

2018

OUTCOMES REPORT



60 YEARS
we're here for you
— Since 1958



NORTHWESTERN
COUNSELING
& SUPPORT SERVICES

LETTER FROM THE EXECUTIVE DIRECTOR

Todd Bauman



Dear Friend,

During this past year we reached a significant milestone in our history as Northwestern Counseling & Support Services (NCSS) celebrates our 60th Anniversary. Our organization has grown to nearly 600 fulltime employees who engage in striving to create a stronger community one person at a time.

The way we think about Health Care is changing. Historically, a sick person would seek medical attention in response to an illness. The Doctor would then diagnose the illness and establish a treatment plan to alleviate symptoms and help the person to regain their health. Today, our system of care is taking a more proactive approach to health. We are now developing models of care to help keep people well.

NCSS is uniquely positioned to excel within this new health care environment. As the Community Mental Health Center, the Parent Child Center, and the Preferred Provider for adolescent substance abuse treatment, we have an opportunity to be innovative leaders and promote health within our community. Through strong partnerships, we have developed innovative models that specialize in providing care to help assure wellness for the individual, family, and community.

Our NCSS Team is talented, dedicated, and compassionate. Our community is stronger because of NCSS.

In closing, we want to also express our appreciation to the towns, companies and individuals for your continued support of NCSS. Support comes in a variety of forms ranging from annual allocations, grants, contracts, sponsorships and financial contributions. It's this ongoing teamwork that makes a difference in the lives of numerous individuals throughout Franklin and Grand Isle Counties.

Sincerely,

A handwritten signature in black ink that reads "Todd P. Bauman". The signature is stylized with a cursive 'T' and a flourish at the end.

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FY18 BALANCED REPORT CARD

The Balance 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.



How well did we do?



2018

BEHAVIORAL HEALTH DIVISION PROFILE

Sally's Story



Sally is a client who receives services in our Behavioral Health Division. She struggles with anxiety, depression and being able to maintain healthy relationships with others.

She has a care team consisting of a NCSS case manager in our Community Support program, a therapist and psychiatrist, and engages with our mobile outreach nurse. She has significant physical health issues that impact her mental health and these include Type 2 Diabetes and Gastroparesis. She has significant use of the emergency department at the regional medical center with 54 visits in 2015. Her team wanted to understand more as to what was influencing this high use of the Emergency Department. Her NCSS care team collaborated with the emergency department case coordinator and reached out to her primary care provider where there is an embedded social worker and nurse care manager.

The team began meeting in 2015, meeting anywhere from monthly to every 3 months based on how the Sally was doing. Once Sally felt comfortable with our mobile nurse, she started seeing her 2-3 times a week at her home. Our mobile nurse removed all unused insulin from her home and identified more effective ways for Sally to manage her insulin and other aspects of her diabetes care. The care team worked to understand and identify times of the year when struggles the most and more likely to seek out the

Emergency Department. An individualized support plan was developed to assist Sally during these times and help her emotionally prepare for them. Once she started to increase engagement with her community support care manager, our mobile nurse started to slowly reduce the frequency of home visits to once a week.

Sally and her counselor have been able to maintain a productive working relationship for a couple of years which has involved learning new skills through a treatment program known as Dialectical Behavior Therapy. The team worked hard to develop consistent messages from everyone to make sure the care plan was clear.

Sally's Primary Care Provider developed a protocol to work Sally into their schedule the same day if she calls to avoid unnecessary use of the Emergency Department Sally's Primary Care Provider now has medications in stock that she was regularly receiving in the Emergency Department so that she can be treated at her Primary Care Provider's office.

When Sally was having a difficult time she would often use our Bay View crisis bed program for two to three days and made good use of that service. It was also noted her blood sugar levels would improve significantly with improved diet and monitoring of her medications following crisis bed stays.

This collaborative method of treatment has led to a significant decrease in visits to the Emergency Department that can be managed by her team. Compared to 54 visits in 2015, Sally had 30 visits in 2016, 39 visits in 2017, and only 5 in 2018.

We think this method of care coordination and support has greatly improved her physical and mental health care and improved Sally's quality of life and also saved the medical system a significant amount of money by providing a coordinated plan of care to address unmet needs.

2,417
Number Served
in FY18

HOW WELL DID WE DO?

99% of our clients felt staff treated them with respect

93% of our clients said they would refer a friend or family to NCSS

IS ANYONE BETTER OFF?

92% of our clients felt they received the help they needed

91% of our clients felt the services they received made a difference

91% of our clients received the services that were right for them

84,416

Hours of care in FY18

CHILDREN, YOUTH AND FAMILY SERVICES DIVISION PROFILE

The Jackson Family Story In the beginning

The Jackson family re-engaged with NCSS services when Paige, a newly pregnant young mother to a four-year-old, had just experienced the tragic loss of an infant. Department for Children and Families (DCF) services had recently become involved and the mother felt overwhelmed and lost. She felt like she was sinking. She was referred to the NCSS Reach Up and Learning Together programs to support her on her journey.

With precarious housing due to domestic violence in the home, Paige, her unborn child, and son soon found themselves homeless and needing various concrete and emotional supports. During her time without stable housing, Paige was also without a vehicle and did not have childcare for her child. Her lack of housing, transportation, and childcare made it extremely difficult to engage in mental health and parenting support services for her child and secure employment.

Paige needed to have stable housing for her family so her NCSS Reach Up Case Manager connected her with a domestic violence shelter in St. Albans. Unfortunately, she had to leave the shelter when her son broke his femur and she was unable to carry him to the various floors of the shelter. Things were becoming increasingly difficult for Paige; she knew she needed additional supports for herself and her family. She moved in with her mother and stepfather and accepted an additional referral at NCSS for an Early Childhood Specialist. Although she felt like her world was crumbling around her, being connected to additional supports helped her to remain hopeful and resilient.

Paige was able to begin accepting and utilizing all of the concrete supports and resources that were offered to her. Through the support of the Reach Up program she was able to secure a part-time position

at a local grocery store. Without childcare, she worked in the evenings while her mother watched her child. Paige was also connected to and completed a Good News Garage workshop and was awarded a vehicle through the program because she had secure and stable employment and had saved up enough money through her part-time job.

Paige's Early Childhood Specialist connected her with a housing case manager, and she was subsequently approved for a Vermont Rental Subsidy voucher. Soon thereafter Paige was able to secure housing for her family. She felt excited and relieved to finally have safe, stable housing. Having secured a vehicle and housing, Paige's Reach Up Case Manager was able to find childcare for her son and newborn daughter with the assistance of team members from the Early Childhood Resource team. Things were falling into place and her skills as a parent were becoming stronger thanks to her Early Childhood Specialist and the Learning Together program.

And today...

With the support of NCSS, Paige has been able to be successful in meeting her children's physical and emotional needs. Through all of her hard work she was also able to have her DCF case closed. Paige remained strong in the face of adversity and continues to enhance her family's protective factors by staying connected to and participating in supports and services of NCSS. Paige and her family continue to grow and thrive. They are thankful that NCSS was there when they needed them most. Paige attributes the hard work and support of her NCSS team to much of her success. These authentic, caring relationships and the amazing care coordination with service providers across agencies helped her family to grow and thrive and begin to feel hopeful once again.

1,734

Number Served
in FY18

168,197

Hours of care
in FY18

HOW WELL DID WE DO?

- 97% of our clients felt staff treated them with respect
- 92% of our clients said they would refer a friend of family to NCSS

IS ANYONE BETTER OFF?

- 95% of our clients felt they received the help they needed
- 91% of our clients felt the services they received made a difference
- 93% of our clients received the services that were right for them

DEVELOPMENTAL SERVICES DIVISION PROFILE

Sadie's Story



Sadie is a 43 year old woman living with a stigmatizing disability. In addition, she has battled obesity for much of her life which has resulted in medical risks including diabetes, sleep problems, and poor mobility.

Sadie has worked hard to manage her health and weight, exercising 3-4 days each week, walking, and playing basketball. Despite her many efforts she continued to struggle to maintain healthy weight which resulted in frequent visits to the Emergency Department for weight related injuries and complications.

With lots of encouragement and support from her Service Coordinator at Northwestern Counseling & Support Services over the past year, Sadie has found her voice. What she shared allowed her team to understand the impact her living situation was having on her wellbeing. She was able to advocate for herself to move from her current living situation where she felt exhausted, taken advantage of and unsupported in her goals towards health.

Within a couple of weeks she was living with a caring Shared Living Provider. Her new team worked with her to re-write her goals in order to highlight the outcomes Sadie hoped to achieve.

Now, Sadie sits across from me having lost 40 lbs. She tells me about her one cheat day a week and holds up her sparkling water bottle that has replaced her big gulp sodas. Sadie proudly talks about her new life. She has come out of her shell spending time with her peers and working at a job she enjoys. She now has a network of people that care and support her.

With a coy look Sadie tells me, "Everyone wants Sadie to come to their house for respite". I am pretty sure I understand why. With the support of caring staff she was able to accomplish her goals and now wears a smile that only comes from being in a place of true contentment.

326

Number Served
in FY18

274,350

Hours of care
in FY18

HOW WELL DID WE DO?

- 94% of our clients felt staff treated them with respect
- 86% of our clients said they would refer a friend or family to NCSS

IS ANYONE BETTER OFF?

- 87% of our clients felt they received the help they needed
- 91% of our clients felt the services they received made a difference
- 88% of our clients received the services that were right for them

SOCIAL DETERMINANTS

ADDRESSING SOCIAL DETERMINANTS OF HEALTH AT NCSS

At NCSS we are acutely aware of health disparities. We recognize that social determinants of health are essential elements we must address in the care we provide our clients to achieve our mission of ensuring that the residents of Franklin and Grand Isle counties have access to high quality services, which promote healthy living and emotional well-being

ACCESS TO HEALTH CARE SERVICES



Many of the services NCSS provides are home or community (schools, doctors' offices) based allowing for easier access to health care. Additionally, we offer care coordination increasing collaboration with providers to increase quality of care.

- The Integrated Health team provides social workers right in the primary care offices
- Mobile crisis staff are able to engage and support clients throughout the community in times of most acute need
- Children's personal care services

SOCIOECONOMIC CONDITIONS

Despite being unable to provide direct financial assistance to our clients we have been very creative in supporting our clients to access local resources to address financial needs. Through care coordination and skill building we:

- Connect individuals and families to many local and state resources i.e. 4 Squares VT, the local food shelf, section 8 etc.
- Support clients to apply for funds which can be used to purchase necessary adaptive equipment
- Support education and job training needs
- Improve financial literacy and budgeting skills

AVAILABILITY OF RESOURCES TO MEET DAILY NEEDS



We know our clients will not benefit fully from our high-quality treatment options if their basic needs are not met. Therefore, we infuse care coordination efforts to increase our client's access to the resources in our community that will meet their basic needs. For example, our parent child center has made tremendous effort to increase the volume and quality of local childcare resources so parents can work.

- Early Childhood Resource Team

ACCESS TO EDUCATION

Across the lifespan we recognize that education is an essential component of independence and life satisfaction. Many of our programs either directly support active engagement in educational opportunities/settings or supports the skills essential for successful admission to and completion of education programs.

- Academy of Learning
- Soar Learning Center
- School Based Behavior Support Teams
- Truancy Specialist
- Early Intervention

JOB TRAINING AND OPPORTUNITIES



Each service division offers job training and support programming as we recognize that not only does employment increase economic stability but that individuals who feel they can gain independence and/or contribute to their families have improved mental health.

- Jump On Board For Success (JOBS)
- CRT Supported Employment
- Employment Services Program

TRANSPORTATION

In a rural area such as ours, transportation can be a significant barrier to accessing health care. Our efforts in embed providers within many environments across our community has helped to reduce the transportation barrier. In addition, we support our client's transportation needs in the following ways:

- Support clients to access Medicaid transportation, CIDER and GMTA
- Driving clients to and from necessary appointments

PUBLIC SAFETY



As a community mental health agency we take our role in contributing to increased public safety very seriously. People cannot thrive in communities where they do not feel safe. We support public safety in the following ways:

- NCSS crisis staff embedded within the local police departments
- Connect individuals and families who are in DV situations to Voices Against Violence
- Mental Health First Aid
- Staff are mandated reporters
- Community Alternative Consultation Services

SOCIAL SUPPORT

Relationships are essential to the lives of our clients. We infuse strategies to improve the social supports of our clients throughout most of our programs.

- Therapeutic and Support Groups
- Camps
- Outpatient Therapy
- Community Support Teams
- We employ interpreter services to respect all communication needs
- Playgroups

CULTURE



We recognize our clients and staff come to NCSS with cultural diversity. We strive to ensure all clients and staffs feel recognized, supported and respected through the following cross divisional activities:

- Required cultural diversity training for new staff to increase cultural awareness and sensitivity.
- Diversity & Cultural Awareness Committee
- Cultural Competency Plan
- We employ interpreter services to respect all communication needs

MENTAL HEALTH FIRST AID

328

Number Served
in FY18

OUTCOME STATEMENT: Strengthen our community by increasing awareness and understanding of mental challenges facing youth. To increase knowledge of and access to available treatments to connect people with care. To reduce stigma within our community through education, compassion, and understanding

INDICATOR: Increase community awareness of mental health challenges facing youth in our community via YMHFA training, which increases the ability to accept, appropriately support, and refer those struggling with mental illnesses

PROPOSAL TO IMPROVE PERFORMANCE: We will focus on broadening our community partnerships, specifically the engagement of community agencies, supervisory unions, and community leaders to broaden the scope and long-term sustainability of Youth Mental Health First Aid within our community.

ACTION PLAN: In FY 18 NCSS continues to provide project coordination for the

Aware Vermont Grant giving oversight to YMHFA implementation through the statewide Designated Agency (DA) System. Through the Aware Vermont grant NCSS has had the opportunity to partner with area DAs to increase YMHFA training efforts throughout the state. NCSS' leadership in this collaborative effort has been vital to the success of Aware Vermont. NCSS has found its collaboration with designated agencies to be instrumental in strengthening partnerships within the DA system through resources sharing and aligned training efforts to implement YMHFA trainings throughout the state of Vermont. As the Aware Vermont grant ends our statewide network is on track to have trained 2,500 YMH First Aiders over the previous three years. In the upcoming year NCSS will partner with Vermont Care Network to secure additional funding that will continue Youth Mental Health First Aid efforts in FGIC and throughout the state.

STORY BEHIND THE BASELINE PERFORMANCE:

Over the last three years NCSS has led the statewide YMHFA initiative through its role in the Aware Vermont grant. NCSS has continued to provide YMHFA trainings in FGIC and has supported area DA's in YMHFA training.

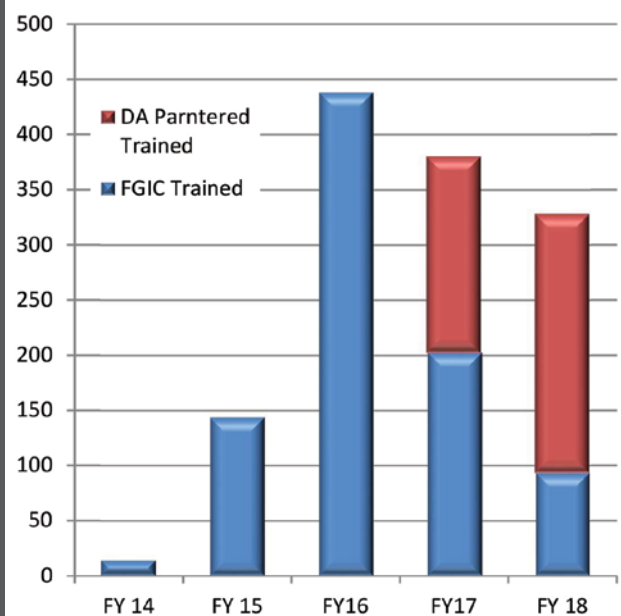
In FY18 NCSS trained 93 Community members within Franklin/Grand Isle Counties (FGIC) and partnered with VT Designated Agencies to train and additional 235 individuals throughout the state. Since FY14 NCSS has trained 890 FGIC community members as Youth Mental Health First Aiders, creating a ratio of 1 Youth Mental Health First Aider for every 5 adolescents in Franklin Grand Isle Counties.

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 collaboration with the DA system has increased statewide partnership and highlighted NCSS' role in the YMHFA initiative.

