
2016
Outcomes Report
Vision – Value – Results
NORTHWESTERN
COUNSELING
& SUPPORT SERVICES

Letter from the Executive Director

Northwestern Counseling & Support Services, Inc. (NCSS) is pleased to share our Outcomes Report for 2016 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 14 years ago.

With changes across the state, in health care and government, the focus on outcomes is paramount. NCSS collaborates with community partners to provide the highest quality of care to those living in Franklin and Grand Isle Counties.

Our Integrated Health initiative continues to move at a fast pace with positive results. NCSS is embedded in 100% of patient centered medical homes; the Emergency Department at Northwestern Medical Center; the St. Albans City Police; and the Vermont State Police. Our partnership with the Northern Tier Center for Health (NOTCH) allows us to provide behavioral health services within their primary care practices. We appreciate these partnerships and the unique opportunities for integration in our community. 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. NCSS provides intervention and support to children, adolescents, and adults with emotional and behavioral problems; mental illness; intellectual and developmental disabilities. We hope that if you or someone you know needs services, you will come to us knowing that we're here for you as an organization that focuses on prevention, wellness, and integration.

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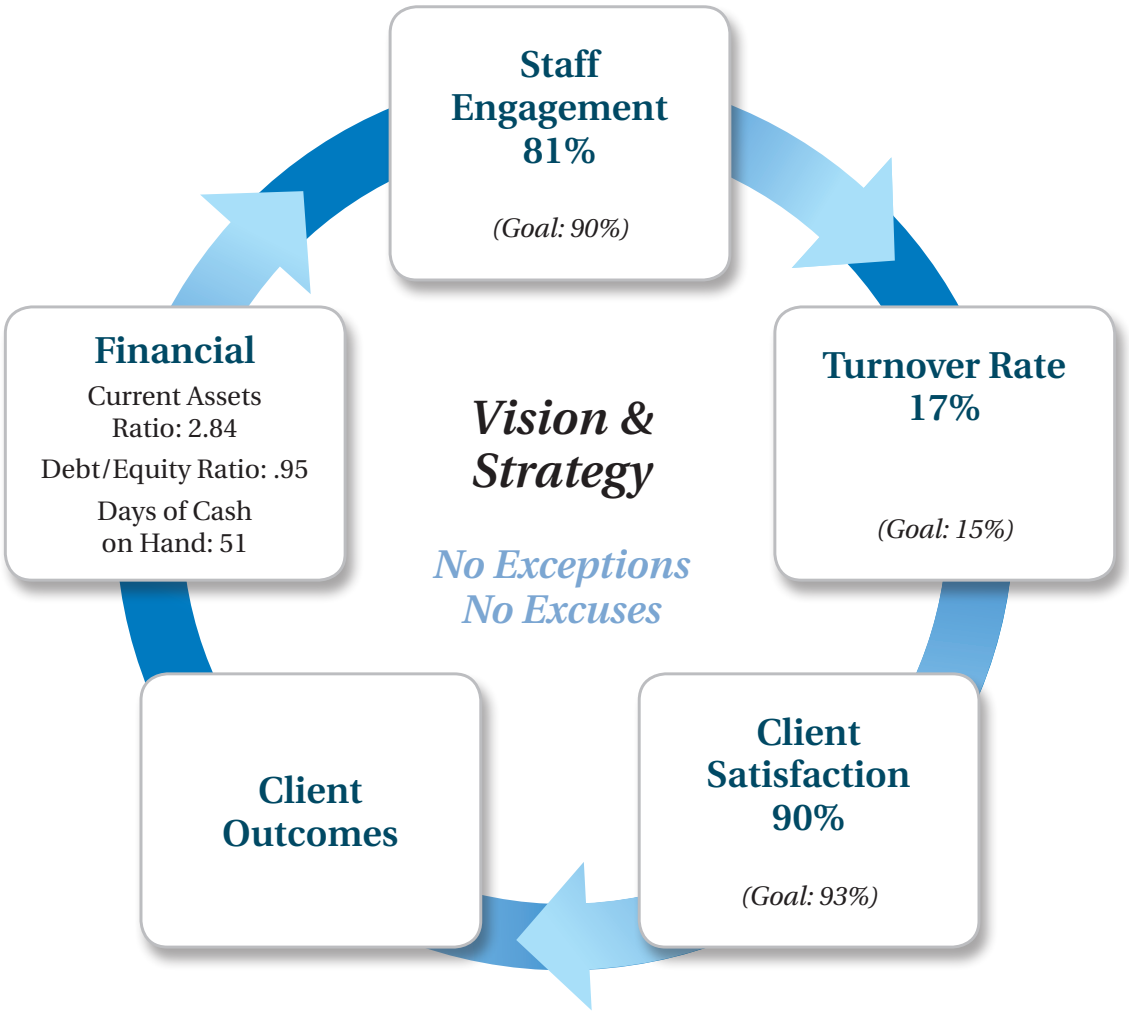
Balanced Report Card



The Balanced Report Card 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 Report Card provides a clear prescription as to what our agency should measure in order to "balance" the financial perspective with other very important outcomes perspectives.

NCSS CLIENTS SERVED

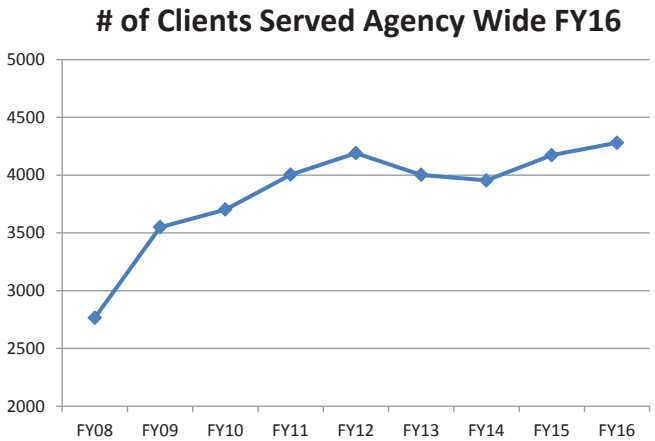
Program Outcome Statement: Clients of NCSS will be satisfied with services they received
Program Indicator: Residents of Franklin and Grand Isle Counties will have access to high quality services

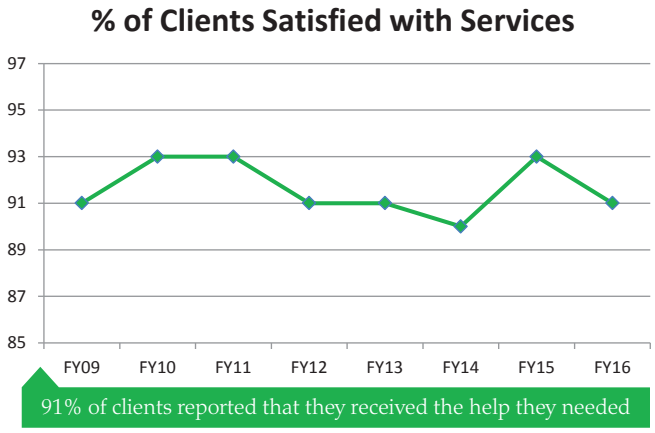
Story Behind the Performance

- 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 our high quality services meet individual needs, make a difference in the lives in our community, and that each client is satisfied with their overall care and experience
- In FY16 NCSS served 4,280 people in our offices, in the local schools, in the community, in their homes and in their places of work. This is a 3% increase from last year
- Consumer satisfaction decreased by 2% from the previous year

Action Plan:

- Each team in the agency is undergoing a Bend the Curve exercise to create an action plan for FY16 to improve our satisfaction survey results
- Continue to work with Vermont Care Partners on having standard survey questions and a standard process throughout the Designated Agencies in Vermont





"So happy that I came here."

"NCSS and many of its staff are invaluable. We greatly appreciate the support we receive."

"They are the best people to have your back."

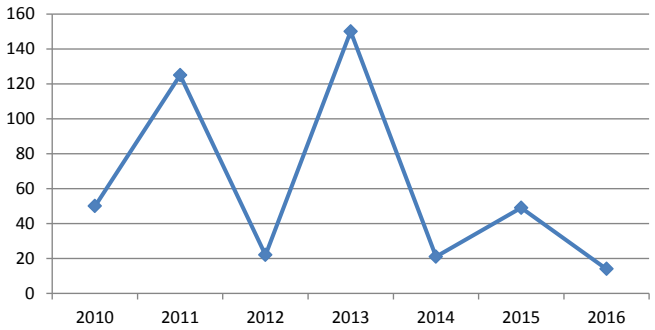
"I always feel very comfortable and am treated with absolute respect. It is a definite safe place for me!"

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 to support a person experiencing a mental health crisis

Story Behind the Performance

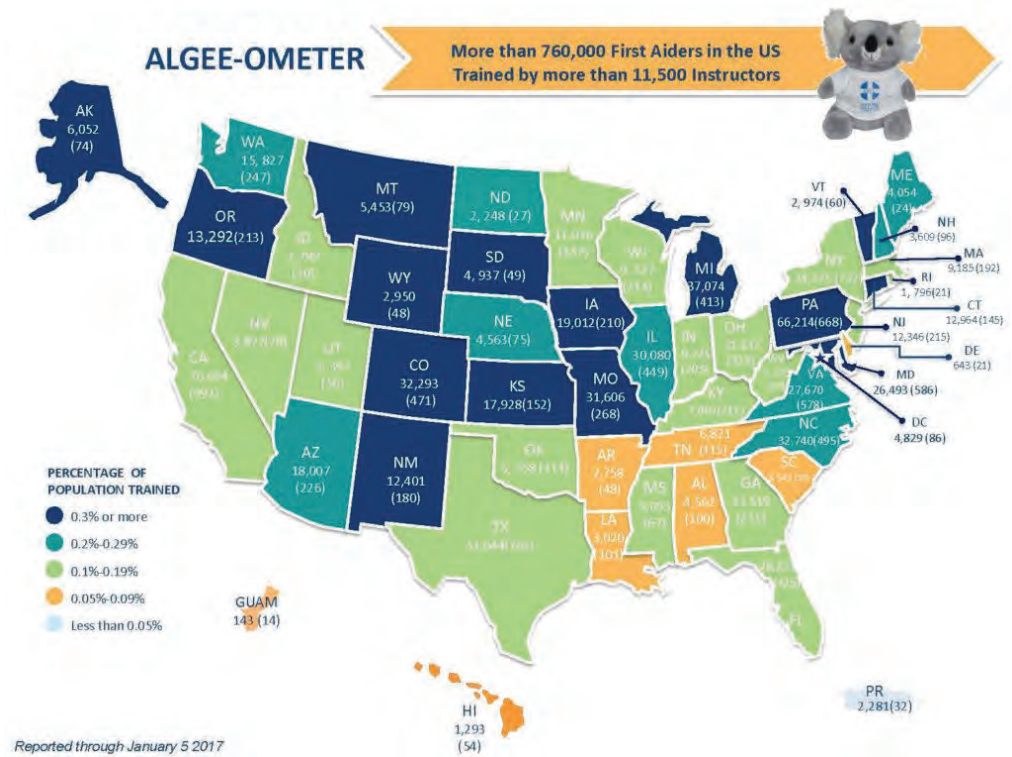
- In the state of Vermont there are 2,952 people certified in the MHFA Adult; Youth; Law Enforcement or the Veterans' curriculum
- Out of the 2,952, NCSS has trained 1,026
- An unexpected training cancelation in FY16 contributed to our numbers being lower than expected for this fiscal year. This training has been rescheduled and will be reflected in FY17 numbers

# of People Certified in Adult MHFA



What Works:

- Helps bring awareness of mental illness to the community
- Builds strong working relationships with community partners
- Helps the community be aware of their resources and understand local issues



