partnership with primary care providers to provide proactive, preventative and chronic care management and assure satisfaction from population served.

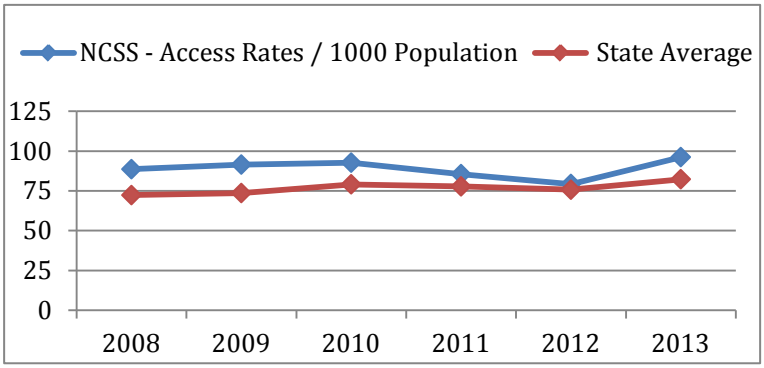
Action Plan:

- Measure **access** to the CHT looking at the date of first Action taken in comparison to the date of the original referral.
- Measure **Effectiveness** looking at the total number of patients who have "graduated" from the CHT services in comparison to the total number of patients referred for services.
- Measure **Effectiveness** looking at the first date of "Action Taken" in comparison to an enrollment status in the program of "graduated".
- Continue to measure **patient satisfaction** as well as provider satisfaction.

Children Youth & Families

Number Served in FY13 - 1,247

Headline Measures – How much are we doing?



In FY13, NCSS served 9.6% of the children living in Franklin and Grand Isle Counties. This figure is a 21% improvement over FY12. As shown in the graph, our access rates are also 16.9% above the state average.

NCSS has worked hard to offer quality services that are relevant to the people of our community. Our integrated intake team offers families a single point of entry into NCSS services. This simplified structure allows families to easily navigate our system of care and access necessary supports.

Theo's Story:*

Life hasn't always been easy for 35 month old Theo*. On the day of his birth, Theo suffered a blood clot which caused an Ischemic Embolic Stroke and seizure. He spent 8 days in the Neonatal Intensive Care Unit at Fletcher Allen Health Care (FAHC). Theo has been given a diagnosis of Cerebral Palsy and Epilepsy.

Because of Theo's complicated birth, he was referred to Northwestern Counseling & Support Services' Children's Integrated Services-Early Intervention program. He was only 11 months old. At that time, most areas of his development were compromised. He had yet to reach many developmental milestones with his left side motor skills of particular delay.

When Theo began services at NCSS, he was assigned to a team of professionals who took an integrated approach to early intervention. He was seen weekly at home by both a physical therapist, as well as an occupational therapist. He was also visited in the home by a Developmental Educator from NCSS. At that time, Theo was being followed by a team including specialist from FAHC, as well as Boston's Children's Hospital.

Theo has made a great deal of progress while receiving integrated wraparound services. Services have helped him achieve his goals and have paved a path for pre-school. Early intervention has certainly been a critical factor in Theo's learning. His progress is due to the strong partnership of not only the professionals, but more importantly the active participation of Theo's parents. Although the road has not been an easy one, Theo's parents have taken on the roles of "accidental advocates" with a great deal of commitment to their child.

Soon, Theo will begin attending preschool. While the future is uncertain, with Theo's strong will and support from his team of professionals and loving parents, he will surely be able to overcome anything.

***Name has been changed for confidentiality purposes**.

Community Partners:

- Public Schools
- Pediatricians
- Home Health
- United Way
- Vermont Family Network
- Community Justice Center
- Agency of Human Services
- Law Enforcement
- Voices Against Violence
- NFI
- Federation of Families for Children's Mental Health
- Department of Children and Families

Proposal to Improve Performance:

- Build a system that promotes preventative and flexible services within an Integrated Family Services Funding Structure.

Action Plan:

- Decrease Waiting Lists
- Standardize Outcomes
- Standardize Documentation
- Increase Breadth of Services
- Increase Preventative Programming
- Increase Number of Locations Where Services Are Provided

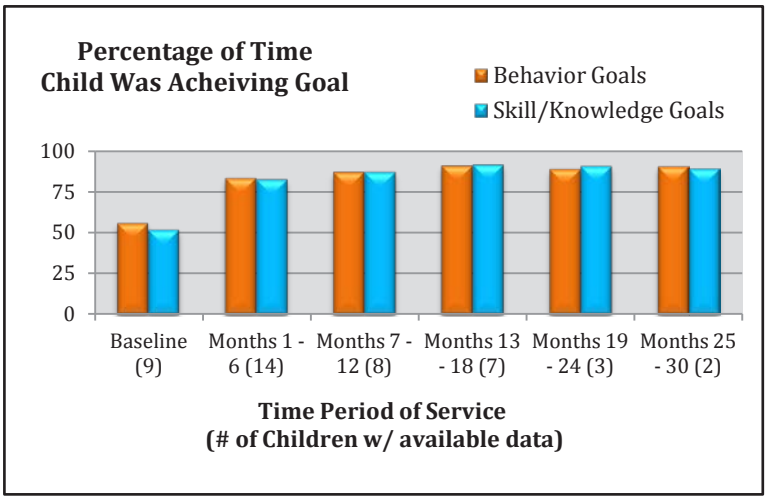
COLLABORATIVE ACHIEVEMENT TEAM – CHILDREN, YOUTH & FAMILY

Served in FY2013 - 24

PROGRAM OUTCOME STATEMENT: CHILDREN WILL BE SUCCESSFUL IN SCHOOL

PROGRAM INDICATOR: CHILDREN WILL ACHIEVE THE BEHAVIORAL GOALS AND ACQUIRE SKILLS/KNOWLEDGE

Headline Measures – Is anyone better off?



Data collected for students served during the 2012- 2013 school year shows that during the first six months of service, targeted behavior goals were met observed an increase of 27% of the school day (300 hours per student per school year), and skill/knowledge goals an increase of 31% (350 hours per student per year). By the end of 18 months, students were achieving their targeted goals in excess of 90% of the school day.

The average student gained over 420 hours of academic instructional time per year, as compared to when they began receiving CAT services.

Story Behind the Baseline Performance:

Team Leader, Amy Irish, completed her Master's Degree in Applied Behavior Analysis (ABA) in the last year and is preparing to sit for the Behavior Analysis Certification Board Examination; five team members are currently pursuing this degree and certification as well.

During the 2012-2013 school year the CAT program served 23 students in 10 local schools, providing over 20,000 hours of individualized supports. Two students were successfully transitioned off all supports in their classroom environment.

What Works:

The Collaborative Achievement Team provides one-on-one behavioral support to students who struggle to regulate their emotions and behavior in the classroom and broader school community. Using practices grounded in Applied Behavior Analysis, we work with the student, their family, and school faculty to identify the circumstances in which children tend to struggle, teach self management skills targeted to their behaviors, and reinforce the use of these skills at appropriate times. The goal of the program is to teach these skills to both students and the adults who support them so they can function effectively in school without the need for one-on-one support.

Community Partners:

- The Collaborative Achievement Team has partnerships with 60% of area public schools.

Proposal to Improve Performance:

- Enhance our Team's overall expertise in Applied Behavioral Analysis.
- Work with local schools to expand capacity to provide consultative services
- Streamline data collection and data reporting structures.