Headline Measures – How much are we doing?

of People Trained in YMHFA Since FY14



COMMUNITY PARTNERS

Franklin Northwest Supervisory Union
Camp Hochelaga/YMCA

Franklin West Supervisory Union
Vermont NEA

Franklin Northeast Supervisory Union
Cold Hollow Career Center

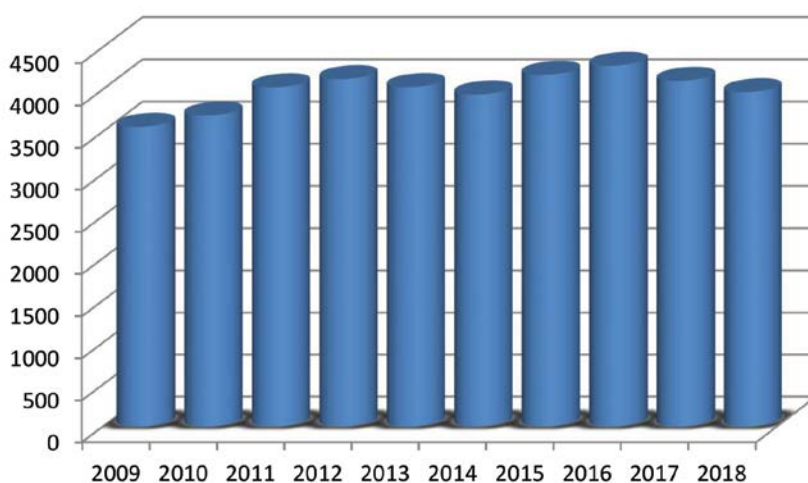
CLIENTS SERVED

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 our high quality series 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 FY18 NCSS served 3,966 people in our offices, in the local schools, in the community, in their homes and in their places of work. This is a 3.3% decrease from the previous year.

Total Clients Served



3,966

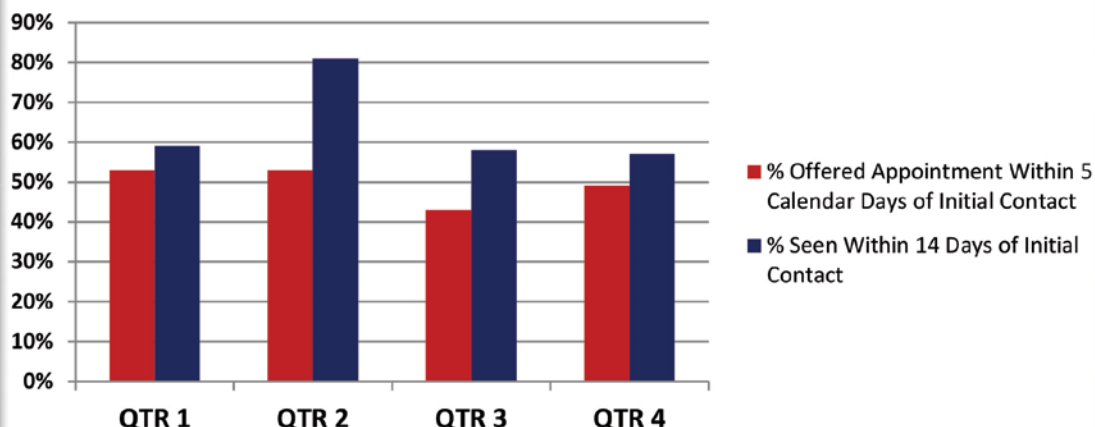
Served in Franklin
& Grand Isle
counties

AGENCY-WIDE ACCESS

Clients who are seen quickly and in person are more likely to engage and remain in services. As a DA system we have just begun to look at access rates across the state and there are currently no benchmarks available for comparison. As part of the Centers of Excellence (COE) process, we adopted two separate performance measures that we intend to trend quarterly and as an agency we are committed to improving our performance in this area.

Our goal is to not only be responsive, but to be providing clients opportunities for face-to-face contact with as little wait time as possible. On average, 50% of clients are offered an appointment within 5 calendar days of initial contact and 64% are seen within 14 days of the initial assessment in FY18.

FY18 Agency Wide Client Access Rates



CULTURAL COMPETENCY

"Thank you for all you do. It is deeply appreciated. I have had a mixture of services from NCSS and the current ones are wonderful. thank you."



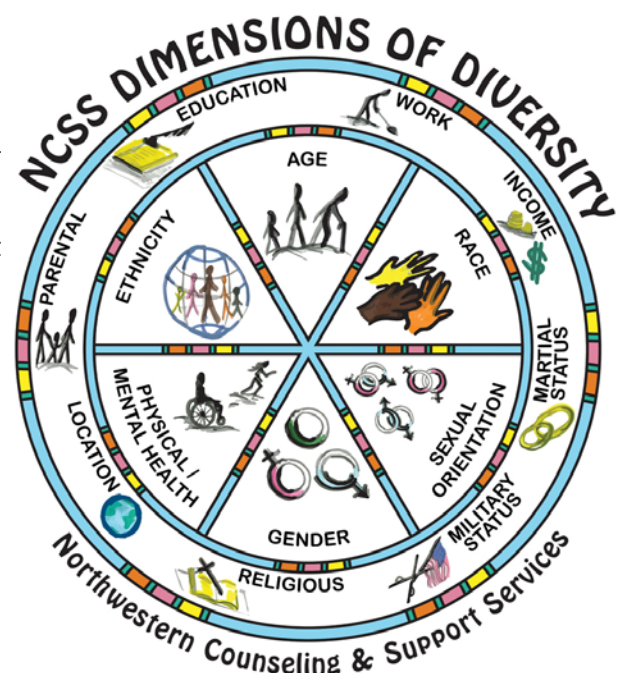
Our Diversity Plan focuses on four key areas – service delivery, organizational environment, staff and human resources, and public relations. To this effort, the cross-divisional committee works to provide a welcoming workplace that is trauma-informed and inclusive for all. In 2018, we displayed the diversity program's logo in all our facilities to highlight some key dimensions of diversity, and NCSS was awarded the Breastfeeding-Friendly Award from the Department of Health!

WHAT WORKS

- Surveying staff and Board of Directors for feedback
- Providing a variety of trainings opportunities, starting with all new employees during orientation; annual all-staff competency trainings through our web-based platform, allows us to review compliance reports in order to keep a finger on the pulse of our environment

ACTION PLAN

- Perform annual survey to identify areas of opportunity
- Develop a diversity calendar in an effort to raise awareness and celebrate

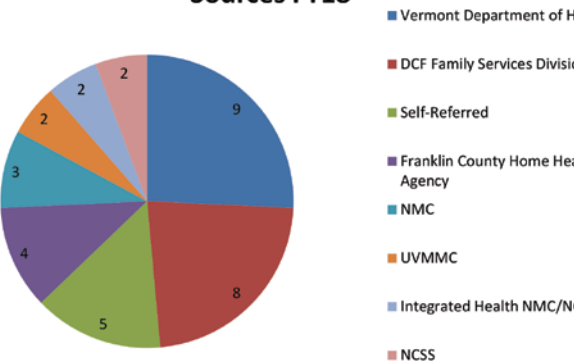


PREGNANT & POST-PARTUM MOTHER AND SOCIAL CONNECTIONS

STORY BEHIND THE CURVE

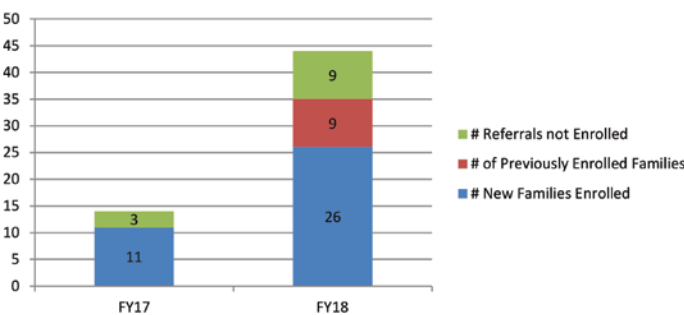
The NCSS Parent Child Center has continued its efforts to address perinatal (pregnancy through postpartum) mental health with a licensed therapist who provides psychotherapy in the home.

Perinatal Mental Health Counseling Referral Sources FY18

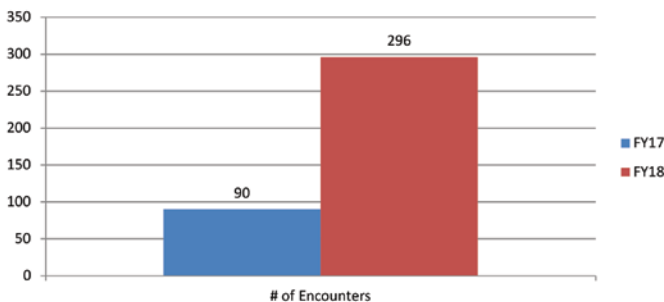


Perinatal Mental Health Counseling (PMHC) has seen an increase in referrals, supported by partnerships with outside agencies such as the Vermont Department of Health and the Department for Children and Families: Family Services Division. We received 35 referrals in FY18, a sharp increase from 11 referrals in the previous year. For a period of time we instituted a waiting list for referrals; however, we were often impacted by frequent cancellations and rescheduled appointments, so capacity was not reached. Our region continues to work as a whole system to provide a full range of services, including a perinatal support group, Baby Bumps, and the development of a perinatal loss workgroup.

Perinatal Mental Health Counseling: # of Families Served



Perinatal Mental Health Counseling: # of Encounters



WHAT WORKS

- Therapy is provided by a Licensed Clinical Mental Health Counselor with certification from Postpartum Support International (PSI) in Maternal Mental Health
- In FY18, our therapist was trained in the Newborn Behavioral Observations tool, and is now a Dialectic-Behavioral Therapy (DBT) trainee therapist Screening mothers at intake using the Edinburgh Postnatal Depression Screening to guide treatment; 10 mothers were screened in FY18 Screening all mothers with the UNCOPE for substance use Treatment plans that address increased attachment between mothers and infants, overall wellness, social support, and reduction in symptoms such as anxiety, depression, and suicidal ideation
- Creation of a safe, therapeutic space for each mother that involves significant others and creates a support network to help in her journey toward wellness and recovery
- Co-facilitation of a perinatal support group, Baby Bumps, with home health Collaboration across early childhood providers and agencies to address

the system of care for lowering rates of perinatal mental health issues

ACTION PLAN

- Consistent use of the Edinburgh Postnatal Depression Screening tool at intake to guide treatment Obtain certification in the Adult Needs and Strengths Assessment (ANSA) for progress monitoring and program outcomes
- Implement a cancellation/no-show policy to encourage consistent engagement in services and increase number of mothers and babies served Explore methods for increasing attendance at Baby Bumps support group
- Start a perinatal loss support group

HOW WE IMPACT

Social Determinants of Health impacted by Perinatal Mental Health Counseling: Access to health care services, resources to meet daily needs, support for chronic health conditions, smoking prevention, substance use prevention, mental health, social support, and suicide prevention.

EARLY CHILDHOOD - PRE-SCHOOL READINESS

STORY BEHIND THE CURVE

Early Intervention (EI) provides a special education service for infants and toddlers, and Early Childhood Support (ECS) provides mental health treatment, social work services, and development-centered parenting support. Both programs aim to ensure that young children thrive and increase school readiness.

EI clients are supported to meet age appropriate developmental expectations, or transition to school services with an IEP at age 3. These rates are expected to vary, and children not eligible for an IEP are introduced to the school system for future preparation. Act 166 in 2015 mandated universal preschool for all 3 and 4 year olds, with a state enrollment target of 60%. ECS continues to surpass this goal, helping families to remove barriers and enroll in preschool.

Universal developmental screenings support the early identification of children who would benefit from further assessment through EI or the school system. NCSS utilizes existing relationships with community partners to ensure the best care and outcomes for families, providing support in the home, child care, school, and community settings. Evidence-based curriculum such as Parents as Teachers and research

informed frameworks such as Strengthening Families: A Protective Factors Framework are utilized by NCSS.

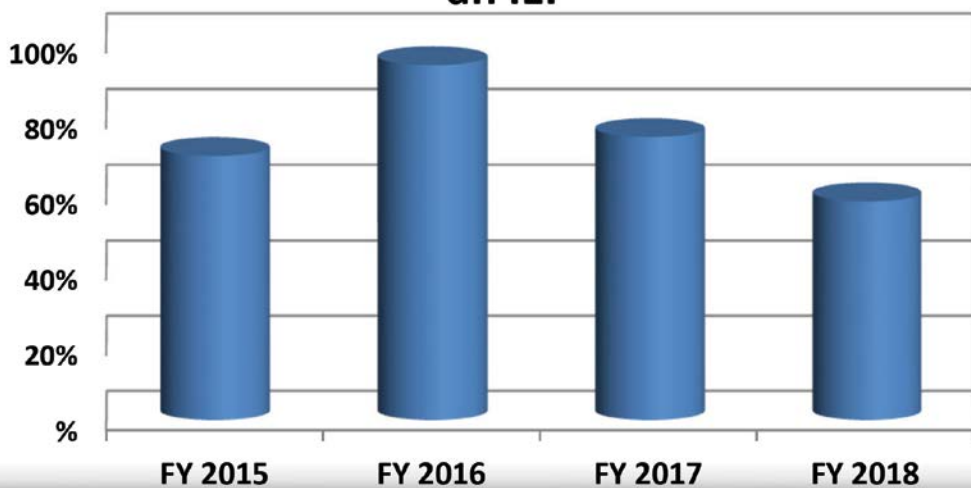
ACTION PLAN

- Continue current partnerships with medical providers and supervisory unions to identify and support the needs of all young children in our counties
- Continue to promote preschool enrollment for all preschool-aged children
- Work on outreach to targeted communities such as Grand Isle county to ensure that we are serving all potentially eligible children in
- Explore opportunities for professional development to expand consultation to child care programs

HOW WE IMPACT

Social Determinants of Health impacted by EI and ECS: access to education, access to health care services, resources to meet daily needs, support for chronic health conditions, transportation, mental health, economic support, housing, substance use prevention, and social support.

% of Children Exiting EI Services at Age 3 to an IEP

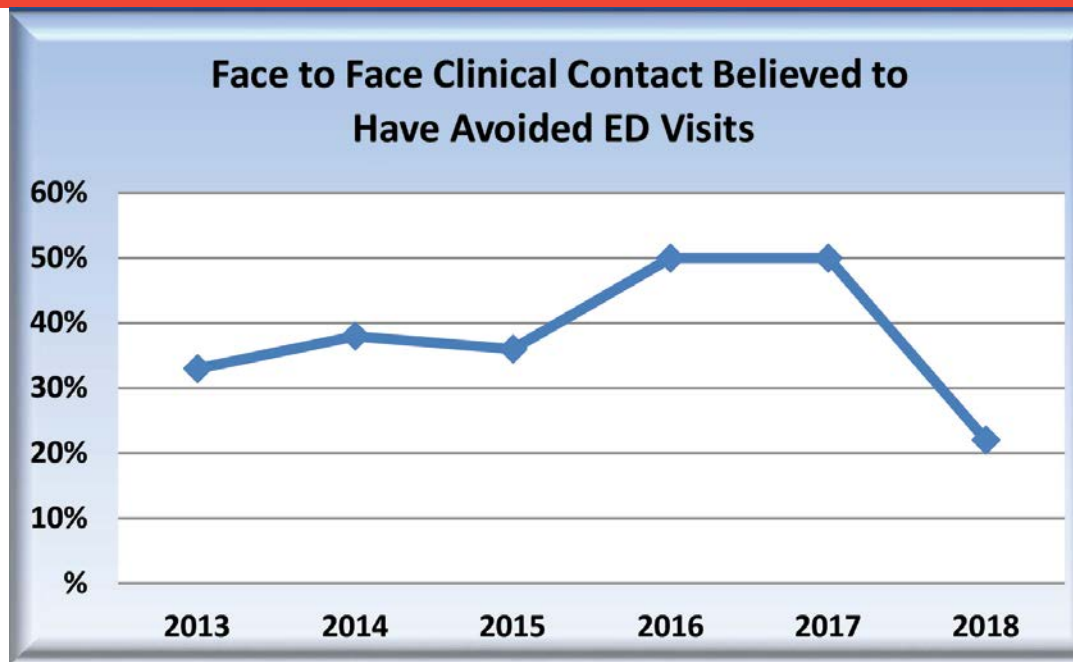


COMMUNITY PARTNERS

Medical: Hospitals, Pediatricians, Franklin County Home Health, Visiting Nurse Association
Education: Local Supervisory Unions, Champlain Valley Head Start
Child Care Centers and Registered Providers
Department for Children and Families, Department of Health
Financial: Community Action, Tim's house



EMERGENCY DEPARTMENT DIVERSION



STORY BEHIND THE CURVE RELATED TO USE OF AN ASSESSMENT MEASURE IN BAY VIEW CRISIS CARE CENTER

We would like to see this number continue to increase, however, with the severity of presentation by some of those we serve (for instance, dangerousness to self or others or unable to stay in community to be assessed, medical complications) there are times when there is no other option for these individuals but to be seen at the Emergency Department (ED). We continue to see individuals with more severe symptom presentations who also experience poorly managed chronic health conditions. These types of complicated presentations require medical intervention and support as well as a mental health screening. We continuing to build positive relationships with regional law enforcement to increase their understanding of the people we can see in the community settings rather than bring to the ED. We are the first agency in the state to have a Memorandum of Understanding with the Vermont State Police to embed NCSS staff in their site with the type of activities and responsibilities being delivered.