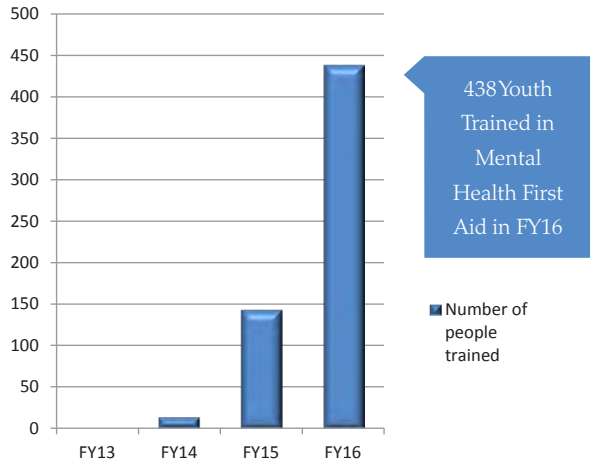
YOUTH MENTAL HEALTH FIRST AID (YMHFA)

Program Outcome Statement: Strengthen our community by increasing awareness and understanding of mental challenges facing youth. Increase knowledge of and access to available treatments to connect young people with care and to reduce stigma within our community through education, compassion, and understanding
Program Indicator: Increase community awareness of mental health challenges facing youth, which increases the ability to accept, appropriately support, and refer youth struggling with mental illnesses

Story Behind the Performance

- Northwestern Counseling & Support Services began expanding focus on Youth Mental Health First Aid (YMHFA) training in 2014 in an effort to increase early intervention, awareness of available services, and reduction of stigma for individuals living with mental health challenges
- Since FY14 NCSS has trained 595 community members as Youth Mental Health First Aiders, creating a ratio of 1 Youth Mental Health First Aider for every 8 adolescents in Franklin and Grand Isle Counties

# of People Trained in YMHFA Since 2012



What Works:

- Raising awareness of Youth Mental Health First Aid has increased NCSS' presence in the community through outreach, education, and increasing knowledge of services available to youth
- YMHFA trainings have allowed us to hear and respond to our community's needs

Action Plan:

In FY16 NCSS Youth Mental Health First Aid efforts were expanded beyond Franklin and Grand Isle Counties when Vermont Care Network (VCN) was awarded a three-year SAMHSA grant. AWARE Vermont established a statewide infrastructure to provide no cost trainings to community members throughout the state of Vermont. NCSS is serving as the Statewide Project Coordinator to this initiative and has provided leadership and guidance to VT Designated Agencies and community partners participating in Aware Vermont. Much of this statewide initiative is based upon the successes and lessons learned in NCSS' previous efforts to provide YMHFA to Franklin and Grand Isle Counties. Through this initiative NCSS has had the opportunity to strengthen relationships with Designated Agencies throughout the state through collaboration, resource sharing, and the aligned effort to implement YMHFA trainings throughout the state of Vermont.

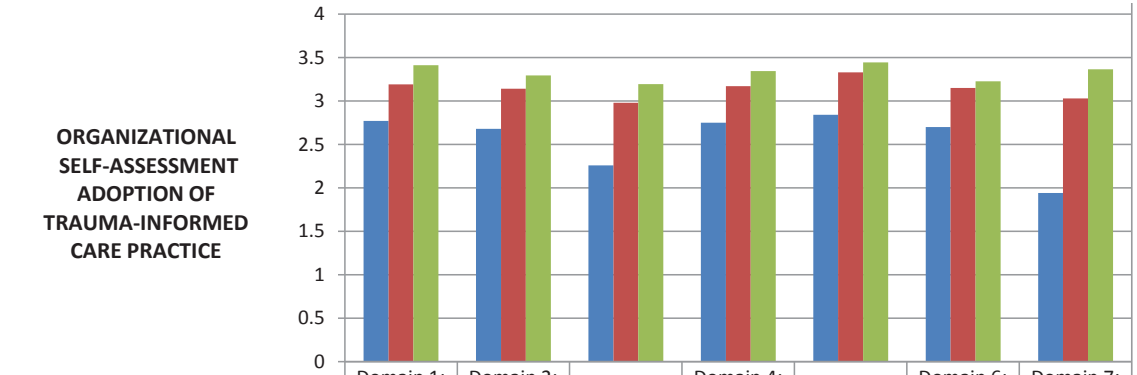
Program Outcome Statement: Transform organizational culture through trauma informed care implementation process developed by the National Council for Behavioral Health
Program Indicator: Demonstrate increased trauma informed care by improving scores in Organizational Self-Assessment domains

Story Behind the Performance

- For the past three years NCSS has been implementing a trauma informed care initiative, which is based on an initial year as a national demonstration project with the National Council for Behavioral Health. This initiative is designed to implement a process for improving trauma informed care
- While there are "pockets" of strengths in certain programs or with specific staff, our goal is to develop a stronger trauma informed culture by increasing staff awareness, competence and improved outcomes for persons served
- The Organizational Self-Assessment data indicates continuing improvement across all domain areas

What Works:

- NCSS continues to maintain a strong cross-divisional implementation team, composed of representatives from all three service divisions, administration, and individuals with lived experience (peers)
- The trauma informed care implementation team continues to carry out action steps from what is learned from Organizational Self-Assessment results & action steps identified in the Performance Monitoring Tool



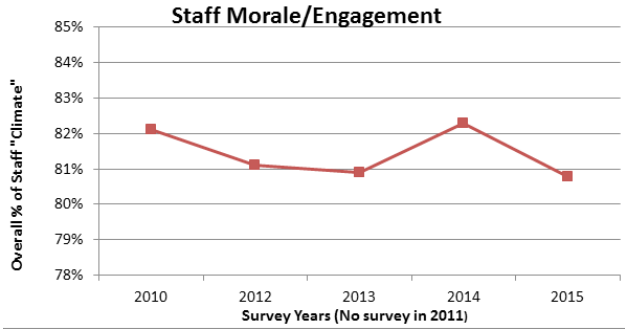
	Domain 1: Screening Assessment	Domain 2: Consumer Driven	Domain 3: Workforce	Domain 4: Best Practices	Domain 5: Safety Env.	Domain 6: Community Outreach	Domain 7: Evaluation Data
2014 Agency Wide Average Domain Score	2.77	2.68	2.26	2.75	2.84	2.7	1.94
2015 Agency Wide Average Domain Score	3.19	3.14	2.98	3.17	3.33	3.15	3.03
2016 Agency Wide Average Domain Score	3.41	3.29	3.19	3.34	3.44	3.23	3.37

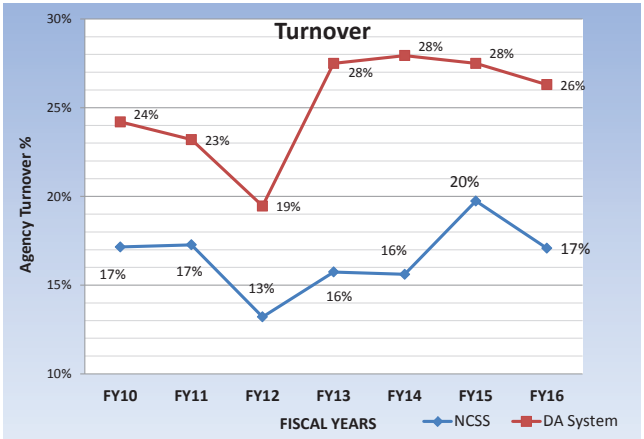
Program Outcome Statement: Engaged staff believe they perform meaningful, important and interesting work, and are committed to NCSS

Program Indicator: Staff fully embracing the agency's mission will be evident in survey scores and maintenance of a healthy turnover rate

Story Behind the Performance

- NCSS uses a national 12 question employee engagement survey developed by Gallup
- This past year our average score did drop slightly. This may be a direct result of the major transformations happening in the healthcare system, which has left employees feeling less certain. However, at an average of nearly **81% employee engagement** we are well above the national rate of 35%
- Turnover decreased modestly in FY16 to 17%. While we would prefer to have our rate be closer to our goal, we continue to achieve a lower rate than our peers
- NCSS' annual goal is 15%; believing that healthy turnover generates new ideas, sparks creativity and provides a career ladder for our seasoned employees
- 50% of departed staff indicated money significantly impacted their decision to leave. NCSS is aware that we are unable to compete financially with some of our competitors, making our focus on culture and morale ever more important





Action Plan:

- Keep an eye on rapid changes in healthcare environment
- Fine tune our total rewards compensation structure to reinforce the value of working at NCSS
- Strive to maintain an attractive compensation program, where staff earn a livable wage and feel good about the exceptional services they deliver

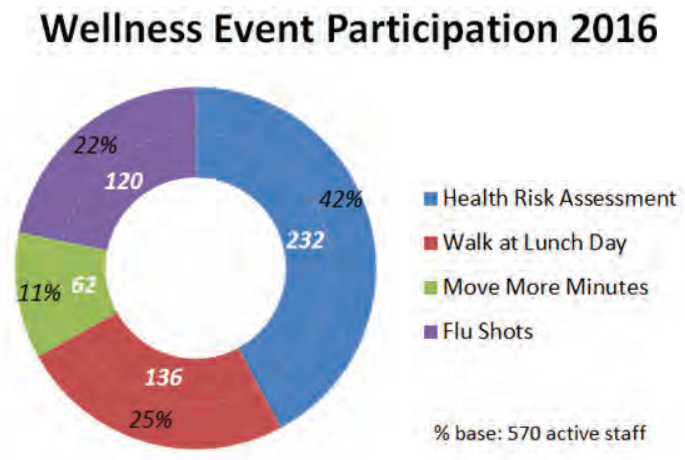
"NCSS truly cares more about its employees than anywhere I have ever worked."

"Love working for NCSS. Such a supportive and positive work environment."

Program Outcome Statement: Design a program that provides support to our employees in leading a healthy lifestyle to create a healthier workforce, one employee at a time
Program Indicator: An increase in program participation rates correlates to decreasing preventable illness over time

Story Behind the Performance

- NCSS unveiled its new wellness program: #wellnessyourway late in the fiscal year. The initiative is comprised of a dedicated cross-divisional committee and partnerships with RiseVT and Blue Cross and Blue Shield of Vermont
- NCSS reached the elite designation of GOLD Certified Employer status by exceeding core requirements that demonstrate our commitment to building an innovative, flexible worksite wellness program to create a healthier workplace
- The team has developed an action plan for the future that highlights our commitment to employees' overall well-being, so we can be at our best when working with our clients



What staff had to say:

"It's really enhanced my self-care and reminded me that I'm stronger and more capable than I feel I am at times."

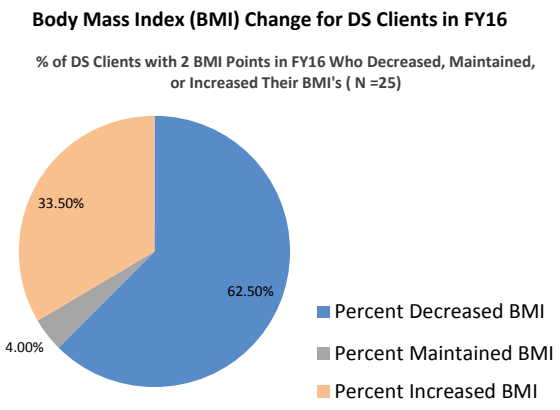
NCSS achieved **GOLD Certified Employer** status through RiseVT!

Director's Statement

Our vision in Developmental Services (DS) is to not only "talk the talk" but "walk the walk" of person-centered planning. This means asking first, respecting the rights of those we serve to have freedom of choice to learn from life experiences, just like everyone else. Success stories begin with inclusion, integrity, respect and advocating for the rights of individuals with developmental disabilities to be integral parts of their communities. The range of community based services promotes integration, creates employment opportunities and facilitates independent living, while optimizing and developing natural supports. Staff is dedicated to promoting independence, and through team collaboration with families, friends, peers and significant individuals in their lives, goals are identified and meaningful activities brainstormed to assure progression. We hold ourselves accountable to the outcomes of those we are privileged to serve in DS. Hopefully, within these pages you will discover the dedication to providing the highest quality services, promoting a healthy inclusive lifestyle for all.