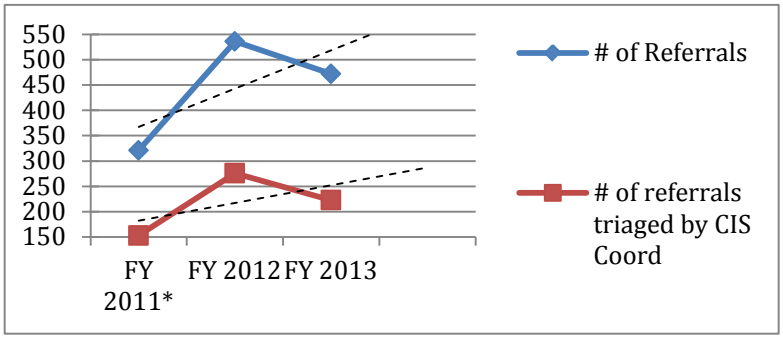
Action Plan:

- 6 individuals on the team are working towards ABA certification
- We are meeting with local school leaders to explore the need for greater consultative services. This will allow us to work with students on a more proactive basis.
- We are working to streamline our data collection and data reporting structures

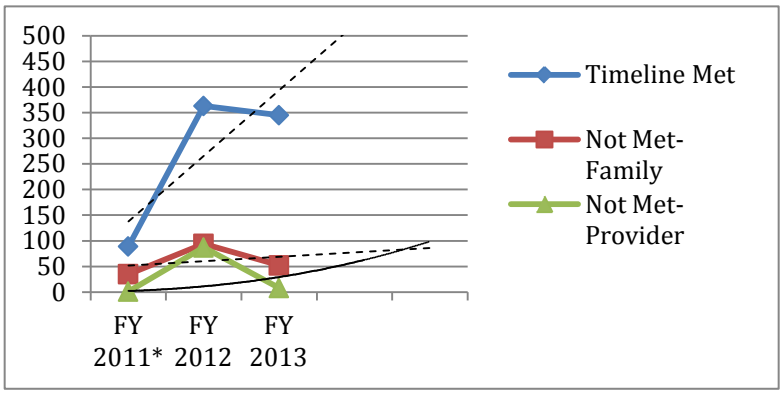
CHILDREN'S INTEGRATED SERVICES – CHILDREN, YOUTH AND FAMILIES
PROGRAM OUTCOME STATEMENT: PREGNANT WOMEN AND YOUNG CHILDREN THRIVE
PROGRAM INDICATOR: FAMILIES IN FRANKLIN/GRAND ISLE ARE REFERRED TO CHILDREN'S INTEGRATED SERVICES

Headline Measures: Is anyone better off?

Of Referrals to Children's Integrated Services



Initial Family Contact Within 2-5 Calendar Days



Story Behind the Baseline Performance:

Children's Integrated Services are part of a coordinated continuum of care across multiple types of providers and settings. Our goal is to provide services to pregnant/postpartum women, children and their families to support them through a systematic referral and intake process that leads to a consultative team review, linking with other community resources as needed. Weekly CIS meetings are held to ensure referrals are reaching the appropriate programs, as well as serves as a forum to discuss breakdown of potential barriers within the referral process. The CIS Coordinator acts as the designated referral door; additionally, referrals are received openly throughout CIS programs.

What Works:

Our Children's Integrated Services program provides health promotion, prevention, and early intervention services. These services ensure that we see improved health and well being of pregnant/postpartum women, infants and children through connections with high quality health care and community support services. Communication between service providers presents families with a stable opportunity to speak with one person in which they can gather information on an array of appropriate services for their family.

Community Partners:

- Vermont Department of Health
- Franklin County Home Health Agency and Visiting Nurse Association of Chittenden and Grand Isle Counties
- Department for Children and Families and Child Development Division
- Pediatricians and physicians
- Supervisory Unions
- Champlain Valley Head Start
- Residents of Franklin and Grand Isle Counties

Proposal to Improve Performance:

- Continue and expand outreach efforts regarding Children's Integrated Services (CIS)
- Maintain "no-wrong door" referral policy for families and community partners
- Continue to provide a seamless process for families to access the CIS team and supports
- Continue to ensure families receive a prompt response when referred to services

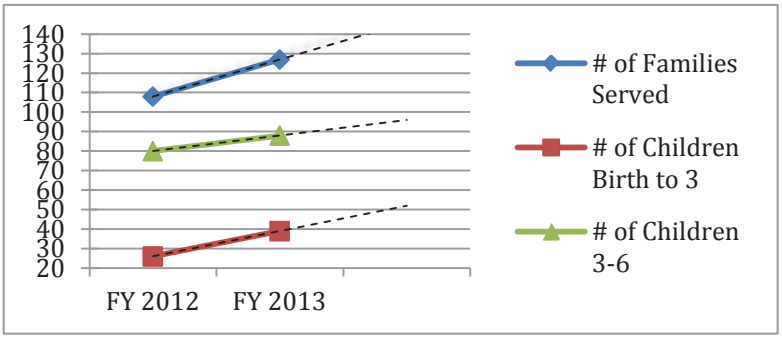
Action Plan:

- Conduct outreach on array of early childhood services with Franklin County Home Health Agency and Vermont Department of Health
- Incorporate the CIS referral and intake model in Northwestern Counseling & Support Services' Integrated Family Services pilot

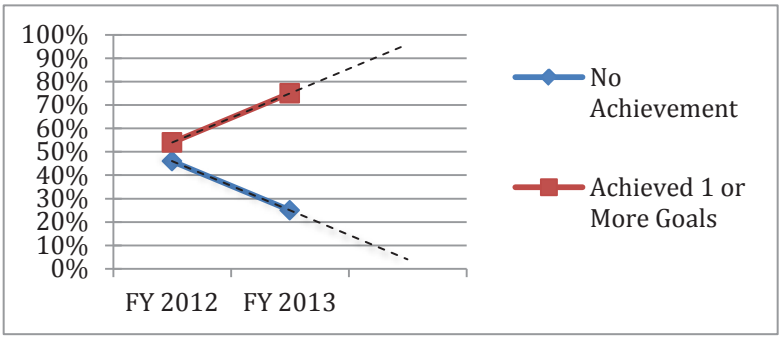
EARLY CHILDHOOD AND FAMILY MENTAL HEALTH – CHILDREN, YOUTH AND FAMILIES
PROGRAM OUTCOME STATEMENT: PROMOTE SOCIAL-EMOTIONAL DEVELOPMENT AND SCHOOL READINESS
PROGRAM INDICATOR: CHILDREN WITH INDIVIDUALIZED PLANS WILL MAKE PROGRESS IN MEETING THEIR IDENTIFIED GOALS

Headline Measures: Is anyone better off?

Number of Families Served



Outcome Achievement at Annual Review or Exit



Community Partners:

- Child care providers
- Local educators
- Champlain Valley Head Start
- Pediatricians
- Vermont Department of Health
- Champlain Valley Office of Economic Opportunity
- Department for Children and Families
- Residents of Franklin and Grand Isle Counties

Story Behind the Baseline Performance:

Early Childhood and Family Mental Health is an early intervention and prevention program that provides services to families and their children birth to age six in Franklin and Grand Isle counties. Services are designed to improve the social-emotional development of young children and improve school readiness. Services are provided in the home, child care, school, and community settings. Case managers provide help with parenting, child development, classroom/child care observations, consultations, trainings, and access to resources. In recent years our team has worked to improve program outcomes by focusing on family engagement and capturing their hopes, goals, and successes.

What Works:

Our team has a variety of professional and educational experiences, providing perspectives from social work, psychology, education, and counseling disciplines, as well as implementing evidenced based models (such as CSEFEL and ARC). Each family completes treatment plans with identified goals that are specific and meaningful. Family goals guide the work and progress is monitored at regular intervals, including the use of assessment tools. Families have identified an increase in parenting confidence and an improved ability to meet their child's needs.

