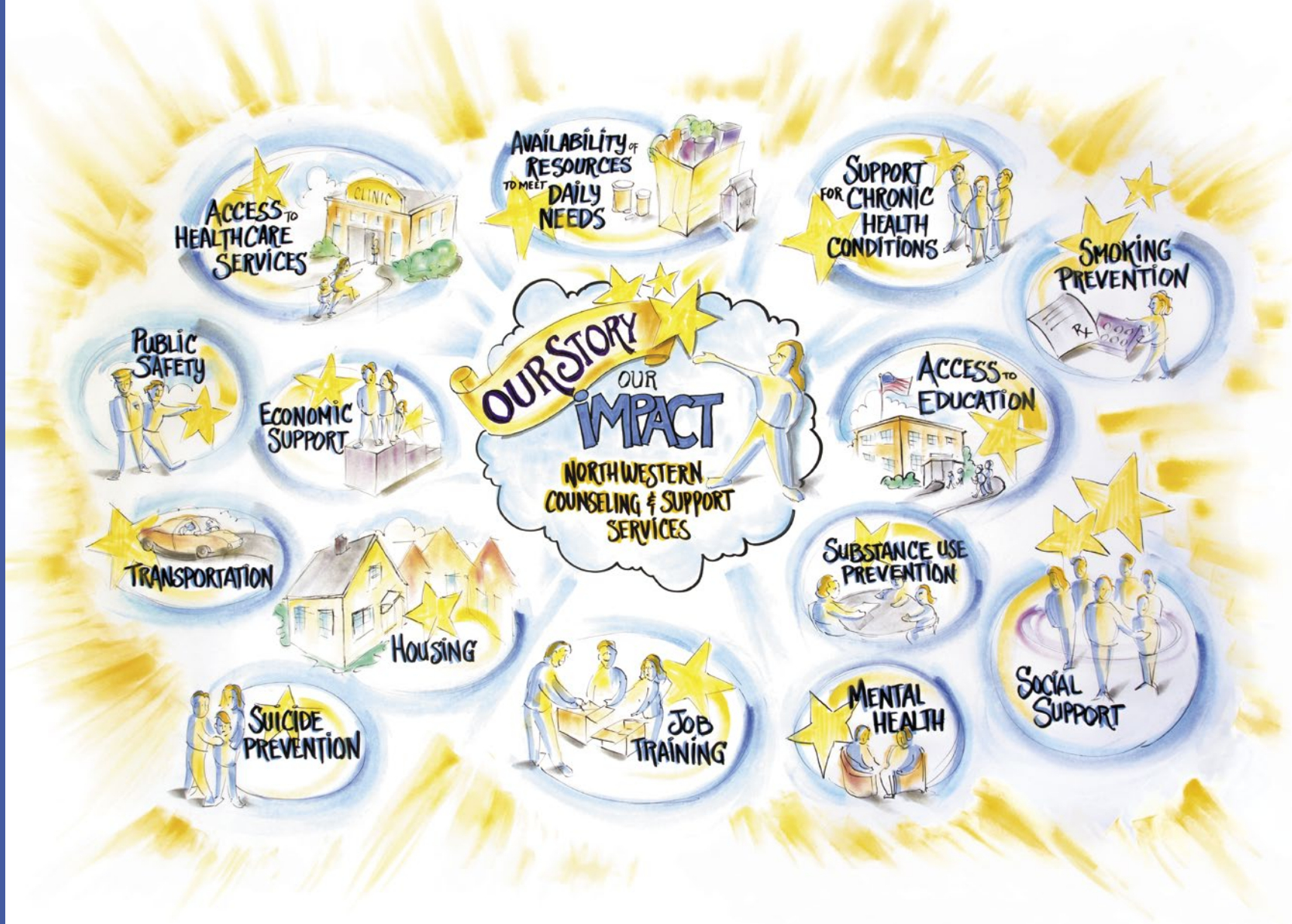


2017

Outcomes REPORT



NORTHWESTERN
COUNSELING
& SUPPORT SERVICES

Letter from the EXECUTIVE DIRECTOR



***Northwestern Counseling & Support Services (NCSS)
is pleased to share with you our 2017 Outcomes
Report.***

On the following pages, you will find information detailing many NCSS Programs. We understand that individual health is closely linked to broader factors in people's lives.

The services offered by NCSS promote wellbeing by improving the underlying social determinants of health. These may include stable housing, food security, gainful employment, educational opportunities, and strong social connections.

NCSS is proud to offer a wide variety of specialty programs that are individually tailored to meet the unique needs of the people living in our community. We believe that this individualized approach is effective, efficient, and respectful of each person served. For sixty years, NCSS has been honored to be part of the Franklin & Grand Isle community. We are proud of our team and the work they do every day to improve people's lives.

A handwritten signature in white ink that reads "Todd P. Bauman". The signature is stylized with a large, looping initial 'T'.

Todd Bauman
Executive Director

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Introduction

How Well DID WE DO?

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 perspective.



Behavioral Health DIVISION PROFILE

Past

Pat has been enrolled with the Community Rehabilitation & Treatment (CRT) program for over 20 years. This program serves adults with severe mental illness and strives to maintain all participants in the community. For many years, Pat lived with his family. He would engage sporadically with case management, skill based groups, and therapy. Unfortunately, his family experienced a significant loss, which was devastating to both Pat and his family. Pat reacted to the tragedy with an increase in anger and challenging behaviors. Ultimately his family withdrew their support and their contact from Pat. He lost his

housing and tried to live in two different CRT homes and had several stays at the Bay View Crisis Care Center, which is a two bed program designed to prevent inpatient hospitalization. Pat increased his behaviors in the community, which grew attention from community businesses, emergency services, police and the courts. Pat over utilized the regional emergency department as a place to escape and a way to cope. At one point in time, Pat accessed the emergency department 18 times in one month. Police contact eventually brought unfavorable consequences for Pat and incarceration.

Present

After months of incarceration by the Department of Corrections, Pat returned to the community and started working with the CRT program in a more productive way. A creative living situation with a home provider in the community was developed. Even though this living situation only lasted a few months, it was enough time for Pat's family to become involved in his treatment once again and resulted in Pat returning to live with his family. Pat started working with a member of the Intensive Case Management (ICM) team. A strong connection was made with Pat and his ICM worker. The ICM staff started meeting with Pat and his family to increase communication and problem solve

conflicts within the family. Pat is attending weekly therapy to try to understand his family's loss. We were able to engage Pat with the CRT Employment team and he found a part time job. When needed, Pat will access the Bay View Crisis Care Center to provide a break for him and his family and work on skills to sustain community placement. With positive changes in his life, Pat's emergency department visits have decreased significantly to less than one per month. Care coordination through his CRT case manager and other supports continue to foster these gains and prevent relapse.



How Much Did We Do?

2470 number of clients were served
= Decrease of 7.8% from last fiscal year

79,224 hours of care provided
= Increase of 8.3% from last fiscal year

How Well Did We Do It?

98% of our clients felt staff treated them
with respect

95% of our clients said they would refer a
friend or family member to NCSS

Is Anyone Better Off?

93% of our clients felt they received the help they needed

88% of our clients felt the services they received made a difference

89% of our clients received the services that were right for them

Children, Youth and Family Services DIVISION PROFILE

THE SMITH FAMILY'S STORY – *In the beginning...*

NCSS began their work with the Smith family when then 5-year-old Charles was referred to the Collaborative Achievement Team for individual school based supports. Charles, who lived with his father, was exhibiting aggression towards peers and adults, flipping furniture in the classroom, and an overall inability to regulate his emotions. About the same time his sister Diana, who lived with her mother, was referred to the Family Support Team to address concerns of safety and supervision in the home that were impacting her behavior. Over the next year and a half both children made slow and steady progress. Tragedy then struck the family as Charles' father was killed in an automobile accident. His family reached out to NCSS Crisis services for support during this incredibly difficult time. Given both children's positive relationship with their service providers, the staff provided supervision and support while crisis staff helped the family process their grief. This intensive support lasted through the weeks immediately

after the tragedy as the family worked through the loss and also identified who would care for Charles moving forward. In the time that followed, Charles began living with Diana and their mother. Family-Based Supports continued to work with the family in the home, while Charles continued to be supported by a Behavior Interventionist in school. Respite services also began with the goal of providing the children needed individual supported breaks outside the home. In the next school year, Charles began to make significant gains as he was more and more able to manage his behavior independently. Shortly thereafter, Charles was transitioned to a lower level of school support provided by NCSS' School-Based Behavior Consultation Team, which no longer included a staff working solely with him. As he continued to require less and less support to effectively manage his behavior, Charles transitioned to complete independence in school, no longer requiring NCSS support.

And today...

Today, the home environment is stable and safe and Charles and Diana are both thriving at school. This is an example of what can be accomplished when the right services are provided at the right time to families, schools, community partners, and individuals working together. While each of these services provided skill development and support in different realms, the care coordination amongst providers working with the family was evident, given the collective positive changes noticed with both children and Mom.

**Multiple services provided
skill development and
support in different realms
for the Smith Family.**

How much Did We Do?

1602 number of clients were served
= Decrease of 1.1% from last fiscal year

152,990 hours of care provided
= Increase of 9.73% from last fiscal year

How Well Did We Do It?

99% of our clients felt staff treated them
with respect

98% of our clients said they would refer a
friend or family member to NCSS

Is Anyone Better Off?

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

90% of our clients felt the services they
received made a difference

92% of our clients received the services that
were right for them



Developmental Services

DIVISION PROFILE

Coty's Story

Coty began life with the odds stacked against him. He was destined to become another statistic, an infant exposed to alcohol and illicit substances in utero. Though his story could be one of many with poor outcomes, Coty experienced triumph through love and support from a host of individuals and service providers.

Coty was born with neonatal abstinence syndrome, which can occur in newborns who have been exposed to illicit substances that caused dependency and addiction in the biological mother. Infants develop dependency on the drug while in the womb, and experience withdrawal at birth. Prenatal alcohol exposed created the possibility for neurodevelopmental challenges, such as potential learning and behavior problems later in life.

After months in the NICU, Coty left and was in the foster care system. He was adopted as a toddler, and his mother states, "I never thought we would get where we are today." Coty struggled when he entered the doors of kindergarten. Within days he was labeled as troubled and in need of specialized services. At the age of 5 he was sent to a residential school, and he bounced from one specialized school to another. His aggressive behavior resulted him in going to four after-school child care programs, and later resulted in police intervention in the school and home on several occasions. He was tested with brain scans, assessments, and psychological evaluations. At the age of 17 he was diagnosed with Autism Spectrum Disorder. He graduated from school at the age of 19.

After graduation, things became worse for Coty. He openly admits that he used substances to try and cope with the intense anger and pressure of life.

He was admitted to a residential program with two staff by his side 24/7 in a hotel room. He was arrested for aggression toward the staff, lighting yet another fire endangering others. He was housed in jail for several days, evaluated, and found to be incompetent to stand trial for his offenses, resulting in ACT 248 disposition.

The court system in Franklin County reached out to Northwestern Counseling & Support Services (NCSS) and Coty was enrolled in the Therapeutic Community Integration Program (TCIP) in Berkshire. Coty was now in a service that had structure, support, clear boundaries, and respect. Coty was allowed to build relationships and experience choice and consequences for his decisions. While he decided to leave after his first week, he was not stopped against his will. Coty walked eight miles down the road, with staff in tow. After having time to process and deescalate, he shared he was ready to return, and his staff supported him in walking back. For the first time, Coty was able to self-regulate without destruction or restraint. Coty smiles from this memory. "The next time I only walked a short distance. I learned from that."

Coty is now 24 years old and has been living in the community with a home provider for over a year. He is getting ready for his driver's test and moving into his own apartment. He said, "Berkshire did it right. They were good people that built relationships with me." It takes a team to find this kind of success, and to beat the odds. In addition to Developmental Services, Coty has a mother/guardian that loves him unconditionally, an involved father who co-parents, and a home provider that has been key in building his independence. Coty's words of wisdom for others.

Director's Note

Our vision in Developmental Services is to provide person-centered planning throughout an individual's life span.

Our staff believes in the rights of those we serve and understand that freedom of choice means respecting the individuals we serve and their abilities.

Programming is designed to promote inclusion, integrity, advocacy, and assuring the rights of individuals with Intellectual Disabilities to be integral parts of their communities.

The range of community-based services includes employment opportunities, interpersonal relationship building, and independent skill building; all while optimizing and developing natural supports.

The work requires team collaboration with families of persons served, as well as friends, peers, counselors and significant individuals. Goals are individualized, measurable outcomes tracked, and we hold ourselves accountable toward progress. Our teams measure their success through the individuals we have the honor to serve.

How Much Did We Do?

306 number of clients were served
= which was 2.5% less than last year

268,774 hours of care provided
= decrease of 2.7% from last fiscal year

How Well Did We Do It?

97% of our clients felt staff treated them
with respect

83% of our clients said they would refer a friend or
family member to NCSS

Is Anyone Better Off?

88% of our clients felt they received the help they needed

87% of our clients felt the services they received made a difference

88% of our clients received the services that were right for them

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. Examples of how we support each of the social determinants of health are:

Access to health care services

Many of the services NCSS provides are home or community-based (schools, doctors' offices) allowing for easier access to health care. Additionally we offer care coordination increasing collaboration of providers to increase quality of care and access and as many of our clients struggle to identify additional health care resources such as:

- Children's personal care services
- 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

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. 3Squares VT, the local food shelf, section 8 etc.
- Support clients to apply for funds which can be used to purchase necessary adaptive equipment
- Support individual 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 child care resources so parents can work. These resources include:

- Learning for Living
- 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 support 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



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

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 embedding 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 GMATA
- Driving clients to and from necessary appointments

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 strive to ensure all clients and staff 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



Mental Health First Aid

CHILD, YOUTH & FAMILY DIVISION

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 young people with care and to reduce stigma within our community through education, compassion, and understanding.

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.

PROPOSAL TO IMPROVE PERFORMANCE:

We will focus on broadening our community partnerships, specifically the engagement of youth serving 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 FY17 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 resource sharing and aligned training efforts to implement YMHFA trainings throughout the state of Vermont.

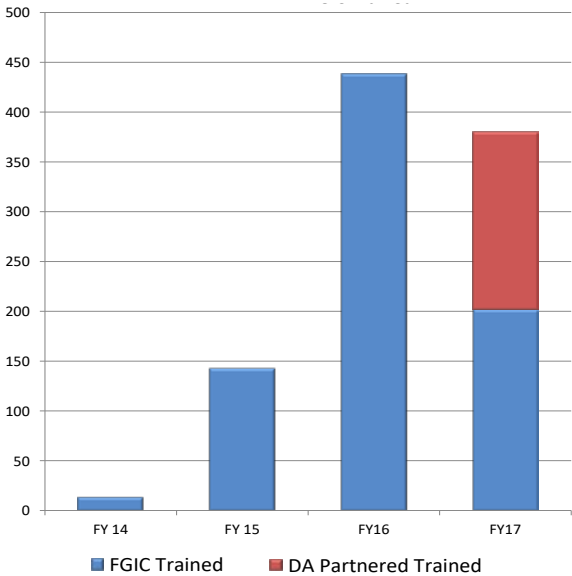
In the upcoming year NCSS will continue to serve as Project Coordinator for Aware Vermont and will continue outreach efforts and training with established partners. NCSS will continue to utilize YMHFA training as a tool to engage our community through outreach, education, and understanding of services available to youth and families.

PARTNERS:

- Franklin Northwest Supervisory Union
- Franklin West Supervisory Union
- Franklin Northeast Supervisory Union
- Camp Hochelaga/YMCA
- Vermont NEA
- Cold Hollow Career Center

380
Number Served
in FY17

Headline Measures – How much are we doing?
of People Trained in YMHFA Since FY14



Story Behind the Baseline Performance:

Youth Mental Health First Aid (YMHFA) was implemented in an effort to increase early intervention, awareness of available services, and reduction of stigma for individuals living with mental health challenges.