WHAT WORKS

- Meeting clients where they are at, such as their homes, primary care and other community settings
- Working closely with law enforcement and community partners to bring clients to alternate locations instead of the ED if it can be avoided
- Meeting with law enforcement monthly
- Support law enforcements understanding of assisting persons with mental illness
- Debriefing situations which did not go as planned

to learn how to modify practices

- Working closely with community partners to continue to build on positive relationships and education

ACTION PLAN

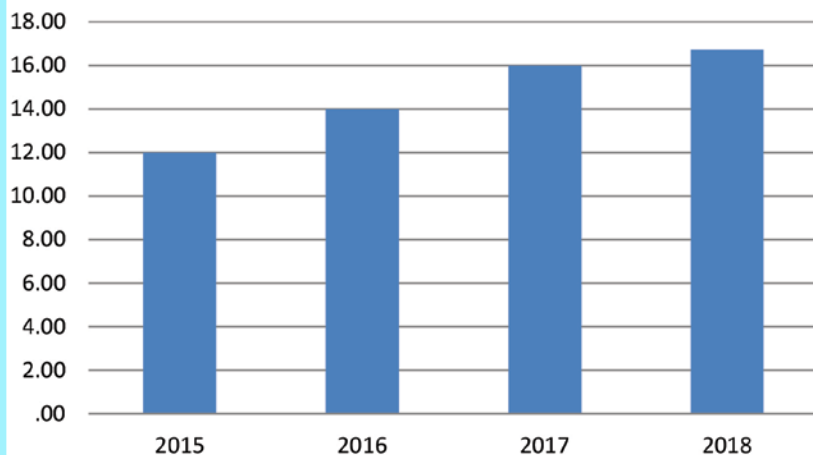
- Hired two specific staff to enhance law enforcements efforts to support the community who are embedded in law enforcement agencies to improve relationships and continue to provide education around mental illness.
- Increased NCSS social workers integration in all patient centered medical homes
- Involved in local community groups to discuss challenging community situations and how we can best support and avoid unnecessary use of the Emergency Department usage
- Rapid Access in our Outpatient program has helped clients access services more quickly. Knowing they have that option at times prevents client from going to the Emergency Department

HOW WE IMPACT

When we see individuals who identify as being in crisis we assess their needs and support plans which typically involve increasing safety and resources that may include access to healthcare services, resources to meet daily needs, support with chronic health conditions, public safety, economic support, access to education, transportation, housing, substance use prevention, mental health, social support and suicide prevention.

BAYVIEW CRISIS BED

**Average Improvement in BSI Score
from Admission to Discharge**



**"Bayview place was helpful
in time of crisis"**

**"The crisis team was very
helpful to me and played a
pivotal role in helping get
better. Their
continued support is very
much appreciated."**

STORY BEHIND THE CURVE

The Bay View Crisis Care Center, which is a two bed crisis program, continues to collect the Brief Symptom Inventory (BSI) data from persons served at admission and discharge. This measure has also been used as a reliable measure of clinical improvement in short term psychiatric hospitalization programs and serves as a good comparison. Though not required by contract, this data has been analyzed in previous years and has demonstrated change at a clinically significant level. The data shows the average improvement of clients at the time of discharge from 2015 (13.89) through 2018 (16.72) which indicates a slight improvement from 2017 (16.04). On average, individuals scored a 31.29 on the BSI upon admission and a 14.57 upon discharge, indicating improvement in symptoms targeted during Bay View stays.

On average, clients entering Bayview were above the 50th percentile in Somatic, Depression and Anxiety Symptoms.

On average, at discharge clients were at or below the 50th percentile in Somatic, Depression and Anxiety Symptoms.

The reduction in symptoms has gradually improved over time. It is hypothesized the primary contributing factor for this trend is the commitment to increasing our clinical capacity by training staff in the use of multiple evidenced-based practices, including Collaboration Assessment and Management of

Suicidality (CAMS), Wellness Self-Management (WSM), and Wellness Recovery Action Plan (WRAP).

WHAT WORKS

We hypothesize that the following factors contribute to the improved BSI scores:

1. Commitment to training all fulltime Bay View staff on the use of the following evidenced-based practices
 - Collaborative Assessment and Management of Suicidality (CAMS)
 - Wellness-Self Management (WSM)
 - Wellness Recovery Action Plan (WRAP)
2. Emphasizing the importance of person-centered care and a non-judgmental approach to providing support while prioritizing building relationships with the individuals who we support.

ACTION PLAN

1. Continue to develop our clinical capacity and use of evidenced-based practices within the Bay View program.
2. Review our current staffing patterns and structure to identify ways of retaining staff to maintain consistency across the program while providing a high level of clinical care.
3. Continue to seek feedback from individuals who stay at the Bay View program and learn from their experiences.

STORY BEHIND THE CURVE RELATED TO USE OF AN ASSESSMENT MEASURE IN BAY VIEW CRISIS CARE CENTER

The LOCUS (Level of Care Utilization System) was designed to determine the level of care an individual should receive needs. The LOCUS scores on six levels, ranging from the least intense to the most intense. The LOCUS scores on 6 different areas: 1. Risk of Harm 2. Functional Status 3. Medical, Addictive and Psychiatric Co-Morbidity 4. Recovery Environment 5. Treatment and Recovery History 6. Engagement and Recovery Status.

Generally, clients who have more severe symptoms when they enter care have a higher LOCUS score and their length of stay can potentially be longer. The LOCUS score helps to guide the treatment and length of stay. The score also helps to highlight their goals for the clients' stay and what discharge should look like. Based on the results of the LOCUS, staff will utilize Evidenced Based Practices, such as CAMS (Collaborative Assessment and Management of Suicidality) or WRAP (Wellness Recovery Action Planning). Wellness Self-Management (WSM) is also used when indicated.

Each person served through the Bay View program is assessed at intake and at discharge using the Level of Care Utilization System (LOCUS) assessment measure. The LOCUS is designed to determine the appropriate level of care for each person served within the larger system of care, with higher values indicating higher acuity. In addition, the LOCUS is used to assess the impact of treatment. In this reporting period the average LOCUS score at intake was 20.43 and 17.62 at discharge (illustrated in Figure 3), which indicates an average improvement of 2.81. Last year the average intake score was 22.96 and the average score at discharge was 19.44 showing an improvement of 3.52 points. At face value it appears that the lower scores would indicate a decrease in acuity and a decrease in improvement. However, this is misleading given the efforts put forth by DMH to provide fidelity training

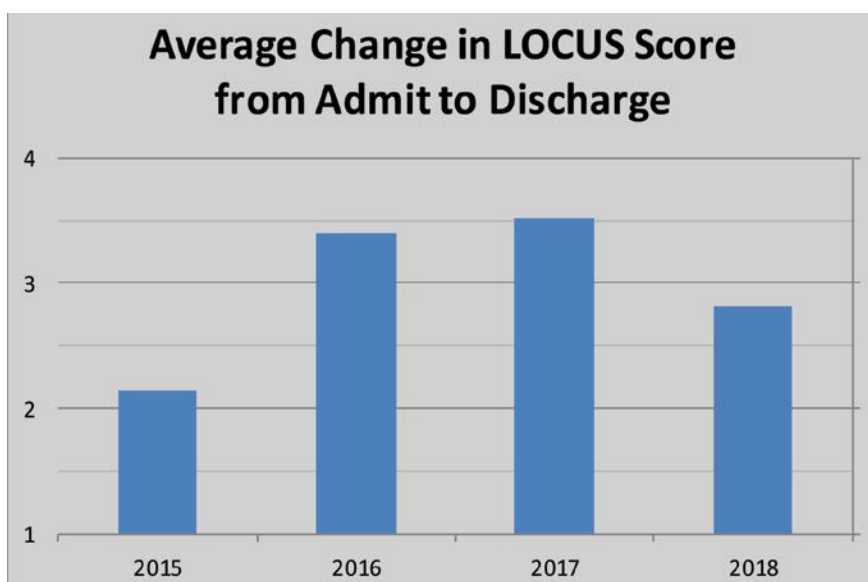
to all staff. This has significantly influenced how we score the results of the LOCUS and therefore it would be misleading to utilize previous year's scores as any sort of baseline. Now that staff is maintaining fidelity, this will provide more accurate data to compare with future reports

WHAT WORKS

- The LOCUS works best when all staff are trained to meet reliable scoring
- At discharge, we should see the LOCUS score reduce to show the Bay View stay was productive
- Department of Mental Health retrained staff in FY17 for better quality assurance
- Moved the LOCUS into the Electronic Medical Record for ease of use

ACTION PLAN

- Consider other ways the LOCUS data can be useful in making individual or program decisions around level of care
- Train new staff and substitutes who cover shifts so the reliability remains strong
- Review scores on a regular basis to ensure clinical effectiveness

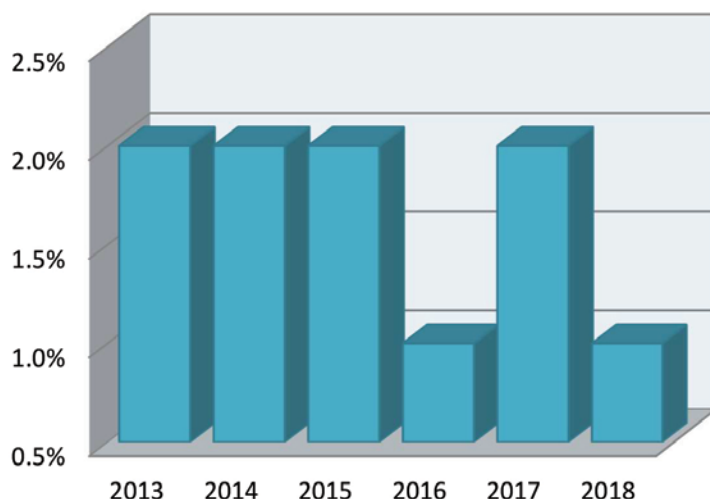


COMMUNITY PARTNERS

Primary Care Physician, Local Emergency Department, Other Designated Agencies, Psychiatric Hospitals, Local Homeless Shelter

BEHAVIORAL HEALTH CRISIS TEAM

% of Involuntary Inpatient Psychiatric Admissions



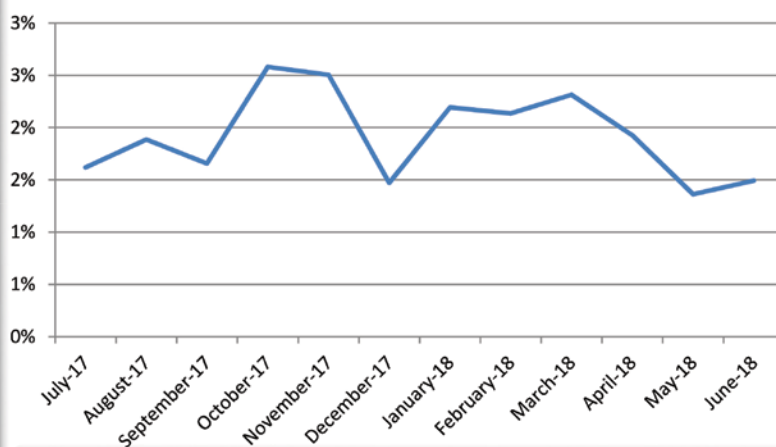
STORY BEHIND THE CURVE

Our team works to support clients in their recovery in the communities in which they live. We have been very successful in being able to avoid involuntary hospitalizations. This graph illustrates that in 2017 inpatient hospitalizations have increased slightly. It is also noteworthy, that in comparison to other state designated mental health agencies, we remain extremely low.

HOW WE IMPACT

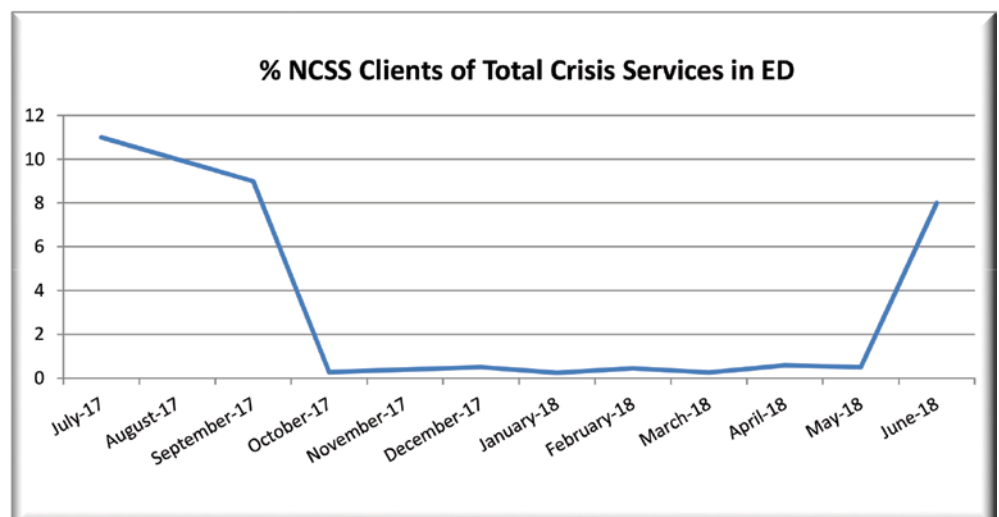
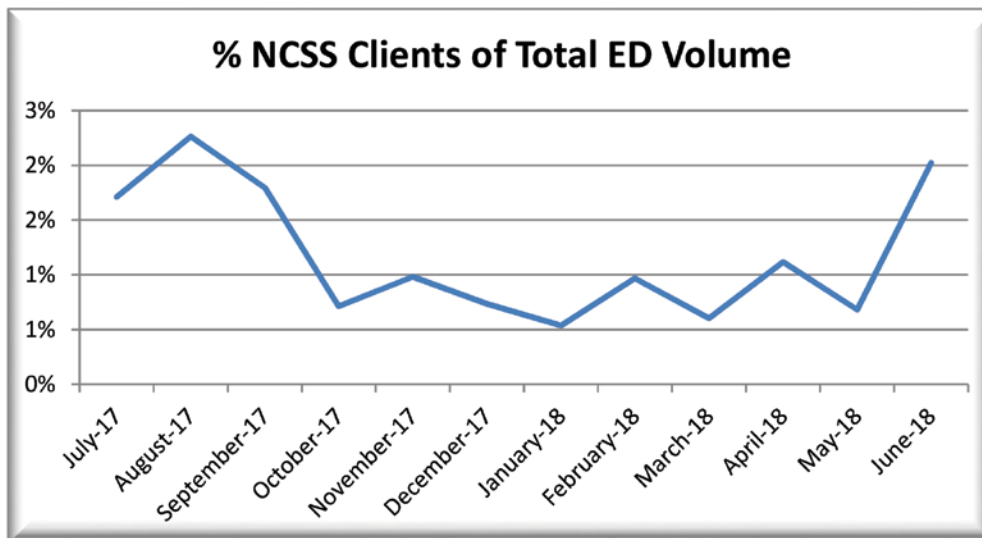
Access to healthcare services; resources to meet daily needs; support for chronic health conditions; public safety; economic support; access to education; transportation; housing; substance use prevention; mental health; social support; suicide prevention.

% Crisis Services in ED of total ED Volume



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, Designated Agency's Crisis Beds



ACTION PLAN

- Decrease inpatient hospitalization through more responsive case management services
- Decrease inpatient hospitalization through proactive outreach to individuals upon discharge from a hospital to prevent re-hospitalization
- Increase access through centralized screening and referral process
- Increase access through Rapid Access for non-emergency situations
- Client Centered Treatment Plans/Crisis Plans to support client with individual needs
- Utilizing Bay View Crisis Care Center and other Crisis Bed programs across the state
- Leverage division resources through clinical leadership to support unique client needs for stability and creative and supportive recovery solutions

COMMUNITY REHABILITATION & TREATMENT HOSPITAL FOLLOW UP

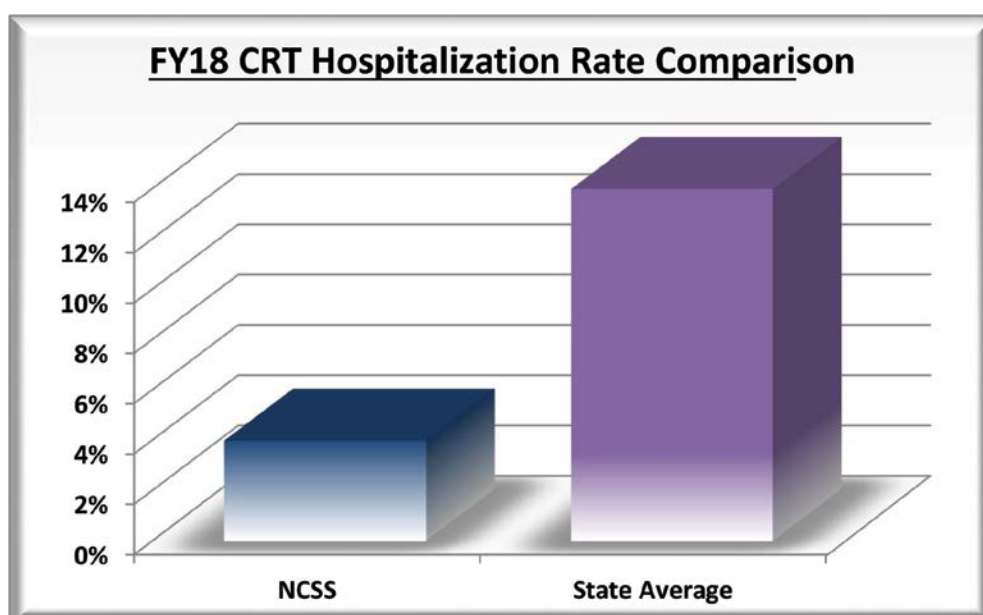
"To receive help from NCSS, was the best choice I have ever made."