Proposal to Improve Performance:

- Develop more cohesive service coordination with community partners assisting families
- Promote participation in community events such as preschool registrations, playgroups, and parent workshops

Action Plan:

- Work with community partners to coordinate intake appointments and share treatment planning
- Develop strategies to document family goals, capture progress, and highlight successes
- Increase access and obtainment of quality child development programs through child care and educational referrals

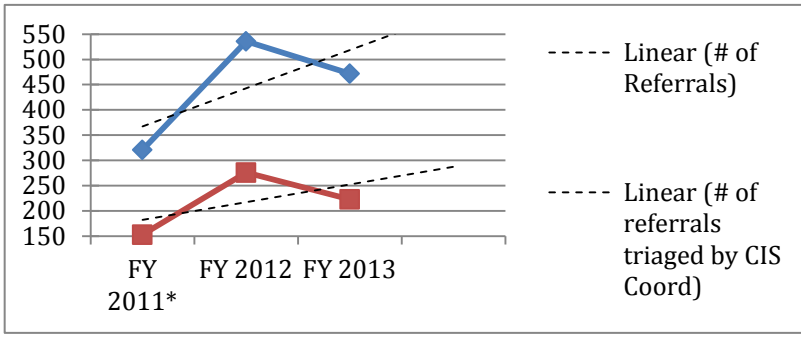
EARLY INTERVENTION – CHILDREN, YOUTH & FAMILY

PROGRAM OUTCOME STATEMENT: CHILDREN ARE READY FOR SCHOOL

PROGRAM INDICATOR: FAMILIES MAKE A SMOOTH TRANSITION FROM EARLY INTERVENTION SERVICES TO SCHOOL-BASED AND COMMUNITY SERVICES WHEN THEIR CHILDREN TERN 3 YEARS OF AGE.

Headline Measures: Is anyone better off (WE NEED DATA From state, this is a place holder)

#



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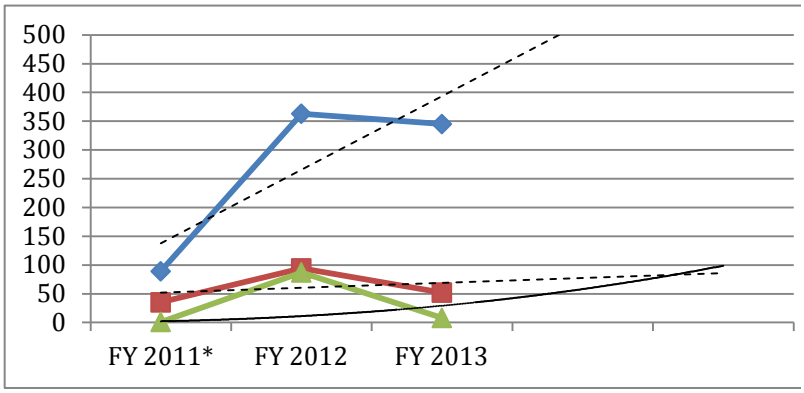


Story Behind the Baseline Performance:

Children receiving services from Early Intervention are eligible for services until the age of 3. At that time, the local school district becomes responsible for their educational services. Children may go on to an IEP, be enrolled in preschool or HeadStart, or receive other community supports to best meet their needs. 90 days before the child turns 3 we are required to have a transition planning meeting. At this meeting the family is introduced to a teacher from the early childhood program in their school district. Each school district that we work with offers different preschool or playschool services, HeadStart is in some communities but not all, some districts provide home-based services, others only provide direct therapy services in the school setting. All of these factors make transition planning complicated not only for EI staff but also for families. Services for children after the age of 3 are strongly determined by where the child lives.

What Works:

Our EI team is working to ensure that transition planning begins well before the child turns 3. In some cases, a child with a complicated medical condition needing numerous supports would have a school special educator assigned as early as 2 years of age. We have worked with families to outline all services available after age 3 and help the family make a decision as to what services they wish to access. The continuing challenge is not only identifying all the services for which a child qualifies but working with the family to ensure access to those

Community Partners:

- Franklin County Home Health Agency and Visiting Nurse Association
- School special educators, early childhood teachers
- Head Start teachers and home visitors
- Children with Special Health Needs
- Vermont Association with the Blind and Visually Impaired
- Vermont Center for the Deaf and Hard of Hearing
- Child Development Clinic (pediatrician, social worker, psychologist)
- Medical providers (pediatricians, nurses, Dept. of Health, specialists at FAHC)
- Childcare Providers

Proposal to Improve Performance:

- Work with our community partners in Franklin and Grand Isle counties to ensure families have accurate information about all programs for which their children may qualify. Help families access available services.

Action Plan:

- Work with individual school districts to outline qualifications for and services available for all children turning 3.
- EI will partner with DCF Family Services to ensure that young children in custody have transition plans when transitioning into school and progress is achieved when applicable

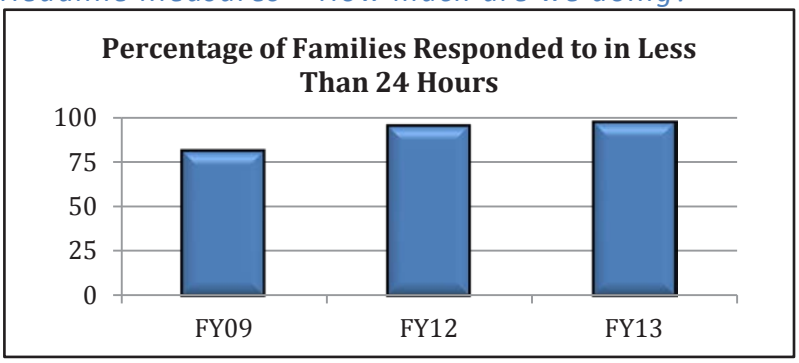
FAMILY ASSESSMENT – CHILDREN, YOUTH & FAMILY

Served in FY2013 - 262

PROGRAM OUTCOME STATEMENT: PROVIDE QUALITY CLINICAL ASSESSMENT AND CONNECT FAMILIES TO SERVICES

PROGRAM INDICATOR: RESPONSE RATE

Headline Measures – How much are we doing?



Responsiveness is one of our top priorities in Family Assessment. We aim to respond to families within 24 hours of receiving a referral to ensure that families feel connected and supported as quickly as possible. We have shown a significant improvement in our responsiveness rate since Fiscal Year 2009. In FY '09 our responsiveness rate was 81%. During this year, FY '13, we responded to families within 24 hours of receipt of referral 97% of the time. Furthermore, 80% of the time we responded to families within the same business day.

Family Assessment also offers interim support and trauma informed treatment through the Child and Family Traumatic Stress Intervention model (CFTSI) to families in an effort to alleviate times of crisis and provide skills and techniques to improve functioning.

Story Behind the Baseline Performance:

- 262 families were served in FY '13 through Family Assessment.
- Family Assessment Staff attended a two day training on the Child and Family Traumatic Stress Intervention (CFTSI).
- We required that each Family Assessment Specialist position be filled by a masters level clinician
- An additional improvement includes our ability to complete evaluations/applications for Personal Care (PCA) hours which support families to address adaptive behavior needs.

What Works:

- Comprehensive Family Based Assessment utilizing evidenced based tools
- Strength-based approach allowing families to build on successes
- Providing services at a time and place convenient for the family
- Coordination of services within the broader system of care
- Providing interim supports throughout the assessment process.
- Trauma informed treatment within the Child and Family Traumatic Stress Intervention model (CFTSI).

Community Partners:

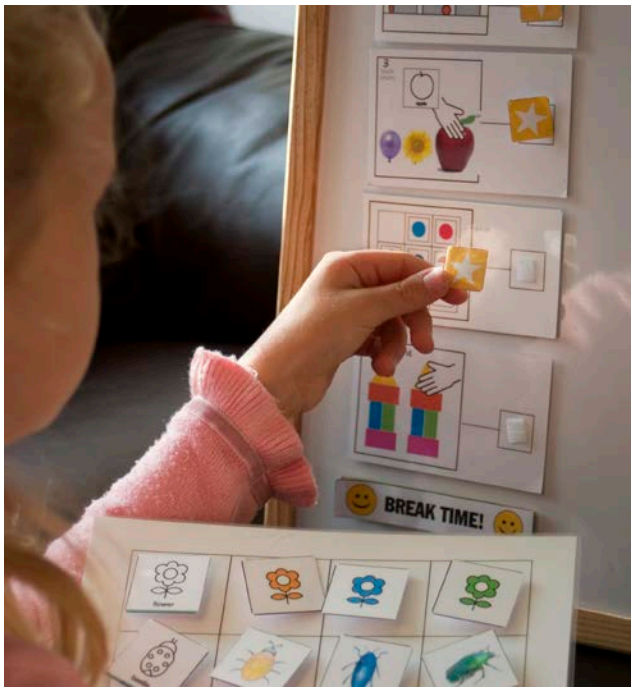
- Local Schools
- Primary Care Physicians
- Department of Children and Families

Proposal to Improve Performance:

- Strengthen trauma informed care through the CFTSI model
- Track referral needs of incoming families to adapt services to the changing needs of our community.