In FY17 NCSS trained 202 Community members within Franklin/Grand Isle Counties (FGIC) and partnered with VT Designated Agencies to train and additional 178 individuals throughout the state. Since FY14 NCSS has trained 797 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.

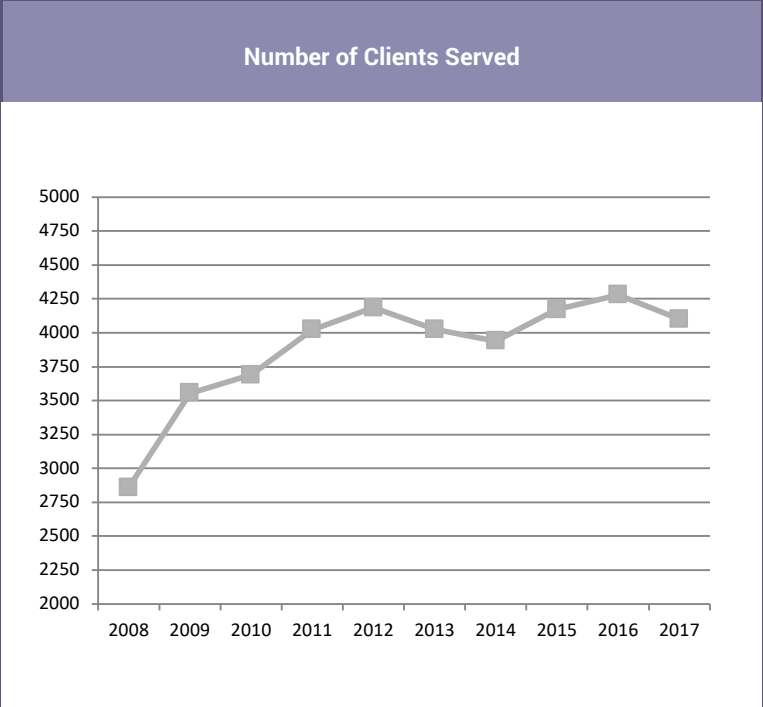
Story Behind the Baseline Performance:

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.

The Number of CLIENTS SERVED

“ NCSS does a great job and I am proud of the services. Thank you very much for all you do. ”

“ The support from our counselor was greatly appreciated. She always had support for us. ”



Story Behind the Curve:

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 FY17 NCSS served 4,100 people in our offices, in local schools, in the community, in their homes and in their places of work. This is a 4.2% decrease from the previous year.

Cultural Competency: DIVERSITY AND INCLUSION

OVERVIEW:

NCSS' Leadership has embraced a culture of diversity and inclusion! The work of the cross-divisional committee focuses on establishing a respectful and welcoming environment that is inclusive for all.

This is done through a variety of means with the intention of raising awareness and increasing sensitivity levels.

NCSS acknowledges that we are not perfect, and we expect to experience failures; it is learning from the failure that is important.

WHAT WORKS:

- Cross-divisional committee focuses on implementing the diversity plan by increasing awareness and inclusion efforts for staff and program services
- Staff, clients & board members are surveyed annually to identify areas of strength, weakness, and opportunities



DIVERSITY AND CULTURAL AWARENESS

NCSS 2015-2017

Education & Training	5.71
Organization Environment	5.80
Linguistic Competency	5.96
Visual Representation	5.86
Public Relations	5.61
Service Delivery (Trauma Informed)	5.87

Story Behind the Baseline Performance:

The committee sponsors Training and Education events that have included Trauma Informed service models and integration; trainings in LGBTQ, deaf, equity, etc. to raise staff and community awareness & sensitivity levels.

Internal policies and information has been updated to be more Linguistically friendly by using gender neutral language, font size, and language translation as appropriate.

Our locations are examined to ensure a respectful and welcoming Environment for all persons served and employed, which has included Visual Representation improvements such as signage and using preferred names and pronouns.

Our Public Relations efforts have included a diverse mix of media campaigns focused on decreasing stigma.

Integrating Family Services

SOCIAL DETERMINANTS

WHAT WORKS:

- Increasing our efforts around collaboration with schools, primary care and child welfare
- Creating person centered goals to build optimism and a sense of locus of control for our clients
- Identifying areas of strengths, as well as needs, focuses our treatment on the positive growth of our clients and informs the treatment process

ACTION PLAN:

- To work with primary care and other health care providers to implement mechanisms to further communication and sharing of information to support holistic care.
- To evaluate evidence based and informed practices to further increase quality of care being provided to children and families.
- To assess gaps and strengths within continuum of care and develop innovative practices that will meet need of community.

HOW WE IMPACT:

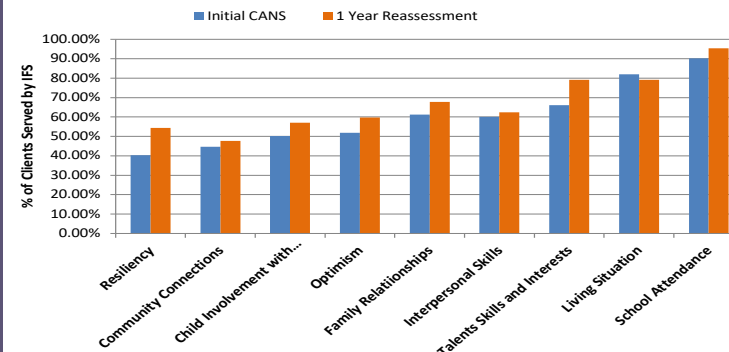
Social determinants of health impacted by integrating Family Services include: access to health care services, smoking, suicide, socioeconomic conditions, access to education, availability of resources to meet daily needs, job training opportunities, transportation, public safety, social support, culture, obesity, mental health & substance abuse, and domestic & sexual violence

PARTNERS:

- Department for Children and Families
- Local Schools
- Primary Care Physicians
- Law Enforcement
- New England Counseling and Trauma Associates
- Northwestern Medical Center
- Vocational Rehabilitation
- Watershed Mentoring
- Vermont Child Welfare Training Partnership
- Restorative Justice
- Home Health
- Child Development Clinic
- Federally Qualified Health Centers



% of Clients Served by IFS with a Strength Related to Social Determinants of Health at Initial CANS vs One Year Reassessment



Story Behind the Curve:

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 care coordination, 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.

IFS completes the Child and Adolescent Needs and Strengths (CANS) tool with children, youth, and families served. The CANS scores indicate that when children are engaged in IFS they develop and gain strengths in several different areas, including resiliency, talents/interests and skills, school attendance, optimism and community connections. IFS has allowed service providers unique opportunities to collaborate and support children and families in achieving goals related to social determinants of health.

Pregnant and Postpartum Mothers & PARENTAL RESILIENCE SOCIAL CONNECTIONS

WHAT WORKS:

- Therapy is provided by a Licensed Clinical Mental Health Counselor with certification from Postpartum Support International (PSI) in Maternal Mental Health
- Treatment plans that address overall wellness and social support, while reducing symptoms of anxiety, depression, suicide, and other mental health concerns
- 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
- Individual wellness goals, such as: reducing tobacco use, joining a gym, walking for weight loss, practicing mindfulness, attending medical appointments with primary care including the 6 week postpartum follow-up, accepting home health home visits, completing substance treatment, and attending the support group Baby Bumps

- Facilitation of a support group, Baby Bumps, by FCHHA for mothers which our therapist will refer to
- Training for the entire staff of Champlain Valley Head Start on Depression in Families in 2017

ACTION PLAN:

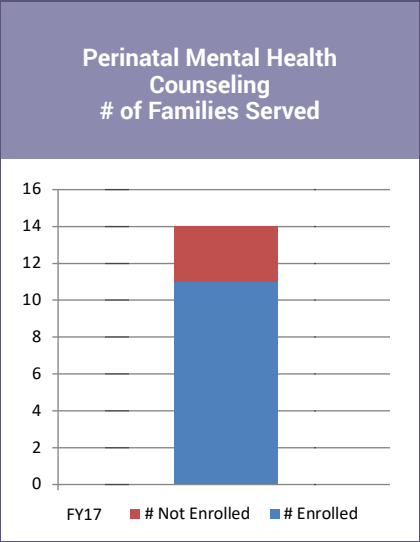
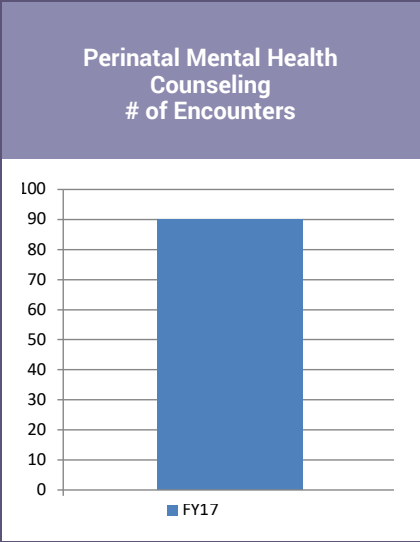
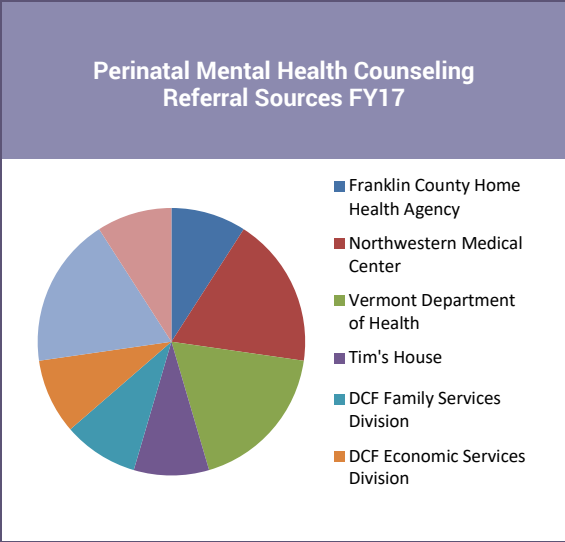
- Utilize Edinburgh Postnatal Depression Screening tool to measure clinical progress
- Continue to pilot the Adult Needs and Strengths Assessment (ANSA) with mothers receiving home counseling. Continue to screen mothers for substance use via the UNCOPE tool
- Create a structured process for supporting mothers impacted by perinatal loss (such as a miscarriage or a death shortly after delivery) with VDH, NMC, and FCHHA

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

PARTNERS:

- Franklin County Home Health Agency (FCHHA)
- Local physicians and obstetric/gynecological providers
- Northwestern Medical Center (NMC)
- Department for Children and Families (DCF)
- Vermont Department of Health (VDH)
- Department of Mental Health (DMH)



Story Behind the Curve:

After a 1 year pilot, NCSS designated a therapist for Perinatal Mental Health Counseling (PMHC). PMHC provides in-home therapy for mothers in the perinatal period (pregnancy and up to one year postpartum). Gradually, referrals have increased and the service is growing in demand across health care providers and child welfare social workers. A local monthly meeting with Franklin County Home Health Agency (FCHHA), Vermont Department of Health (VDH), and Northwestern Medical Center (NMC) continues to focus on maternal mental health through screening, referral, and a support group. At the state level, the Department of Mental Health (DMH) and VDH are working with designated mental health agencies and parent child centers to increase training across disciplines regarding perinatal mental health.

Early Childhood PRESCHOOL READINESS

WHAT WORKS:

- Conducting developmental screenings and full developmental assessments
- Facilitating monthly meetings with supervisory union and EI staff to provide updates on upcoming transitions
- Partnering with medical providers and specialists to ensure the best care & outcomes for children & families
- Providing mental health consultation and classroom observations for Champlain Valley Head Start (CVHS)
- Working with CVHS to fill classroom openings
- Offering on-site observations and consultation to preschool classroom teachers and staff
- Promoting and recommending preschool for all children
- Promoting and supporting families in accessing high quality child care to support their child's development
- Troubleshooting barriers families face to increase access to education and other needed supports and community resources, (e.g. housing, finances, transportation, and safety concerns)
- Implementing evidence-based curriculum such as Parents as Teachers and research-informed frameworks such as Strengthening Families: A Protective Factors Framework

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
- Develop a committee within the Parent Child Center to explore opportunities for professional development and collaboration in the area of early childhood services, specifically consultation to child care programs

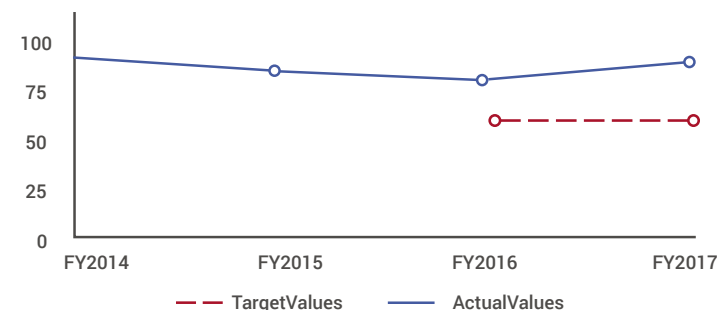
HOW WE IMPACT:

Social Determinants of Health impacted by Parent Child Center early childhood home visiting: 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

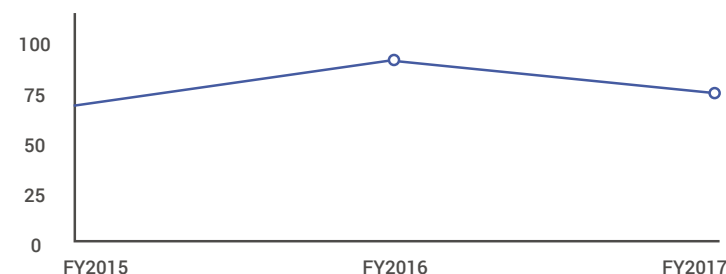
PARTNERS:

- Medical: Pediatricians, hospitals, Franklin County Home Health Agency, Visiting Nurse Association of Chittenden and Grand Isle Counties
- Education: Local supervisory unions, Champlain Valley Head Start
- Child Care: Centers and registered providers
- State: Department for Children and Families, Department of Health
- Financial: Community Action, Tim's House

CYF - Early Childhood Support: % of Preschool-Aged Children Enrolled in Preschool



CYF - Early Intervention: % of Children that Exit Early Intervention Services at Age 3 to an Individualized Education Plan (IEP)



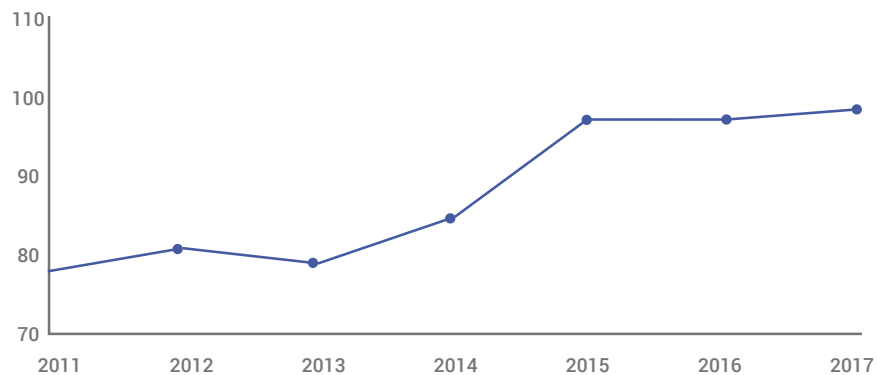
Story Behind the Curve:

Early Intervention (EI), a special education service for children birth to 3, and Early Childhood Support (ECS), mental health and parenting programming, provide home visits to ensure young children thrive and increase school readiness. Children are supported to meet age appropriate developmental expectations, or are supported with a 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 reach goals.