The Community Rehabilitation and Treatment (CRT) Program supports individuals experiencing severe mental illness. At times inpatient psychiatric hospitalization is necessary to establish stabilization and safety. One goal of the CRT program is to minimize the need for psychiatric hospitalization and allow individuals the opportunity to stay within their communities. FY18 data report the statewide average rate of inpatient hospitalizations for individuals receiving supports through CRT programs was 14%. The rate of hospitalization for individuals receiving CRT services at NCSS was 4%.

We believe that the CRT hospitalization rate is substantially lower than the state average due to the System of Care and the array of services individuals are offered at NCSS. These services include community supports/ case management, assistance with medication deliveries, employment supports, housing supports, outpatient therapy, and psychiatry. The CRT Program works closely and collaboratively with our Bay View Crisis Care Center. Bay View experienced a 90% utilization rate during this time period, suggesting effective hospital diversions and contributing to the overall lower CRT Hospitalization rate.

The Integrated Health Team has social workers in primary care and specialty care medical and substance use settings. Our Crisis Services and their Mobile Outreach team work to provide the additional supports necessary to minimize the need for inpatient psychiatric hospitalization and allow persons served to stay in their community and closer to their treatment teams and natural supports.



INTEGRATED HEALTH TEAM

The Integrated Health Team at Northwestern Counseling & Support Services (NCSS) has been implementing and expanding services in medical and specialty settings since 2012. The Integrated Health team consists of social work care coordinators/Wellness counselors employed by (NCSS) through multiple collaborations with Northwestern Medical Center (NMC), the Blueprint for Health and our regions Federally Qualified Health Center (NOTCH). Social Workers/Wellness Counselors are embedded in both Primary Care and Specialty medical settings.



NOTCH Contracted Services Scope of practice

Screening: <ul style="list-style-type: none"> GAD 7, PHQ9 & PHQ9 Teen Modified, Mood Disorder Screening, CAMS screener, PTSD Civilian Checklist, Dissociative Experiences Screener, etc 	Groups: <ul style="list-style-type: none"> CBT I, WRAP, Stanford University Self-Management Workshops (HLWD, HLCP, HLCD)
Wellness Coaching: <ul style="list-style-type: none"> Nutritional/dietary counseling, fitness/weight loss goals, SMART goals, behavioral aspects of medication Management, MI, Tobacco cessation, etc 	Consultation: <ul style="list-style-type: none"> Immediate consultation with staff and providers, Provider support with patient needs, etc
Care Coordination/Navigation of services: <ul style="list-style-type: none"> Assistance with applying for financial assistance, food Insecurity, insurance, housing, SSI or SSDI; coordination of services with multiple community partners; etc 	Psychotherapy: <ul style="list-style-type: none"> Gestalt, DBT, Mindfulness Based, Relational, Narrative Therapy, EMDR, Couples, Exposure Response prevention, CAMS, CBT, Solution Focused, Emotion-focused, MI, treatment of co-occurring disorders etc

Patient Data

	#	%
Total # of Patients Scheduled	427	100%
Of Those Scheduled, Seen	320	75%
Of Those Scheduled, No Show	114	27%
Total Patients Seen	331	100%
Warm Handoffs	3	1%
Same Day Additions	11	3%
CAMS Sessions	4	1%
Health Coaching	79	24%
Tobacco Cessation	11	3%
# Accessing MH for the 1st Time	12	4%

Outcomes Data: Provider

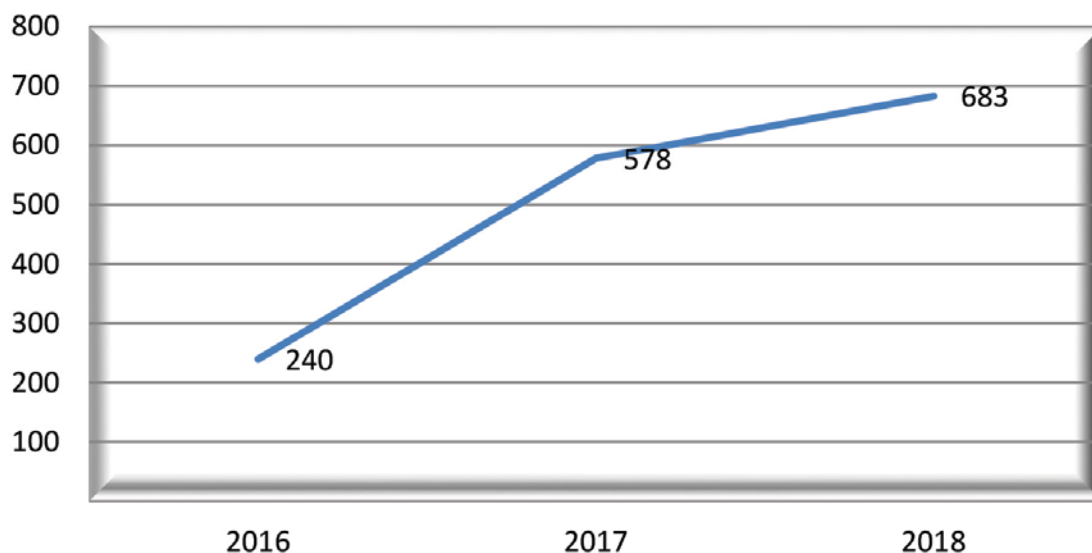
	%
NCSS consults have helped my patients.	100%
NCSS consults have helped my staff.	100%

Outcomes Data: Patient

	#	%
Patients Reporting Improvement	123	37%
I am better off as a result of the help I received		98%

DEVELOPMENTAL CRISIS TEAM

DS Crisis: # of Crisis Hours Provided



STORY BEHIND THE CURVE

The DS Crisis team has more than doubled their contacts with the served population over the last year. This indicates a shift in the culture regarding willingness to access Crisis.

The served DS population and their support teams continually utilize the DS Crisis team to avoid Emergency Department visits, police intervention, etc.

The team has increased mobile responses and face-to-face services. Each team member is empowered to be fully attentive to the request for supports, which has increased hours spent in service.

The team has increased cross-divisional supports, providing for comprehensive responses when needed.

WHAT WORKS

- Increased face to face supports
- Increased collaboration with community partners

ACTION PLAN

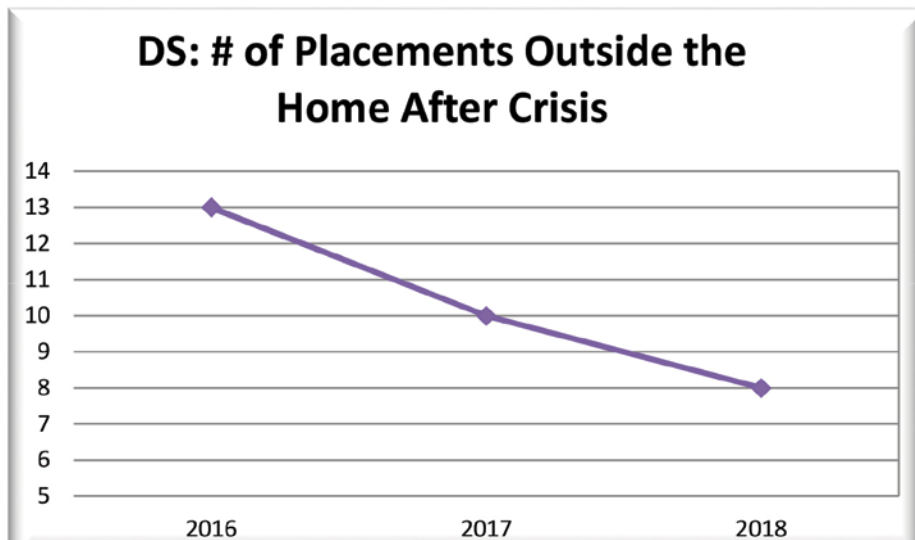
- Continuing to educate and train for Crisis
- Create individual crisis plans
- Decrease emergency department utilization

HOW WE IMPACT

- Access to healthcare services
- Resources to meet daily needs
- Public safety
- Economic support
- Housing
- Substance use prevention
- Mental health
- Social support
- Suicide prevention

Community Partners

Saint Albans City Police
Vermont State Police
Behavioral Health Crisis Team
Northwestern Medical Center



"To receive help from NCSS, was the best choice I have ever made."

STORY BEHIND THE CURVE

Over the last year, the DS Crisis team has strived to support collaborative practices, utilize conflict resolution models, and wrap-around support systems, with the intent to support the longevity of the relationships that our consumers have with their home providers.

The team has worked to proactively support tenuous situations before they turn into a "crisis", in order to avoid unresolvable conflict.

This graph indicates the success of the teams efforts, as the majority of situations do not require a consumer to be separated from their typical residential support systems.

The team provides face-to-face support of both the consumer and the home provider in order to promote satisfactory resolution for everyone.

WHAT WORKS

- Increased trainings for the team in conflict resolution
- Proactive supports
- Wrap around, flexible supports

ACTION PLAN

- The team is continuing to build additional supports to ensure optimal resolution to situations that jeopardize home placement
- Training opportunities are increasing for home providers, to help promote educated, supportive environments

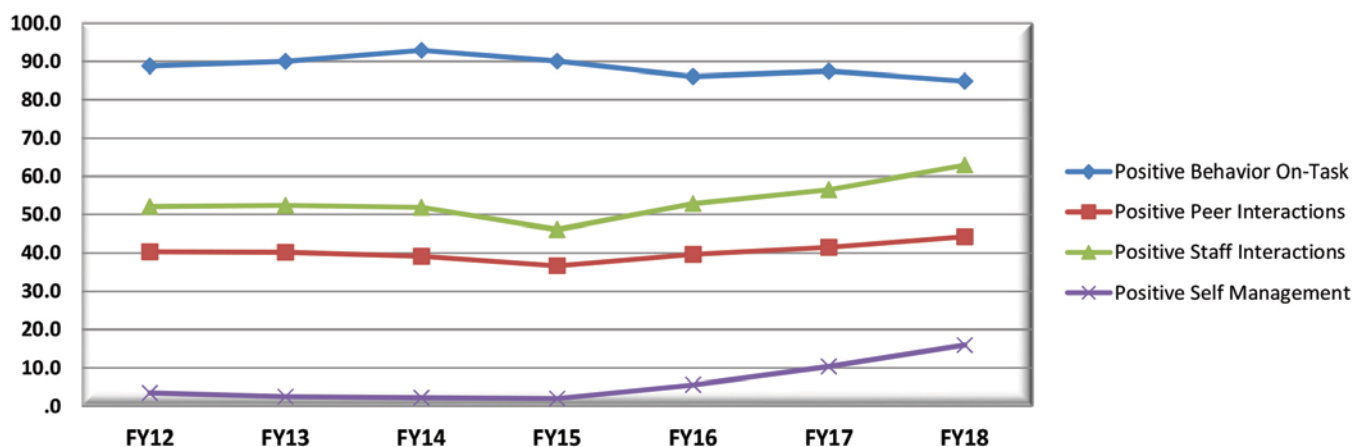
HOW WE IMPACT

- Support for chronic health conditions
- Public safety Economic support Transportation
- Housing
- Mental health Social support
- Social support
- Suicide prevention



SOAR LEARNING CENTER

Positive Behaviors Comparison



STORY BEHIND THE CURVE

Soar Learning Center (SLC) supports students and families with a positive classroom and school wide culture, as well as individualized classroom accommodations. Students and staff engage in collaborative problem-solving to teach and support students' self-awareness and competency. SLC builds community connections, and supports families by proactively meeting basic needs without the experience of stigma.

Students who learn to identify and cope with their emotions are more effectively able to develop higher level competencies in areas such as: effective verbal communication of both positive and negative feelings, building and identifying nonverbal communication skills, and seeking help from an adult or a peer. Staying on-task may be more indicative of executive functioning skills, such as planning, organizing, remembering and using information, problem-solving, and ignoring distractions. Strengthening executive functioning is done on the foundation of identifying and managing emotions and as Soar Learning Center

continues to learn and develop resiliency in students, it is hoped that a greater increase in on-task behavior will be observed.

ACTION PLAN

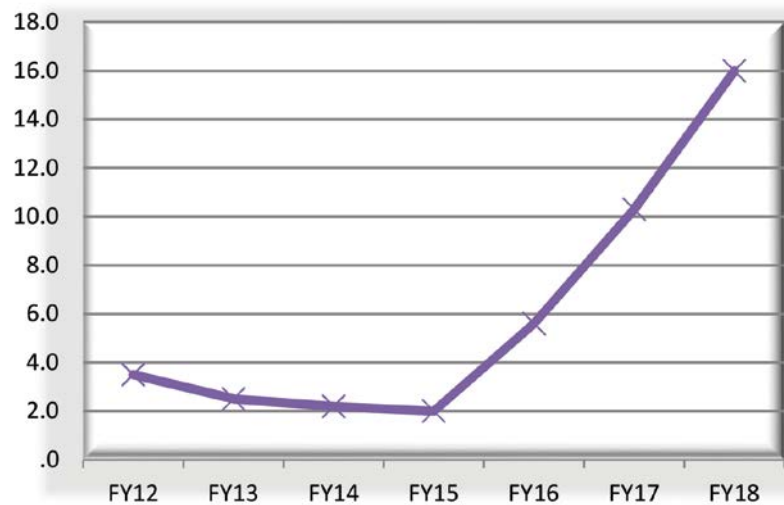
- Add executive functioning skills assessments to programming
- Implement executive functioning skills development interventions & supports across all grade levels
- Implement additional brain-based teaching strategies that address executive functioning deficits

HOW WE IMPACT

Social Determinants of Health impacted by Soar Learning Center: access to education, access to healthcare, resources to meet daily needs, vocational assessment & training, transportation, mental health, substance use prevention, social support, and public safety



Positive Self Management



STORY BEHIND THE CURVE

Soar Learning Center's recent initiative to create and foster a school environment that cultivates resiliency amongst our students has demonstrated significant initial success. This initiative included the implementation of mindfulness strategies within the classroom, including the use of the Mind Up curriculum for our K-8 students, Brain Breaks, and student access to the Calm App. More specifically, Soar Learning Center's introduction of sensory spaces within the classroom during the 2017-2018 school year has allowed improved outcomes in the areas of self-management and emotional regulation. These spaces have been designed to reduce stress and allow access to sensory items or manipulatives that appeal to the five senses. Classroom teachers and behavioral interventionists receive ongoing professional development to engage students in not only educational activities, but also social-emotional learning that assists in identifying and self-managing their emotions. Staff create and maintain routines, traditions, and celebrations to build predictability and connection among students, family, and the school community.

ACTION PLAN

- Continue to develop a trauma sensitive school community through professional development, leadership support, and implementation of program practices that promote resiliency in students
- Implement ongoing training for staff that increases awareness and knowledge of increasing resiliency in vulnerable learners
- Develop classroom, school-wide, and community-based support that promote positive connections between staff and students, among students, and between the school and home

Community Partners

Franklin and Grand Isle Counties' supervisory unions and school districts
 Chittenden County schools (Winooski Elementary School, Milton Elementary School, Milton High School, Colchester Elementary)
 Department for Children and Families
 Vocational Rehabilitation
 St. Albans Town
 St. Albans City Police Department
 Local pediatricians

COLLABORATIVE ACHIEVEMENT TEAM

STORY BEHIND THE CURVE

During the 2017-2018 school year CAT provided services to 32 students within four school districts including: Franklin West Supervisory Union, Franklin Northwest Supervisory Union, Franklin Northeast Supervisory Union, and Maple Run Supervisory Union – supporting nine local school communities in Franklin/Grand Isle Counties. This program has a 100% client satisfaction rate when surveyed in FY18.

CAT transitioned eight students (25%) to a less restrictive model of programming or independence - of those eight, five students (63%) transitioned to the support of the School-Based Behavior Consultation Team (SBBC) and three students transitioned to the universal level of support within their school community.

Due to the implementation of the SBBC program – CAT is able to transition students to a less restrictive model of support in six local schools.

The average months in programming (MIP) prior to transition to a lesser restrictive level of support in the 2017-2018 school year ranged from 9-93 months in programming.

WHAT WORKS

- Providing 1:1 social, emotional and behavioral support for students who struggle with self-regulation, student who have difficulty engaging in the safety expectations, and are in need of a more intensive level of support.
- Working in close collaboration with families, school staff and other outside providers to develop a comprehensive and individualized behavior

plan that employs specified interventions that are rooted in the theories of Applied Behavior Analysis (ABA) to aligned with the student's needs and provide strengths based approaches.