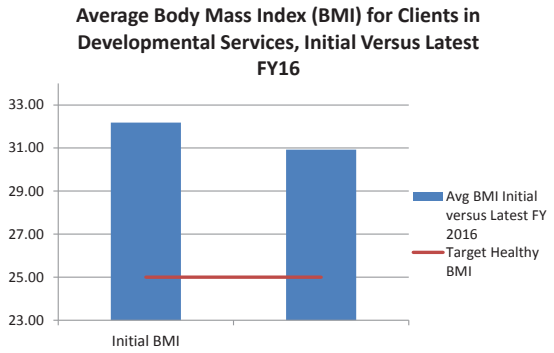
Kathy Brown, *Director of Developmental Services*

Jonathan's Story



The work is more than "just a job" when staff develop relationships that are the catalyst for real change in people's lives. Real life changes can happen when relationships are formed, individuals have choice in their own goals and a person-centered team approach is at the core of service delivery. Jonathan, a 24-year-old man, found his health and emotional well-being careening out of control. In 2015 his weight had jumped to an all-time high of 250 lbs. only to continue creeping up and in January of 2016 Jonathan was at 268 lbs. The primary care doctor, along with home provider, services coordinator, and community support staff, started working with Jonathan on health goals. The increasing weight was not the only challenge; along with it came increased stress and Jonathan was struggling with coping strategies. The team began working on an overall exercise routine that began with walking whenever and wherever possible. Jonathan began walking to the local stores, doctors' appointments, and work; whenever there was an opportunity Jonathan and his staff would walk. Shortly after Jonathan started to see his BMI and weight dropping, he decided to join the gym and began going a few times a week. With ongoing support and positive feedback the weight continued to come off and the exercise routines became a daily part of his regimen. Jonathan, with the support of the team, started to take a real interest in nutrition

and began working on planning healthy meals, joining Pinterest for recipes and received support and training on cooking nutritiously. Jonathan's journey has brought him to a healthy 235 lbs., 33 lbs. lighter than when the journey began. Jonathan has also learned that exercise is an outlet for his stress and frustrating events, and he has developed life-long coping strategies. Jonathan's story is not that unusual in the services being provided through the caring teams in the Developmental Services (DS) division here at NCSS. In 2016, of the clients having recorded 2 BMI points, 62.5% of them showed a decrease and 4% maintained. Life changes happen when teams come together to support the goals of those we have the privilege of serving; Jonathan's story is one that is the norm here in DS. When the mind-body connection gets made, individuals are empowered to move towards healthier living and more overall control in their lives. After all, isn't that what we all seek? Control and homeostasis in our own lives?



How Much Did We Do?

1. 324 number of clients were served = Increase of 1.5% from last fiscal year
2. 137,440 hours of care provided = Decrease of 5% from last fiscal year

How Well Did We Do It?

1. 94% of our clients felt staff treated them with respect
2. 90% of our clients said they would refer a friend or family member to NCSS

Is Anyone Better Off?

1. 90% of our clients felt they received the help they needed
2. 85% of our clients felt the services they received made a difference
3. 89% of our clients received the services that were right for them

Access + Responsiveness
+ Efficiency Measures + Effectiveness Measures =
Results Based on Accountability

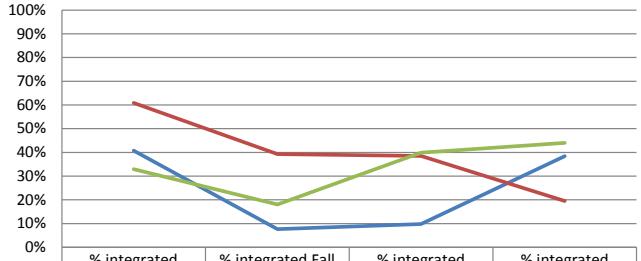
Program Outcome Statement: Address the increasing needs of individuals with disabilities and families to provide skill building, training, academics, and practical community-based programming to increase independent living
Program Indicator: Individuals and families will be satisfied with the programming and make progress toward community integration

Story Behind the Performance

The Academy of Learning runs three days a week with a different theme and group of clients each day. The Monday group focuses on independent living skills, the Wednesday group learns skills to help foster their health and wellness, and the Thursday group focuses on academic skills. The goal is to increase community integration in each of these groups and to see a decrease in Independent Living Assessment scores, which indicates improvement in the clients' ability to function independently.

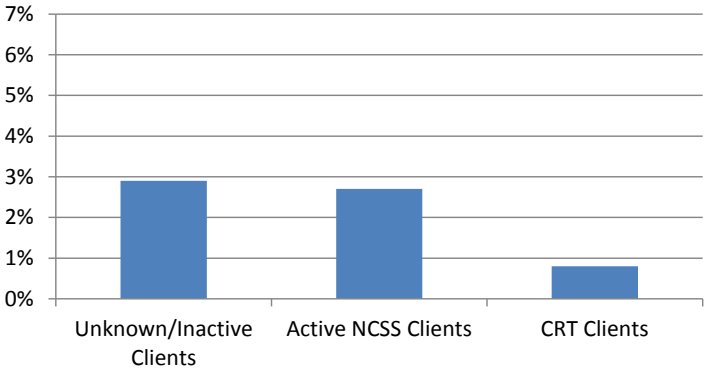
- The Academy of Learning focuses on community integration in order to foster and promote skills in the community setting so individuals can utilize these skills at any times
- Provides hands-on learning to help clients practice skills and work on socialization in a safe setting
- Utilizes an Independent Living Assessment (ILA) to help identify areas of need and monitor progress over time

% Integrated in Community



	% integrated Summer '15	% integrated Fall '15	% integrated Winter '16	% integrated Spring '16
Indep Liv Skills	40.74%	7.69%	9.76%	38.46%
Health & Wellness	60.87%	39.27%	38.55%	19.47%
Academic	32.95%	18.09%	39.90%	44.00%

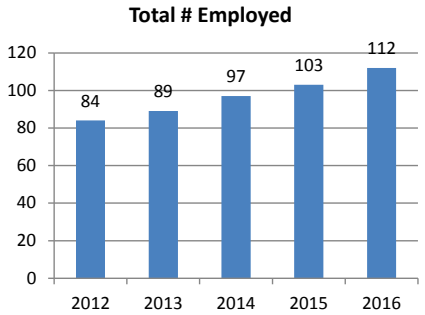
Percentage of Face-to-Face Crisis Contacts that Resulted in Psychiatric Hospitalization by Type



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

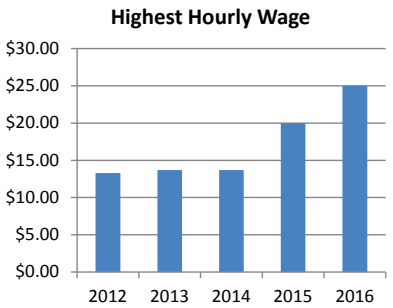
Story Behind the Performance

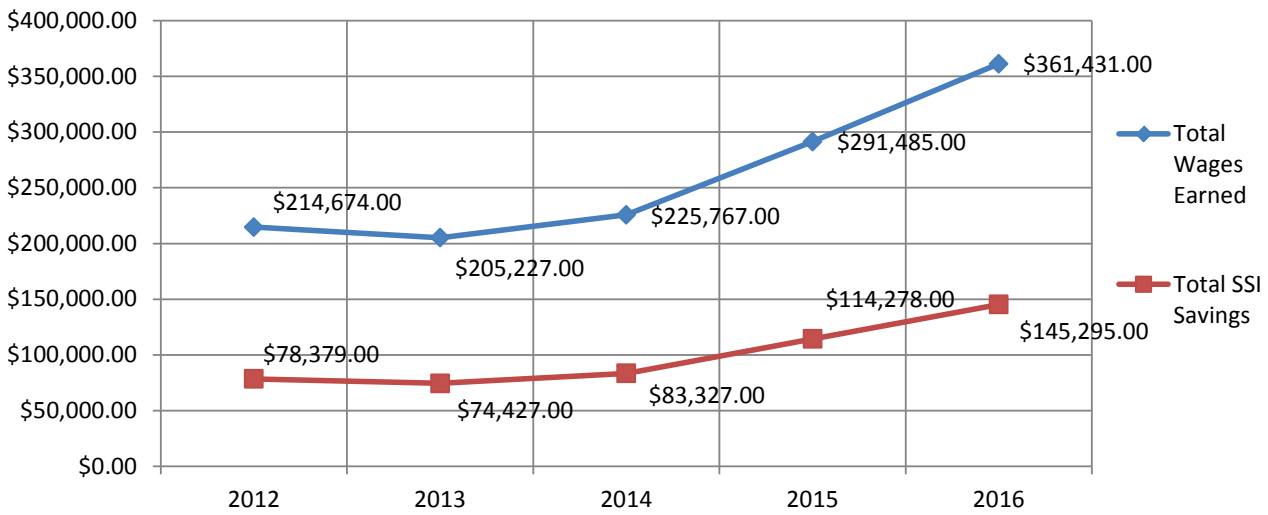
- The Developmental Services Community Employment program has produced a 33% increase in the number of clients employed over the past five years
- Total wages earned have gone up by more than $146,000 over the past five years
- Total Social Security savings has almost doubled over the past five years

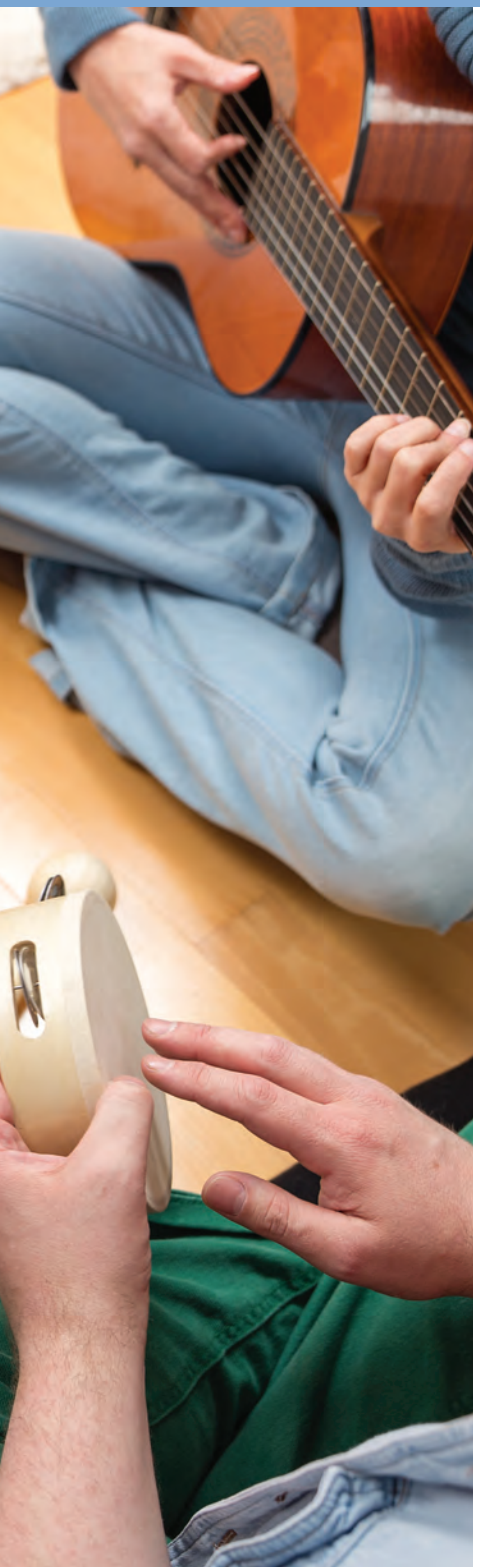


What Works:

- We provide supportive employment by building natural supports on the job site
- We support skill development to help encourage individuals working to be as independent as possible on the job. This approach increases a person's self-esteem
- We work in tandem with community partners, such as Creative Workforce Solutions, VocRehab, and local schools and businesses





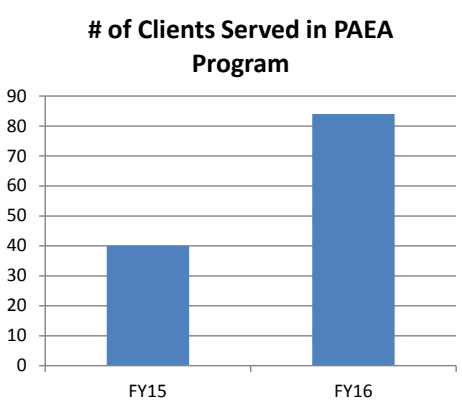


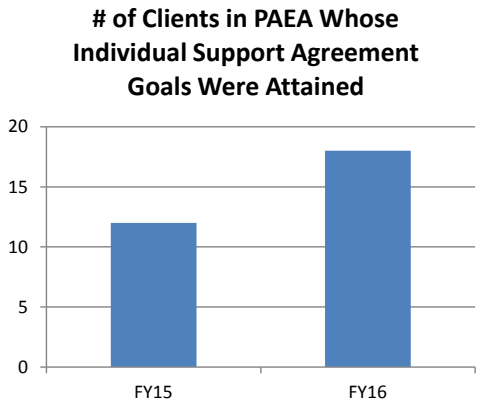
Program Outcome Statement: Specialized Services offers therapeutic and recreational music, art and sensory exploration experiences, as well as support in total communication for people with developmental disabilities, and community supports for individuals in the deaf and hard of hearing community

Program Indicator: Individuals will obtain ease of access to specialized services, move toward attaining individual goals and experience increased access to communication through training of NCSS staff and community members

Story Behind the Performance

- The First Annual Upcycled Art Library Tour was held displaying the art of 15 consumers in the libraries of Franklin County throughout the summer
- Our participant count more than doubled mostly due to the addition of sensory sessions
- We increased the number of participants whose Individual Support Agreement (ISA) goals were attained and who moved to a new goal!