Action Plan:

- Train all Family Assessment Team on the CFTSI model of trauma informed care
- Develop a mechanism to track the needs of families referred to services



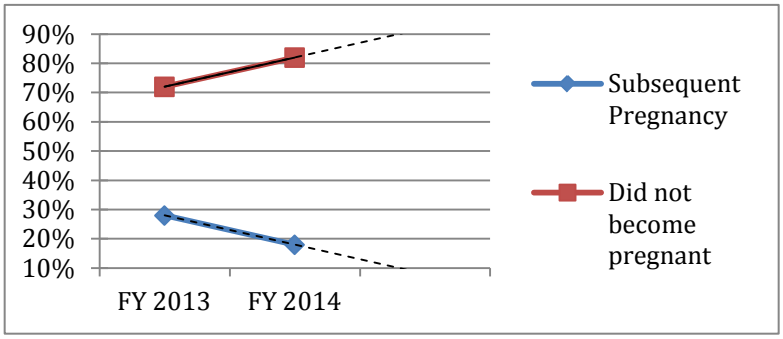
LEARNING TOGETHER – CHILDREN, YOUTH & FAMILY

PROGRAM OUTCOME STATEMENT: PREGNANT WOMEN AND YOUNG CHILDREN THRIVE

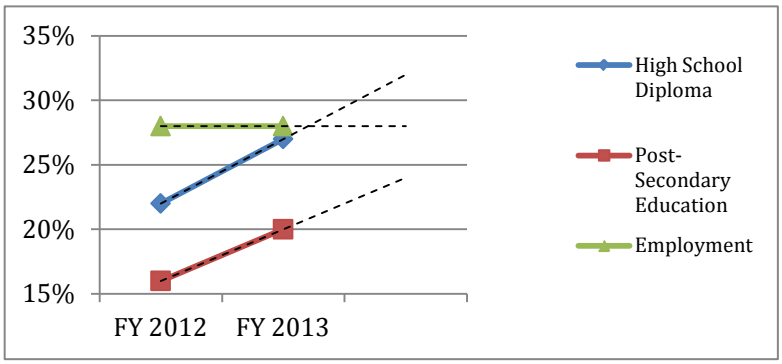
Program Indicator: Pregnant and parenting teens are self-sufficient, make healthy reproductive choices, and know how to care for their children

Headline Measures: Is anyone better off:

Reduction in Subsequent Pregnancies



Increase in Education and Employment



Story Behind the Baseline Performance:

Learning Together is a program offered throughout Vermont through the Parent Child Centers to support pregnant and parenting teens and young adults. The program goals are to reduce the teen birth rates, reduce the young teen pregnancy rate, and to reduce the percentage of new families at risk. Services work to increase educational levels, employment skills, access to health/dental/mental health services, use of birth control, and development of positive parenting strategies.

What Works:

Our Learning Together program is well known in the community as a supportive team and environment for young parents, for both mothers and fathers. Collaboration with medical providers, educators, mental health clinicians, and state employees ensure that eligible individuals are referred and connected to services. Provision of regular groups, workshops, and activities discussing a range of topics including prenatal care, birth control, and healthy relationships contribute to our participants making healthier, more informed decisions about their bodies and families. Vermont Adult Learning, local high schools, Reach Up, and area businesses are helpful with creating opportunities to earn education credits, develop job skills, and pursue new goals.

Community Partners:

- Vermont Adult Learning
- Department for Children and Families Economic Services Division
- Local educators, school nurses
- Child Development Division
- Physicians (Pediatricians, OB/GYNs, Planned Parenthood, etc.)
- Vermont Department of Health
- Residents of Franklin and Grand Isle Counties
- Champlain Valley Office of Economic Opportunity

Proposal to Improve Performance:

- Increase protective factors such as: completion of education, involvement in community, increase in healthy relationships
- Provide education regarding sexual health and birth control options

Action Plan:

- Continue comprehensive education plan utilizing community partners (such as Vermont Department of Health nurses and Northwestern Counseling and Support Services Adolescent Services team) to provide classroom education on sexual health and birth control
- Provide incentives for participation in programming and continue to display a culture that celebrates accomplishments

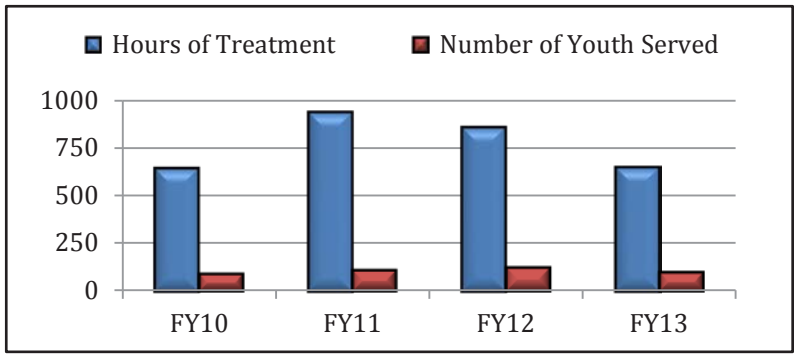
Substance Abuse Program – children, youth & family

Program Outcome Statement: Reduce the rate of Teen Substance Use in Franklin and Grand Isle Counties

Program Indicator: Number of hours of care and number of youth served

Served in FY13 - 91

Headline Measures – How much are we doing?



NCSS is a preferred provider for adolescent substance abuse treatment for Franklin and Grand Isle Counties. We provide substance abuse assessment and treatment services to youth 12-18 years of age. Substance Abuse Services are overseen by a Licensed Alcohol and Drug Counselor.

In FY13, 91 youth accessed drug and alcohol treatment services through NCSS with a total of approximately 650 hours of total treatment provided. 11 of the youth were served on site at Enosburg High School.

NCSS receives only enough funding from the state to support about 1 fulltime substance abuse treatment provider for all of Franklin and Grand Isle Counties. We strongly believe that our regions substance abuse needs far outpaces available funding. We are working with state and community partners to increase substance abuse treatment capacity for the youth of our community.

Story Behind the Baseline Performance:

All youth receiving Substance Abuse Treatment have an Individual Plan of Care (IPC). The IPC is built from a comprehensive assessment that is designed to identify a child's substance abuse needs as well as strengths and hopes. The goals of treatment include skills developed to support a higher level of functioning at home, school and within the community while a youth is entering or maintaining sobriety from psychoactive substances. We utilize the Global Assessment of Independent Needs (GAIN), an assessment tool based on the biopsychosocial model, as well as Cognitive Behavioral Therapy and Motivational Enhancement Therapy in our work. We facilitate groups that support relapse prevention. Staff members are licensed or certified as substance abuse counselors, with one staff member dually licensed.

What Works:

- Currently partnered with Enosburg High School to provide services directly in the school.
- We also work closely with Franklin County Court Diversion, DCF and Vermont Department of Probation and Parole to provide substance abuse assessment and treatment services to youth involved in these programs.
- We also provide substance abuse treatment in an office based setting through the NCSS Family Center.

"Kayla has been of great help to me and my son throughout his treatment." ~ Parent 2013

Community Partners:

- Public Schools
- Franklin County Court Diversion
- Department of Children and Family
- Department of Probation and Parole

Proposal to Improve Performance:

- Stronger partnerships to area schools
- Increase access by securing additional funds to increase treatment capacity.

Action Plan:

- We are working with ADAP to identify ways to increase capacity
- We are working closely with area high schools to embed a substance abuse clinician in the school.