- CAT staff are highly trained in the areas of Life Space Crisis Intervention (LSCI) and the Attachment, Regulation, and Competency (ARC), and Youth Mental Health First Aid framework to enhance our ability to provide trauma informed care to the students and families we support.
- Currently there are 16 CAT staff that are taking classes or are enrolled in graduate level ABA coursework.

ACTION PLAN

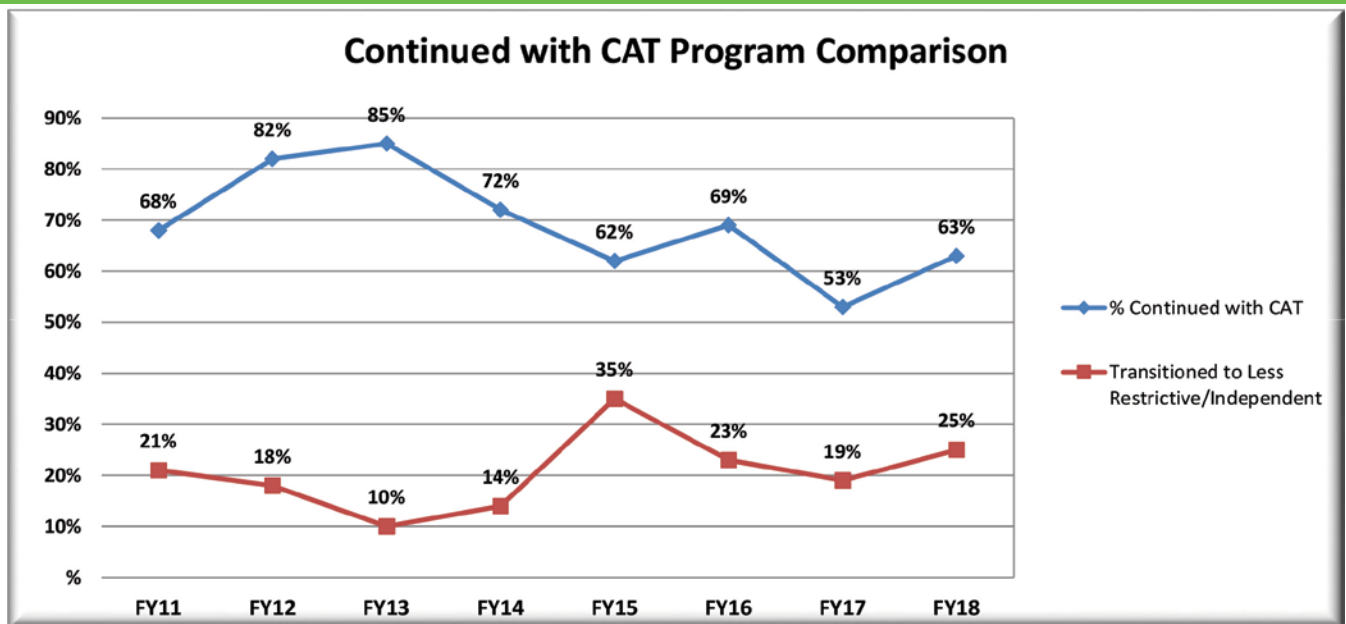
- Continuing to provide high quality supports in the local school communities.
- Continue to boost overall knowledge and expertise in the area of ABA.
- Continue to provide schools with education in ABA to help support and improve their support of students using data driven programming and evidence based practices.

HOW WE IMPACT

- **Social Determinants of Health –**
- Access to Education
- Social Support
- Transportation
- Mental Health
- Connecting with Resources to Meet Daily Needs

Community Partners

Franklin West Supervisory Union (Bellows Free Academy Fairfax – Elementary and Middle Schools)
Franklin Northwest Supervisory Union (Sheldon Elementary School, Highgate Elementary School, Swanton Elementary School)
Franklin Northeast Supervisory Union (Berkshire Elementary School, Enosburg Elementary School)
Maple Run Supervisory Union (St. Albans Town Educational Center, Fairfield Center School)
Department of Children and Families (DCF)
Northeastern Family Institute (NFI)



STORY BEHIND THE CURVE

The Collaborative Achievement Team (CAT) provides 1:1 social, emotional and behavioral support for students who struggle with self-regulation, have difficulty engaging in safely expectations, or are in need of a more intensive level of support. CAT works in close collaboration with families, schools, and other providers to develop a comprehensive and individualized behavior plan rooted in Applied Behavior Analysis (ABA). Staff are trained in Attachment, Regulation and Competency (ARC), Life Space Crisis Intervention (LSCI), and Youth Mental Health First Aid. Currently 16 CAT staff are taking classes or are enrolled in graduate level ABA coursework.

During the 2017-2018 school year, CAT provided services to 32 students within 4 school districts. CAT transitioned 8 students to a less restrictive model of programming or independence. Of those 8, 5 students transitioned to the support of the School-Based Behavior Consultant (SBBC) Team and 3 students transitioned to the universal level of support within their school community.

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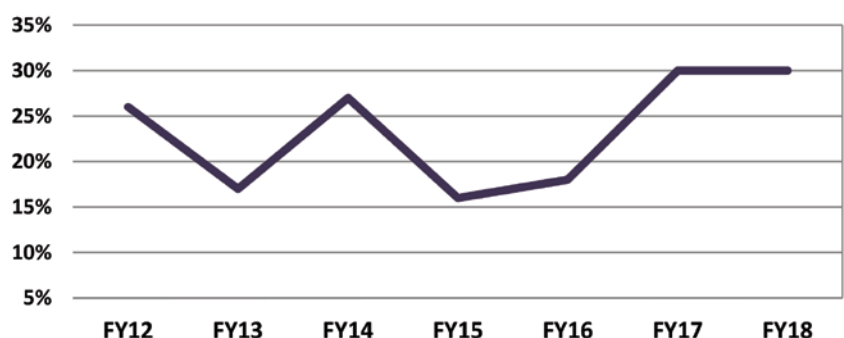
ACTION PLAN

- Continuing to provide high quality supports in the local school communities
- Continue to boost overall knowledge and expertise in the area of ABA
- Continue to provide schools with education in ABA to help support and improve their support of students using data driven programming and evidence based practices

HOW WE IMPACT

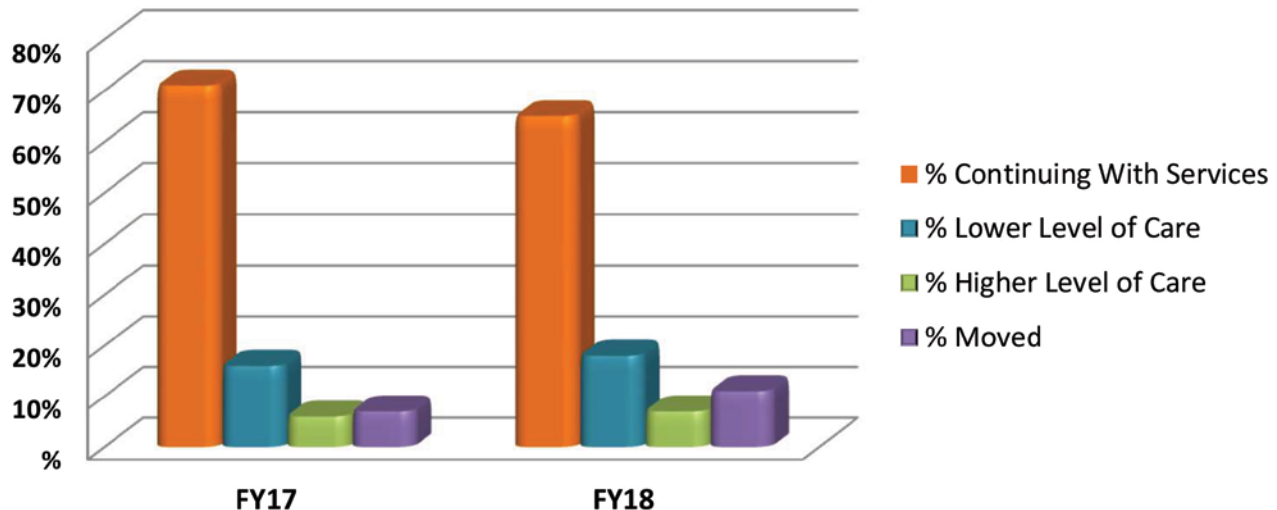
Social Determinants of Health that are impacted by CAT: access to education, social support, transportation, mental health, and connecting with resources to meet daily needs.

Average MIP Transition to Less Restrictive



SCHOOL BASED BEHAVIOR CONSULTATION

Status of Students Comparison



STORY BEHIND THE CURVE

The School-Based Behavior Consultant (SBBC) Team implements comprehensive universal Positive Behavior Support Systems throughout the school and community with fidelity. Regular support and supervision of school staff is provided by a highly qualified Behavior Consultant to build capacity within the school staff. SBBC uses proactive system-wide adjustments that adjust how the environment responds to challenging student behavior.

In 2017-18 SBBC provided services that supported 88 tier II students to access their education in the public school setting. SBBC transitioned 18% of students to the universal level of supports in the school and made referrals for 7% of students to access the right level of care through a tier III support program. SBBC also continued to support 61% (n=57) students in their public school and provided continuity of care for 9 students who moved from one school to another SBBC school.

ACTION PLAN

- Continuing to build partnerships with more schools- Opening Contracts within Fairfield Center School & Missisquoi Valley Union Middle School for 2018-19
- Broadening the impact of the work within the school community through the systemic support of developing interventions rooted in Applied Behavior Analysis and Positive Behavior Supports
- Continue to develop the integrated consultation model for all classrooms/staff

HOW WE IMPACT

Social Determinants of Health impacted by SBBC: access to education, social support, mental health, connecting with resources to meet daily needs, transportation, and access to health care services.

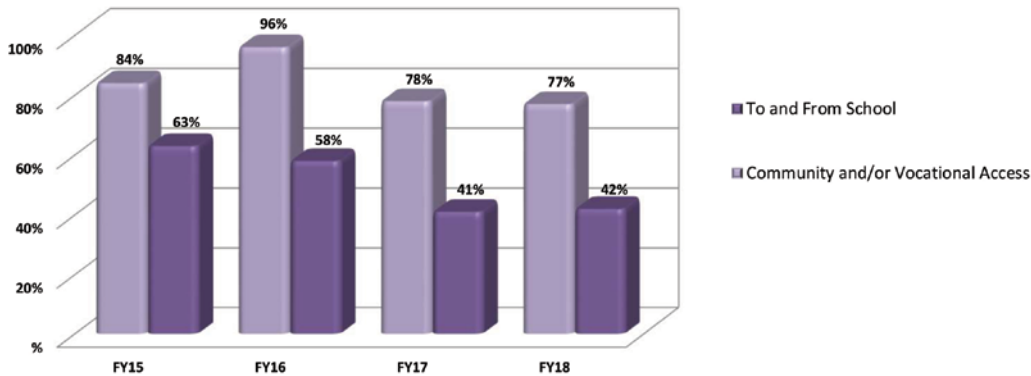
Community Partners

Franklin Northwest Supervisory Union (Sheldon Elementary School, Highgate Elementary School, Swanton Central School, Swanton Babcock School)

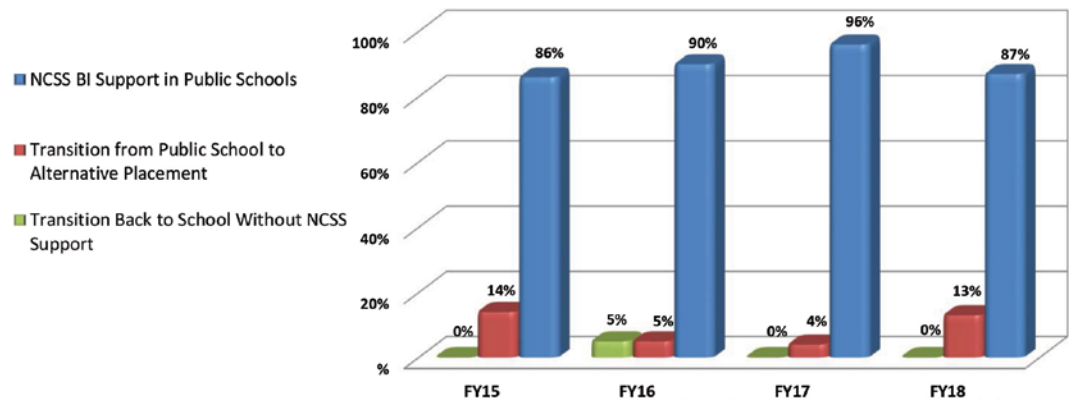
Franklin Northeast Supervisory Union (Berkshire Elementary School, Enosburg Elementary School)

SCHOOL BASED AUTISM

Partnerships for Appropriate Level of Student Support



Partnerships for Appropriate Level of Student Support



STORY BEHIND THE CURVE

The School-Based Autism Program provides 1:1 behavior intervention and consultation to students, families, and their educational teams. Staff are highly trained and skilled in the areas of Autism Spectrum Disorder (ASD), other Neurodevelopmental Disorders, and Applied Behavior Analysis (ABA). The 1:1 support allows access to individualized education (academic modification and support, community exposure, social inclusion, and daily living skills).

The program utilizes a data-centered approach to provide recommendations for programming, and to report on individual progress to school teams. When students meet their goals, the program helps to build capacity for transition back to the public school (with or without staff). The schools may determine this program's higher level of support remains the most appropriate for their student (represented by the orange on the bar graph) or if needs become too acute for the public school environment, alternative placement can be pursued within our system of care.

Due to maladaptive behaviors, many students are unable to ride the school bus or in the family vehicle safely; this presents a hardship to families and schools.

Our program allows access to safe and consistent transportation. Over the last three years, 78-96% of students have been able to access their local community during the school day for generalization of skills, social support, public safety goals, job training, and other resources.

ACTION PLAN

- Continue to build capacity to increase transitions back to school without 1:1 support from NCSS for those students that this is deemed appropriate. This can be achieved by continuing to provide trainings and consultative support for school staff
- Continue to educate the community as to the scope of services provided beyond students diagnosed with Autism
- Continued collaboration with schools to build internal capacity and provide consultation to support clients outside of the BI model.

HOW WE IMPACT

Social Determinants Supported by the School-Based Autism Program: resources to meet daily needs, public safety, access to education, transportation, job training, mental health, and social support.

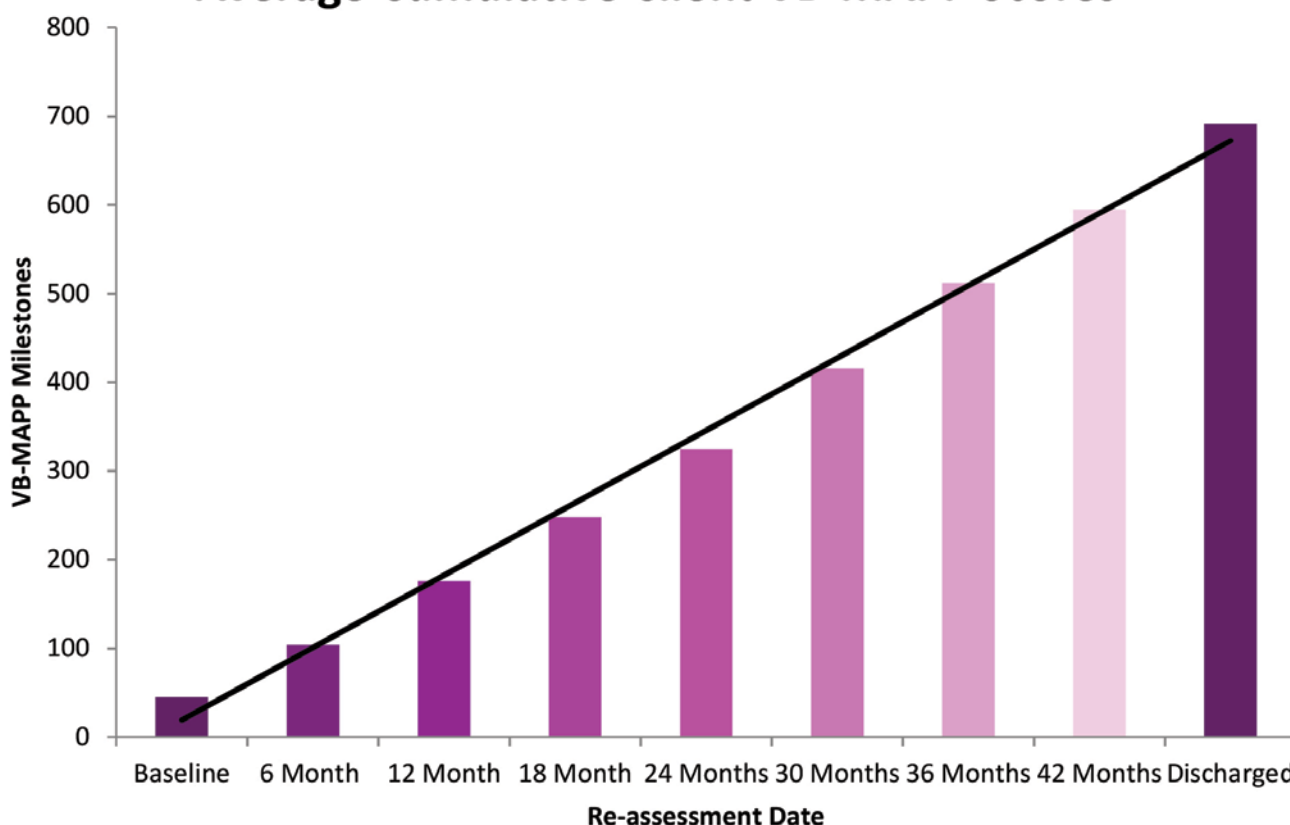
APPLIED BEHAVIORAL SERVICES

52

**Number of
children served by
ABS**

The Average score of Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP) (based on time in treatment) (see graph below) ABS received 100% positive responses on the satisfaction survey %/# of clients who accomplish a goal related to reducing interfering behavior – out of the client's that had a goal related to reducing interfering behavior 83% met that goal.