Integrated Care

Bay View CRISIS CARE CENTER

BH - CRT: Bay View Crisis Care Center - % of Clients who Successfully Diverted Hospitalization



Story Behind the Curve:

Bay View Crisis Care Center has invested energy into increasing their program's ability to provide supportive counseling and a more clinical focus over the past few years. All staff are now trained in CAMS (Collaborative Assessment and Management of Suicidality). Other skills based programs include: WRAP (Wellness Recovery Action Plan), Wellness Self-Management and NAPPI (Non-Aggressive Psychological and Physical Intervention). These practices enabled the program to support clients with more acute needs and factored into the increase in successfully diverting hospitalizations.

ACTION PLAN:

- Develop a process to systematically train staff on administration of the BSI (Brief Symptom Inventory) to maintain reliability
- Continue to enhance and maintain clinical program offerings such as CAMS, WRAP and Wellness Self-Management
- Continue to include the client's natural supports based on client preference

WHAT WORKS:

By having the client remain in their community, the Bay View Crisis Care Center is able to:

- Maintain connection with client's natural supports as part of their treatment plan and/or discharge
- Maintain connection with ongoing clinical support staff, including PCP
- Access to psychiatry and mobile supports through NCSS as part of transition home

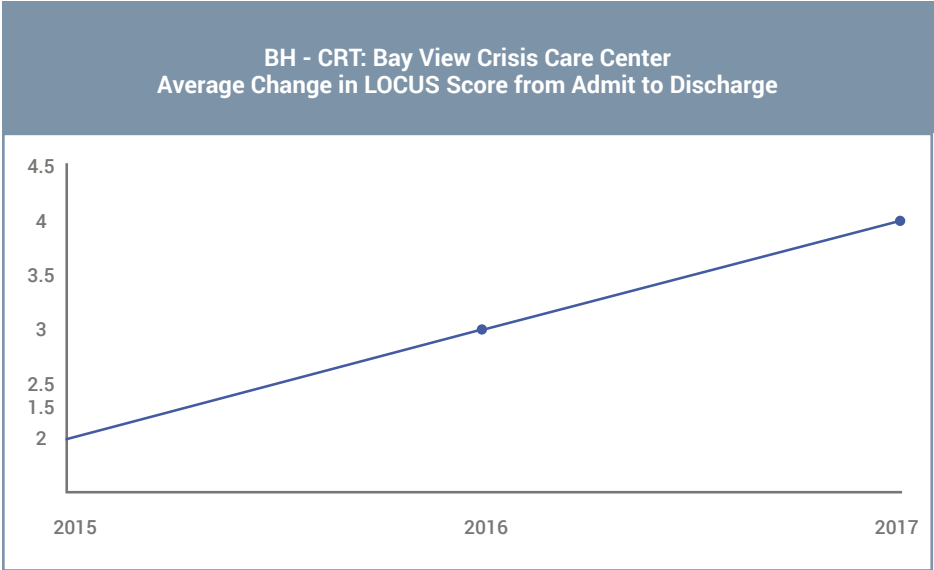
HOW WE IMPACT:

Social determinates of health impacted by Bay View: access health care services; connecting with resources to meet daily needs; access to education: job training and opportunities: transportation; social support; mental health support and substance abuse prevention, suicide prevention, public safety

PARTNERS:

- Local Primary Care Physicians and Medical Providers
- Local Emergency Department
- Local Mental Health Private Practices
- Psychiatric Hospitals
- Homeless Shelters
- Other Designated Agencies





Story Behind the Curve:

The LOCUS (Level of Care Utilization System) was designed to determine the level of care an individual should receive. 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, Additive and Psychiatric Co-Morbidity 4. Recovery Environment 5. Treatment and Recovery History 6. Engagement and Recovery Status.

Generally, clients who are acute at intake have a higher LOCUS 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 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.

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.

HOW WE IMPACT:

Social Determinant of Health can interfere with client's ability or desire to work, connecting with resources, socialization and access to mental health care. Bay View can help clients to overcome some of these barriers, such as access to health care services; connecting with resources to meet daily needs; access to education; job training and opportunities; transportation; social support; mental health & substance abuse; and smoking

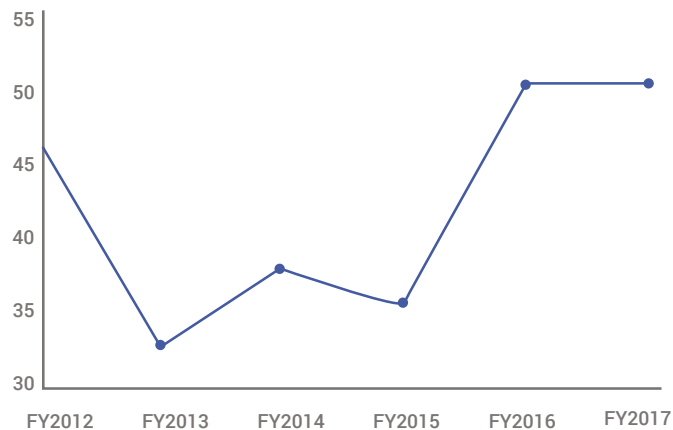
PARTNERS:

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



Emergency Department DIVERSION

% of Face to Face Contacts Clinician Believed Avoided
Emergency Department Contact



Story Behind the Curve:

We would like to see this number continue to increase, however, with the acuity of some clients (i.e. dangerousness to self or others or unable to stay in community to be assessed/or medical complications) there are times when there is no other option but being seen at the Emergency Department (ED). Our acuity continues to increase along with clients served who have poorly managed chronic health conditions, which requires medical intervention and support as well as a mental health screening. We continue 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:

- Debriefing about situations that didn't go as planned
- Support law enforcements understanding of assisting persons with mental illness
- Working closely with law enforcement and community partners to bring clients to alternate locations vs. ED if it's not warranted
- Working closely with community partners to continue to build on positive relationships and education
- Meeting clients where they are at such as their home, primary care and other community sites if medical intervention is not needed to be assessed
- Meeting with law enforcement monthly

ACTION PLAN:

- Hired two specific staff to navigate the law enforcement world and be implanted in offices to improve relationships and continue to provide education around mental illness
- Increased social workers being embedded at all patient centered medical homes
- Be involved in local community groups to discuss challenging patients and how we can best support in community for recovery and avoid unnecessary trips to the Emergency Department usage
- Rapid Access in our Outpatient program help clients access services quickly and knowing they have that option at times prevents client from going to the ED

HOW WE IMPACT:

When we see clients who identify as being in crisis we support client with safety and resources that may include 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

PARTNERS:

- Vermont State Police
- St. Albans City Police
- Swanton Police Franklin & Grand Isle County Sheriff
- Lamoille County Sheriffs for non-intrusive transports
- Homeland Security
- Northwestern Medical Center Local Primary Care offices



Continued from PREVIOUS PAGE (ED DIVERSION)

WHAT WORKS:

- Debriefing about situations that didn't go as planned
- Support law enforcements understanding of assisting persons with mental illness
- Working closely with law enforcement and community partners to bring clients to alternate locations vs. ED if it is not warranted
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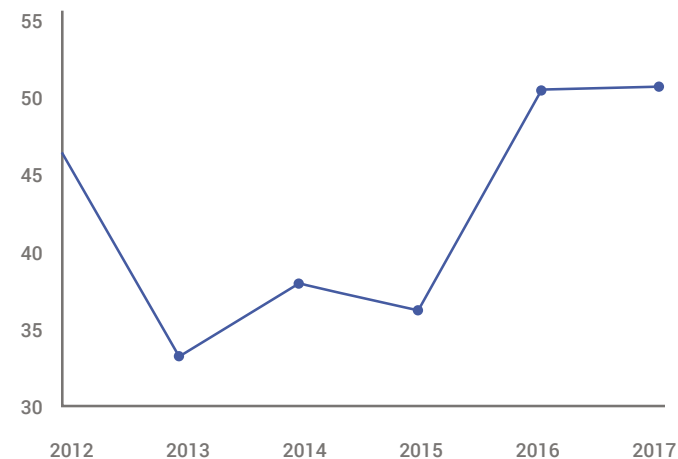
HOW WE IMPACT:

When we see clients who identify as being in crisis we support client with safety and resources that may include 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



Your professional services have provided me with ability to experience a better life.

% of Face to Face Contacts Clinician Believed Avoided Emergency Department Contact



Story Behind the Curve:

We would like to see this number continue to increase, however, with the acuity of some clients (i.e. dangerousness to self or others or unable to stay in community to be assessed/or medical complications) there are times when there is no other option but being seen at the Emergency Department (ED).

Our acuity continues to increase along with clients served who have poorly managed chronic health conditions, which requires 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.

Continued from PREVIOUS PAGE (ED DIVERSION)

WHAT WORKS:

- 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 same day access for non-emergency situations with a range of services
- Client Centered Treatment Plans/Crisis Plans to support client with individual needs and wants
- Utilizing crisis bed programming across the state

ACTION PLAN:

- Manage high acuity cases in leadership clinical discussion to support unique client needs for stability and creative and supportive recovery ideas
- Consultation with outside sources
- Minimize length of stay for these hospitalizations to increase recovery in home environments



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

PARTNERS:

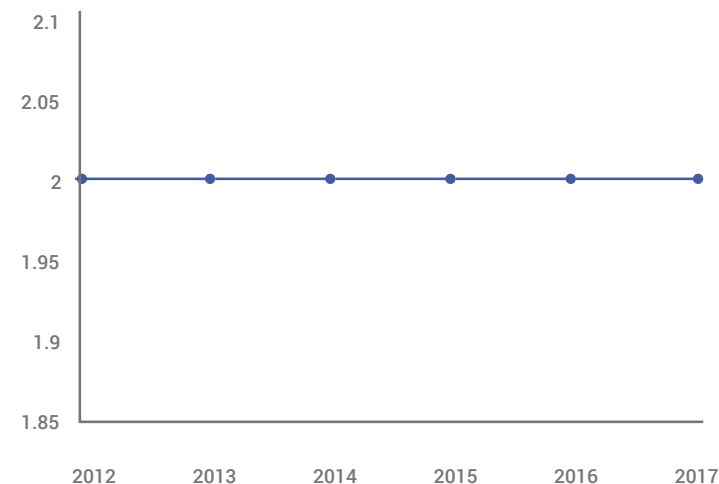
- Economic Services
- Department for Children & Families
- Department of Vermont Health Access
- Community Action
- Champlain Valley Agency on Aging Hospitals
- Primary Care Providers
- Department of Corrections
- Blueprint Team
- Designated Agency's Crisis Beds

“

The staff at NCSS are very nice and are very helpful and they work with you and are patient. Would recommend them to family and friends.

”

% of Involuntary Inpatient Psychiatric Admissions



Story Behind the Curve:

Our team works extremely hard to support clients in their recovery and the least restrictive care. We have been very successful in being able to avoid involuntary hospitalizations.

We have had a few clients struggling with severe mental health symptoms who could not remain safe in any community setting despite our attempts. These clients need a facility that could keep them safe and meet their psychiatric needs. This cannot always be avoided.

Our graph illustrates that in 2017 it has increased slightly. It is also noteworthy, that in comparison to other state designated mental health agencies we remain extremely low.

Community Rehabilitation and Treatment HOSPITAL FOLLOW-UP

WHAT WORKS:

- Maintaining contact with inpatient hospital
- Social workers to be part of the treatment in the hospital and to be apprised of discharge with enough time to secure follow up services appropriately
- Department of Mental Health provides this data, so no manual tracking is required
- Prioritize hospital discharges from a step down to our crisis bed program in order to ensure positive transition back into their community

ACTION PLAN:

- Review Performance Improvement Plan (PIP) reports and address any concerns about data quality
- Ask Department of Mental Health for PIP data in a timely manner
- Continue to educate/train Community Support Workers on the importance of having contact throughout the hospitalization and to be part of the discharge plan

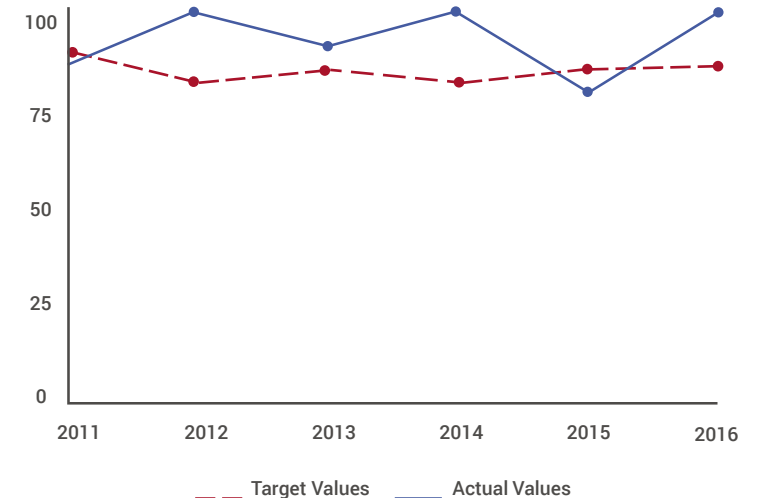
HOW WE IMPACT:

Social determinants of health impacted by providing follow-up services within 7 days after discharge from psychiatric hospitalization: access to health care services, connecting with resources to meet daily needs, job training and opportunities, social support, public safety, transportation, housing, mental health support, suicide prevention substance use prevention

PARTNERS:

- Psychiatric hospitals
- Local primary care physicians and medical providers
- Pharmacies
- Crisis bed program
- Local emergency room
- Local mental health private practices

Number of clients who were provided a follow-up service within seven days after discharge from psychiatric hospitalization



Story Behind the Curve:

Our Community Rehabilitation and Treatment (CRT) program seeks to provide follow up service with our clients as soon as possible after discharge from any psychiatric hospitalization.

An analysis of the average follow up time after discharge from 2011 - 2015 put NCSS at 95% seen within 7 days.

The latest data provided by the Vermont Department of Mental Health indicated we reached 100% in FY16 with 83% of clients receiving follow up the same day.

The transition from hospital to home is a period of particularly higher risk. Follow-up with the client's treatment team for further treatment has been shown to have an effect on reduced readmission among discharged clients.



Patient Centered MEDICAL HOMES (PCMH)

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

ACTION PLAN:

- Working toward the ability to capture outcomes in a systematic way to better measure impact of this program moving forward

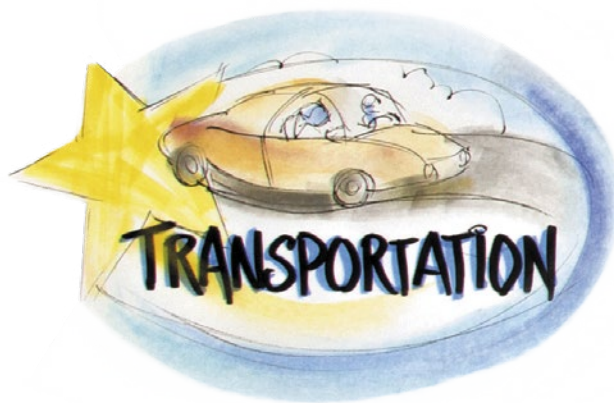
HOW WE IMPACT:

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

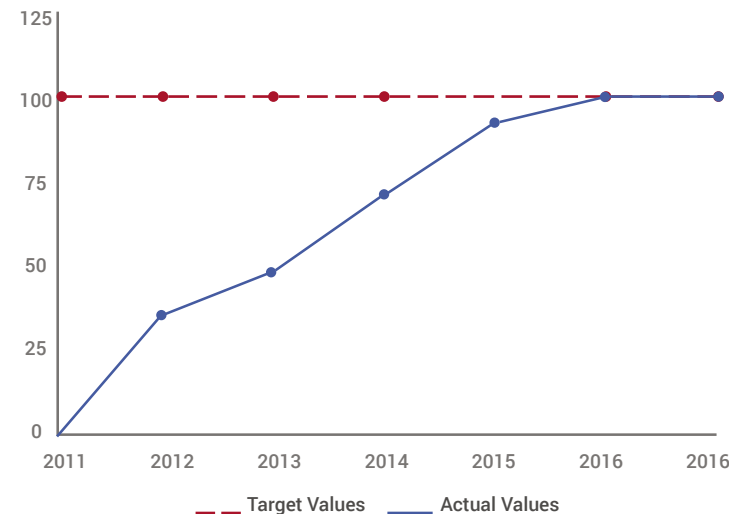
PARTNERS:

- National Council on Quality Assurance
- Patient Centered Medical Homes

The Patient-Centered Medical Home (PCMH) is a care delivery model where patient treatment is coordinated through their primary care provider to ensure they receive the necessary care when and where they need it.