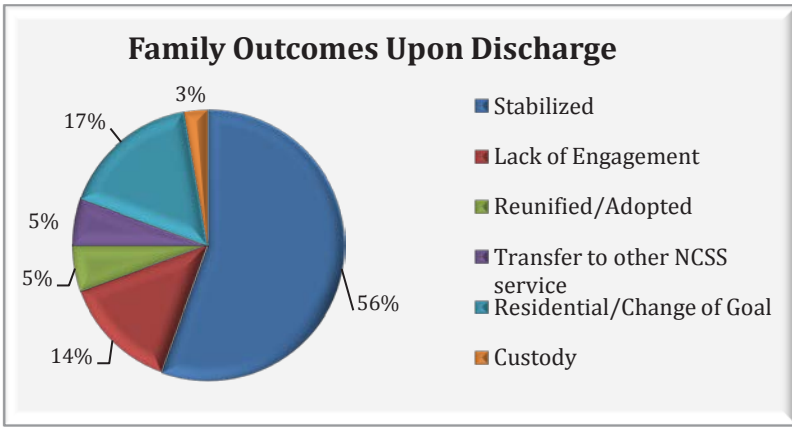
INTENSIVE FAMILY BASED SERVICES – CHILDREN, YOUTH & FAMILY

Served in FY13 - 62

PROGRAM OUTCOME STATEMENT: CHILDREN WILL BE SAFE IN THE HOME AND FAMILIES WILL THRIVE

PROGRAM INDICATOR: FAMILY STATUS UPON DISCHARGE

Headline Measures – How much are we doing?



Upon enrollment, we work with the child's team to identify the purpose and goal of services regarding child placement. Every month, we assess progress towards goals. Upon discharge, we assess the status of the family's goal progress. Results indicate the vast majority of families enrolled in services are able to either safely maintain the child in the home or have their child return home from foster care.

The IFBS program collects and reports information detailing the Family outcome upon discharge. Using a family centered approach; the family is able to define their own unique goals. These goals are then grouped into the broader categories as detailed above. The data shows that of 3% of families accessing IFBS supports ended with their child entering DCF Custody. 14% ended services due to a lack of parental involvement. The remaining 83% of families served had some level of success within the program.

Story Behind the Baseline Performance:

Over the last year, the IFBS Team has accessed the following trainings:

- The ARC model to support families who have experienced significant trauma.
- Strength-based treatment approaches such as No Such Thing as a Bad Kid in order to work with youth who have experienced trauma.
- Developed play therapy strategies.
- Attended a state-wide Department of Children and Families Teaming Consultation.
- Have started training in American Sign Language.
- Developed expertise in working with children diagnosed with Autism Spectrum Diagnosis.
- Bowen Theory and Dyadic Attachment Psychotherapy to address the effects of disrupted attachment on child development.
- Parenting the Strong Willed Child, 1-2-3 Magic, and The Explosive Child to support parents in managing unsafe and difficult behaviors.

What Works:

IFBS provides strengths-based, short term in-home services that promote healthy family systems. We use a family centered, solution-focused framework that allows parents to identify goals that correlate with safety and stability. We work with families to create structured and stabile environment through behavior management strategies, communication skills, and creating routines and rituals.

Community Partners:

- Local Schools
- Pediatricians
- Department of Children and Families
- Home Health

Proposal to Improve Performance:

- Recognizing the importance of partnering with community partners and stakeholders, the IFBS team has created a schedule in which IFBS worker spends 1 day of their week at the DCF office in order to increase treatment planning and collaboration. IFBS is also working with DCF to create a system of Operating Agreements that will allow for more efficient communication and teaming, which will increase the efficacy of services.

Action Plan:

- Increase partnerships with community resources who share our goal of improved child safety
- Identify and implement more proactive public health models of child safety

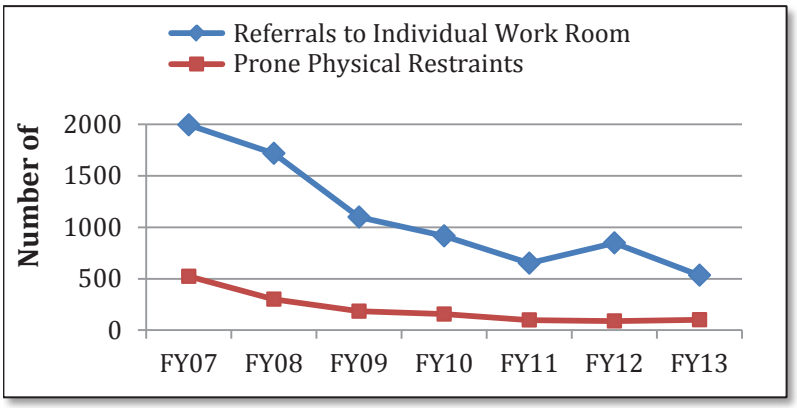
SOAR LEARNING CENTER – CHILDREN, YOUTH & FAMILY

Served in FY13 - 94

PROGRAM OUTCOME STATEMENT: STUDENTS WILL SUCCESSFULLY TRANSITION BACK TO PUBLIC SCHOOL

PROGRAM INDICATOR: BEHAVIORAL & ACADEMIC SUCCESS. SUCCESSFUL TRANSITIONS TO PUBLIC SCHOOL

Headline Measures – How much are we doing?



Soar Learning Center has implemented Life Space Crisis Interview and Handle With Care as intervention models. Annual data show a decrease in both restraints as well as referrals to the individual work room. Additional analysis shows that a small number of students (8%) accounted or the majority of physical interventions (71%).

At the start of the FY13 academic year, the average student was scored 3.5 grades behind in Math and 2.1 grades behind in Literacy. By the end of the FY13 academic year, 77% of students showed improvement in Math and 67% showed improvement in Literacy after one year.

Soar Learning Center's primary goal is to successfully transition students to the public school in their community. Over the past five years, the program has transitioned sixty students to the public school system with only two students returning within a six month period for a for a 97% success rate as of October 28th, 2013.

Story Behind the Baseline Performance:

The mission of the Soar Learning Center is to provide children and youth with high quality educational opportunities and personal growth experiences in a safe, supportive and respectful environment. By integrating academic, behavioral, and clinical services within the framework of a typical school structure and setting, the school is able to assist students in achieving success in their public school and community.

What Works:

- Individualized educational and behavioral supports through differentiated instruction, small classroom size and personalized behavioral supports
- Utilization of alternative educational approaches including experiential, adventure based, vocational and interdisciplinary programs of study
- Effective intervention models including trauma informed care (ARC), applied behavior analysis and positive behavior intervention
- On site clinicians providing individual and group counseling as well as support to students on such topics as bullying, stress management, social skills and other areas of personal development
- Home-School Coordination

~ "I have been treated with the utmost respect, especially with my son being so difficult. I was never judged or blamed for his behavior; which was important because at times I blamed myself." - Parent

Community Partners:

- Local Schools
- Pediatricians
- Department of Children and Families
- Department of Corrections Probation and Parole Office

Proposal to Improve Performance:

- Help students to achieve academic success
- Successfully transition students back to their public school
-

Action Plan:

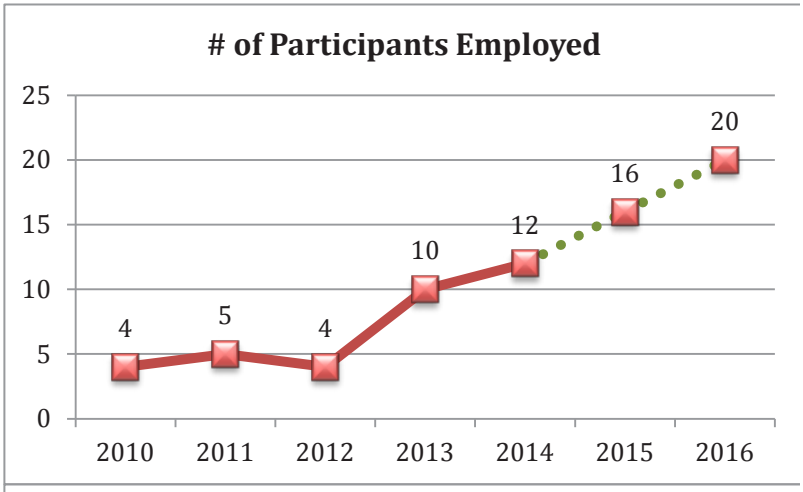
- Develop supports to assist students once they have returned to public school
- Integrate agrarian themes and hands on learning opportunities