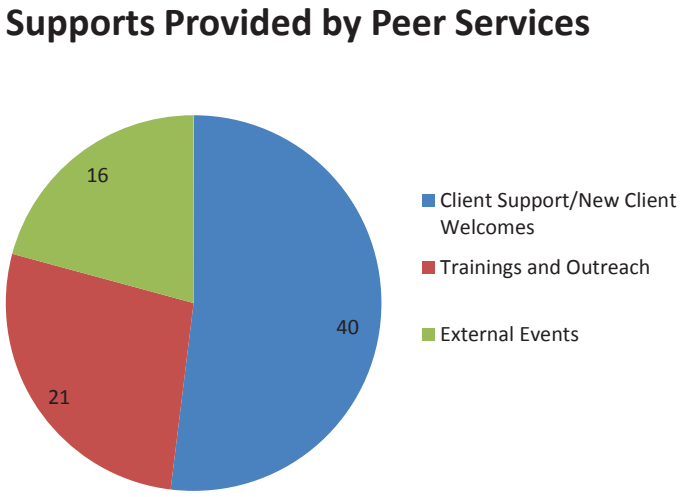


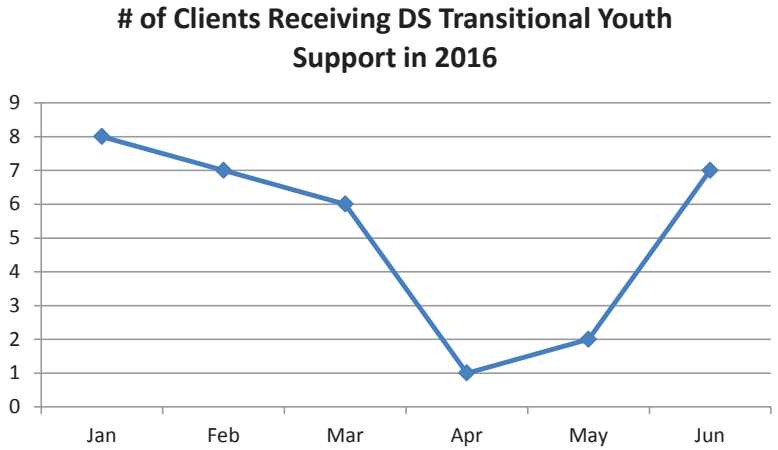


Program Outcome Statement: Programs that employ paid and volunteer Peer Advocates to create support systems and learning cultures that help individuals achieve self-directed, satisfying lives
Program Indicator: Increase options to develop independent living skills, healthy relationships, community connections, meaningful employment, and life-long learning

Story Behind the Performance

- Peer Services team initiatives in FY16 focused on Franklin and Grand Isle County transitional youth. With the continued need to better prepare high school students with disabilities for adulthood, support and trainings were offered on self-advocacy
- Students were taught by Peer Advocates how to speak up for themselves about their goals, their strengths, and their passions and then identify the supports they needed to be successful in their lives, whether it be with a job, living on their own, being their own guardian, having relationships, or being contributing members of their communities
- Peer Advocates have the insight of living with a disability and this common experience shows young adults that anything is possible and you don't have to go it alone





"The Peers gave me hope. If they can be independent, then I can too."

"Listening to the Peer Advocates tell their stories. It changed me."

Director's Statement

The Children, Youth & Family Services Division of NCSS had a very successful FY16. Alignment of services across the system of care was a top priority and we took steps to achieve that goal. Specifically, each Supervisory Union and our Child Protective Services partners have an NCSS point person dedicated to supporting the unique needs of each community and streamlining referrals to promote timely access to care. This emphasis on collaboration achieved great results. Through these partnerships, we have significantly increased the number of families served within the home, community, and school. The data reflects that NCSS provides high quality care. In FY16, families reported that services had a positive impact and improved their well-being.

In addition to our more intensive services, the Children, Youth & Family Services Division has strived to develop preventative models of care designed to promote wellness. Oftentimes, these community activities were done in collaboration with our partners at the Northern Tier Center for Health, Northwestern Medical Center (NMC) and the Health Department. Specific FY16 examples include Early Childhood Wellness Activities, foster parent trainings, workshops to help caregivers talk with teens, Youth Mental Health First Aid, and Healthy Heart activities.

NCSS, together with our community partners, will build on the success of FY16 to strengthen the health of our community.

Todd Bauman, *Director of Children, Youth & Family Services*

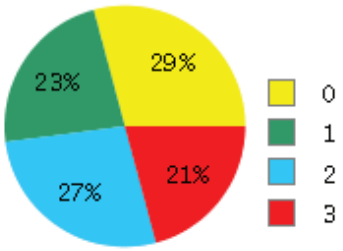
Justin's Story

Justin was a 10-year-old boy with an extensive trauma history and a diagnosis of Autism. He began exhibiting behaviors that were making it difficult for him to remain safe and supported at his school as well as increasing the concern in his foster home. Justin was initially being served by the Resource Team who had been primarily focused on supporting the foster mom to connect him to needed social activities and providing guidance around managing his behaviors in the home. As the behaviors began to grow more intense and concerning he began working with the Applied Behavioral Services (ABS) Team with a focus on increasing his ability to communicate his wants and needs. Due to his increase in unsafe behaviors at his school, his time there was reduced to two hours a day, adding increased strain on his already tenuous foster placement, ultimately leading to his need to change homes. The intense nature of Justin's behavior difficulties made finding a new placement difficult, and the Local Interagency Team (LIT) became involved. This team is made up of local representatives from schools, NCSS and DCF with the goal of consulting around how to keep kids safe and placed in their own communities.

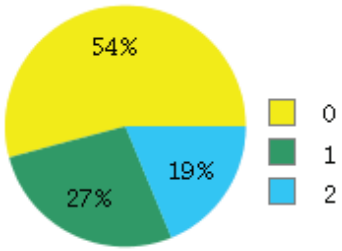
With the support of the LIT, an increase in services and supports was implemented to stabilize Justin while a new foster home was identified. At the same time, the school was supported to refer Justin to Soar Learning Center as an education placement that could support his level of need. After a couple of months, a new foster home was identified. The ABS and Resource Team worked to train and support the foster care providers regarding Justin's needs and

Justin's Progress Illustrated by the Child and Adolescent Needs and Strengths Assessment

Score	Needs	Strengths
0	No Evidence	Centerpiece Strength
1	Watchful Waiting	Useful Strength
2	Action Needed	Identified Strength
3	Immediate/ Intensive Action Needed	No Strength Identified



Baseline CANS



CANS 6 Months

behavior plan as he transitioned into his new home.

At this time Justin is now stable and thriving in his new home. He is succeeding at Soar, his negative behaviors have drastically decreased across all environments and his foster parents are planning to adopt him. Justin's story is one positive example of what can happen when resources are used collaboratively and effectively and everyone pulls together with a common goal centered on the well-being of the client.

Justin was assessed using the Child and Adolescent Needs and Strengths assessment (CANS) to monitor his progress over this time period. The pie chart above illustrates his reduction in Immediate and Intensive Needs.

How Much Did We Do?

1. 2,199 clients were served = an increase of 14% from last fiscal year
2. 143,667 hours of care provided = an increase of 42% from last fiscal year

How Well Did We Do It?

1. 97% of our clients felt staff treated them with respect
2. 91% of our clients said they would refer a friend or family member to NCSS

Is Anyone Better Off?

1. 92% of our clients felt they received the help they needed
2. 90% of our clients felt the services they received made a difference
3. 91% of our clients felt they received the services that were right for them

Access + Responsiveness
+ Efficiency Measures
+ Effectiveness Measures =
Results Based on Accountability

Program Outcome Statement: Children and families will be safe and successful
Program Indicator: Children and families will show improved functioning as evidenced by decreasing Needs and increasing Strengths identified on the Child and Adolescent Needs and Strengths assessment (CANS)

Integrating Family Services (IFS) is a bold initiative designed to streamline the entire child and family system of care. IFS offers greater flexibility with our funding which has allowed us to develop innovative programming better suited to the unique needs of children and families in our community.

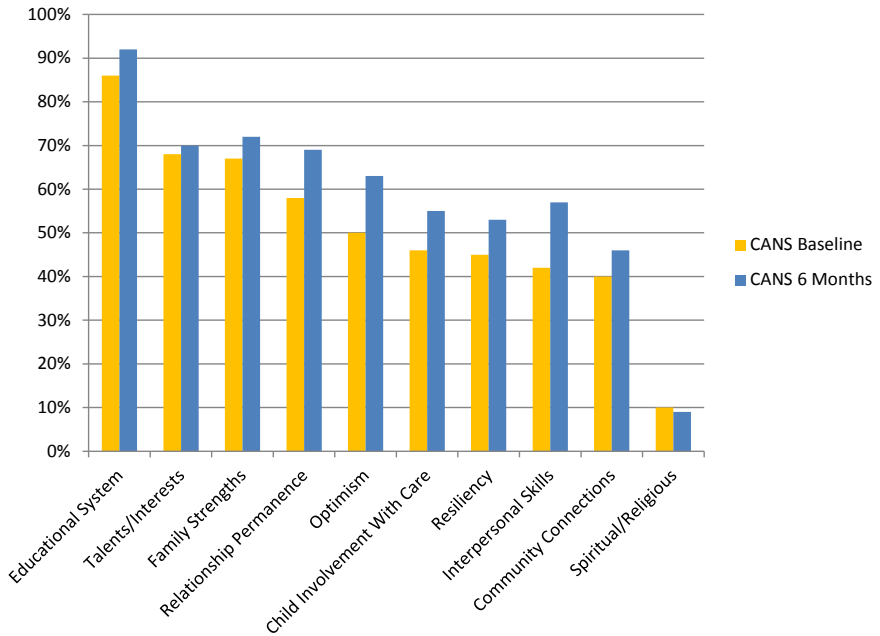
IFS services include a comprehensive assessment completed by a masters level clinician and a wide range of supports including resource identification and prevention; supports for children with severe emotional disturbance provided in their home and in the community; supports to parents around safe and effective parenting, and respite and crisis services.