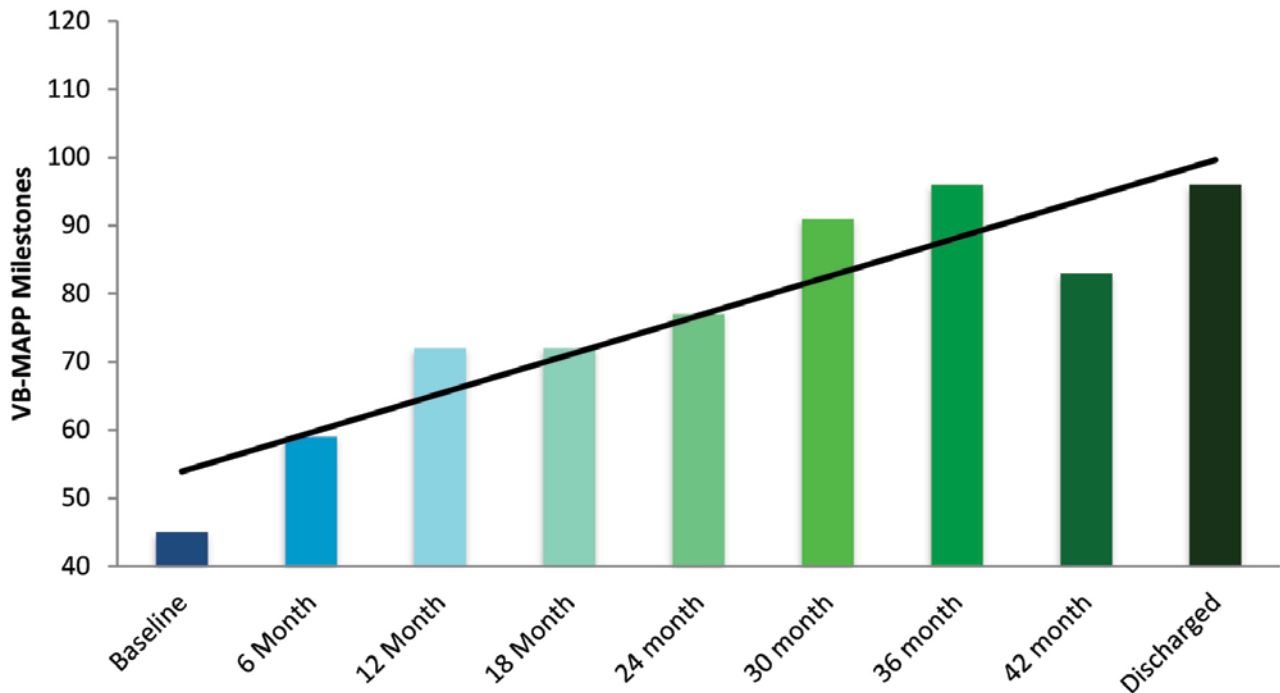
Average Cumulative Client VB-MAPP Scores



Community Partners

Local Schools
Local Child Care Providers
Franklin County Home Health
Pediatricians
UVM Developmental and Behavioral Pediatrics Clinic
DVHA, DMH, DAIL

Average Client VB-MAPP Scores



STORY BEHIND THE CURVE

The Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP) is the most widely utilized developmental curricula through ABS. The data above only captures those served using the VB-MAPP. Figure 1 represents the average VB-MAPP scores for all clients at re-assessment dates and Figure 2 represents the average cumulative VB-MAPP scores for all clients at re-assessment dates. The VB-MAPP is primarily utilized to support school readiness and the slight decline seen in Figure 1 is due to a decrease in the number of clients utilizing the VB-MAPP at the 36 and 42 month re-assessment dates as many clients have either transferred to more advanced developmental curricula or to other individualized behavioral programming when they have been served by ABS for over 36 months utilizing the VB-MAPP.

WHAT WORKS

- Staff require training to implement behavior analytic interventions and need to be overseen by

a Board Certified Behavior Analyst (BCBA).

- Children need to be re-assessed every 6 months to track progress and guide interventions.
- At discharge, VB-MAPP scores should increase demonstrating progress towards skill acquisition that will support the child with independence and success in school, at home, and in the community.

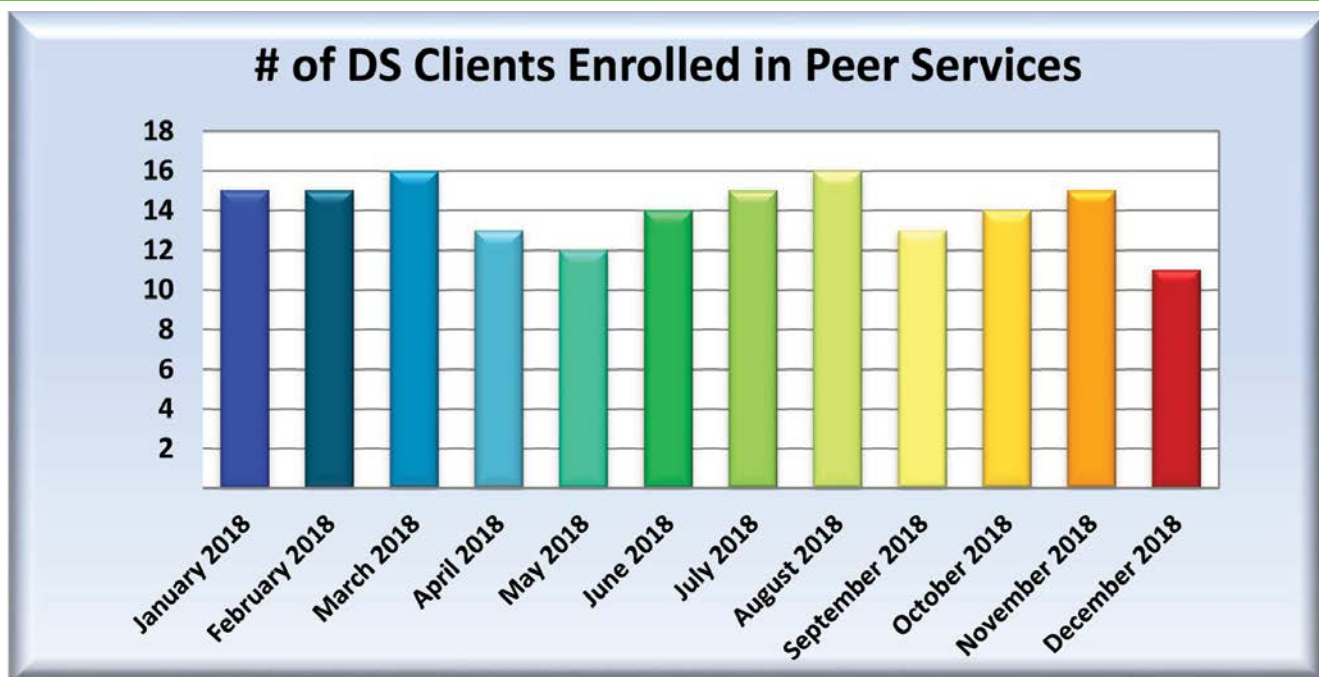
ACTION PLAN

- Continue to utilize the VB-MAPP to support school readiness and children acquiring verbal behavior milestones that will lead to an increase in communication skills and healthy interactions with the adults and peers in their lives.

HOW WE IMPACT

- Socioeconomic Conditions
- Availability of Resources to Meet Daily Needs
- Access to Education
- Transportation
- Social Support

DS PEER SERVICES



STORY BEHIND THE CURVE

NCSS DS Peer Services group meets once a week to discuss topics such as housing, interpersonal relationships, advocacy, and independent living skills. Peer Support attendance varies based upon several factors:

- Client work schedules
- Appointments/vacations
- Transportation

"The crisis team was very helpful to me and played a pivotal role in helping me get better. Their continued support is very much appreciated."

STORY BEHIND THE CURVE

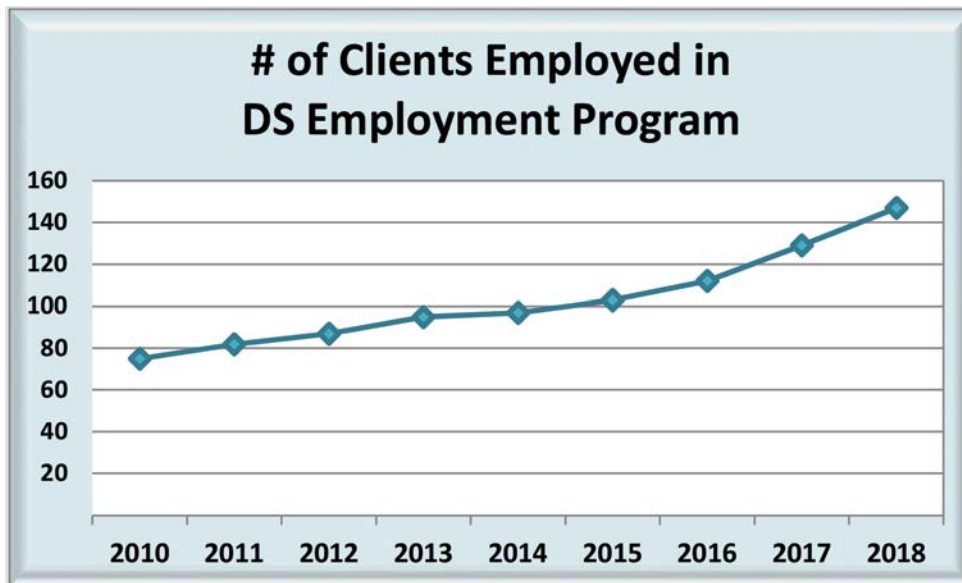
The NCSS DC Peer Advocate Training Team holds internal trainings for clients and staff quarterly, in addition to several one-time trainings as requested. Staff training content consists of:

Learning how to be more helpful to those you serve by gaining awareness of their perspective. Trainings is presented through personal stories and activities geared towards the goal of helping and empowering the people we serve in a way that promotes dignity, ownership and success on the job and in their personal lives.

The Peer Advocate Training Team is working to increase advertising of these trainings to NCSS staff through distribution of flyers and e-mails sent to all DS staff.



DEVELOPMENTAL SERVICES SOCIAL SECURITY SAVINGS



STORY BEHIND THE CURVE

NCSS's Supported Employment (SE) Team has (2) full time, Employment Team Specialist (ETS) working to find competitive employment for all individuals served expressing an interest in competitive jobs. This ratio of ETS's has not increased over the past five years yet the team's ability to continually find more jobs for more individuals is steady. With fewer dollars coming to SE programs the success of this team is based on strong community partnering.

WHAT WORKS

- Networking is the number one way to locate and retain employment for all individuals with or without disabilities
- The Employment Team Specialists (ETS's) utilize work placement assessments that help the individual identify all their own natural networking resources both personal and community based
- The team also works with all community partners to cast a wide network creating substantial leads both existing and new

ACTION PLAN

- Continued partnerships with members of the Creative Workforce Solutions and Education representatives will be paramount as funding rescissions continue
- Employment is seen as one of the most beneficial programs for increasing self-image and identity, it will remain a priority within our practices here at NCSS

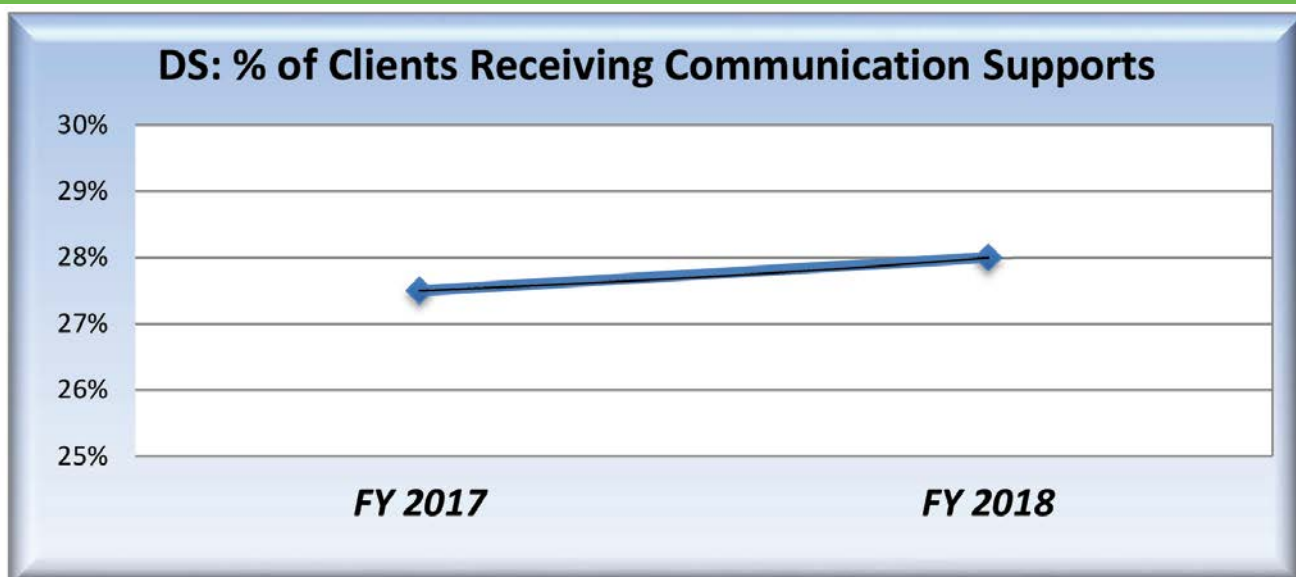
HOW WE IMPACT

- Public Safety
- Access to education
- Transportation
- Housing
- Job training
- Mental health
- Social support
- Resources to meet daily needs
- Economic support

Community Partners

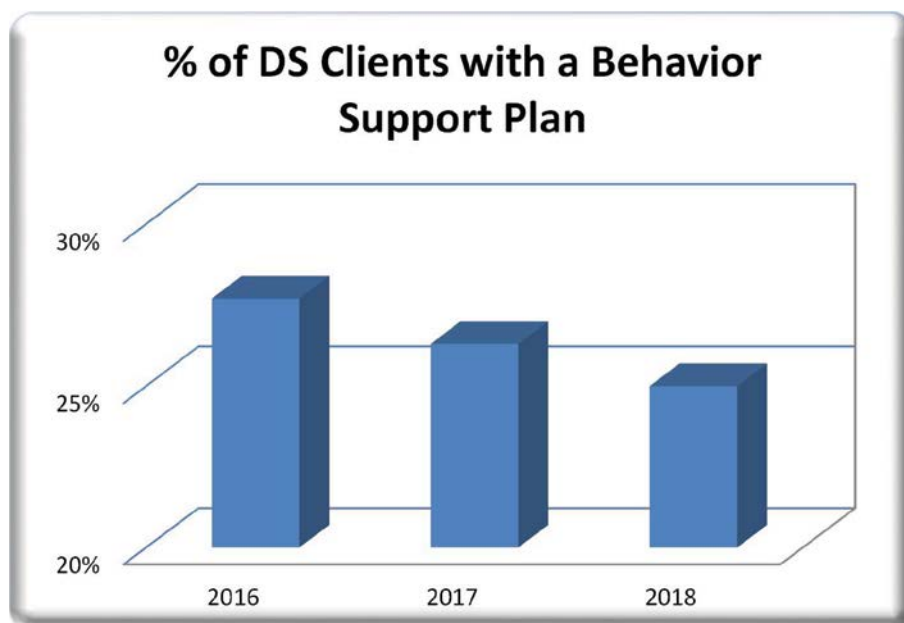
DAIL & Designated Supported Employment coordination Team
Vocational Rehabilitation
Creative Workforce Solutions
Franklin/Grand Isle County Core Transition team
Community High School special education employment programs

DS CLINICAL SERVICES



STORY BEHIND THE CURVE

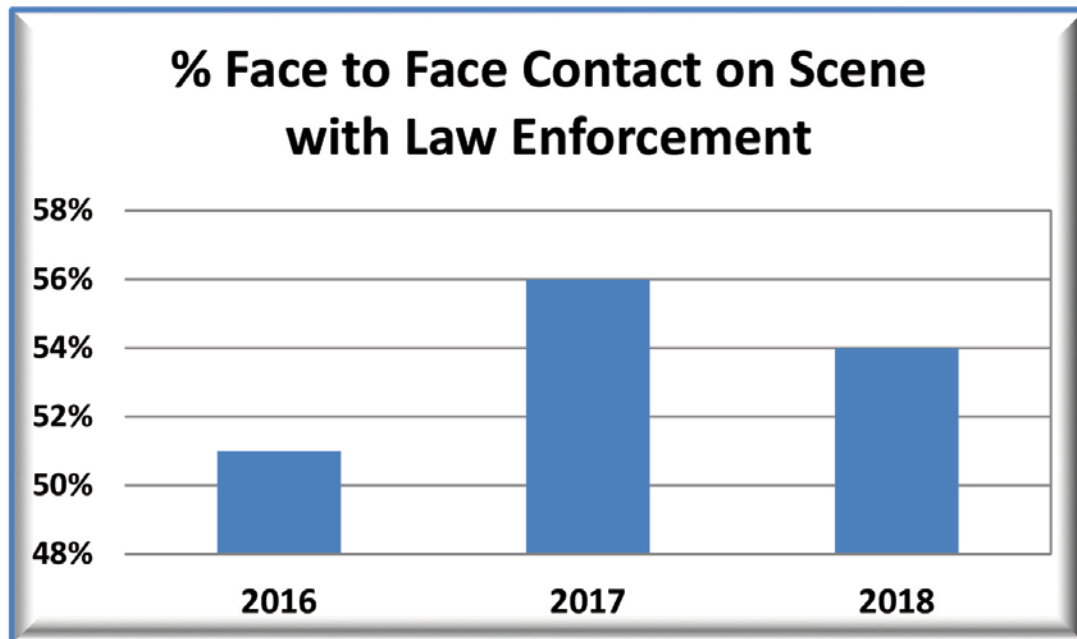
In 2014, the internal Communication Committee was revitalized in the Developmental Services (DS) division. This allowed for teams to expand on the communication needs of persons being served through DS. The Communication Committee provides trainings on communication, support around communication, internal and external resources and guidance on communication plans.