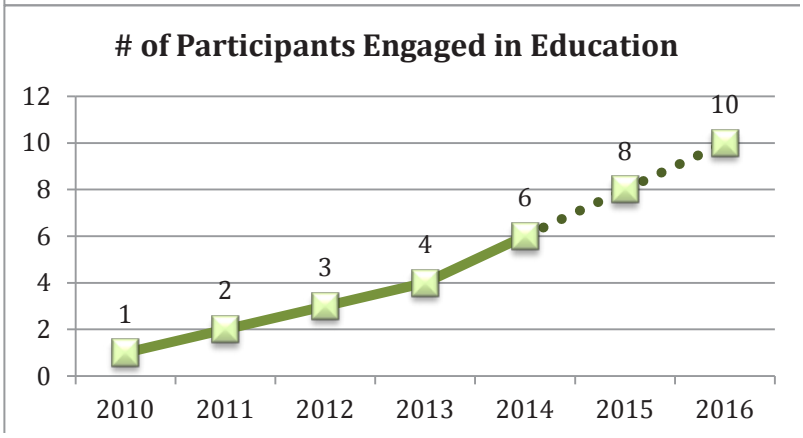
REACH UP – CHILDREN, YOUTH & FAMILY

PROGRAM OUTCOME STATEMENT: YOUTH SUCCESSFULLY TRANSITION INTO ADULTHOOD

PROGRAM INDICATOR: YOUNG ADULTS WHO GAIN ACADEMIC OR EMPLOYMENT SKILLS

Headline Measures – How much are we doing?





Story Behind the Baseline Performance:

The Reach Up program is administered by the Department for Children and Families, Economic Services Division (DCF/ESD). DCF/ESD grants in conjunction with the Parent Child Center, support young parents in completing their education, gain parenting skills and practices that promote family well being and secure employment opportunities to ensure long-term financial resiliency. Reach up case managers have been "working well" at connecting with community partners to keep participants engaged and meeting their work requirements. This connection also allows case managers to address barriers and create new participant resources as well hold participants accountable.

What Works:

At NCSS's Parent Child Center, Reach Up Case Managers' provide enhanced case management services, which includes caseloads that are smaller and allow for more contact with young parents. Development of a Family Development Plan helps young parents meet the requirements of the program, including but not limited to attaining a High School Diploma or GED, job skills and employment, and establish a positive work history with the goal of becoming self sufficient. Minor parents receive, in addition to education: life skills, housing assessment and recommendation, parenting support and have access to all necessary services. Child care services are authorized for parents who are employed or attending an education program. Currently, 67% of all Reach Up participants are engaged in education, training or employment activities.

Community Partners:

- Vermont Adult Learning
- Vocational Rehab
- Community Action
- Creative Workforce Solutions
- NCSS' Learning Together Program
- NCSS' JOBS Program
- HowardCenter
- Tim's House
- Department of Labor
- Department of Economic Services
- VT Chronic Care Initiative

Proposal to Improve Performance:

- Increase the number of participants that are actively engaged in employment and education, while caring for their children's basic needs. The expectation is that once employed, with stable housing and child care, participants will be able to become self sufficient.

Action Plan:

- Reach Up Case Managers will continue to work with community partners to increase work site opportunities within organizations and businesses
- Case Managers will implement Family Support Matrix and document progress towards goals at three month increments.

Developmental Services

Our vision in Developmental Services is that all individuals with developmental disabilities have access to opportunities that promote person-chosen comprehensive inclusion. Our services support our vision by providing community-based support to adults, children and their families. The range of services creates employment opportunities, facilitates independent life skills, while optimizing natural supports. We do this in partnership with individuals, their families and the community. The direction of our services is, in many ways, decided by those we support through the use of forums and groups where there is active involvement and idea exchange. The Developmental Services staff assists individuals to exercise their citizenship in a number of ways.

~ Kathy Brown, Interim Director of Developmental Services

Randy's Story:

Randy, self-advocate extraordinaire and president of Green Mountain Self-Advocates, works part time for Northwestern Counseling & Support Services, where he coordinates self-advocacy activities and serves as an ally to the Next Step Self-Advocacy group, the local self-advocacy group; co-facilitates the Learning for Living Program, teaching independent living skills; provides peer advocacy to people who receive developmental disabilities services when they attend their team meetings, and acts as a mediator. "Working at NCSS gives me a sense of purpose and I feel that I belong. Having a disability myself, I understand different learning styles and different perspectives." "People with disabilities are capable of working beyond a cleaning capacity. There is a lot of talent out there that is not being used. Providing peer mentorship is the way that services are heading."

NEXT STEP SELF ADVOCATES

COMMUNITY EMPLOYMENT SERVICES – DEVELOPMENTAL SERVICES

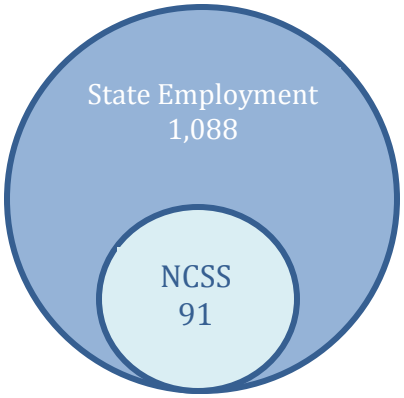
Served in FY13 - 91

PROGRAM OUTCOME STATEMENT: ASSIST PERSONS SEEKING EMPLOYMENT TO CHOOSE, OBTAIN AND RETAIN COMPETITIVE INTEGRATED EMPLOYMENT IN THE COMMUNITY

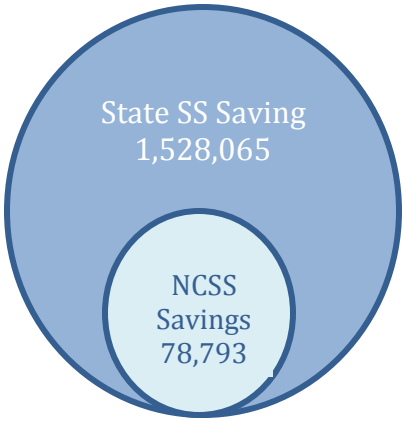
PROGRAM INDICATOR: DEVELOP MEANINGFUL JOB PLACEMENTS, MAINTAIN JOB PLACEMENT AND INCREASE SOCIAL SECURITY SAVINGS

Headline Measures – How much are we doing?

Number of Developmental Services Clients Employed In 2013



Social Security Savings in 2013



Story Behind the Baseline Performance:

In the last fiscal year, we have 77 job placements of 141 eligible participants. We exceeded the State's expectation of 4 new job placements to 16 demonstrating a 400% increase. The Department of Aging and Independent Living reported that NCSS did an excellent job matching individuals to the right job, helping to support long-term employment. Because of our excellent performance our grant doubled in size. In NCSS, employment service participants received 419 hours of job development supports.

What Works:

We provide supportive employment by building natural supports on the job site, through independent employment, and job carving. We support skill development to help encourage individuals working to be as independent as possible on the job with natural supports in place. This approach increases a person's self-esteem. We work in many settings throughout Franklin and Grand Isle Counties, such as schools, maintenance/janitorial positions, agricultural, self-employment, convenience stores, office buildings, hospitals, restaurants, grocery stores, and manufacturing environments.