Building Client Strengths Through IFS Programming

One of the best features of the CANS, IFS' clinical monitoring tool, is it also assesses client and family strengths. The following graph illustrates improved functioning by increasing client strengths over time

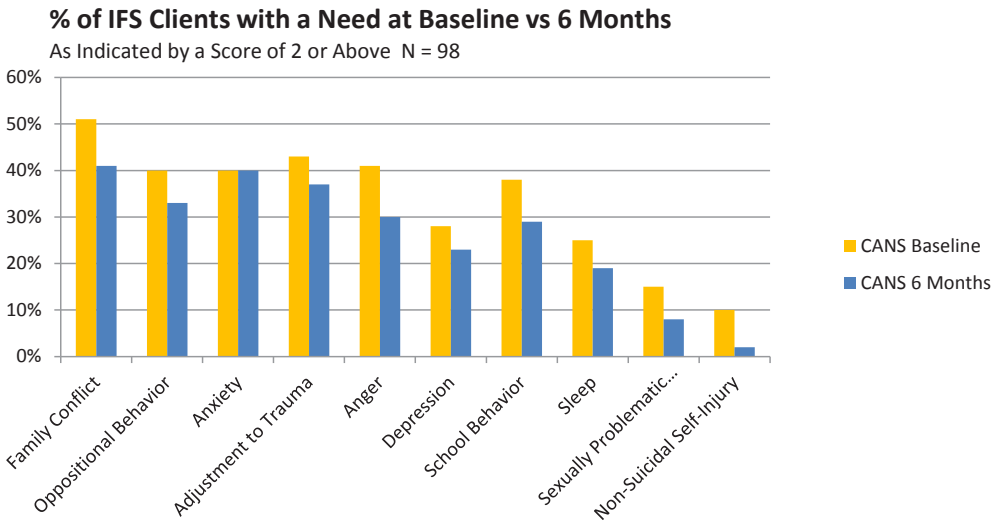
- IFS' primary tenet is to encourage efficiency and effectiveness of services by allowing teams to focus on unique child and family outcomes through strength-based and family-centered work
- Strengths offer protective factors against emotional disturbance and serve as coping mechanisms for managing adversity

% of Clients in IFS Programming with Strengths Identified as Useful to Treatment Planning
As Indicated by Score of 0 or 1 - CANS Baseline vs CANS 6 Months N = 98



Meeting Client Needs Through IFS Programming

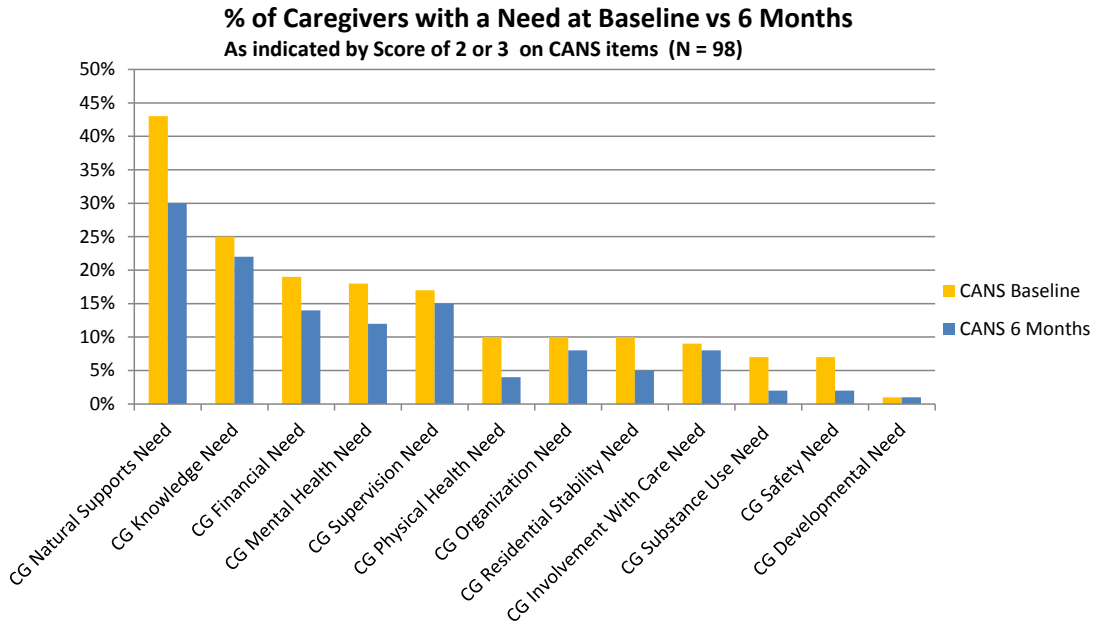
The CANS assesses Emotional/Behavioral needs, Life Functioning, and Risk Behaviors of the client to monitor progress over time. In FY16 we were able to significantly impact areas such as Family Conflict, Adjustment to Trauma and School Behavior, among others. An area identified for improvement would be to look at our approach for treating anxiety, as were not able to significantly impact this need for this sample of our population.



"I love my son's team!! He gets support at home, school, and community. He is encouraged, challenged and supported and I have the best team helping him be the best he can be."

Meeting Caregiver Needs Through IFS Programming

The most prevalent need for caregivers in our IFS population is Natural Supports to help in caring for their children. IFS programming assists caregivers in identifying and accessing these supports.



Story Behind the Performance

- IFS services include Family Support programming that focuses on caregiver identified needs as they relate to the child. Our services build on the intrinsic strengths within families that can be utilized to meet their goals
- IFS services work closely with community partners to align service delivery goals across the children's system of care

Action Plan:

- Continuous quality improvement to assure that specific services are aligned with community needs and relevant to the families of Franklin and Grand Isle Counties

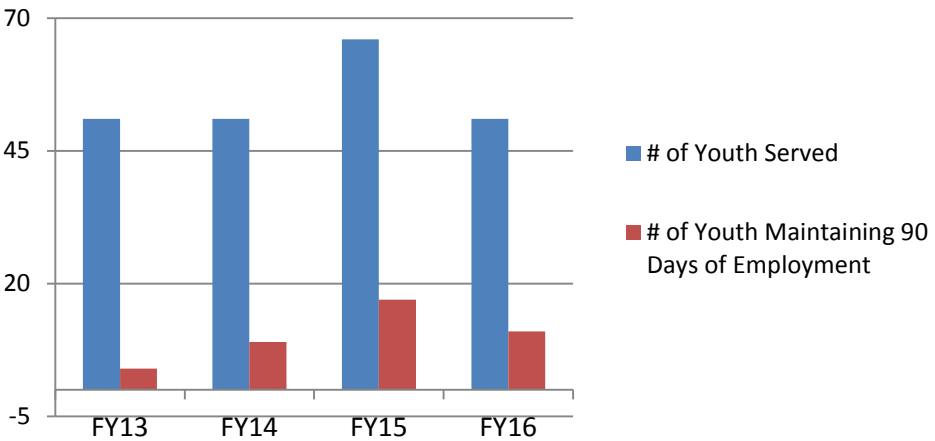
Program Outcome Statement: Increase the number of youth steadily employed in Franklin and Grand Isle Counties
Program Indicator: Number of youth maintaining 90 days of employment

Story Behind the Performance

NCSS served a total of 51 youth through the JOBS/PETS programs in FY16, ages 14 to 23. These programs provide employment services and other appropriate services to reduce obstacles to employment for youth.

- NCSS works closely with Vocational Rehabilitation (VocRehab) who recognizes 90 days of continuous employer paid work as success. In FY16 we met our goal of having 11 youth meet this 90 day benchmark
- NCSS staff develop positive, trusting relationships with youth, integrating employment supports with mental health/case management services to support youth through all phases of employment
- Staff develop work placements that fit the needs and interests of the young adults that we serve. Job placements vary from industries such as food service; retail; general labor/factory work to more long-term employment interests such as small business plan development; plumbing and electrical apprenticeships and licensed nursing

Youth Served and Youth Maintaining Continuous Employment in FY16

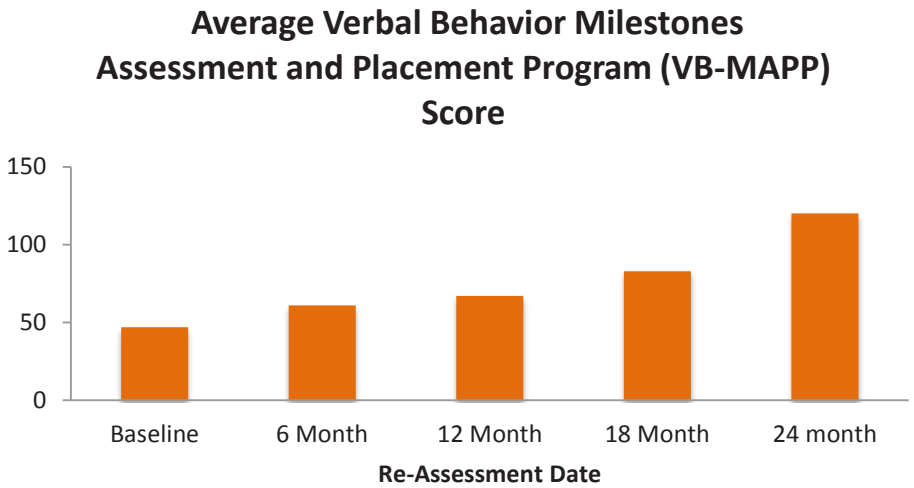


Program Outcome Statement: To help children gain the skills necessary to lead more independent and productive lives within our community
Program Indicator: Children will acquire and retain new skills utilizing the Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP)

Story Behind the Performance

The Applied Behavior Services team began in November of 2014 providing supports for children diagnosed with Autism Spectrum Disorder and other developmental disabilities.

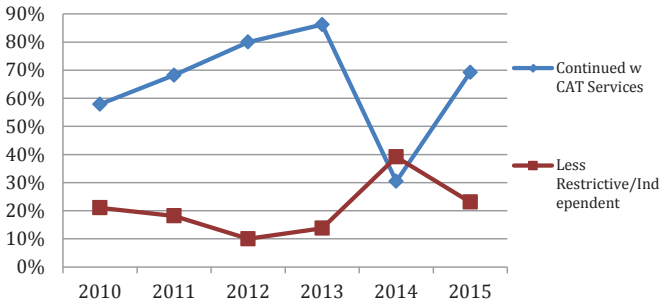
- The ABS team served 47 clients in FY16; 37 of which are doing the VB-MAPP programming; 26 of these children are under the age of 7
- The total score possible on the VB-MAPP is 180. Improvement is indicated by VB-MAPP scores increasing. Average VB-MAPP scores for our clients increased 155% over baseline after 24 months of intensive teaching strategies based on ABA techniques
- We provide services to children in the home, community, and here at NCSS. Providing transportation for clients to receive ABS services has been successful in allowing services to take place within the environment that works best for each family



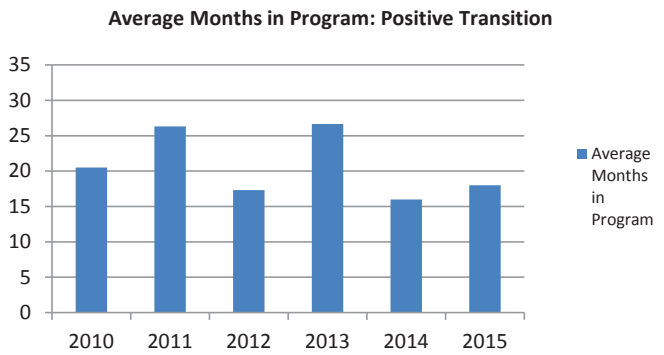
Program Outcome Statement: Children will successfully access their public school education
Program Indicator: Children will acquire skills/knowledge and achieve their behavioral goals

Story Behind the Performance

- During FY16 the CAT program provided 1:1 intensive Behavior Intervention (BI) services to 26 students in Franklin County
- Twenty four students were able to access their education in their community and public school with the support of CAT services
- By the end of the year, six clients transitioned to independence in their public school setting



Students who were able to transition from BI services engaged in intensive programming for an average of 18 months prior to transition back to independence in their public schools.