% of Patient Centered Medical Homes with NCSS Staff Embedded



Story Behind the Curve:

The Integrated Health services are a team of Social Workers and Wellness Counselors embedded within the Primary Care setting available to individual's 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.

Developmental Services CRISIS TEAM

WHAT WORKS:

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

ACTION PLAN:

Develop a model for alternative crisis placements under critical situations

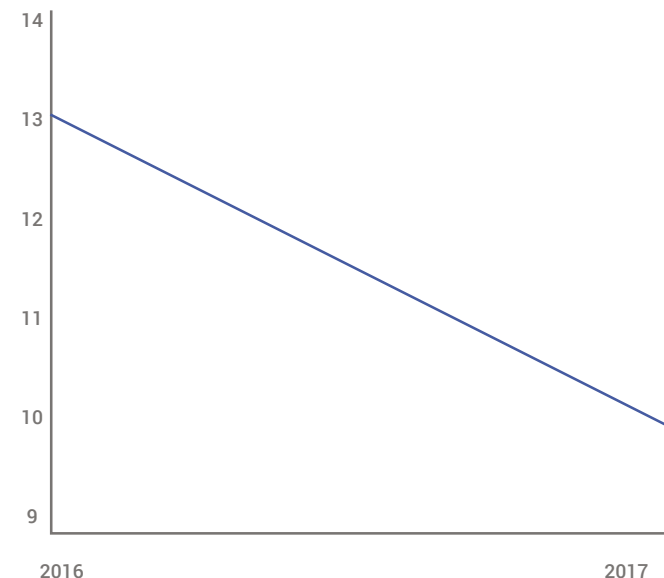
HOW WE IMPACT:

Access to healthcare services, resources to meet daily needs, support for chronic health conditions, public safety, economic support, transportation, housing, mental health, and social support

PARTNERS:

- Developed internal proactive communication system within the division
- Saint Albans City Police
- Vermont State Police
- Behavioral Health Crisis team

Number of Placements Outside the Home After a Crisis



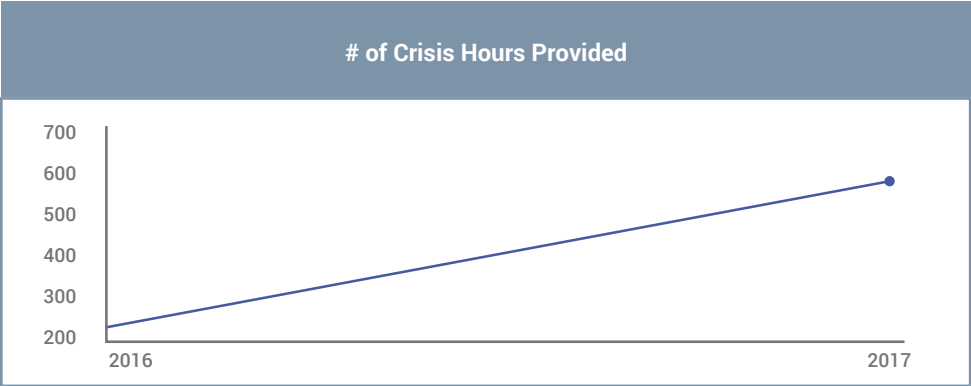
Story Behind the Curve:

Over the last year, the Developmental Services (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.

The above 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.

Continued from
PREVIOUS PAGE



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:

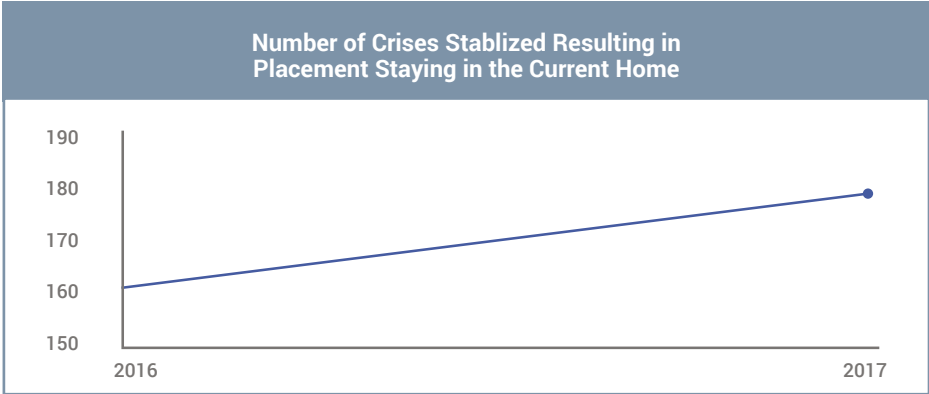
- Continuing to educate and train for crisis
- Create individual crisis plans
- Decrease emergency department utilization

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

PARTNERS:

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



Story Behind the Curve:

Over the last year, the Developmental Services (DS) Crisis team has strived to support those in their living arrangements and provide resources and skills to increase stability to foster and strengthen the supports that are already in place. The team has worked to proactively support tenuous situations before they turn into a “crisis” in order to avoid unresolvable conflict. By maintaining permanent housing options, the consumers’ needs are most likely to be met by a trained team who is familiar with the necessities of care. Sustainable, stable placements in family style homes support the inclusion of all people within the community in a welcoming, encouraging fashion. The DS Crisis team’s devotion to this model encourages the outreach from those in need of supports. 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:

Access to healthcare services, resources to meet daily needs support for chronic health conditions, public safety, economic support, transportation, housing, mental health, social support

PARTNERS:

- Saint Albans City Police
- Vermont State Police
- Behavioral Health Crisis team

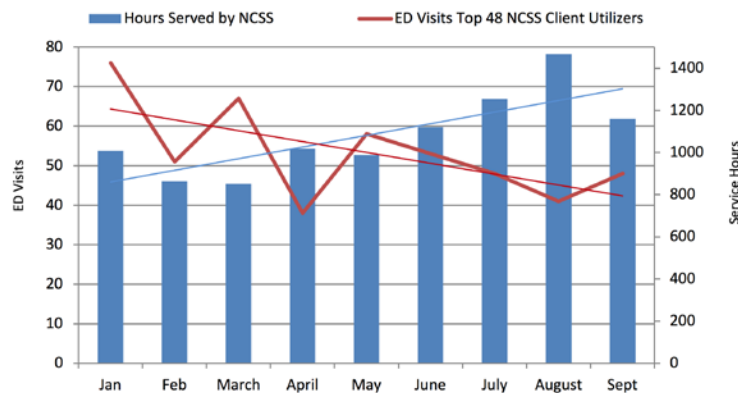
NCSS High ED Utilizer Summary

HOW CLIENTS ARE IDENTIFIED AS HIGH ED

- NMC tracks High ED Utilization monthly and provides NCSS a quarterly report from which NCSS clients are identified
- An individual is identified as an Active NCSS Client if they are engaged in any service beyond a Crisis only service
- From January 2017 through Sept 2017, 48 clients who are engaged in services at NCSS have been identified as High ED Utilizers *

WHAT HAS CONTRIBUTED TO THE REDUCTION OF ED VISITS:

- Monthly meeting with NMC focusing on identifying high utilizers and developing a collaborative approach
- Hired Full Time Employee (FTE) Embedded ED Crisis Clinician – funded by NCSS
- Provide care management resources for personal and family adjustments, finances, employment, food, clothing, housing and symptoms of mental illness
- Utilize Bay View Crisis Care Center proven effective at reducing symptoms of anxiety, depression and somatic symptoms
- Initiate and track community referrals
 - Between Jan – Sept of 2017 the NCSS ED Embedded Clinician connected 35 patients to a PCP who previously did not have one identified

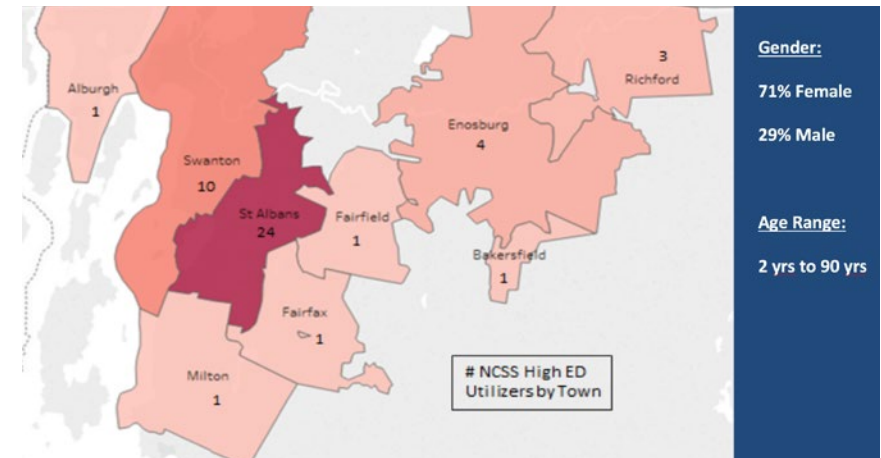


37% Reduction in ED
Visits by NCSS Active Clients
January to September 2017

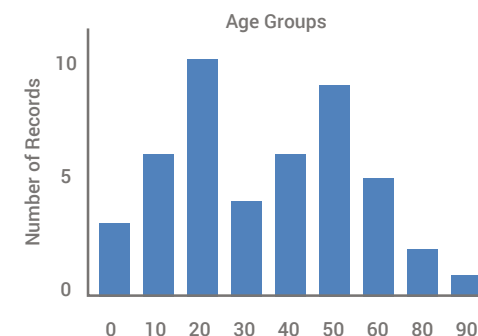


Profile of NCSS High ED Utilizer Population

Number of NCSS High ED Utilizers by Town



Age Breakdown

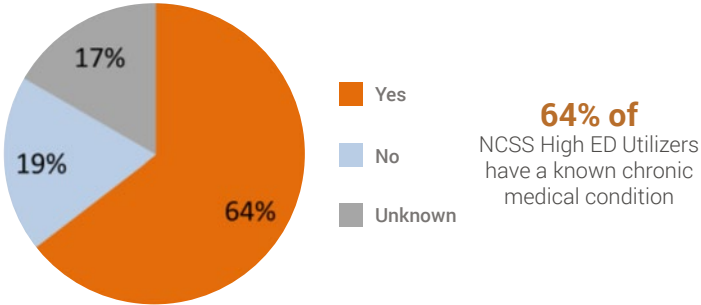
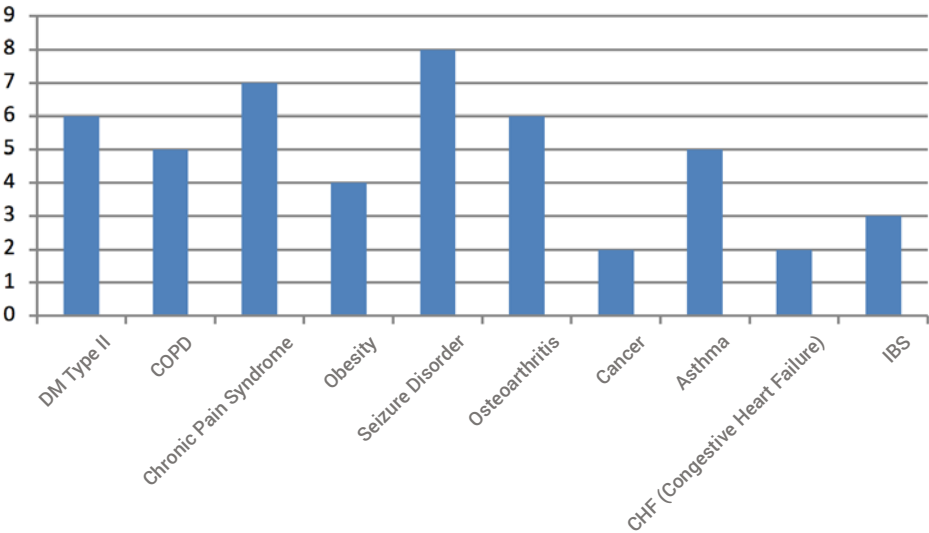


Primary Care Affiliation

The Notch	31%
St. Albans Primary Care	21%
Northwestern Primary Care	15%
Northwestern Pediatrics	8%
Northwestern Georgia Health Center	2%
Unknown Affiliation	23%

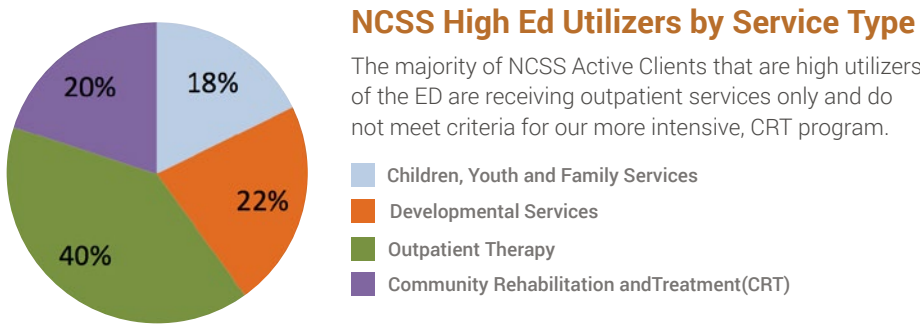
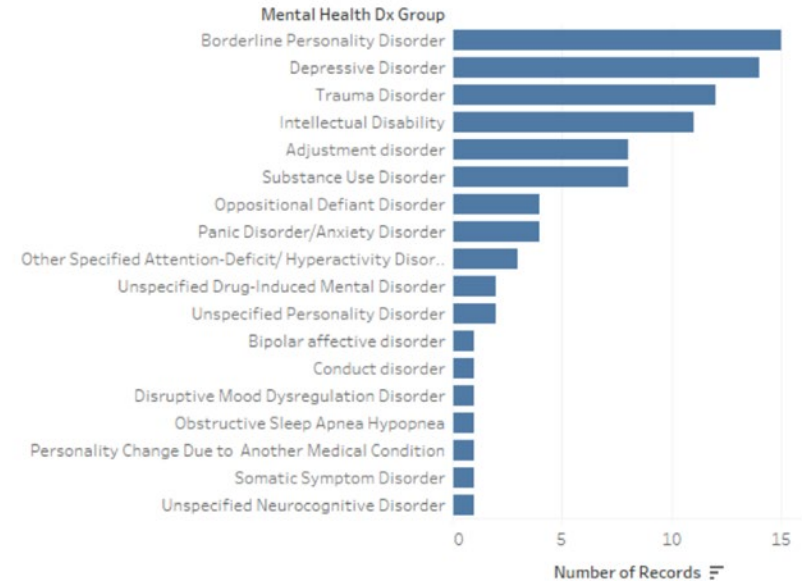
Medical Profile of NCSS High ED Utilizer Population

Prevalence of Chronic Conditions for NCSS High ED Utilizers



Mental Health Profile of NCSS High ED Utilizer Population

NCSS High Ed Utilizers by Mental Health Dx



Police Department COLLABORATION

WHAT WORKS:

- Working closely with law enforcement and community partners to bring clients to alternate locations other than the Emergency Department
- Requesting community partners contact NCSS vs. the police if no one is at imminent risk
- Completed the Mental Health First Aid course with law enforcement

ACTION PLAN:

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

HOW WE IMPACT:

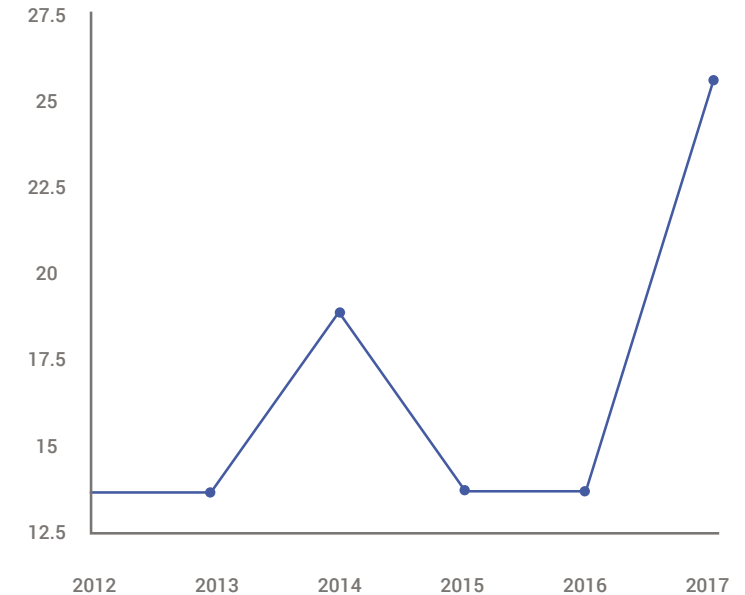
Access to healthcare services; resources to meet daily needs; support for chronic health conditions; public safety; economic support; transportation; housing; substance use prevention; mental health; social support; suicide prevention

PARTNERS:

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



BH - Crisis: % of Face to Face Contacts
with Any Police Involvement



Story Behind the Curve:

We would like to see the contact we have with law enforcement increase. Law enforcement is often the first line of crisis response involving community members struggling with mental illness. Law enforcement has asked for more support and education in working with individuals struggling with mental health symptoms. Working in tandem partnerships has been very effective in deescalating non-criminal community events. Our data shows that being on scene may prevent unnecessary ED visits and decrease unnecessary incarcerations.