Community Partners:

- Creative Workforce Solutions
- VocRehab
- Local Businesses
- Local Schools

Proposal to Improve Performance:

- Develop strong partnerships within the school systems
- Making sure that 'job fit' continues to be the priority in placements

Action Plan:

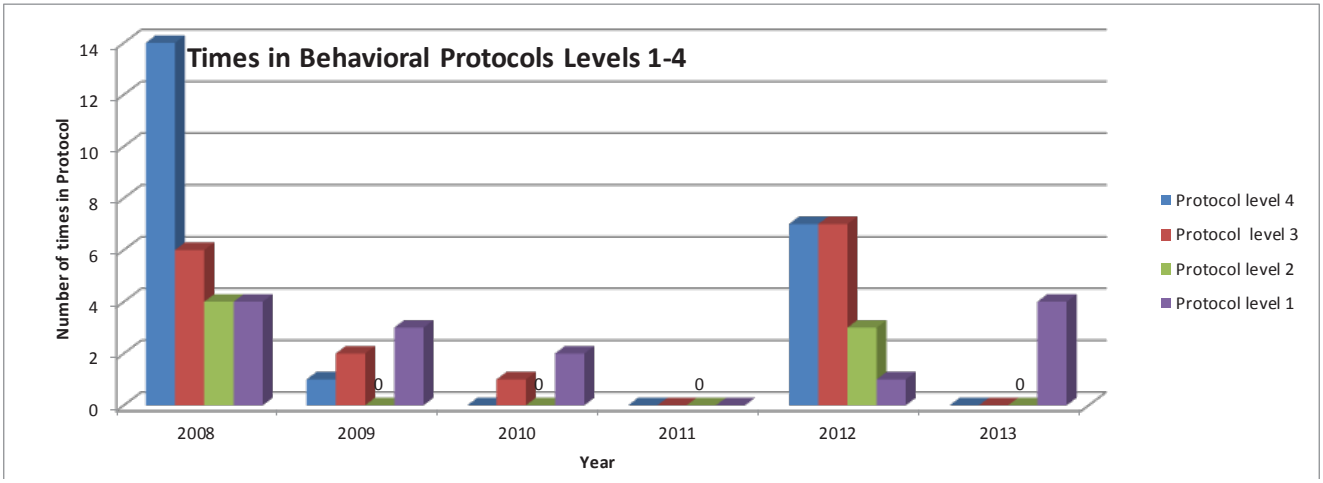
- Reach out and provide education to individuals and their families for those eligible to work
- Make solid contacts within the schools to support earlier job development skills
- Working with public relations to assist with educational marketing material

Behavior Support/Offender Services – developmental services

Program Outcome Statement: Programming that increases individual skills through a three tiered individualized transitional plan, leading to safe community re-integration.

Program Indicator: Reduction in the number and severity of protocol placements, as well as, increase in individuals transitioning to least restrictive placements.

Headline Measures – How much are we doing?



Story Behind the Baseline Performance:

In 2012-2013, the program supported over 28 individuals in the community and in residential settings to reduce recidivism. Individuals developed independent living skills helping many to transition to least restrictive living arrangements.

NCSS services have helped many individuals with Intellectual Disabilities who were victims of trauma and abuse. Services have helped to prevent individuals assessed for high risk from inappropriate incarceration. 84% of individuals report that NCSS treats them with respect and compassion; more than 50% have been released from Act 248 restrictions. 75% of individuals served by the Behavioral Support Team with court ordered restrictions have completed or are in transitional step down planning without reoffending.

What Works:

The Team provides 24-hour residential programming and community based programming. Supports are geared toward helping individuals with behavioral challenges, many with juvenile or adult criminal histories, Act 248 dispositions, and offender registry restrictions. Through community settings with role model based training individuals gain the skills required to achieve personal goals and become contributing members of the community.

Community Partners:

- Public Health and Safety
- Probation & Parole
- Community Based Support Groups
- Department of Corrections

Proposal to Improve Performance:

- Reviews and recommendations of behavioral support plans specific to the individuals needs including transitional planning
- Increase training appropriate models and implementation of therapeutic interventions

Action Plan:

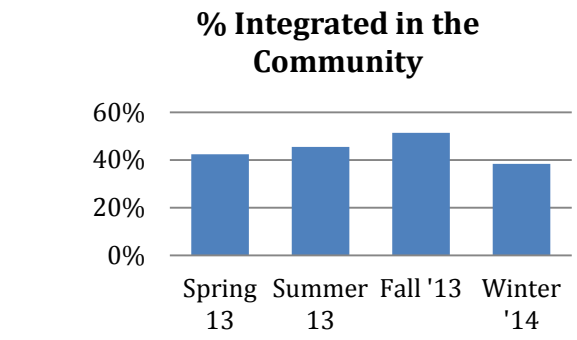
- Transitional planning for all individuals within the residential settings
- Utilization review of behavior support plans
- Implementation of the Independent Living Assessment

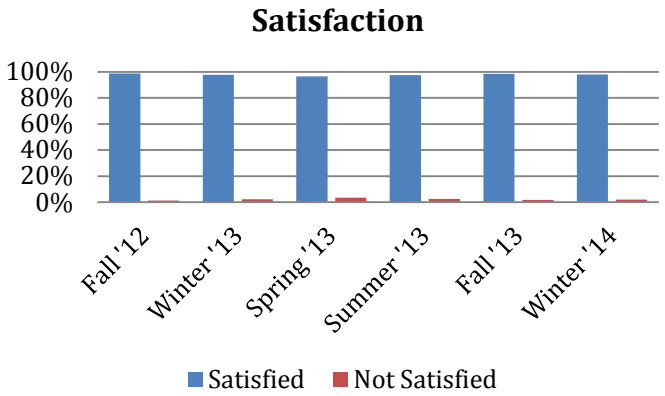
THE ACADEMY OF LEARNING – DEVELOPMENTAL SERVICES

PROGRAM OUTCOME STATEMENT: PROGRAMS ADDRESS THE INCREASING NEEDS OF INDIVIDUALS WITH DISABILITIES AND FAMILIES TO PROVIDE SKILL BUILDING, TRAINING, ACADEMICS, AND PRACTICAL COMMUNITY BASED PROGRAMMING TO INCREASE INDEPENDENT LIVING

PROGRAM INDICATOR: INDIVIDUALS AND FAMILIES WILL BE SATISFIED WITH THE PROGRAMMING AND MAKE PROGRESS TO COMMUNITY INTEGRATION

Headline Measures – How much are we doing?



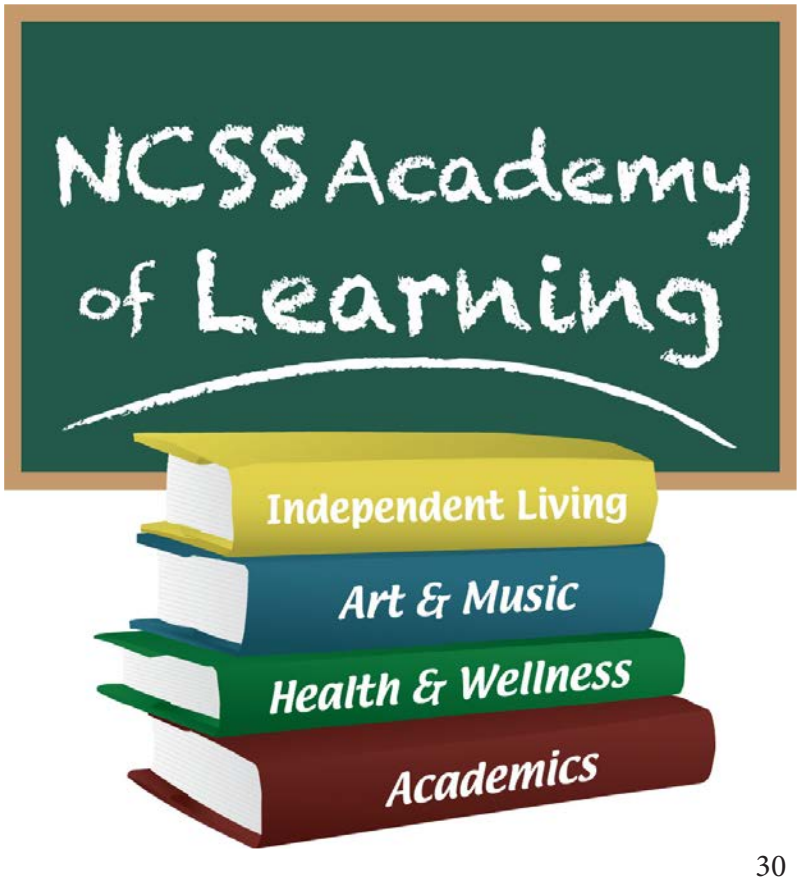


Story Behind the Baseline Performance:

97.5% of students are satisfied with programming at the Academy of Learning for content and class selection. Along with satisfaction in the skills being taught, the % of integration into the community runs from 42% - 50% during 3 semesters; while the winter semester involves more community partnering at the AOL site.