WHAT WORKS

The NCSS Developmental Services Clinical Oversight Committee (COC) provides clinical support and consultation to individuals served in Developmental Services. COC offers guidance in creating positive behavior support plans for individuals and their support systems so that they have the tools they need to be safe at home and in the community. The reduction in numbers for behavior support plans, restrictions of rights and restraints is due to several reasons. COC conducts quarterly and yearly clinical reviews with individuals and their teams to access and evaluate clinical supports. We have also increased staff trainings that focus on positive practices to promote less physical intervention in preventing and managing aggression. Our clinicians believe a wrap-around approach is critical to individuals we serve to best support them in achieving their goals.

POLICE DEPARTMENT COLLABORATION



STORY BEHIND THE CURVE

Number of contacts may increase or decrease due to the unpredictable nature of contacts. We are observing a practices shift by increasing our community capacity and assisting police to de-escalate persons in their home vs. the hospital/jail. So at times, the police are not called at all to intervene at all as we build trust in those relationships and confidence in response needs. Another practices shift is collaboration with law enforcement to determine if it is safe for mental health worker to go to scene without law enforcement being involved at all. We have also developed a practice with Franklin County Sheriff to proactively reach out to individuals who are in a housing eviction process.

WHAT WORKS

- Working closely with local law enforcement and building on relationships
- Offering to be on scene for police wellness checks
- Debriefing with mental health and law enforcement following resolution of situations to learn from experience
- Developing practice protocols for specific situations (evictions, family support after arrests etc.)

ACTION PLAN

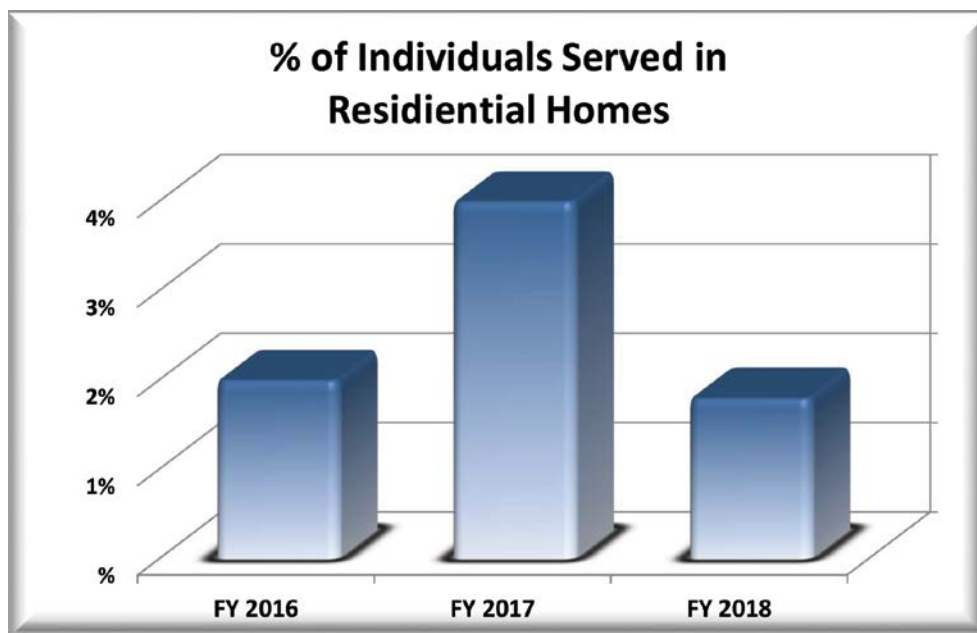
- Mental Health First Aid (MHFA) class for law enforcement to support intervention strategies
- Support law enforcement in understanding and assisting persons experiencing mental illness

Community Partners

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

"The crisis team was very helpful to me and played a pivotal role in helping me get better. Their continued support is very much appreciated."

DS THERAPEUTIC COMMUNITY INTEGRATION



"The crisis team was very helpful to me and played a pivotal role in helping me get better. Their continued support is very much appreciated."

STORY BEHIND THE CURVE

Berkshire served 6 individuals during 2017/2018. All 6 were part of the Berkshire Residential Program. One individual transitioned out of LBH to a Home Provider. One individual transferred back into the Criminal Justice System.

WHAT WORKS

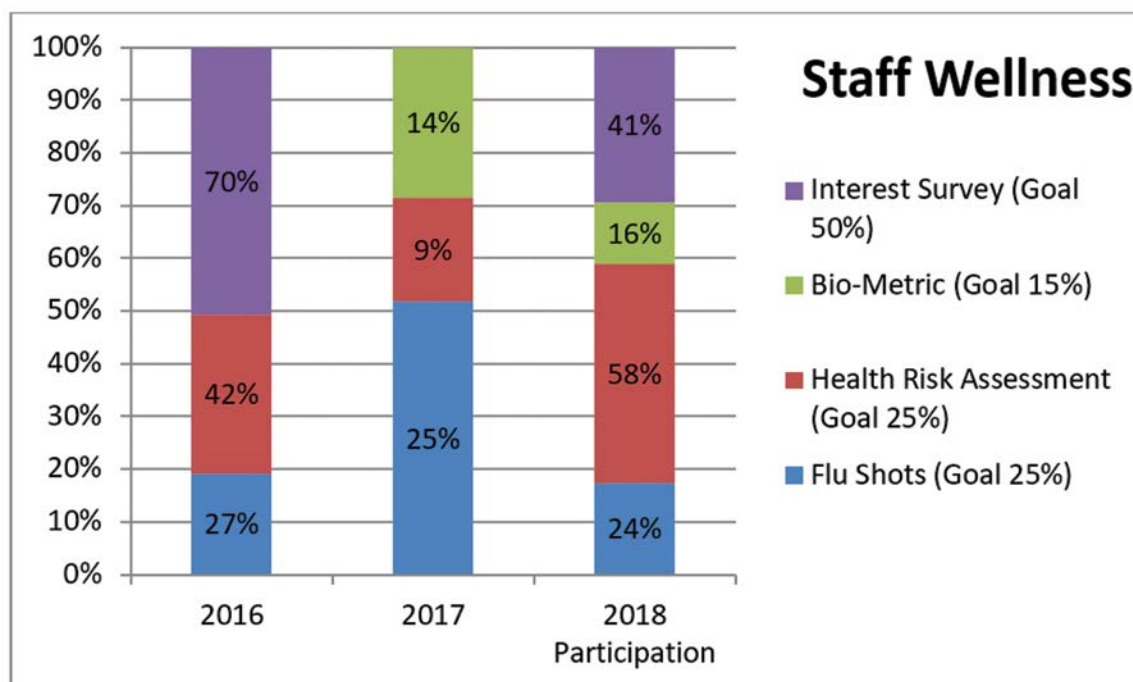
Development of the Berkshire program is, by design, meant rehabilitative model that helps individuals re-integrate back into their communities within 1-2 year period. Constant assessment of the individual's progress and stage of change is monitored and programming adjusted to help continued growth and forward movement. Once the team assesses that an individual has criteria they are moved to a "Step Down" process that allow them to safely continue their socialization and emotional maturation toward complete independence.

ACTION PLAN

- Develop more "step down" transitional housing in the community
- Consistent on-going employment
- Reduction in supervision during transitional placement
- Consistent monitoring of least restrictive placement
- Consistent monitoring of risk factors
- Slow and progressive steps towards community independence

HOW WE IMPACT

- Access to healthcare services
- Resources to meet daily needs
- Public Safety
- Transportation
- Housing
- Job Training
- Mental Health



EMPLOYEE WELLNESS

Our Wellness Committee was in full swing this fiscal year, bringing staff a variety of events, activities and healthy food options in support of five primary goals:

1. Raise awareness and provide opportunities for preventive care
2. Provide opportunities to increase level of physical activity
3. Encourage healthy food choices at home and work
4. Alleviate and prevent musculoskeletal disorders
5. Provide education, which promotes emotional, physical and financial well-being

WHAT WORKS

Continuous promotion of wellness and self-care helps engrain is a critical component of providing high-quality services to our clients. Staff participation in completing a personal health risk assessment bounced backed when a financial incentive was reinstated. With so many noteworthy data points, it's hard to highlight just a few!

IMPACT

- The cross-divisional committee delivered a variety of fresh veggies grown in our community garden, and 1300 pieces of fruit!
- Onsite, subsidized massage, chiropractic and fitbit programs are well received and impact overall health.
- Passport program provides financial incentives for staff to engage in healthy behaviors.

	% increase
Onsite Massage & Chiropractic	107%
Fitbits	22%

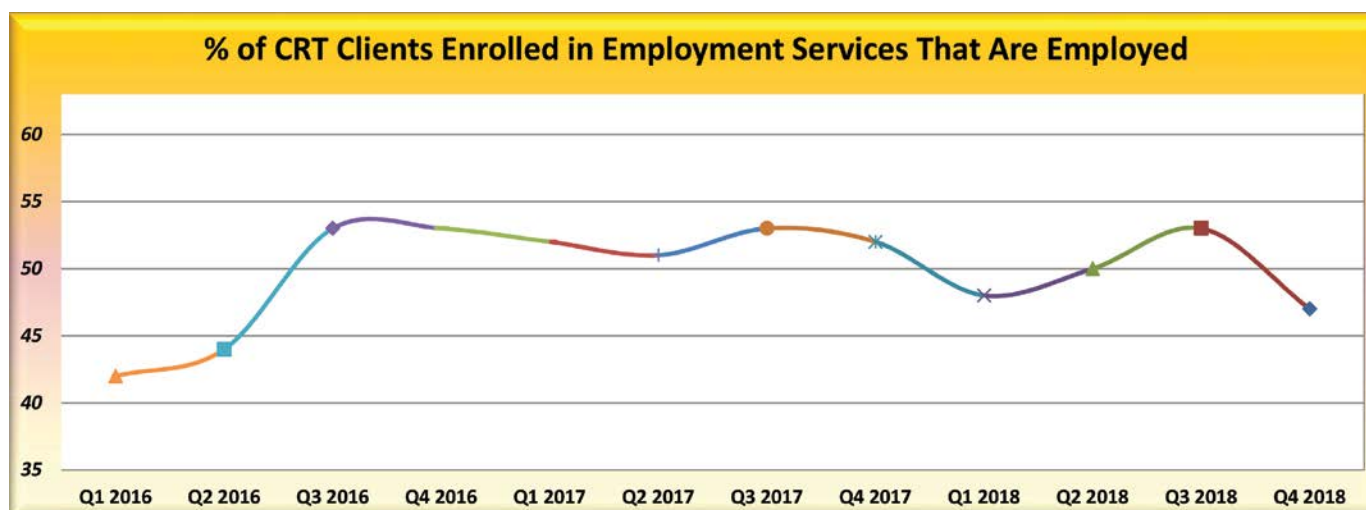


COMMUNITY REHABILITATION & TREATMENT EMPLOYMENT



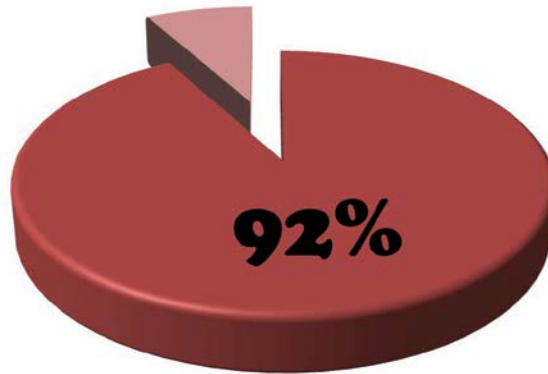
STORY BEHIND THE CURVE

The mission of the Johnson & Johnson Mental Health Program is to increase access to evidence-based supported employment (SE), also known as Individual Placement and Support (IPS), for adults with serious mental illness who are interested in improving their work lives. This national program systematically works with states to implement supported employment following the evidence-based guidelines. Sharing outcome data is one of items important to Johnson & Johnson to track trends and progress.



DEVELOPMENTAL SERVICES EMPLOYMENT

**DS Employment: Employer Satisfaction
Rate With Employee Performance**

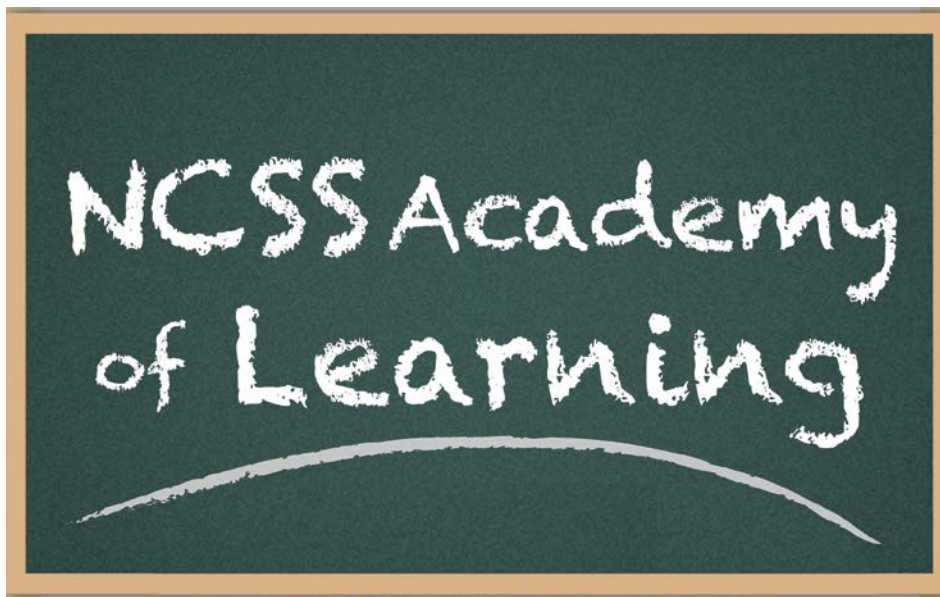


STORY BEHIND THE CURVE

We believe the reason there are so many employers who are satisfied with the individual working for them is that we strive to make the best job matches for our clients. We have developed strong relationships with employers and offer follow along support to ensure the success of the person employed. That support also extends to the employer. They may need us to provide extra support for their employee around changes on the worksite, disciplinary issues, trainings, etc.