Developmental Services

SOCIAL SECURITY SAVINGS

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) 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:

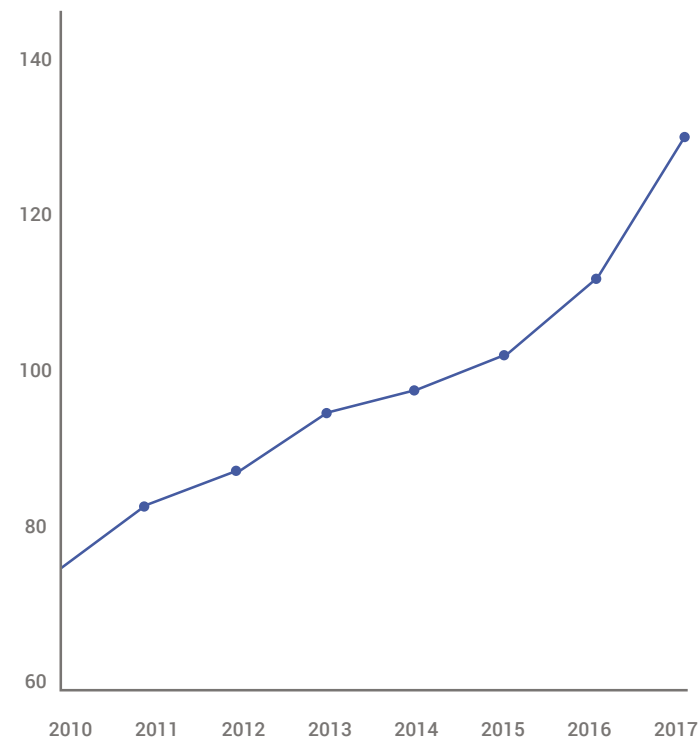
Public safety, economic support, access to education, transportation housing, job training, mental health, social support, resources to meet daily needs

PARTNERS:

- Department for Aging and Independent Living (DAIL) and Designated Agencies Supported Employment Coordination Team
- Vocational Rehabilitation
- Creative Workforce Solutions
- Transitioning Youths Group
- Community high school special education employment programs



DS - Employment: # of Clients Employed in Employment Program



Story Behind the Curve:

NCSS's Supported Employment (SE) Team has two full-time, Employment Team specialists (ETS) working to find competitive employment for all individuals served expressing an interest in competitive jobs. The ETS to client ratio 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.

Soar Learning Center

POSITIVE BEHAVIORS

WHAT WORKS:

- Student/staff collaborative problem-solving
- Developing a positive classroom and school-wide culture
- Individualized classroom accommodations
- Building staff knowledge & skill in critical areas
- Teaching and supporting students' self-awareness and competency
- Proactively meeting basic needs without shame
- Family and community connections

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:

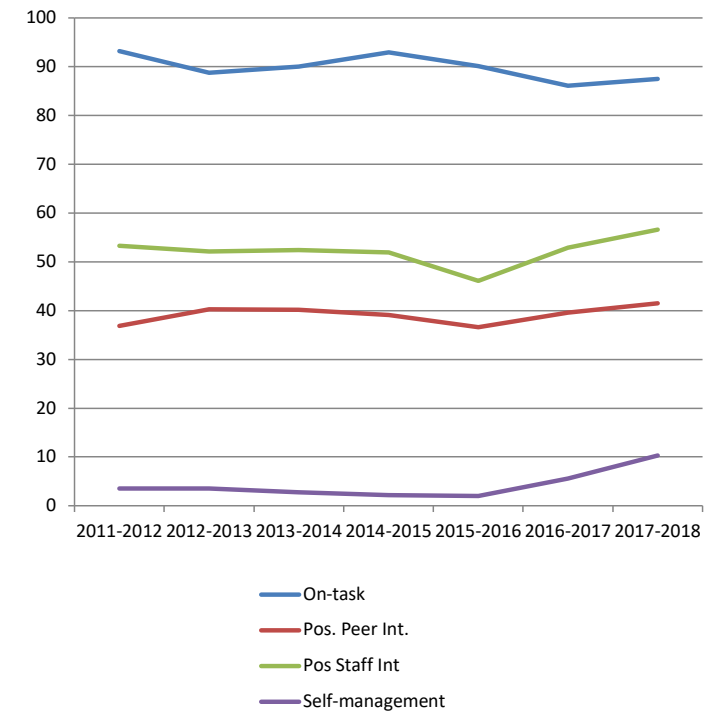
Access to education, access to healthcare resources to meet daily needs, vocational assessment & training transportation, mental health, substance use prevention social support, public safety

PARTNERS:

- Maple Run Unified District
- Franklin Northwest Supervisory Union
- Franklin West Supervisory Union
- Franklin Northeast Supervisory Union
- Grand Isle Supervisory Union
- Winooski Elementary School
- Milton Elementary School
- Milton High School
- Colchester Elementary
- VT Department for Children and Families
- VT Vocational Rehabilitation
- St. Albans Town
- St. Albans City Police Department
- Local pediatricians



Positive Behaviors: First Trimester



Story Behind the Curve:

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.

Soar Learning Center SELF-MANAGEMENT

WHAT WORKS:

- Reliable and nurturing relationships with staff and peers
- Creating opportunities for students to develop coping skills and self-mastery
- On-going professional development for staff
- Providing consistent and timely information and social support to families
- Creating and maintaining routines, traditions, and celebrations to build predictability and connection among students, family and the school community
- Classroom mindfulness & individualized stress reduction strategies
- Classroom sensory spaces

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

HOW WE IMPACT:

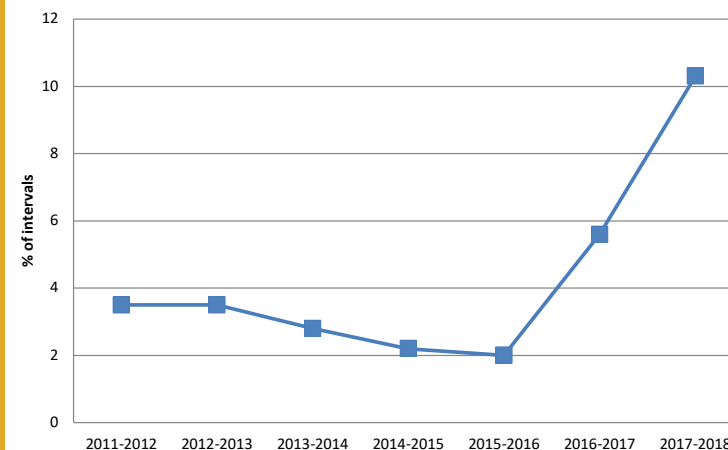
Access to education, access to healthcare, resources to meet daily needs, vocational assessment & training, transportation, mental health, substance use prevention, social support

PARTNERS:

- Maple Run Unified District
- Franklin Northwest Supervisory Union
- Franklin West Supervisory Union
- Franklin Northeast Supervisory Union
- Grand Isle Supervisory Union
- Winooski Elementary School
- Milton Elementary School
- Milton High School
- Colchester Elementary
- VT Department of Children and Families
- VT Vocational Rehabilitation
- St. Albans Town
- St. Albans City Police Department
- Local pediatricians



Self Management



Story Behind the Curve:

Soar Learning Center has begun a new initiative with the goal of creating a school environment that cultivates resiliency in students. We implemented mindfulness strategies in the classroom, introduced MindUP curriculum for K-8 students, Brain Breaks, and the Calm App.

Students can choose to access the sensory room or use a hand-held manipulative at their desk. The room is designed to reduce stress and has items that appeal to the five senses. Classroom teachers and behavior interventionists are trained to engage the students in educational activities and social-emotional learning that assists in identifying and self-regulating emotions.

Therapeutic Community INTEGRATION PROGRAM

WHAT WORKS:

The 3 R's: Respect, Responsible, and Reasonable. Deficiencies in these areas have been identified as primary obstacles for many of the people supported under the Public Safety umbrella in the Berkshire Residential Homes. Therefore, skill building and development in these areas are paramount to improving the quality of life for the individuals we support. The residential staff at Berkshire role model behavior that is respectful, responsible, and reasonable both in the home and in the community. Health & Safety Protocols (1-4) are utilized by staff to support the development and skill building of the 3Rs. This is a tiered system that enables staff to support individuals in identifying behaviors that are a detriment to the health and safety of themselves, professional supports, natural supports, and the public.

ACTION PLAN:

- Development of a "step-down" transitional house
- Consistent employment
- Reducing supervision during transitional placement
- Increase in Independent Living Skills
- Support/growth of natural networks
- Slow and progressive steps towards community independence

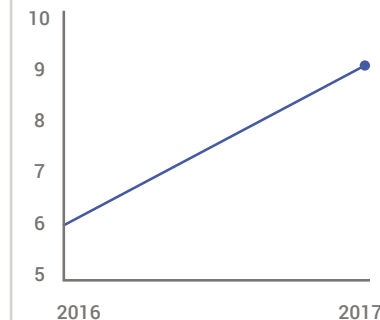
HOW WE IMPACT:

Access to healthcare services, resources to meet daily needs, public safety support, transportation, housing, job training, substance use and prevention, mental health, and social support

PARTNERS:

- DAIL (Department of Public Safety Probation & Parole)
- NCSS Employment Services
- Vocational Rehabilitation
- Clinical Consultants (SODG)
- Judicial System
- State & Local Police

of Individuals Served in Residential Home



Story Behind the Curve:

Berkshire has served nine individuals during 2017, five individuals as part of its residential program. Long-term residential support has been provided to 2 other individuals with significant medical and behavioral support needs. Two individuals have been supported on short-term (crisis) residential needs. These individuals were involved with the legal system due to current restrictions and recent criminal behavior. One individual transitioned out of UBH to less restrictive placement and 1 individual transitioned back into the criminal justice system.

WHAT WORKS:

Development of the Berkshire program is, by design, meant to be a 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 met the exit criteria they are moved to a "Step Down" process that allows them to safely continue their socialization and emotional maturation as they work 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

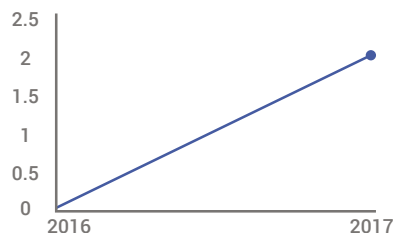
HOW WE IMPACT:

Access to healthcare services, resources to meet daily needs, public safety, transportation, housing, job training, mental health, and social support

PARTNERS:

- DAIL – Department of Public Safety Probation & Parole
- NCSS Employment Services
- Vocational Rehabilitation
- Clinical Consultants (SODG)
- Judicial System
- State & Local Police

of Persons Moving Off Public Safety Mandated Restriction



Story Behind the Curve:

In 2016, seven individuals were served through the TCIP team with mandated public safety restrictions and in 2017, eleven individuals were served through the TCIP team with mandated public safety restrictions. Two individuals transferred out from the 24/7 residential to step-down community placement in 2017. The past year has seen an increase in individuals with trauma history being referred to the Berkshire program; 2 individuals, over the past year, have moved off Public Safety restrictions. Berkshire Residential Program is a four-bed site that works on a 1-2 year transition period.

Collaborative ACHIEVEMENT TEAM (CAT)

WHAT WORKS:

- Providing 1:1 social, emotional and behavioral support for students who struggle with self-regulation within their school communities
- CAT uses the comprehensive functional behavior assessment (FBA) model to identify the function of a student's engagement in aberrant behavior
- CAT staff work closely with school and families to develop an individualized behavior plan with specific interventions rooted in Applied Behavior Analysis (ABA) to fit a student's needs and provide strengths based approaches
- CAT staff provides daily behavioral support and individualized skill instruction
- CAT staff are trained in Attachment, Regulation, and Competency (ARC) and the Life Space Crisis Intervention (LSCI) framework to enhance our ability to provide trauma informed care to our students and families
- 88% of CAT staff have completed Applied Behavior Analysis 1 (ABAI)
- CAT team includes two Board Certified Behavior Analysts (BCBAs) who hold Consultant positions within the team

ACTION PLAN:

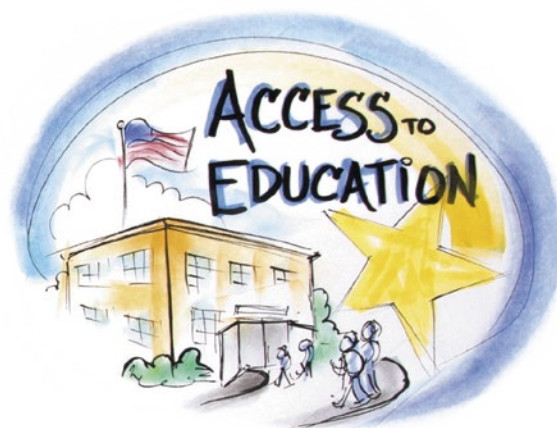
- Currently there are 13 CAT staff who are taking classes or are enrolled in graduate level ABA coursework
- CAT is looking to fill another Senior Behavior Interventionist position
- CAT will continue to boost team's overall expertise in ABA, and will continue to provide schools with education in ABA to improve their support of students using evidenced based practices

HOW WE IMPACT:

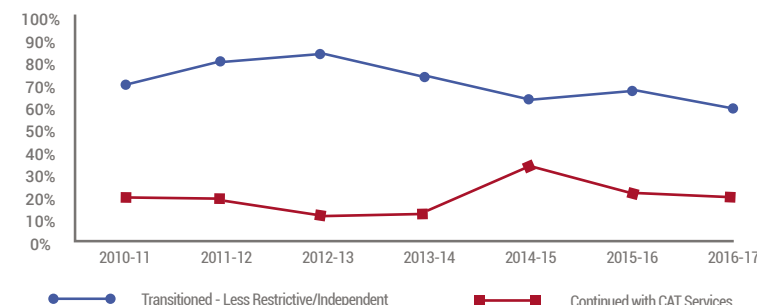
Access to education

PARTNERS:

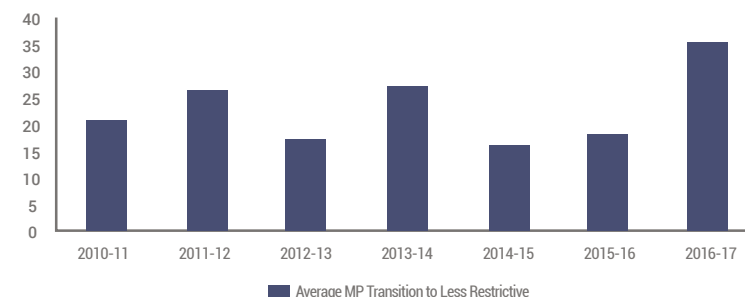
- 48% of the local public schools in Franklin and Grand Isle County
- Department for Children and Families
- Northeastern Family Institute



Percentage of CAT Students that Transitioned to Less Restrictive Environment or Independence



Average Months in Programming Positive Transitions



Story Behind the Curve:

During the 2016-17 school year CAT provided services to 32 students within 4 school districts at 10 different local public schools. Of the 32 students, 5 transitioned to a less intensive level of support through the School-Based Behavior Consultation (SBBC) team and 1 student transitioned independently. Due to the implementation of the SBBC program, CAT is able to transition students to a less intensive level of support prior to transition, independently accessing their education. The average months in programming (MIP) prior to transition to a less restrictive level of support for 2016-2017 school year ranged from 4-60 MIP. This included a student who transitioned back from an alternative placement to their school community with CAT support and eventually transitioned to SBBC support based on the student's needs.