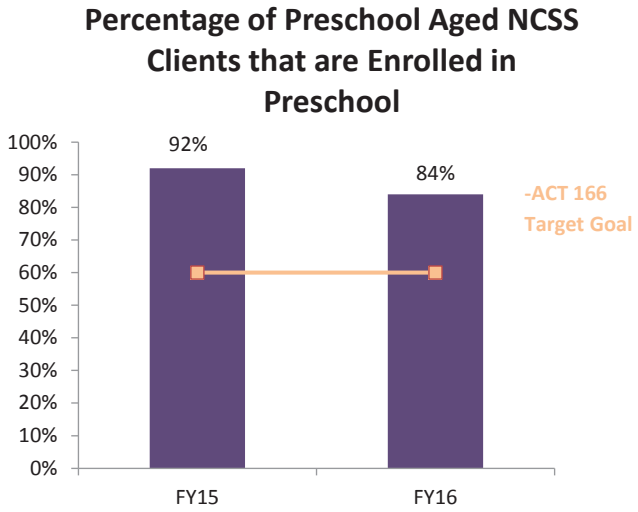


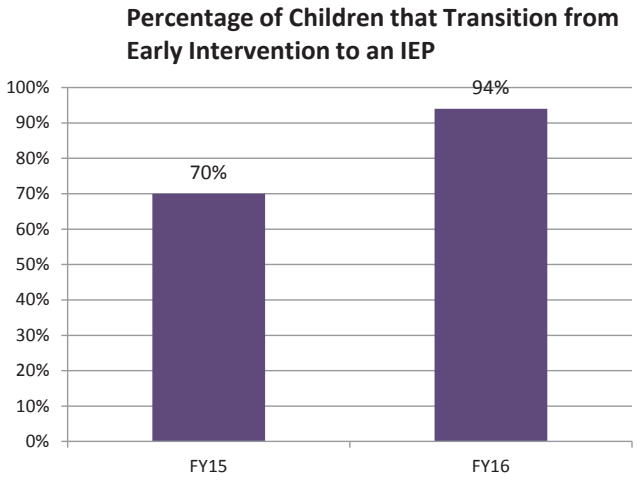
"I LOVE the CAT team members I have had the pleasure of working with this year. They have significantly changed the climate of our school."

Program Outcome Statement: Promote social-emotional development and school readiness
Program Indicator: Provide developmental screening and assessment; increase access to high quality child development services; help children be ready for school

Story Behind the Performance

- Early Childhood Support addresses the developmental and social-emotional needs of young children to support healthy family functioning and school readiness through home visiting
- NCSS hosts regular meetings between Developmental Educators and the school's supervisory union staff to share information and prepare the transition to school services, whether the child will have an Individualized Education Program (IEP), attend preschool, or start school at a later age
- ACT 166, a law passed by the Vermont Legislature to ensure equal access to high quality pre-kindergarten programs across the state, set a target of 60% of the state's preschool-aged children accessing pre-school by 2020. Children in ECS program already exceed this target at 84%
- ECS programming believes in what many studies have proven, that children who receive a high-quality early childhood education are more likely to succeed in school and beyond



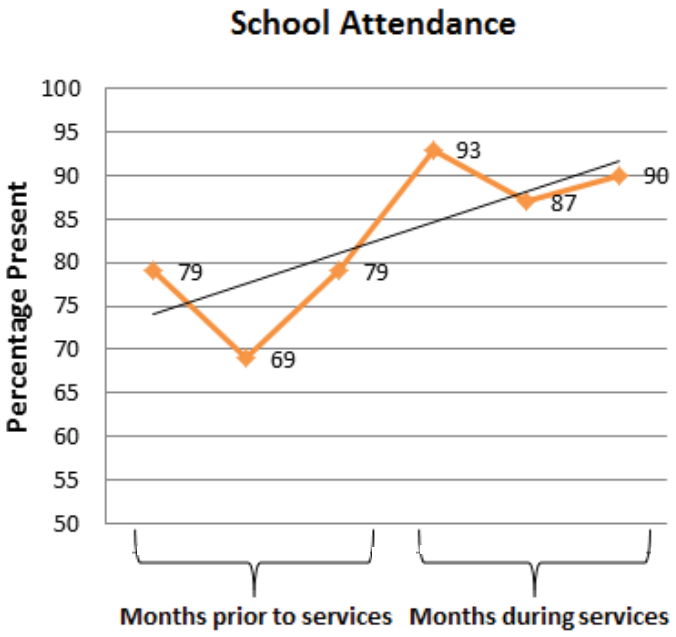


"Thank you for providing Early Childhood services at my child's day care and at home. He is making great progress (and so am I)."

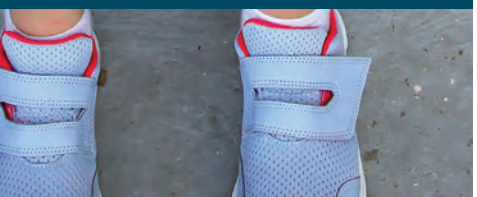
Program Outcome Statement: Promote social-emotional well-being through education for children and families served
Program Indicator: Children will demonstrate increased school engagement and attendance as outlined in Individual Plans of Care

Story Behind the Performance

- Students served attended an average of 76% school during 3 months before services, compared with 90% during the first 3 months of services
- At these average rates, students would miss 43 days in a school year without services versus 18 days with services
- More than half of the individuals served had reached 20 absences prior to services; by focusing future services on individuals beginning at 15 absences, the TS predicts even better outcomes
- The Truancy Specialist works with community partners to establish consistent truancy protocol, attain referrals, track outcomes, coordinate services and plan transitions to ensure continued success for clients and families. Frameworks used are but not limited to: Motivational Interviewing, Cognitive Behavioral Therapy and Attachment, Self-Regulation and Competency (ARC) framework



Supervisory Unions Served in NCSS catchment area 100%



Program Outcome Statement: Children will be successful in their public school
Program Indicator: Children will achieve their behavioral goals and acquire skills/knowledge

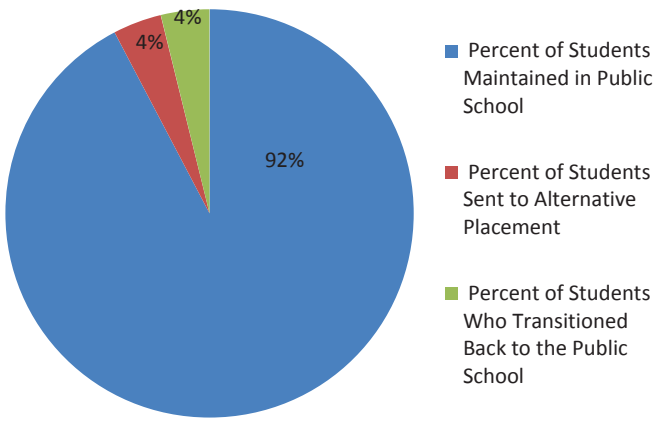
Story Behind the Performance

Our team helps schools to provide effective, strengths based interventions with individualized programming for students diagnosed with Autism Spectrum Disorder, Intellectual and Developmental Disabilities, Genetic Disorders, and/or Down Syndrome. The program supports schools, students and their families by providing a trained Behavior Interventionist to work one-on-one with identified children, with Behavior Analysts and Autism Specialists developing all behavior programming and providing supervision and ongoing training.

- Students served FY16: 25 kids aged 5-22, served in 11 public schools
- Partnerships with 46% of school served in the catchment area
- Program tenets are based on Applied Behavior Analysis (ABA) along with other evidence-based practices
- Typical students in this program have behavioral, social, communication, academic and/or daily living challenges

We believe that students, regardless of their abilities, belong in their local community schools. Our services are student centered where the child and ongoing collected data drive programmatic decisions.

The pie chart denotes that 92% of students served were maintained within their public schools/least restrictive environment. The addition of a 1:1 Behavioral Interventionist and Behavior Consultation were the two primary services provided to the student, family and educational team.



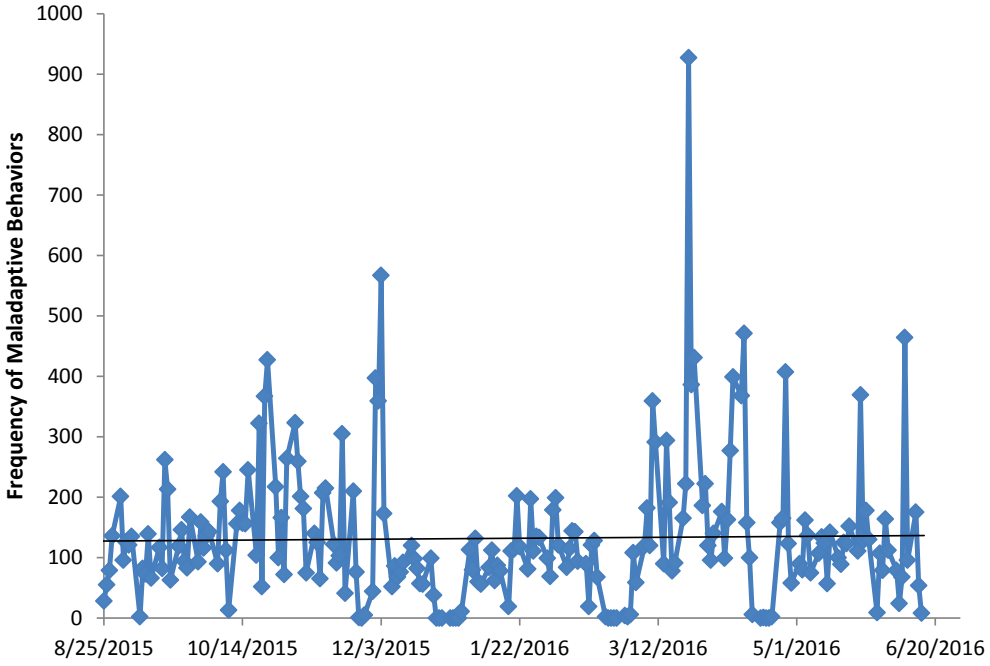
Story Behind the Performance

The graph below illustrates aggregate data of maladaptive behaviors of aggression, property destruction, and noncompliance frequency of occurrence from all students served. Typical referrals strive to decrease aggressive behaviors so students can remain in public school, access their education and learn coping skills.

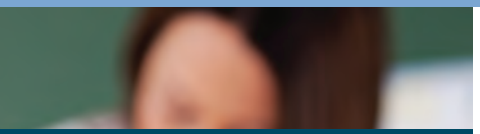
- This graph denotes a slight increasing trend line in maladaptive behaviors from the beginning to the end of the school year. We believe this increase was impacted by the fact that in FY16 our program took on two new students in March, affecting our ability to assume August as baseline data for everyone and to expect a consistent decrease over time

Action Plan:

- We plan to continue to accept students mid-year, as flexibility is key for partnering effectively with schools. We may look to adjust how we monitor aggregate maladaptive behaviors in the future to better reflect the baseline for all students



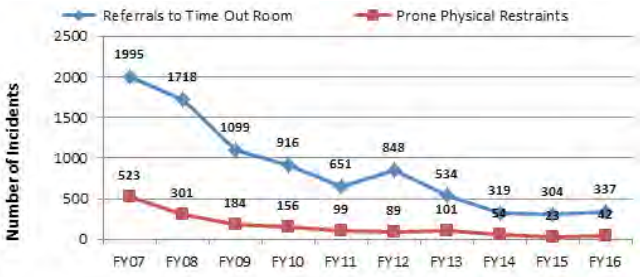
Aggregate Maladaptive Behaviors of All Students Served: Aggression, Noncompliance, & Property Destruction



"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

Program Outcome Statement: Students will successfully transition back to public school
Program Indicator: Behavioral and academic success. Successful transitions back to school

Story Behind the Performance



Soar Learning Center has implemented Life Space Crisis Intervention and Handle With Care as intervention models. Annual data shows a decrease in both restraints as well as referrals to the Time Out room. Additional analysis shows that although there was a small increase from FY15 there is still a 13% decrease from FY14 and a nearly 60% decrease from FY13.

Soar Learning Center's primary goal is to successfully transition students to the public school in their community. Over the past eight years, the program has transitioned 88 students to the public school system with only three students returning within a six month period, indicating over a **95% success rate**.

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, Applied Behavior Analysis, Responsive Classroom, and Positive Behavioral Intervention & Supports (PBIS)
- 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

Action Plan:

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

Director's Statement

The Behavioral Health Division serves children, adolescents, adults and families. NCSS Psychiatry and Nursing services operate out of this division and also serves the two other service divisions (Children, Youth & Family; Developmental Services). Services within the Behavioral Health Division include: Crisis & Mobile Outreach Services, Integrated Health Services, Outpatient Services, and a range of services through the Community Rehabilitation & Treatment (CRT) Program. Programs and services continue to change to meet new and growing demands. To improve access to services, we have added to our rapid access clinican staff, expanded our mobile outreach team to serve those who might not otherwise seek care, and worked with our community partners on projects to increase access. To address growing acute care needs, we implemented a uniquely designed program for the return of two adults who have been in long-term residential treatment, enhanced our crisis bed program, expanded our outreach services to law enforcement, continued our commitment to a position at Northwestern Medical Center's Emergency Department, and entered our second year wellness activities and evidenced-based practices to enhance both mental and physical health. We continue to seek more effective ways to evaluate the impact of our services and look forward to developing more data based performance systems to improve the care we provide.