What Works:

The Academy of Learning provides educational and personal enrichment through a diverse learning environment that provides opportunities for continued learning and skill building. Curriculum is taught on location, on average 45% of the time these skills are re-presented assuring the ability to generalize in community settings.



Community Partners:

- Local Schools
- Local Landlords and Housing Programs
- Benefits Counseling
- Transportation Providers

Proposal to Improve Performance:

- Improve its curriculum and utilize Independent Living Assessments to demonstrate the effectiveness
- Continue to grow and track the integration into community

Action Plan:

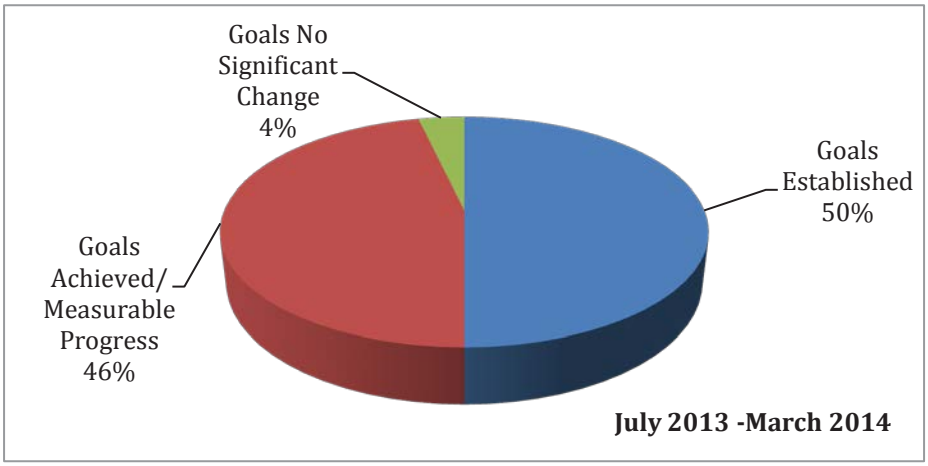
- Work on re-presentation on the transitional services team to assure that all individuals improve their skills for a more improved quality of life.
- 25% of class curriculum taught will be practiced in community settings

Bridges program – Developmental Services

Program Outcome Statement: Bridges program was developed to meet the needs of one of the most challenging areas to provide services, children with Intellectual Disabilities and their families. Bridges implementation closed the gap between families and community partners by providing the resources and referrals that were missing for these families.

Program Indicator:

Headline Measures – How much are we doing?



Story Behind the Baseline Performance:

Families are more connected with community resources to support individual needs as a result of service coordination. 73 clients graduated from services and 83% of the people served were satisfied with services, reporting improved family living based on supports. This allows the model to fit the individual not the other way around. One team member has a Masters in Applied Behavioral Analysis and another member is working toward a Business Management degree. In 2012, 91% of families surveyed responded that "My care coordinator understands our stated situation and tries to address my child's goals."

What Works:

The Bridge program provides care through service coordination to help families determine what supports or services are needed such as medical, educational, social or other services to help address their child's needs. Bridges helps coordinate multiple community-based services and develop an individualized Care Coordination Plan that is unique to the needs of the family and individual.

Community Partners:

- United Way
- Local Schools
- Department of Economic Services
- Department of Children & Families

Proposal to Improve Performance:

Continued and ongoing communication will be key in the new IFS programming. Helping children and their families continue to access appropriate services. Moving under the children's services umbrella will open up many new programs to families and making this known and providing easy access will be the ongoing task of Care Coordinators.

Action Plan:

Developmental Services expertise will be transferred into the IFS program and cross training of staff will assist in a seamless transition into a new service delivery program. Cross pollination of skills, treatment plans, assessments, and resources across IFS and Developmental Services to broaden the base of staff skills.

NCSS is continually striving to collect outcomes data that is meaningful to our staff that provides the services, as well as telling our story to community partners and different state entities. As we grow and look at our different performance measures, we realize there are new programs or changes to existing programs in which we want to start collecting information. At this time, we would like to give you a sneak peek on the different areas that you will see in our next Outcomes Report.

Integrated Family Services (IFS)

In the coming year, NCSS will begin to pilot Integrated Family Services (IFS). Currently, the children's system of care is separated across 11 Divisions of the Agency of Human Services and 6 other departments of state government. This fragmentation has resulted in a system of care that is confusing and inefficient. IFS is a comprehensive restructuring of the children's system of care. IFS is designed to integrate services into a single unified model of care. This streamlining of services should result in a more efficient and effective system that is easier for families to navigate. We project to implement IFS in the spring of 2014.

Integrated Health Care

This area of program development has included a range of innovative services which have significant implications as part of the solution for health care reform. We anticipate more development of the Blueprint Community Health Team, which involves mostly social workers employed through NCSS who provide integrated care in primary care practices. The contract we have provided to deliver mental health services in our region's Federally Qualified Health Center (the NOTCH) is expected to develop further. Our partnership with the NOTCH in providing primary care through the NOTCH at one of NCSS practice settings is exciting and full of potential as another option for the persons we serve. All of these services need to be evaluated for their impact in terms of" how much we do", "how well we do it", and "is anyone better off".

Accountable Care Organizations (ACO) Outcome Measures

There are three ACO's in Vermont; OneCare VT, Community Health Accountable Care (CHAC) and Health First. NCSS has signed Shared Savings agreements with OneCare VT and CHAC. Currently, there are 33 quality measures and only six measures pertain to the services that the Designated Agencies provide. As NCSS and the other Designated Agencies become more involved with the ACO's, there will be additional outcomes measures for us to report on.

Results Scorecard

The Results Based Accountability Scorecard 3.0 is an interactive way to monitor population results and performance of programs and services that work towards improving overall population care. The software will help our organization and other DA's use the same outcomes language, use the same outcomes measures and standardize our data collection processes across the state. NCSS is one of five agencies that are involved in the Designated Agency Pilot that will create a system wide Results Scorecard. Having this technology will give us the ability to report outcomes aggregately as a system or as individual agencies. The software will also help connect our outcome results with the Agency of Human Services as well as pulling their population outcomes into our system. By using Results Scorecard, our next Outcomes Report may have a different look and format.

HERE FOR YOU

Our Office Locations

Main Office
107 Fisher Pond Road
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(802) 524-6554

Soar Learning Center
P.O. Box 372
178 McGinn Drive
St. Albans Bay, VT 05481
(802) 527-7514

Residential Site
22 Upper Welden Street
St. Albans, VT 05478
(802) 524-0568

The Family Center
130 Fisher Pond Road
St. Albans, VT 05478
(802) 524-6554

Bayview
6 Home Health Circle
St. Albans, VT 05478
(802) 524-5863

Join us online

learn more about our services at www.ncssinc.org

Academy of Learning
27 Lower Newton Street
St. Albans, VT 05478
(802) 782-8694

Alburgh Parent Child Center
22 Lake Street
Alburgh, VT 05440
(802) 796-3013

Residential Site
174 North Main Street
St. Albans, VT 05478
(802) 524-2421

Serving Franklin & Grand Isle Counties

NORTHWESTERN COUNSELING & SUPPORT SERVICES

For copies of this Annual Report, please call NCSS Community Relations, 524-6555 ext. 6414. You may also request a detailed financial report.

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stronger community
one person at a time.

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Franklin-Grand Isle United Way

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NCSS is recognized with the highest level of accreditation from the Commission on Accreditation of Rehabilitation Facilities

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