Children’s Behavior Services

SCHOOL-BASED AUTISM TEAM

WHAT WORKS:

- Strong partnerships between supervisory unions and NCSS to determine appropriate level of student support
- School Based Autism Team utilizes a data centered approach to provide recommendations for programming and report out on progress of individual student goals to school teams
- 1:1 support allows for access to individualized education (academic modification and support, community exposure, social inclusion, daily living skills)
- Highly trained staff skilled in the areas of Autism and other Neurodevelopmental Disorders, Applied Behavior Analysis (ABA) and collaborative approaches to student support

ACTION PLAN:

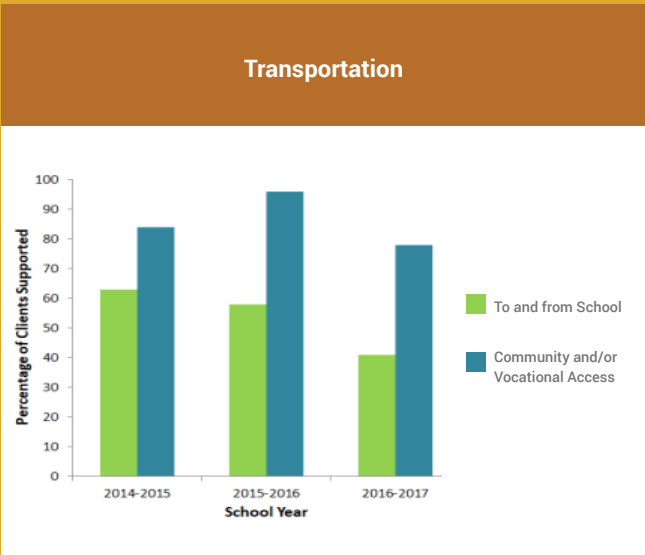
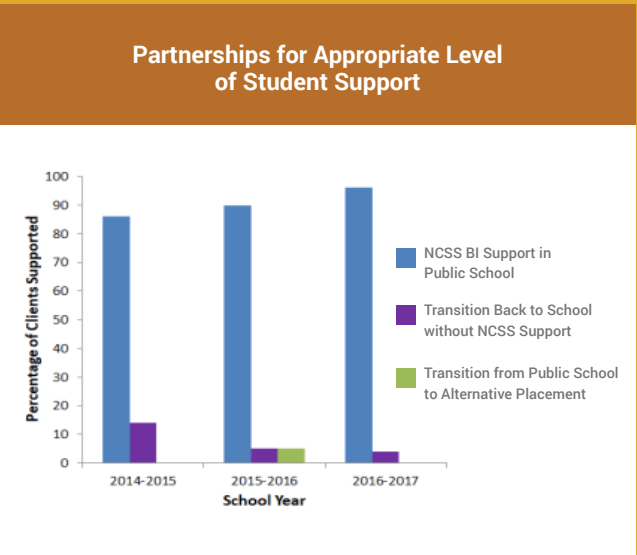
- Continue to build capacity to increase transitions back to school without 1:1 support from NCSS for those students that this is deemed appropriate. This can be achieved by continuing to provide trainings and consultative support for school staff
- Continue to educate the community as to the scope of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

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, social support

PARTNERS:

- Franklin Northwest Supervisory Union
- Franklin Northeast Supervisory Union
- Franklin Central Supervisory Union
- Franklin West Supervisory Union



Story Behind the Curve:

Partnerships for Appropriate Level of Student Support: The addition of a 1:1 Behavioral Interventionist and Behavior Consultation are two primary services provided. When students meet their specific goals the School-Based Autism Team helps to build capacity for transition back to the public school (with or without staff). Based on students served, schools determine a higher level of support for the student due to the level of need. If needs become too high level for the public school alternative placement can be discussed.

Transportation: Due to maladaptive behaviors, many students are unable to ride the school bus or in a family vehicle safely. 78 – 96% percent of students supported by this program over the last three years 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.

Outpatient Therapy ACCESS

WHAT WORKS:

- Maintaining rapid access for individuals in crisis by using two Clinicians in a new role, and maintaining an expectation for new client admissions from therapists
- Implementing same day access option for brief treatment for individuals not in crisis
- Centralizing communication through Access Coordinator role
- Implementing the Feedback Informed Treatment (FIT) Model
- Implementing wider range of brief treatment options
- Regular tracking of demand for services and number of days until first appointment
- Increased provider panel of Medicare and female providers, which are in the highest demand
- Adding an "Adult Case Manager" position to help clients meet needs outside of therapy and decrease overall length of stay in therapy and other action steps that can't be addressed in the therapeutic session fully
- Implementing part time employment services

ACTION PLAN:

- Expand rapid access option by adding another therapist skilled in brief treatment
- Maintain rapid access clinicians
- Maintain case management options to serve more individuals who need this service to address some specific social determinants of health outside the therapy session such as housing applications, coordination with PCP, support groups, and other psychosocial needs
- Continue to measure access and other factors which may contribute to improving access

HOW WE IMPACT:

Access to healthcare services, resources to meet daily needs, support for chronic health conditions, smoking prevention, public safety, economic support, access to education, housing, job training, substance use prevention, mental health, social support, suicide prevention

PARTNERS:

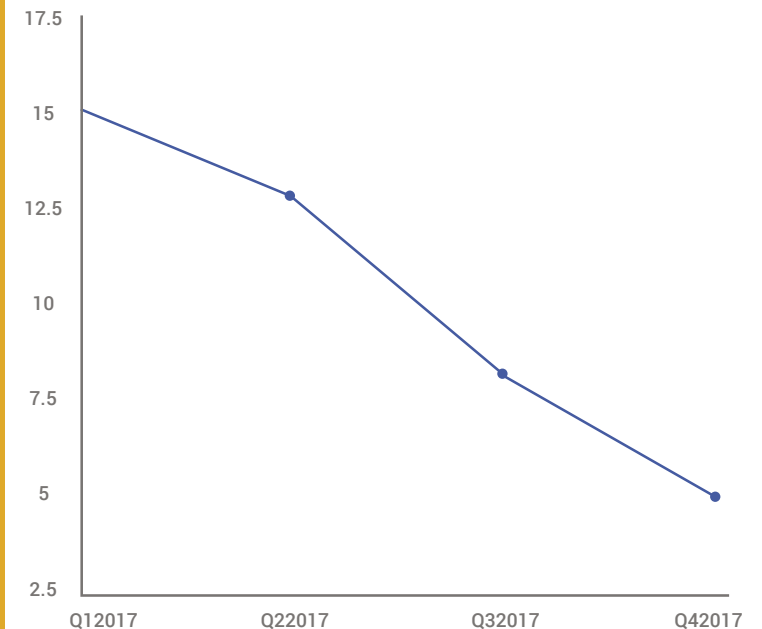
- Direct referrals from persons seeking services
- Referrals from Primary Care and other providers
- Referrals from Crisis and other NCSS providers

“

*I'm thankful for
your agency.*

”

BH - Outpatient Access: # of Days to Wait from 1st Call to 1st Offered Appointment - Quarterly



Story Behind the Curve:

The Outpatient service has experienced a steady demand with no significant drop throughout the year. This is a consistent trend over the years. Implementation of a centralized communication role (Access Coordinator) and a rapid access option for non-emergencies has demonstrated improvements in access time from initial call to first date of service. Data demonstrates reduction in number of days to access outpatient services.

Applied BEHAVIORAL SERVICES

WHAT WORKS:

- Comprehensive Universal Positive Behavioral Interventions + Support (PBIS) that are implemented throughout the school community with fidelity
- Proactive system-wide adjustments that adjust how the environment responds to challenging student behavior
- Targeted tier II plans that are rooted in function based interventions
- Regular support/supervision of school staff by a highly qualified Behavior Consultant to build capacity within the school staff

ACTION PLAN:

- Continuing to build partnerships with more schools
- 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 Interventions + Supports
- Continue to develop the integrated consultation model for all classrooms/staff

HOW WE IMPACT:

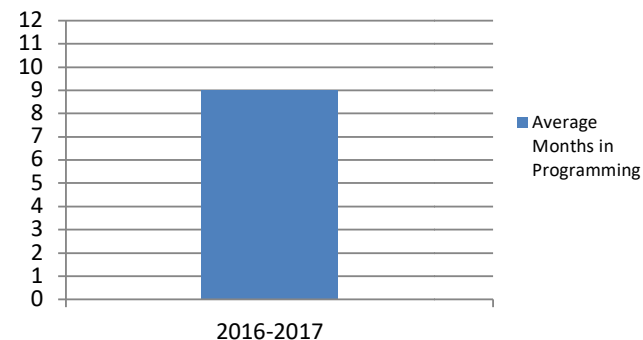
Access to education, social support, mental health, connecting with resources to meet daily needs, transportation, access to health care services

PARTNERS:

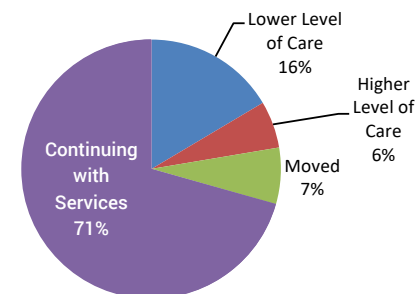
- Franklin Northeast Supervisory Union
- Berkshire Elementary-Middle School
- Enosburg Elementary School
- Franklin Northwest Supervisory Union
- Sheldon Elementary-Middle School
- Swanton Babcock School
- Swanton Central School
- Highgate Elementary School



Average Months in Programming Until Transition to Lower Level of Care



Status of Students



Story Behind the Curve:

In 2016-17 we provided services that supported 87 tier II students to access their education in the public school setting, transitioned 16% of students to the universal level of supports in the school and made referrals for 6% of students to access the right level of care through a tier III support program. We also continued to support 71% (n=59) students in their public schools and provided continuity of care for 3 students who moved from one school to another SBBC school.

Continued from PREVIOUS PAGE

WHAT WORKS:

- Staff training to implement behavior analytic interventions which are overseen by a Board Certified Behavior Analyst (BCBA)
- The Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP), a developmental curricula used by ABS
- Behavior analytic interventions include discrete trial learning (DTL), shaping, chaining, video modeling, and the use of reinforcement. Children are re-assessed every 6 months to track progress and guide interventions
- At discharge, an increase in VB-MAPP scores demonstrates 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 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

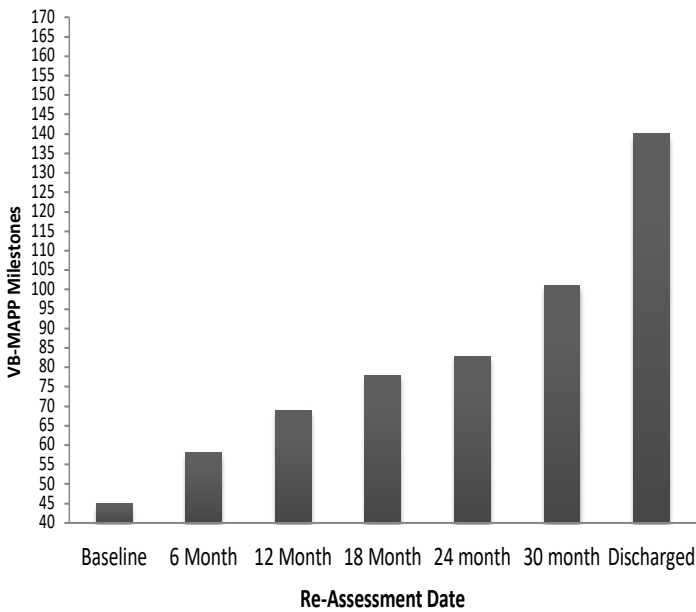
HOW WE IMPACT:

Social Determinants of Health that are impacted by the Applied Behavior Services program: socioeconomic conditions, availability of resources to meet daily needs, access to education, transportation, and social support.

PARTNERS:

- Local schools
- Local child care providers
- Franklin County Home Health Agency
- NCSS Early Intervention program

Average ABS Client VB-MAPP Scores



Story Behind the Curve:

Services provided through the Applied Behavior Services (ABS) team are individualized to meet the needs of children with developmental delays or diagnoses including Autism Spectrum Disorder, and their families.

ABS places a strong emphasis on specific skill acquisition, behavior, communication, and a family-centered approach to treatment. Behavior analytic interventions provided through ABS are created through developmental curricula, functional skills curricula, and/or a functional behavior assessment (FBA).

Skills are assessed frequently and progress is monitored and measured through data tracking for each child.



Employee Wellness

Still in its infancy the NCSS employee wellness initiative has experienced some great results overall and included some new financial education pieces, specifically related to student debt through a partnership with VSAC. This past year we rolled out biometric screenings with an aggressive goal of screening 25% of the staff, but not surprisingly we came up a little short as this was a new concept for staff.

We continued to maintain a relatively stable level of engagement in flu shot clinics and achieving our goal of immunizing 25% of staff.

WHAT WORKS:

The cross-divisional committee has been designed to align with our agency's mission, purpose and overall fiscal health. By providing opportunities, incentives and supports to our employees to lead healthy lifestyles we truly will "create a healthier workforce, one employee at a time."

IMPACT:

- Access to free activities and education
- Screenings to identify potential employee health concerns
- Positively impacting healthcare claims, organizational culture and staff engagement

ACTION PLAN:

The five primary goals are:

1. To raise awareness and provide opportunities for preventive care
2. To provide opportunities for employees to increase their level of physical activity
3. To encourage employees to make healthy food choices at home and work
4. To alleviate and prevent musculoskeletal disorders
5. To provide overall education to employees and their family, which promotes emotional, physical, and financial well-being

Year 1: 2016-2017

Your Wellness Program at Work

Health Risk Assessment	42%	Pieces of fruit delivered	1344
Interest surveys	68%	Standing desks	49
Flu shots	25%	Onsite chiropractic visits	40
Increase in snowshoe rentals	240%	Onsite massages	65
Onsite wellness class	402	VSAC attendees	26
Corporate Cup / Run for Jim	29	Onsite mindfulness	20
Training/tuition Cont. Ed	300		

To encourage healthy food choices, the committee delivered 1344 pieces of fruit to all staffed locations.