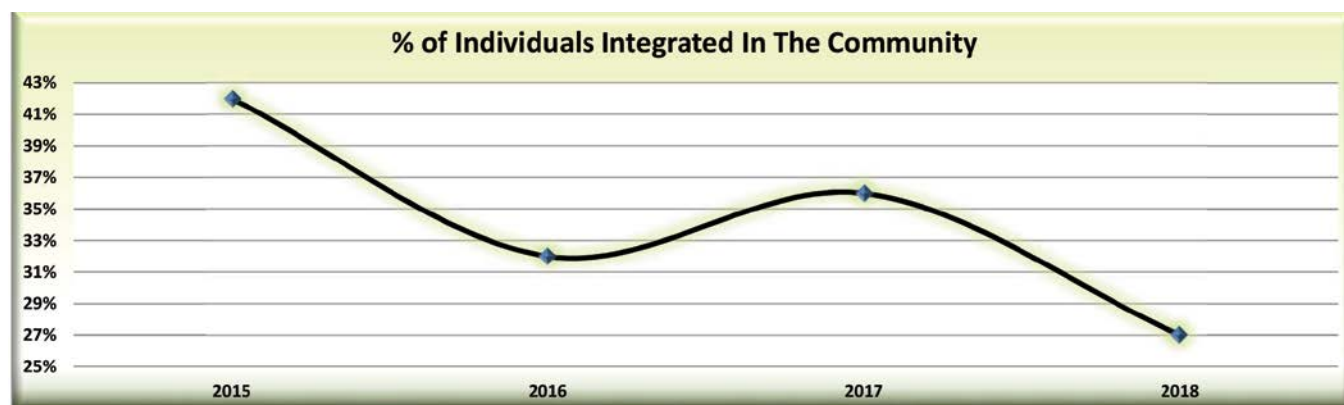


ACADEMY OF LEARNING



STORY BEHIND THE CURVE

The Academy of Learning program runs 3 days a week with a different theme and group of consumers 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 Interpersonal Relationship 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 client's ability to function independently. The Academy of Learning program focuses on community integration in order to foster and promote skills that can be utilized at any time. Individuals in the program get hands on learning to help practice skills and work on socialization in a safe setting.



Community Partners

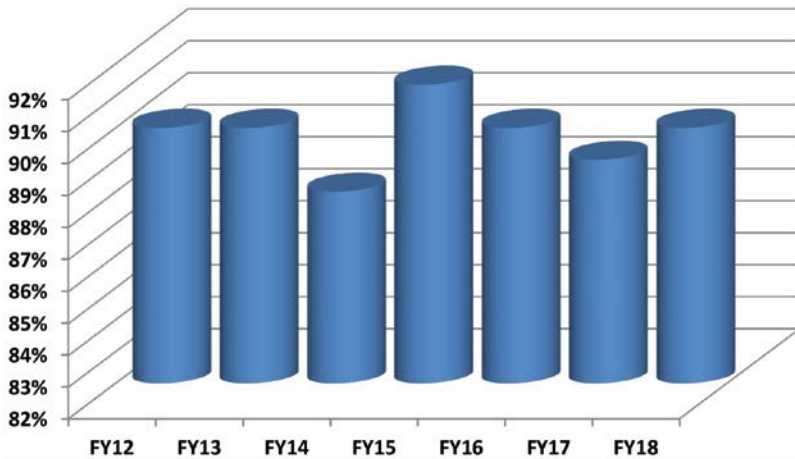
Franklin County Senior Center
Local Area Schools
Healthy Roots
St. Albans Town
Project Linus
Habitat for Humanity
Martha's Kitchen

CLIENT SATISFACTION

STORY BEHIND THE PERFORMANCE:

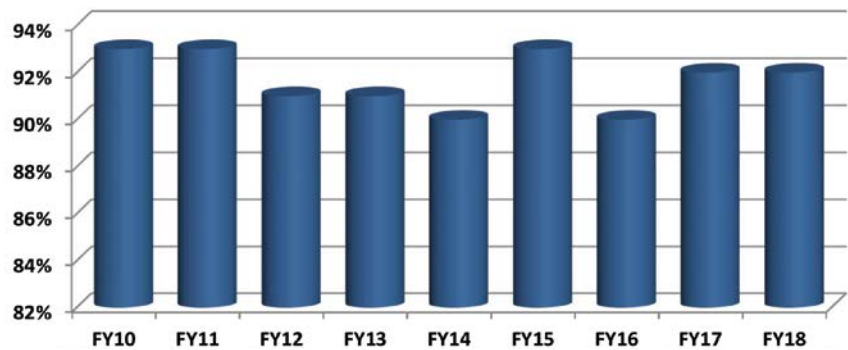
This year our return rate for client satisfaction survey stayed steady at 21% which continues to be the highest return rate recorded and the highest among the DA system.

NCSS Services Recieved Made a Difference

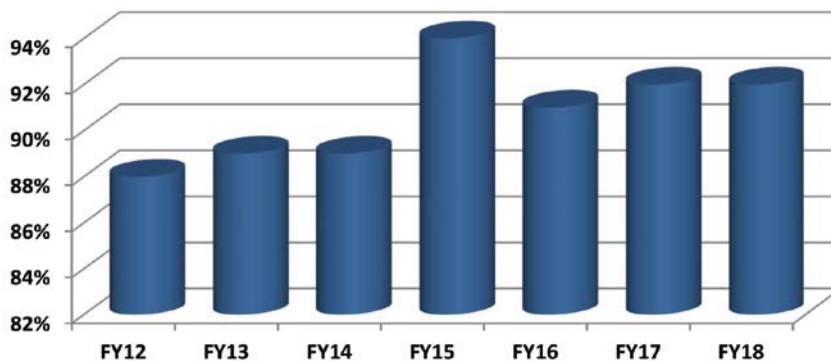


- Overall client satisfaction rate was 91%.
- 94% of the clients felt they received the help they needed which is slightly above the DA average at 93%.
- 90% of clients felt the services they received made a difference in their lives. This is also above the DA average of 88%.

Clients Satisfied with Services



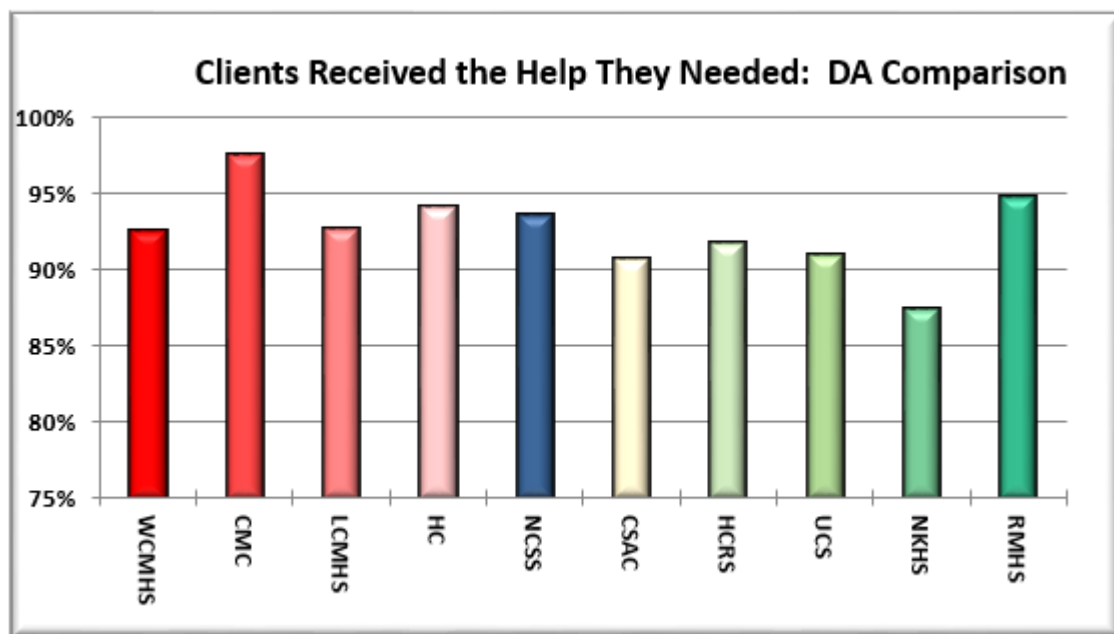
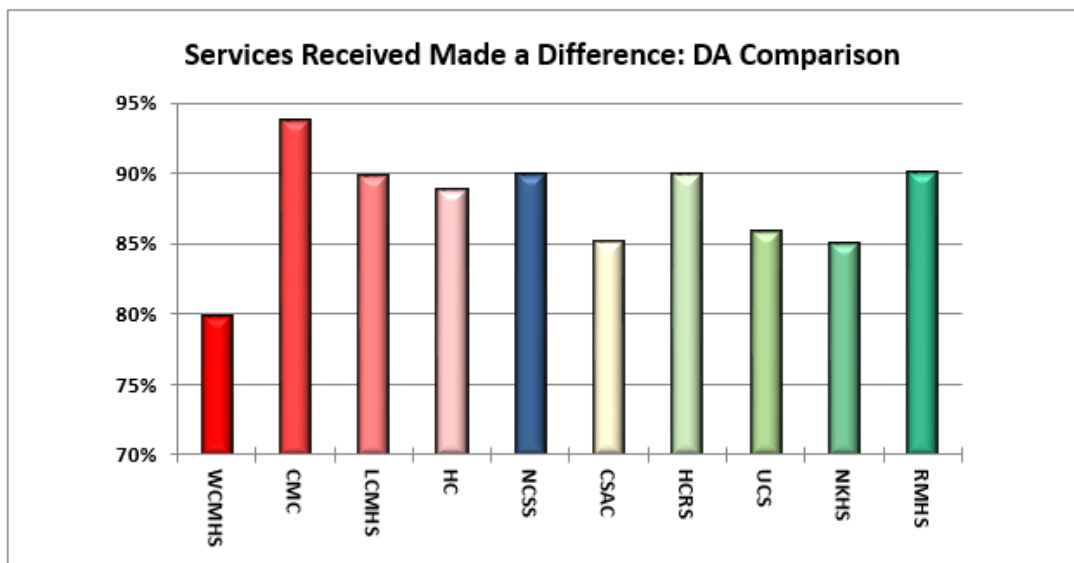
Clients Received the Help They Needed



CLIENT SATISFACTION

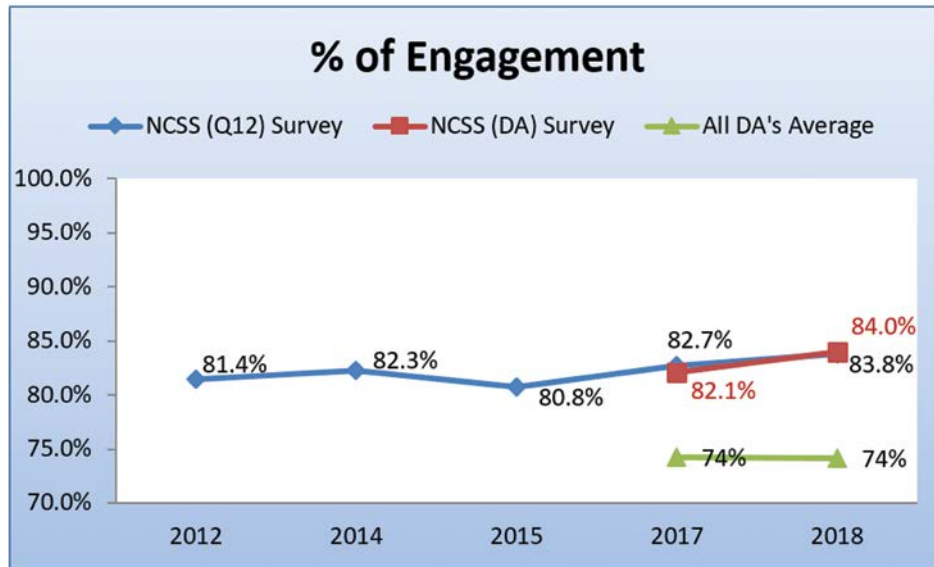
ACTION PLAN

- Each team in the agency is undergoing a Bend the Curve exercise to create an action plan which looks at methods of dissemination and language used. These will be reviewed and measures will be implemented for improving our satisfaction survey result for FY19.
- Continue to work with Vermont Care Partners with standardized satisfaction questions and benchmark our outcomes to the state average.



"Everyone I've asked for assistance or have spoken with has been very helpful and friendly"

STAFF ENGAGEMENT AND TURNOVER



"What a great bunch of people to work with."

STAFF ENGAGEMENT

Staff engagement is at an all-time high of 83.8%, which leads us to believe we truly have a “culture by design, not by default”. We put a lot of focus on safety and employee health to highlight our most valuable asset – the staff. This was also our second year of benchmarking ourselves again the state-wide designated system. Our engagement scores in both our internal survey (Gallup Q12) and external comparison far surpass our peer average.

WHAT WORKS

- Reinforce practices that promote our #1 value of safety
- Look for ways to promote NCSS as a place people desire to work
- Focus on compensation for key positions and highlight total compensation packages

ACTION PLAN

- Continue to promote our culture by expanding our benefit strategies to meet the changing demographic needs of our staff
- Look for ways to promote NCSS as a place people desire to work
- Work towards becoming a center of excellence (COE)

"I feel very fortunate to have such a supportive team that is always willing to help and go the extra mile!"

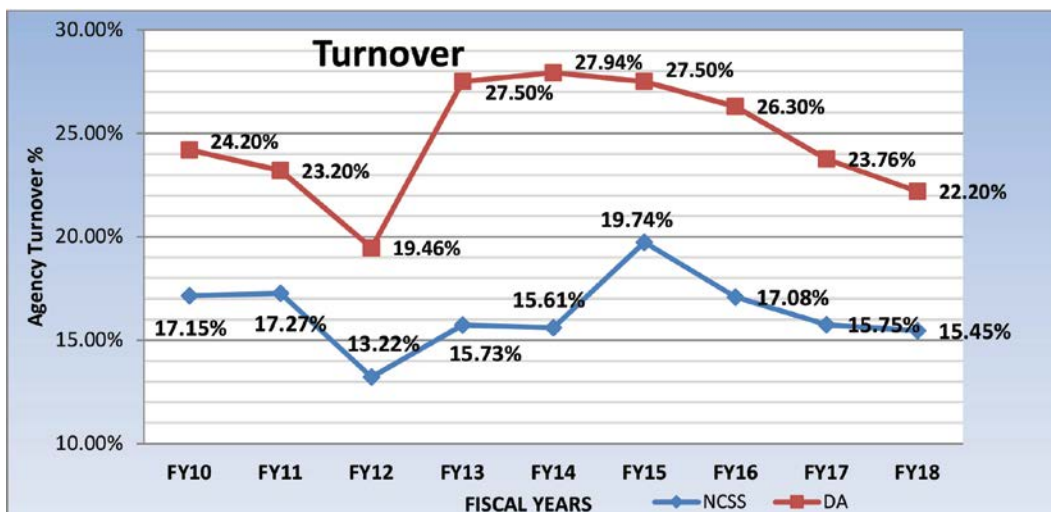
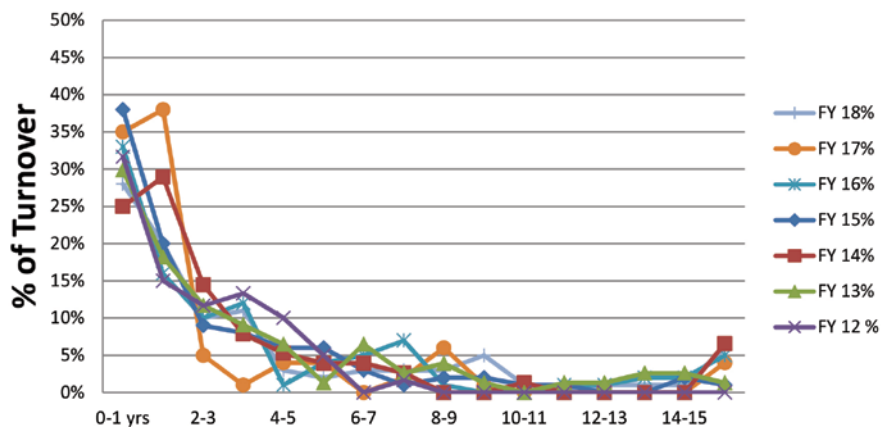
STAFF ENGAGEMENT AND TURNOVER

STAFF TURNOVER

We're pleased to see the agency-wide turnover rate continue to decline while Vermont's Designated Agency system continues to experience a much higher rate. We take this as an indication that our "work hard, play hard" strategies have been well received. In most cases, turnover is a result our inability to be competitive in wages compared to our state peers. However, funds allocated through the legislative process in Fiscal Year 2018 helps us target specific positions of

high level mental health service credentials and experience, to reduce the compensation gap. We continue to have strong onboarding practices and retention efforts. It's not unusual for new staff to leave employment in the first year, which is clearly indicated in the graph. That being said, Fiscal Year 2018 highlights our energies with the best turnover rate in the first 12 months of employment, only second to Fiscal Year 2014.

Longevity Turnover Trend FY12-FY18



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.

NORTHWESTERN COUNSELING & SUPPORT SERVICES

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(802) 524-6554

Join us online



**Learn more about our services at
www.ncssinc.org**