Dr. Steve Broer, *Director of Behavioral Health Services*

Kathy's Recovery Story

This story illustrates the challenges many individuals face on their path to recovery and what types of services support them along their way. It also illustrates how an improved quality of life is possible and can ultimately result in a productive and meaningful future.

Past

Four years ago, Kathy's family contacted the NCSS Crisis Team, worried about Kathy's ability to take care of herself and live alone. Kathy was unable to cook, or clean and had not left the house on her own in seven years. She experienced panic, anxiety, and paranoia; her thoughts were disorganized and she refused treatment. Our Mobile Outreach team began supporting Kathy in her home; the team connected her with general assistance, supported her in obtaining health insurance, and referred her for much needed medical care. After that, Kathy began receiving Psychiatry and Community Rehabilitation and Treatment (CRT) Intensive Case Management services. With medication management and the support of CRT, she moved into Transitional Living and began engaging in groups, meeting with her case manager, and receiving medication deliveries to support her mental health and independent living goals. Kathy became increasingly open to utilizing these supports which resulted in significant improvements.

Present

Kathy no longer requires intensive supports and is stable enough to live without oversight. She moved into her own apartment with a roommate and continues to build a sense of community. She was connected to the CRT Supported Employment team for volunteer work and assistance in finding a job. Because Kathy has taken advantage of the range of resources available to her within the Behavioral Health Division, her overall health and well-being has significantly improved and she successfully maintains her independent living.

With the new car she bought after saving for two years, Kathy offers rides to people who do not have transportation to appointments. She recently knitted some scarves and donated them to a charity for the homeless. She has volunteered for the last year and is excited about starting a new job. After a lifetime of smoking, Kathy quit two years ago; in an effort to stay healthy, she and her friends go to the gym together. She is intelligent, funny, and a strong worker; she has accomplished many of her goals. In many ways, Kathy is a role model for what is possible in mental health recovery.

How Much Did We Do?

1. 2,965 clients were served = 12% increase from last fiscal year
2. 20,577 hours of care provided = 13% increase from last fiscal year

How Well Did We Do It?

1. 96% of our clients felt staff treated them with respect
2. 91% of our clients said they would refer a friend of family member to NCSS

Is Anyone Better Off?

1. 91% of our clients felt they received the help they needed
2. 90% of our clients felt the services they received made a difference
3. 90% of our clients received the services that were right for them

Access + Responsiveness + Efficiency Measures + Effectiveness Measures = Results Based on Accountability

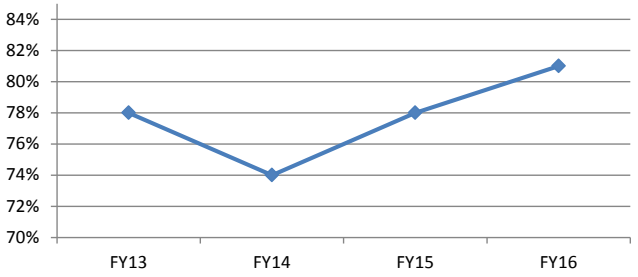
Program Outcome Statement: Support community options for persons experiencing crisis
Program Indicator: Reduce inpatient psychiatric hospitalization through increased access

Story Behind the Performance

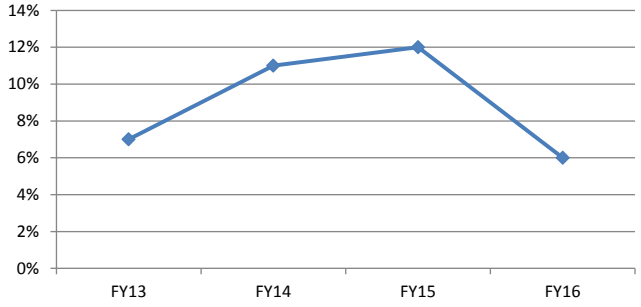
In 2011 the Vermont State Hospital was destroyed due to a devastating flood associated with Hurricane Irene. Act 79 increased funding to enhance our capacity to reduce inpatient psychiatric admissions and provide access to a wider range of services to maintain community living for those in crisis.

- There are times when persons served need to be hospitalized for their own safety. However, NCSS has successfully decreased our hospitalization rate through our efforts to provide more wrap-around services in the community pre and post crisis
- Mobile outreach teams have expanded to include clinicians embedded within the Emergency Department and law enforcement. The ability to intervene sooner, particularly with law enforcement, can help to deescalate situations that likely would have ended up in placement in psychiatric hospitals or correctional facilities
- While our overall hospitalization rate has remained low, it is noteworthy that approximately half of all clients hospitalized were unknown to the agency or not engaged in any kind of treatment at the time of hospitalization. We have a greater ability to provide appropriate supports to clients that are actively involved in treatment. Our CRT clients have the most intensive services available to wrap around them, which is reflected in the very low rate of hospitalizations

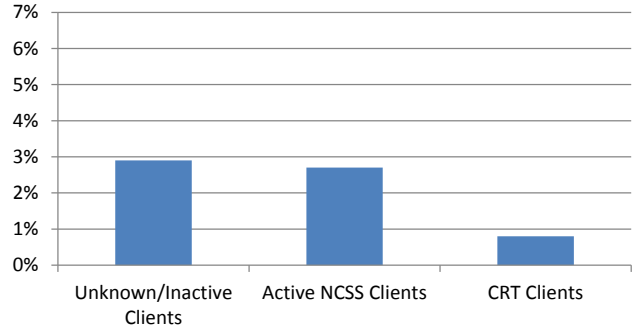
% of Face-to-Face Contacts Where Client Was Discharged Home



% of Face-to-Face Contacts that Resulted in Inpatient Psychiatric Admission



Percentage of Face-to-Face Crisis Contacts that Resulted in Psychiatric Hospitalization by Type

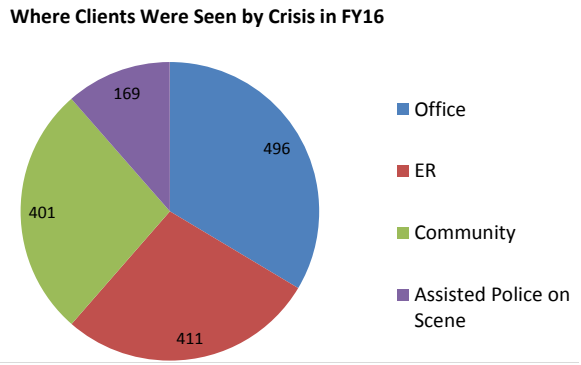


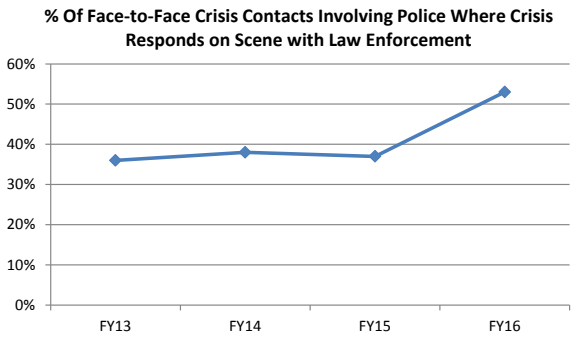
BEHAVIORAL HEALTH SERVICES: CRISIS PROGRAM OUTREACH WITH LAW ENFORCEMENT AND TO EMERGENCY DEPARTMENT (ED)

Program Outcome Statement: Support community options for persons experiencing crisis
Program Indicator: Increase collaboration with Northwestern Medical Center's (NMC) Emergency Department and with local law enforcement to decrease overutilization, improve outcomes and demonstrate cost savings across systems

Story Behind the Performance

- Our Mobile Outreach team is able to meet clients where they are, providing proactive support to clients going into crisis and necessary follow-up supports after the initial crisis contact
- There has been a significant increase in collaborative responses between crisis and law enforcement in FY16



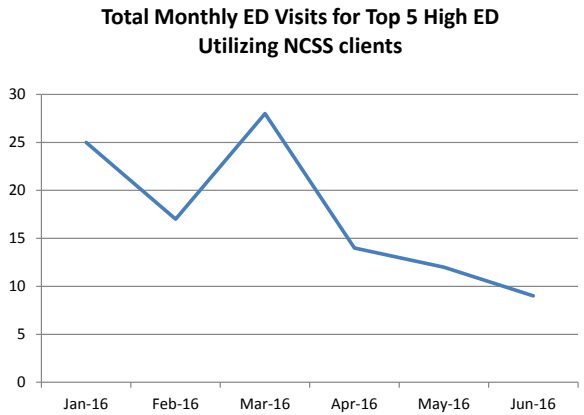


What Works:

- We attribute the increase in collaborative responses to our increased mobility within the community and increased trainings provided to law enforcement in our community regarding mental health issues and crises
- Another notable factor to increased collaboration is that NCSS embedded a crisis worker within St. Albans City Police starting October 2015

Story Behind the Performance

- This graph illustrates the progress made by a subset of high ED utilizers who were also NCSS clients
- Progress is attributed to interventions led by our Mobile Outreach Clinician who was embedded in the Northwestern Medical Center Emergency Department in an effort to build on a strong partnership with NMC and intervene with complicated factors associated with high Emergency Department Utilization



What Works:

- Embedded position in Emergency Department
- Team-based care across systems
- High level of collaboration with hospital and community teams
- Home provider model for high needs clients

  Note: funding for this option is outside typical services and likely unsustainable unless cost shifting occurs

Action Plan:

- Improved data tracking and sharing of information across programs
- Proactive identification and intervention of those at risk of increased utilization
- Policy and practice guidelines for interventions when individuals are identified as high utilizers

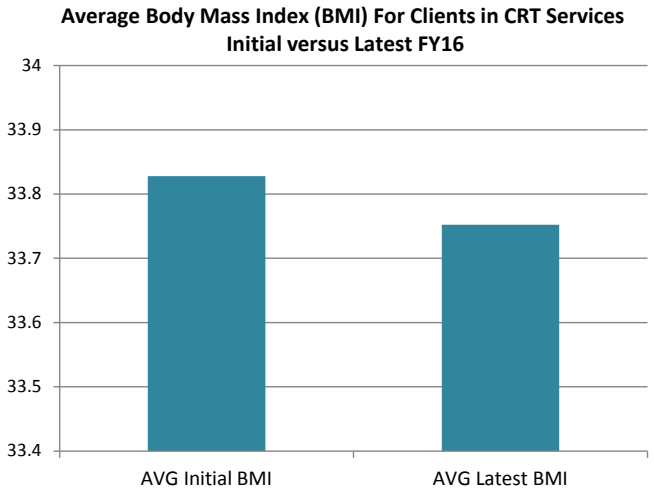
Population Indicators: Northwestern Medical Center, our community hospital, has experienced an almost 12% reduction in "avoidable visits" to their ED over the past year, the equivalent of about 1,256 visits

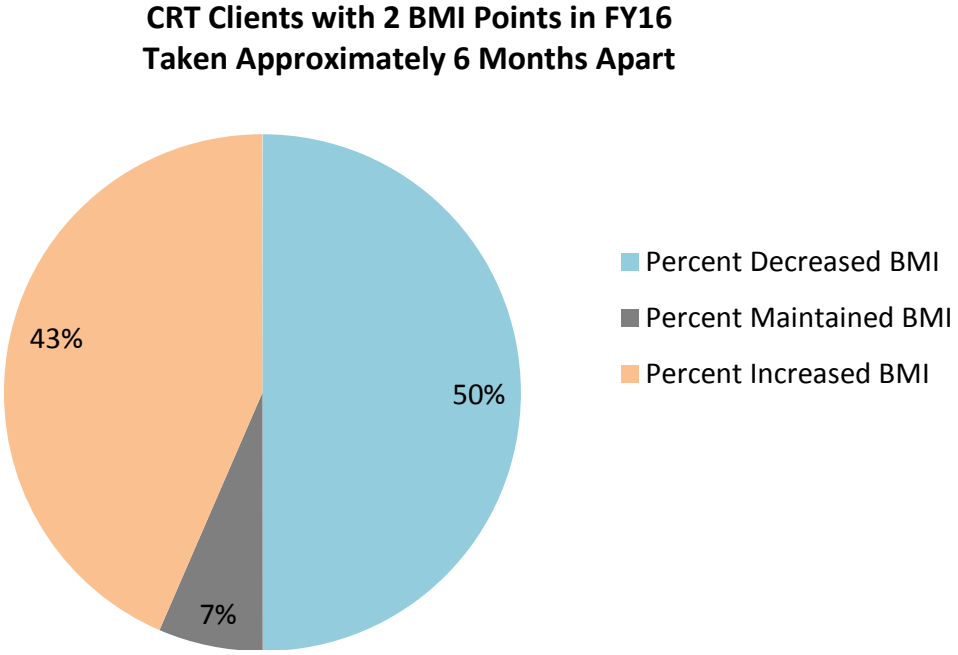
Program Outcome Statement: To increase the overall wellness of clients with severe and persistent mental illness
Program Indicator: Reduce BMI to within a healthy range, reduce smoking and increase healthy coping skills

Story Behind the Performance

These graphs illustrate that our CRT population is making progress toward the goal of BMI reduction toward the healthy range.