Community Rehabilitation And SUPPORTED EMPLOYMENT

WHAT WORKS:

- Community Rehabilitation and Treatment (CRT) employment team's main partnership includes Vocational Rehabilitation (VR) services along with benefit counselor supports
- The relationship with VR provides our clients with extra levels of supports, including paid supports the CRT employment team isn't able to provide.
- CRT clients also have individual benefits meetings with our benefits counselor to answer questions around their Social Security benefits. Both client's and the NCSS employment team find this support very helpful as clients explore their work options. However this benefit has been cut through VR funding
- Staff check in with employers to find job leads and build relationships and fill anticipated openings with clients from CRT

ACTION PLAN:

- The CRT employment team's next goal is to obtain an employment rate of 25% in 2018
- The team will build on relationships with VR and employers in our region
- Employment staff will continue to be trained in the Individual Placement & Support (IPS) model through Department of Mental Health

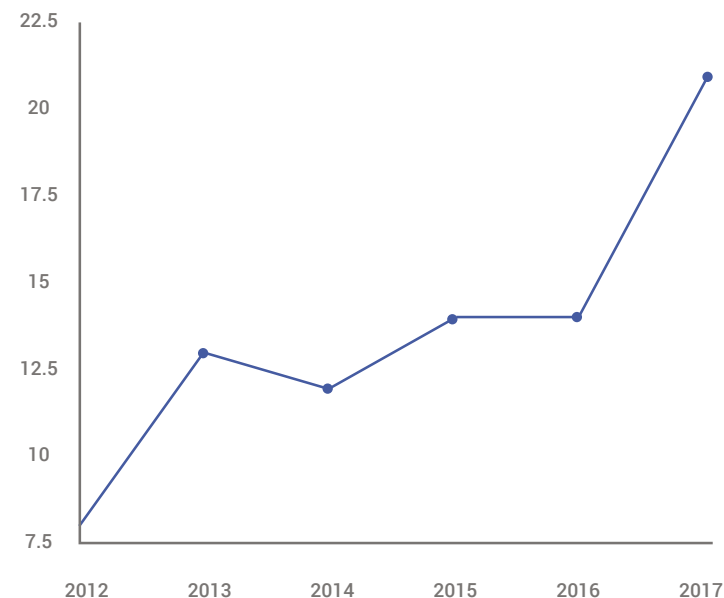
HOW WE IMPACT:

Resources to meet daily needs, economic support, job training, social support, suicide prevention, transportation, housing, access to education

PARTNERS:

- Vocational Rehabilitation (VR)
- Department of Mental Health
- Department of Labor
- Local Businesses
- Social Security Administration
- Department of Education & Training

% of CRT Clients Employed in First Quarter of Each Fiscal Year



Story Behind the Curve:

The Supported Employment team helps client's with severe mental illness find and maintain employment. CRT Supported Employment believes that work is an important part of the wellness and recovery process. Indeed, research shows most people living with Severe Mental Illness want to work, and many can with the right supports. In Quarter 1 of 2017 (July-September) the CRT program had an employment rate of 21% (clients enrolled between the ages of 18-65), up from 14% in Quarter 1 of 2016 and 2015. This number shows the great work by staff in CRT at NCSS and the strengthening economy in Franklin County. CRT employment staff has been able to build strong relationships in the community with employers and find placements for client's that haven't worked in years. The CRT Employment team's biggest impact is being able to find clients the right employment for them.

Developmental Services EMPLOYMENT

WHAT WORKS:

- Networking is essential in meeting and building relationships with employers
- The Employment Team Specialists (ETS) utilize progressive employment, which is funded through Vocational Rehabilitation
- The job seeker has an opportunity to “try out” a job. It is an effective way for a prospective employee and employer to get to know each other
- Quite often a work experience can lead to paid employment, in addition it can help build a resume
- Ongoing collaboration with community partners such as the Creative Workforce Solutions team and the sharing of job leads is important

ACTION PLAN:

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

HOW WE IMPACT:

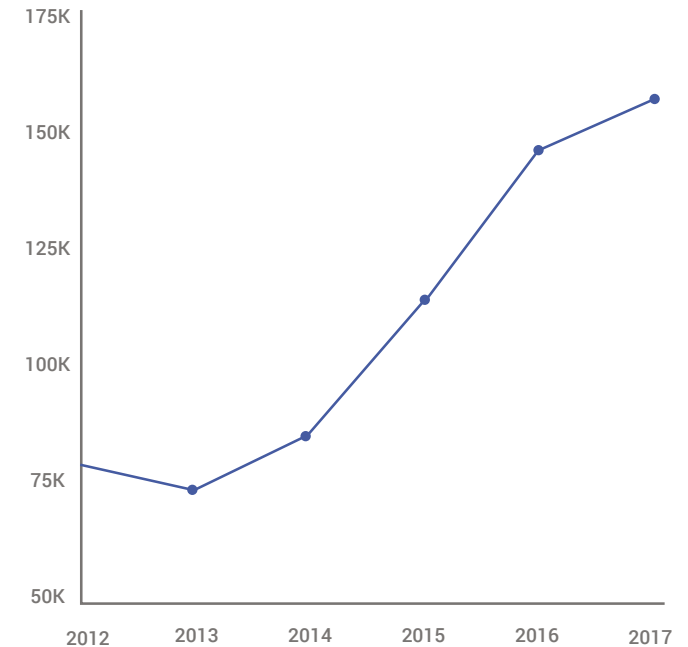
Public safety, access to education, transportation, housing, job training, mental health, social support, resources to meet daily needs, economic support

PARTNERS:

- Department for Aging & Independent Living (DAIL) and 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 - Employment: Annual Social Security Savings, Based on How Much Clients Earned Annually



Story Behind the Curve:

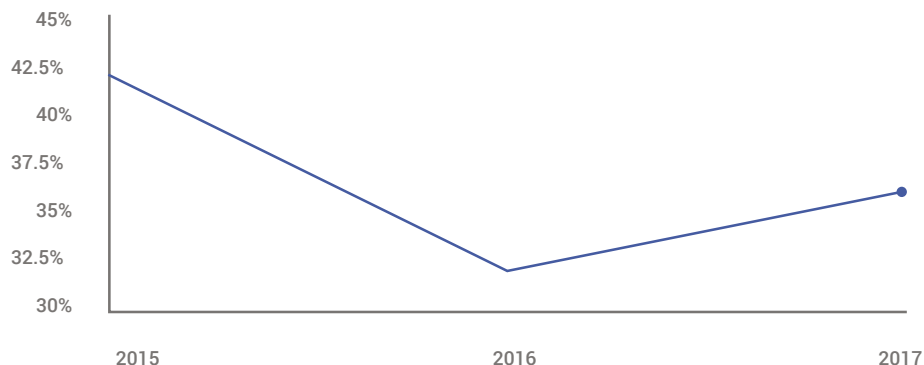
NCSS's Supported employment team has two Full Time Employment Team Specialists (ETS) working to find meaningful, competitively paid employment. The ETS works with any individuals served who express an interest in working.

Having two full time employment team specialists has helped increase the number of people who are working.

With fewer dollars coming in to the Supported Employment (SE) program, maintaining the strong relationships with community partners such as Vocational Rehab, and Creative Workforce Solutions is vital.

Academy of LEARNING

% of Individuals Integrated in the Community



Story Behind the Curve:

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 (ILA) 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.

WHAT WORKS:

- Community based practice at local stores and other local businesses to allow participants a chance to practice the skills being taught to ensure skill is being used outside the program
- Community members come to the program to teach skills to the consumers that they can generalize in the home and in the community

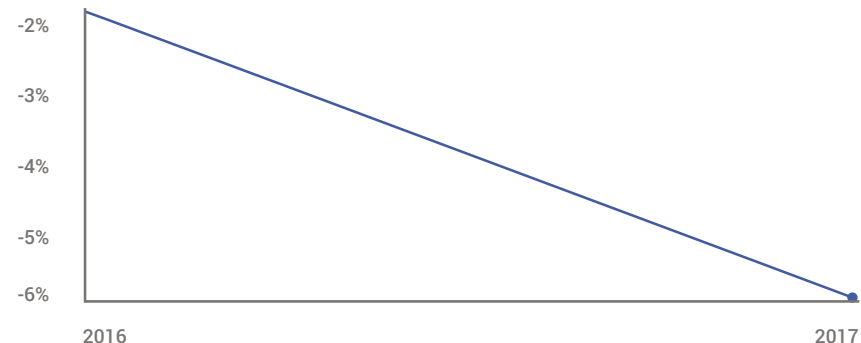
HOW WE IMPACT:

Resources to meet daily needs, access to education, job training, social support

PARTNERS:

- Franklin County Senior Center
- Local Area Schools

% of Decrease on the Independent Living Skills Assessment



Story Behind the Curve:

Independent Living Assessment - the lower the number, the more skills the individual has. The program strives to lower this number to show growth in the skills learned in the program.

Skills assessed are cognitive skills, home care, budgeting and numerical, shopping and retail, transportation, vocational, behavioral support, receptive language, reading, writing, food preparation and cooking, personal hygiene, health and safety, social and leisure skills.

WHAT WORKS:

- The ILA works best when completed several times a year
- ILA score should be reduced in order to see that program was productive

HOW WE IMPACT:

Resources to meet daily needs, support for chronic health conditions, public safety, social support, job training, transportation education

PARTNERS:

- Local high schools

Children, Youth and Family YOUTH EMPLOYMENT PROGRAM

WHAT WORKS:

- Career exploration and job readiness skills training with case managers at NCSS
- Education to local businesses and employers to reduce stigma of hiring youth
- Increase opportunities for progressive employment, where youth can increase work experiences toward obtaining competitive employment
- JOBS helped a young woman who was living with an adoptive parent. The relationship was contentious and the youth was in danger of not graduating from high school. With support from JOBS, she graduated, participated in Vermont Youth Conservation Corps (VYCC), and currently has a full-time manufacturing position

ACTION PLAN:

- Increase number of youth accessing the JOBS program
- Increase number of youth obtaining and maintaining competitive employment through our continued work with CWS, VR, and local businesses

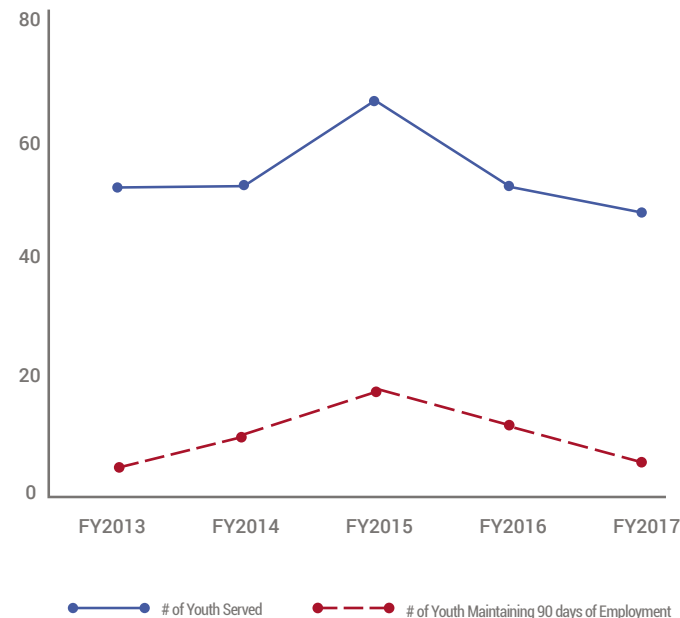
HOW WE IMPACT:

Social determinants of health that are impacted by the jobs program: job training and opportunities, access to education, availability of resources to meet daily needs, social support, and transportation.

PARTNERS:

- Local businesses
- Vocational Rehabilitation (VR)
- Vermont Adult Learning
- Creative Workforce Solutions (CWS)
- Department for Children and Families
- Local high schools

CYF: # of Youth Served - Comparison



Story Behind the Curve:

Jump on Board for Success (JOBS) is a program for youth which provides employment services and related supports to reduce obstacles to employment, increase self-esteem, and reduce risky behavior. Our region continues to need potential employers with a willingness to hire youth.

JOBS focuses on building partnerships to increase awareness in our community that our youth are committed and willing to learn and work. Personal relationships with employers and businesses are crucial to creating needed work opportunities.

Ongoing support is needed to address discrimination of youth, including the perception of substance use and crime.

Integrating Family Services

FAMILY SUPPORT PROGRAM

WHAT WORKS:

- The Family Support team practices an outcomes-based approach:
- Utilizing motivational interviewing skills alongside a narrative therapy approach has been a longstanding practice of the Family Support team to build rapport and gather information from clients and their caregivers around their specific needs
- Child and Adolescent Needs and Strengths (CANS) data has enhanced our approach by defining and organizing individually identified needs based on the immediacy of the need
- Solution-Focused Therapy and Attachment, Regulation and Competency (ARC) continue to be avenues to increase connections among families

ACTION PLAN:

Continue to utilize the visual tools of the CANS to support communication with members of the treatment team

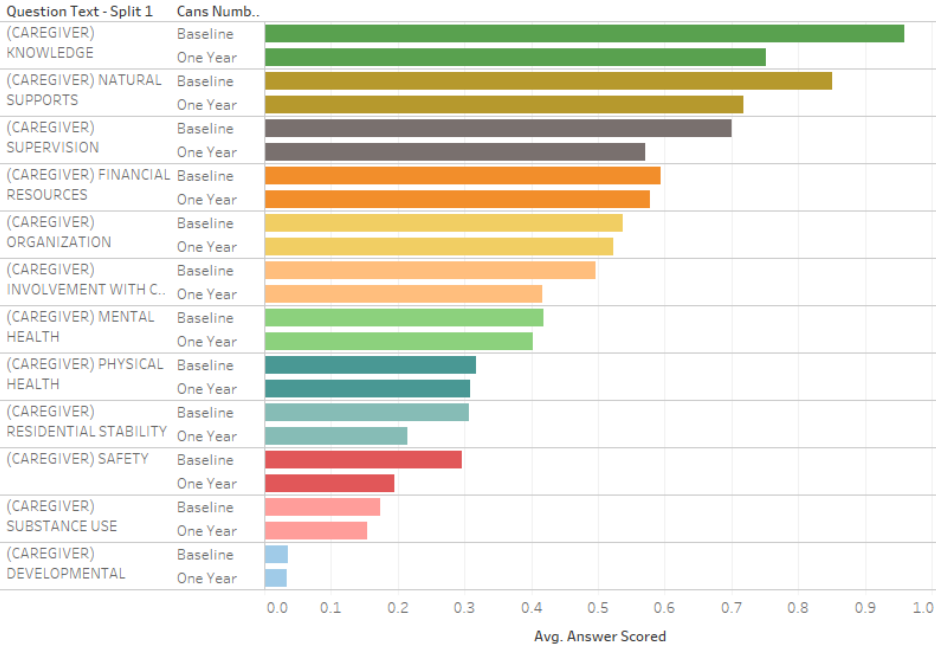
HOW WE IMPACT:

Access to health care services, socioeconomic conditions, availability of resources to meet daily needs, access to education, job training opportunities, transportation, public safety, social support, culture, mental health & substance abuse, obesity, smoking, suicide, domestic & sexual violence

PARTNERS:

- Department for Children and Families
- Local schools
- Northwestern Medical Center
- Primary Care Physicians
- Law Enforcement
- Restorative Justice
- Vocational Rehabilitation
- Watershed Mentoring
- Vermont Child Welfare Training Partnership
- New England Counseling and Trauma Associates
- Franklin County Home Health Agency
- Child Development Clinic

Reduction in Needs for Caregivers after One Year of IFS Services
Avg CANS Scores for Caregiver Items at Baseline and One Year in FY17



Story Behind the Curve:

The Family Support team has had a significant impact on caregiver knowledge and caregiver natural supports.

Through the use of the Child and Adolescent Needs and Strengths (CANS), we have been able to use visual tools to help caregivers and community partners identify challenges that consistently impact family well-being. This intentional focus on caregiver knowledge has led to positive outcomes in caregiver safety and caregiver supervision.

As the CANS data showed a need in the area of caregiver natural supports, we identified this as an area where we could increase our efforts to help families build their own natural connections to family, friends and their community.

Continued from PREVIOUS PAGE

of IFS Clients who have Received a Follow-up CANS Assessment:

WHAT WORKS:

Clinical monitors have started triggering CANS reassessments to staff task list. More staff have been trained to complete the CANS and programs are embedding it into their culture and how they talk about their clients and families.

ACTION PLAN:

- Meeting scheduled with DCF Family Services Division in May to discuss better process for partnering on the completion of CANS reassessments DCF leadership has expressed intention to support this agenda throughout their agency
- NCSS to discuss process of completing the reassessments at monthly consultation meeting

HOW WE IMPACT:

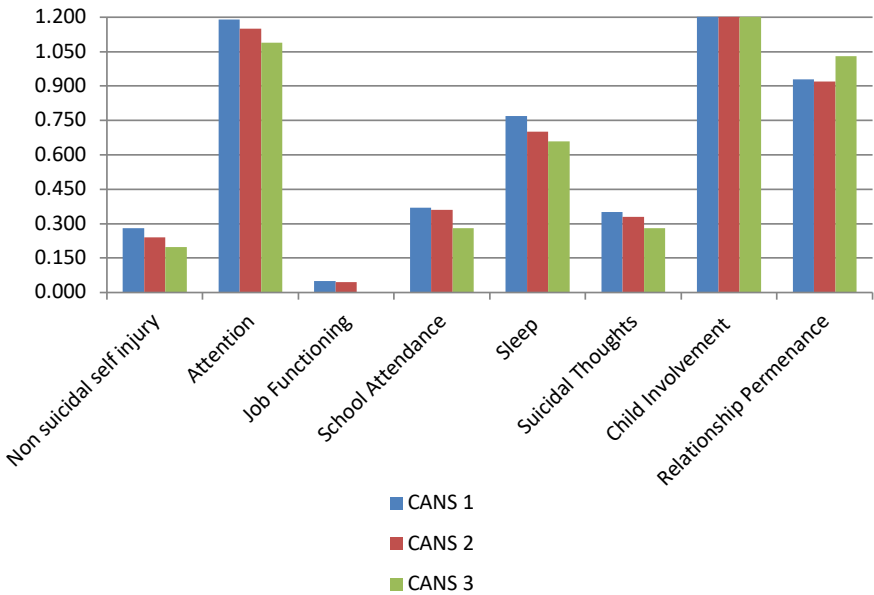
Social determinants: access to education, access to health care services, resources to meet daily needs, support for chronic health conditions, transportation, mental health, economic support, housing, substance use prevention, and social support

PARTNERS:

- Department for Children and Family (DCF)
- Franklin Northwest Supervisory Union
- Franklin Northeast Supervisory Union
- Permanency Initiative
- Department of Mental Health (DMH)
- Federally Qualified Health Centers



Average Needs for IFS Population
who received CANS in FY17 (744 clients)
at Initial CANS 6 Month and 12 Month Reassessments



Story Behind the Curve:

A big factor in the number of CANS reassessments is the number of clients who are eligible that month for their reassessment, which is six months following their initial. As more children receive initial CANS we expect to see an increase in CANS reassessments.

In the beginning we had a few trickling in each month, and the upward trend was slow due to EMR issues that needed to be addressed before entering more data.

By October we began seeing a larger sample eligible for a CANS 2 and our EMR issues were resolved.

The increase since that time has been exponential, and we expect the growth trend to continue, with the goal of matching the number of clients who receive initial CANS.

Continued from
PREVIOUS PAGE

Increase in Educational Systems from Baseline to 12 month Reassessment for Clients in IFS:

WHAT WORKS:

- Collaboration and communication between NCSS teams, local school systems and parent partners
- Parent advocacy supports
- Youth Mental Health First Aid (YMHFA) trainings were provided with support from NCSS personnel

ACTION PLAN:

- To work with primary care and other health care providers to implement mechanisms to further communication and sharing of information to support holistic care.
- To evaluate evidence based and informed practices to further increase quality of care being provided to children and families.
- To assess gaps and strengths within continuum of care and develop innovative practices that will meet need of community.

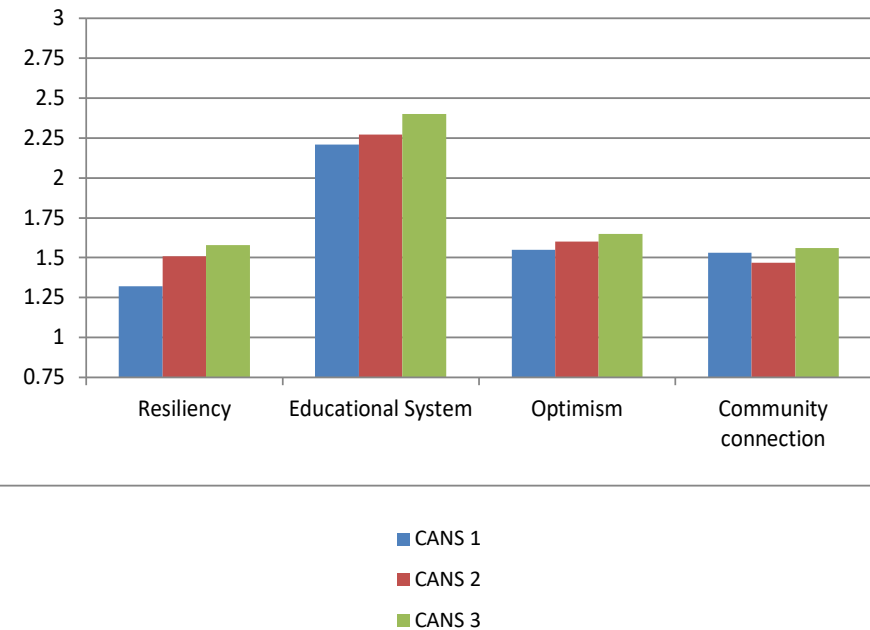
HOW WE IMPACT:

Mental health, social supports, access to education, transportation, resources to meet daily needs, and access to health care services

PARTNERS:

- Department for Children and Families
- Local schools, teachers, administrators and supervisory unions
- Parents/primary caregivers
- Vermont Federation of Families for Children's Mental Health
- Youth Mental Health First Aid

Building Strengths over Time for Children and Youth who Received a CANS in FY17 (744 clients) at Initial, 6 Month and 12 Month Reassessments



Story Behind the Curve:

The ability of the educational system to support the changing needs of a client is shown to improve when the client is engaged in IFS programming as indicated by the CANS scores of clients when comparing the baseline score to the 6 month and 12 month reassessments.

Within IFS there are opportunities for children and families to improve and maintain positive relationships with educational systems through collaboration with NCSS providers and school systems.

When the educational system is able to support the varying needs of a child, the opportunities for the child to thrive in the school system increase which can positively impact their mental health.

Experience of Care

Number of Clients SATISFIED

“ NCSS is like our family. Our son would not be in a better mindset & life without the wrap around care from NCSS. Thank you! ”

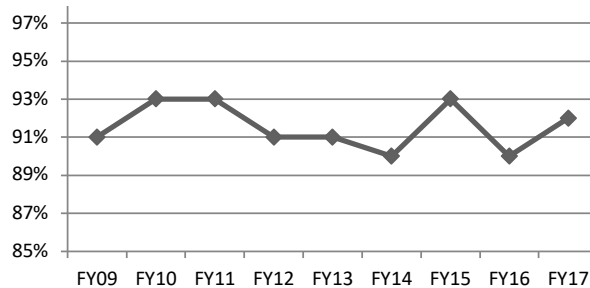
“ NCSS has made a huge impact on my quality of life. Thank you. ”

“ I feel NCSS is one of the best around [in St. Albans]. ”

“ All your staff is wonderful and very accommodating. Love the home visits. Thanks again. ”

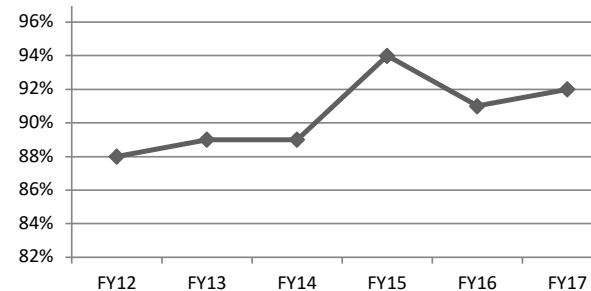
“ NCSS is very responsive when I have needed help. ”

Clients Satisfied with Services



90% of clients felt the services made a difference in their lives

Client Received the Help They Needed



92% of clients felt they received the help they needed

Story Behind the Curve: Experience of Care - Satisfaction

This year there was a 21% return rate for this year's client satisfaction, which is the highest return rate we have seen. There was a 2% increase in client satisfaction. 92% of the clients felt they received the help they needed and 90% felt the services made a difference in their lives.

ACTION PLAN:

- Each team in the agency is undergoing a Bend the Curve exercise to create an action plan for FY18 to improve our satisfaction survey results
- Continue to work with Vermont Care Partners with standardized satisfaction questions and benchmark our outcomes to the state average.

Staff ENGAGEMENT

WHAT WORKS:

- Collaboration and communication between NCSS teams, local school systems and parent partners
- Parent advocacy supports
- Youth Mental Health First Aid (YMHFA) trainings were provided with support from NCSS personnel

ACTION PLAN:

- Continue to implement a total rewards structure to reinforce the value of working at NCSS and strive to maintain an attractive compensation program
- Continue to expand our employee health & wellness programs using data to provide programming that targets employee needs and desires.

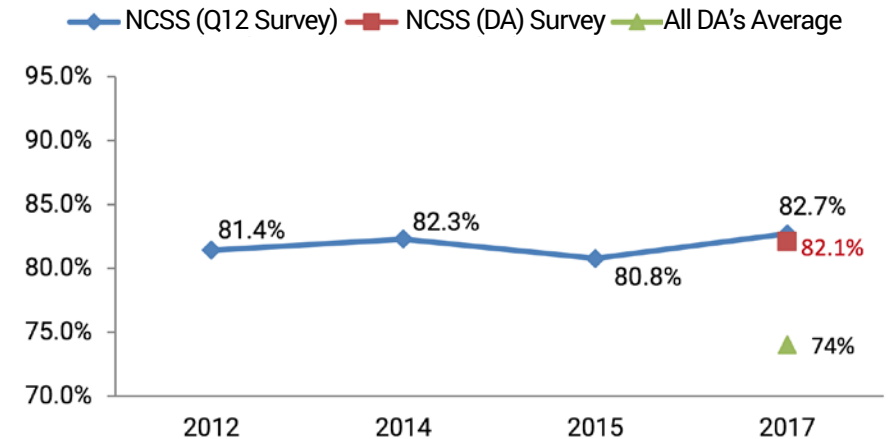
I am grateful for what NCSS has done for me and for members of the community. Never in my dreams did I think I'd be part of such an amazing organization who actually cares! (2013)

I have never felt as valued and supported as I do at NCSS! (2015)

NCSS not only has demonstrated its commitment to this community, but it is evident that it is committed to its staff! (2016)

% of Engagement

% of Engagement



Story Behind the Curve:

Since 2004 NCSS has measured employee engagement grounded in the nationally renowned Gallup Q12 Employee Engagement Survey as a measure of overall morale. The survey contains 12 simply questions tied directly to performance outcomes.

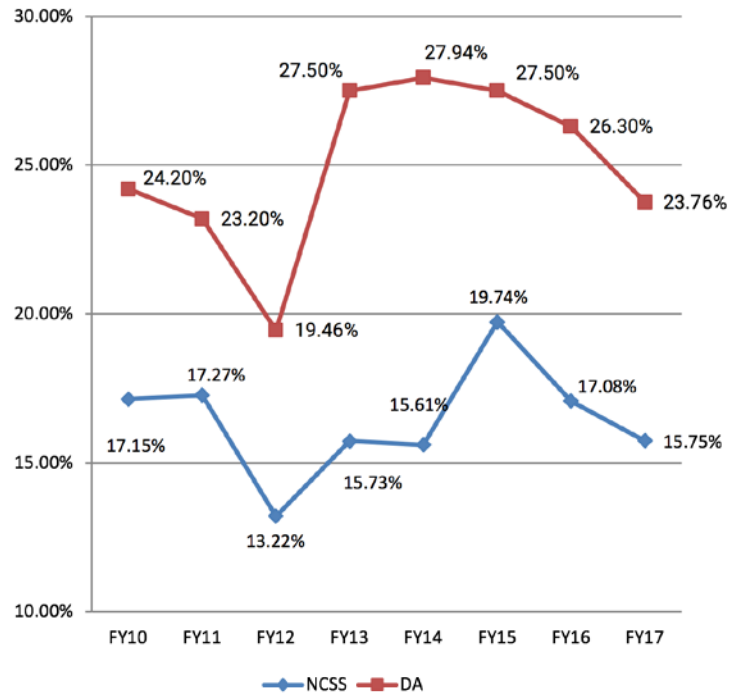
We correlate the survey questions to the four stages of employee engagement: 1) Primary Needs, 2) Individual Contributions, 3) Do I Belong, and 4) Growth & Innovation. This allows us to keep our eye on the ball by pin pointing areas of strength and weakness.

At 83% in 2017, NCSS continue to see high staff engagement that is far above the national average that hovers around 33%.

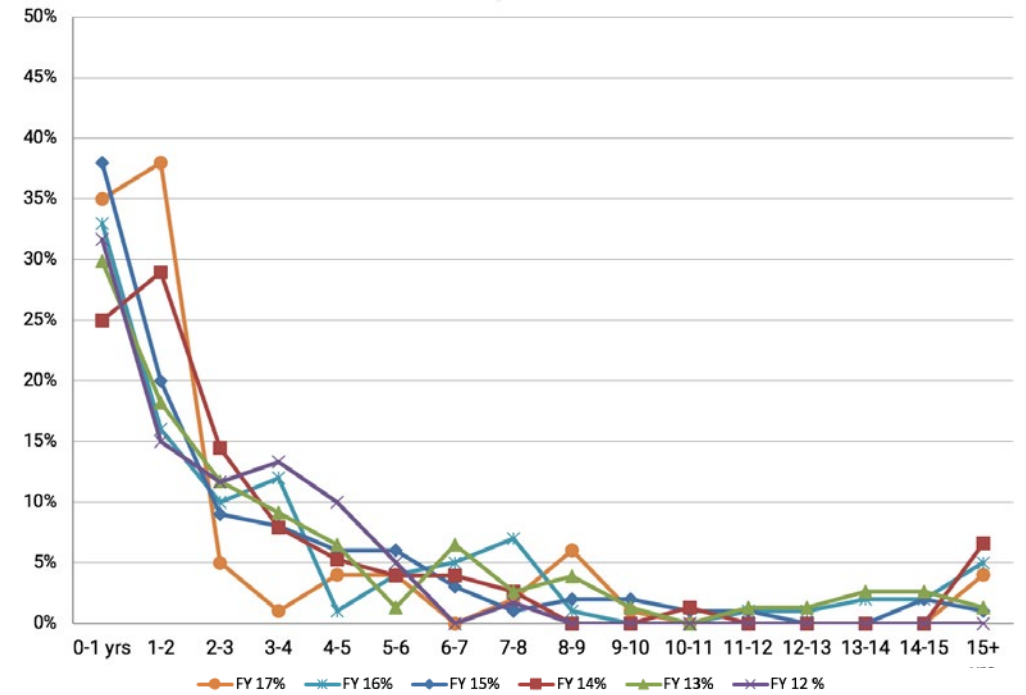
In 2017 all designated agencies began using same survey to benchmarking performance.

Staff TURNOVER

Agency % Turnover



Longevity Turnover Trend FY12-FY17



Story Behind the Curve: Turnover

The number one employee disclosed reason for leaving is money related; turnover decreased nicely over the past couple of years, which we attribute to a number of strategies implemented:

- Modest increases in compensation of key turnover positions
- Career ladder development
- Culture of caring - about employee safety, health & wellness
- Employee engagement efforts are directly related to retention

Research indicates employees will make a decision to stay or go within the first 90 days of employment; our data indicates that if we can retain employees 12 months our turnover drops significantly.

- Onboarding process & training improvement
- New employee diversity & inclusion training

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