- 50% of our CRT clients who had two BMI points in FY16 (101 clients) showed a decrease in BMI over this time period
- On average, our population showed a reduction of .08 BMI score over FY16. We will look to improve on this change annually





The United States Department of Health and Human Services defines recovery from mental health disorders as"A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to achieve their full potential."

As part of our collaboration with the Vermont Cooperative for Practice Improvement & Innovation, our CRT program has supported the work of the Culture and Wellness Initiative through the Department of Mental Health, promoting smoking cessation and wellness initiatives for our population. Through this collaboration we learned the following:

- People served by the CRT program, who live with severe and persistent mental illness, are 2-3 times more likely to have a chronic disease than those without a serious mental illness
- People served by the CRT program, who live with persistent mental illness, have a life expectancy much shorter than those without a serious mental illness
- The most prevalent diseases contributing to this higher mortality rate for our CRT population are Chronic Obstructive Pulmonary Disease (COPD), pneumonia, diabetes, cardiovascular disease and suicide

To help those we serve build healthy coping skills to manage their mental illness as well as improve the state of their overall health our CRT program has done the following:

- Provided pedometers to all CRT clients who were willing to accept them
- Provided a healthy cooking group for clients
- Increased utilization of walking as a coping mechanism
- Collected height, weight and BMI data on all clients seeing a psychiatrist
- Collected tobacco use information on all clients at intake

Action Plan:

Our CRT program has a timeline to go smoke free at all of our sites by 7/1/17. We will offer educational materials, provide smoking cessation groups at all locations, supply gum and patches, and connect clients with their primary care providers for additional supports

"The CRT group programs offer exercise classes that have been beneficial to my mental and physical health. This also keeps my medications to a minimum."

92% of our CRT clients surveyed in FY16 indicated the services that they received made a difference

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

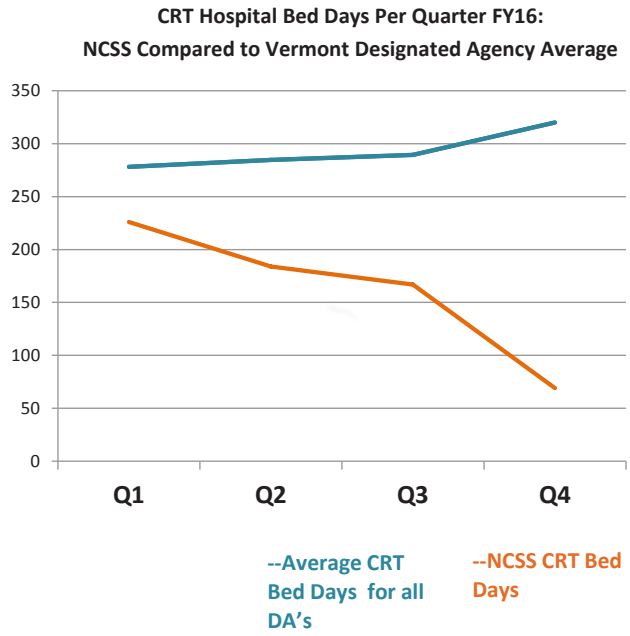
Program Indicator: Demonstrate reduction in psychiatric hospitalization rate for clients in CRT programming

Story Behind the Performance

CRT serves clients with severe and persistent mental illness, providing tiered level services to meet the needs of clients and enable them to maintain in their communities. In FY16 our CRT program maintained a significantly lower amount of bed days than their counterpart programs throughout the state.

What Works:

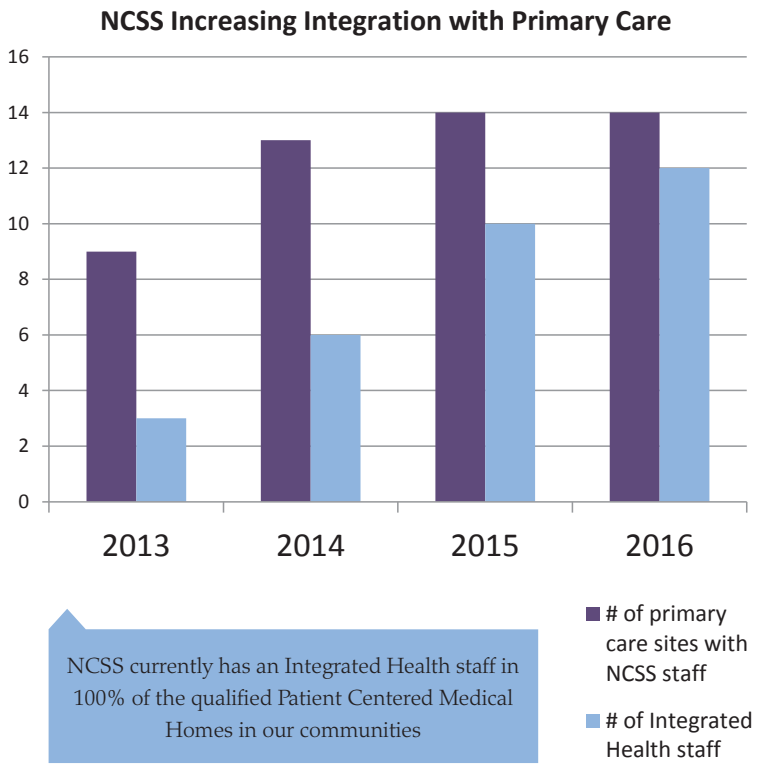
- Relationship between client, case manager and psychiatrist
- Evidence Based Practices/Recovery focused groups. Examples include: WRAP – Wellness Recovery Action Plan; CAMS – Collaborative Assessment and Management of Suicidality; NAPPI – Non-Abusive Psychological and Physical Intervention; and Wellness Self-Management
- Peer supports – We have peer services staff meet with clients on an individual basis as well as facilitate groups with our clients
- Medication deliveries
- Collaboration with Community Partners



Program Outcome Statement: The goal of the Integrated Health Team is to wrap around the patient at the time of service to meet their overall health and wellness needs
Program Indicator: Increasing presence of Integrated Health staff in community Primary Care offices with the goal to be in 100% of practices qualified as a Patient Centered Medical Home

Story Behind the Performance

- The Integrated Health Services team is comprised of Social Workers and Wellness Counselors embedded within the Primary Care setting available to individuals right at that point of access. They can address social determinants of health through short term solution-focused counseling, enhanced care coordination and self-management supports
- Since 2012 Primary care settings in the St. Albans Health Service Area (HSA) have chosen to initiate the rigorous process of becoming a Patient Centered Medical Home (PCMH) through the National Council on Quality Assurance (NCQA). As the number of PCMH's increased the demand for Wellness Counselors/Social Workers within each office has increased



NCSS currently has an Integrated Health staff in 100% of the qualified Patient Centered Medical Homes in our communities

The Integrated Health Team provides:

- Coping and relaxation strategies
- Nutritional goal setting
- Tobacco cessation
- Identification of mental health barriers to meet health goals
- Symptom management strategies
- Assessment and screening
- Specialty referrals to outside resources when needed

What Works:

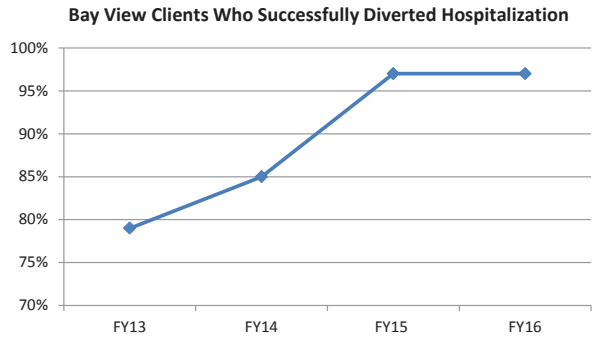
- Integration within a PCMH has proven to be effective at identifying additional needs of patients outside of their medical needs
- The warm hand off (that is the introduction of the patient by the Primary Care Provider to the Wellness Counselor/Social Worker) is a strong predictor of follow up

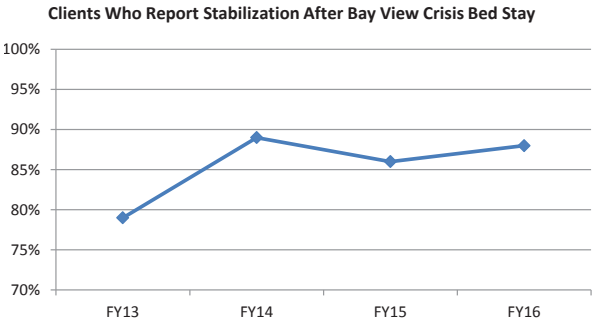
Program Outcome Statement: Offering community based supports and resources to increase symptom management and independent living and offer a local alternative to reduce the need for psychiatric hospitalization
Program Indicator: Decrease psychiatric hospitalization rate for clients accessing the Bay View Crisis Care Center

Story Behind the 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.

- The program experienced 245 total admissions in FY16, which is a 6.5% decrease from the last reporting period
- The program experienced an increase in average length of stay from 2.18 to 2.84 days





What Works:

- There has been an increased focus over the past fiscal year on providing more structured, evidence based practices at Bay View to ensure a high level of quality care is provided. This intensified effort contributes to an increase in average length of stay and decreased total admissions
- The increase in clients who report stabilization indicates these efforts to increase our quality of care have been successful
- The continued high rate of 97% of clients avoiding hospitalization illustrates the incredible value Bay View provides for systems costs savings, and for clients, who are able to remain in their community during times of acute stress due to having a safe, recovery-based place to stay

"The one place people should go."

"Saved my life."

Action Plan:

Develop a process to systematically train staff on administration of the Level of Care Utilization System (LOCUS) assessment measure in order to reliably use this measure to monitor outcomes

NCSS is a member of the Vermont Care Partners network

Vermont Care Partners

Vermont Care Partners network has over 35,000 clients and touches the lives of 50,000 Vermonters each year.

VCP helps people live healthy, safe and satisfying lives in their communities. Our mission is to provide statewide leadership for an integrated, high quality system of comprehensive services and supports. Our sixteen non-profit community-based member agencies offer care to Vermonters affected by developmental disabilities, mental health conditions and substance use disorders.

We achieve this mission through:

- Advocacy and Policy Development
- Data Collection and Analysis
- Education and Training
- Health Care and Payment Reform Initiatives
- Identification of New Opportunities and Markets
- Network Planning and Support
- Technology and Program Innovation
- Quality Assurance and Improvement

Vermont Care Partners (VCP) is a collaboration between Vermont Care Network and the Vermont Council of Developmental and Mental Health Services. VCP is both a trade association and a provider network and is committed to high quality and innovation.

NCSS is proud is be part of a network of agencies that make up Vermont Care Partners. For more information about how NCSS' outcomes relate to the community mental health outcome initiatives across the state, please visit http://www.vermontcarepartners.org.

we're here for you

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.

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learn more about our services at www.ncssinc.org

For copies of this Outcomes Report, please call NCSS Community Relations, 524-6555 ext. 6414.

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