Compiled Annual Performance Outcome Reports CCMHB Funded Programs, Contract Year 2019

Compiled Annual Performance Outcome Reports (PORs)

CCMHB Funded Programs, Contract Year 2019

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Champaign County Children's Advocacy Center
Children's Advocacy Center Program
Performance Outcome Report PY19

Agency name: Champaign County Children's Advocacy Center
Program name: Champaign County Children's Advocacy Center
Submission date: 8/22/19

Consumer Access – *complete at end of year only*
Eligibility for service/program
1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application) **Referrals to the CAC are made by law enforcement agencies and the Illinois Department of Children and Family Services in accordance with the CAC Protocol.**
2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)? **The National Children's Alliance standards for accreditation and the Champaign County Children's Advocacy Center's Protocol for the Multi-disciplinary Investigation of Child Sexual and Physical Abuse revised in May 2018, require that children are only accepted for services through a referral from law enforcement entities or the Department of Child & Family Services where it is suspected that the child is a victim of sexual abuse or serious physical abuse.**
3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.) **Direct referrals from law enforcement and Department of Child & Family Services.**
4. a) *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application): **The estimated number of service contacts for the year was 175 (100% of persons referred to the CAC receive services from the CAC).**

b) *Actual* percentage of individuals who sought assistance or were referred who received services: **223 children (100%) who were referred for services received services. Of the 223 children 179 were opened as treatment plan clients and 44 were opened as non-treatment plan clients.** **5. a)** *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application): **48 hours**
b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application): **98%**
c) *Actual* percentage of referred clients assessed for eligibility within that time frame: **100%**
6. a) *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application): **48 Hours**
b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application): **98%**
c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame: **100%**
7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application): **6-12 months**

b) *Actual* average length of participant engagement in services:

3.24 months

Demographic Information

1. *In your application* what, if any, demographic information did you indicate you would collect beyond those required (i.e. beyond race/ethnicity, age, gender, zip code)? (Demographic Information, question #1 in the Program Plan application)

none

2. Please report here on all of the extra demographic information your program collected.

None collected specific to Champaign County for FY19

Consumer Outcomes – *complete at end of year only*

During the application process, you identified participant outcomes that your program activities would impact. Here, report the actual participant outcomes achieved as a result of your program activities

1. *From your application,* what impact on consumers did you expect your program activities to have? That is, what outcome(s) did you want your program to have on the people it is serving? (Consumer Outcomes, question #1 in the Program Plan application). Please number each outcome.

1. **Were the child's/parent's needs met during the initial visit**
2. **The parent was satisfied with the services received from the CAC**

2. For each outcome, please indicate the specific survey or assessment tool you used to collect information on this outcome in the chart below. (Please remember that the tool used should be evidence-based or empirically validated.)

The CAC utilized the OMS Qualtrics parent survey to collect information from the non-offending caregiver who accompanies the child to our center for the forensic interview.

Additionally, in the chart below, please indicate who provided this information (e.g. participant, participant's guardian(s), clinician/service provider, other program staff (if other program staff, indicate their role).) Please report all sources of information that

apply for each assessment tool (e.g. the XYZ survey may be completed by both a youth client and their caregiver(s).

Outcome:	Assessment Tool Used:	Information Source:
E.g. 1. Increased empowerment in advocacy clients	Measure of Victim Empowerment Related to Safety (MOVERS) survey	Client
1. Increased report of that the child's/parent's needs were met during the initial visit to the CAC	OMS initial caregiver survey	Non-offending caregiver
2. Increase in the number of parents who were satisfied with the services received from the CAC	OMS initial caregiver survey	Non-offending caregiver

3. Was outcome information gathered from every participant who received service, or only some?

The outcome information (parent survey) was offered to every participant who received services.

4. If only some participants, how did you choose who to collect outcome information from?

N/A

5. How many total participants did your program have?

223

6. How many people did you *attempt* to collect outcome information from?

223 (100% of caregivers were given the opportunity to participate in the Initial visit caregiver survey)

7. How many people did you *actually* collect outcome information from?

81 (36%)

8. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc)

The information was collected after the completion of the post forensic interview caregiver meeting. Each parent was given a copy of the initial visit caregiver survey. Caregivers were asked to place the survey in the survey box after completing the form before they exit the facility.

Results

9. What did you learn about your participants and/or program from this outcome information? Please be specific when discussing any change or outcome, and give appropriate quantitative or descriptive information when possible. For example, you could report the following:

i. Means (and Standard Deviations if possible)
ii. Change Over Time (if assessments occurred at multiple points)
iii. Comparison of strategies (e.g., comparing different strategies related to recruitment; comparing rates of retention for clients of different ethnic or racial groups; comparing characteristics of all clients engaged versus clients retained)

During FY19, 100% of the parent surveys were completed via a paper/pencil survey. The center received 48 completed surveys in FY18 (21%) with a mixed collection method of agency tablet vs. paper pencil. The center received 81 completed surveys in FY19(36%).

A comparison of results from FY18 and FY19 parent survey results:

	FY18-CAC	FY19-CAC	Statewide results
My child felt safe at the center	**98%**	**97.4%**	**91.5%**
The Center Staff made sure I understood the reason for our visit (strongly agree response)	**100%**	**100%**	**94.9%**
My questions were answered to my satisfaction (strongly agree response)	**100%**	**98.8%**	**92.3%**
The staff members at the CAC were friendly and pleasant (strongly agree response)	**99%**	**100%**	**97.7%**
The center staff provided me with resources to support my child in the days and weeks ahead	**100%**	**100%**	**90.1%**
I was given information about the services and programs provided by the Center	**100%**	**98.7%**	**94.5%**

10. Is there some comparative target or benchmark level for program services? Y/N

Yes

11. If yes, what is that benchmark/target and where does it come from?

National Children's Alliance (accrediting entity for the CAC) recommends that overall parent satisfaction should be at 95%

12. If yes, how did your outcome data compare to the comparative target or benchmark?

The CAC parent satisfaction rate is above the national recommendation and statewide results.

(Optional) Narrative Example(s):

13. Describe a typical service delivery case to illustrate the work (this may be a "composite case" that combines information from multiple actual cases) (Your response is optional)

A significant role of a family advocate includes being able to quickly and adequately assess the individual needs of a family, as well as take into consideration any cultural barriers or issues. There are times when she needs to provide education to families on a variety of issues. She worked with a family from Guatemala with a 14-year-old female who had been raped in Guatemala and was 16 weeks pregnant at the time of the forensic interview. The family advocate secured an interpreter for the family for the interview and all follow-up contacts with the family. The family was contemplating what to do with the pregnancy but had misconceptions about the available options. She arranged, accompanied, and linked the family to The Pregnancy Resource Center in our area so they could meet with qualified professionals who could provide them with accurate and important information regarding their situation. It was important that the family

received this educational and supportive opportunity, so they could feel more knowledgeable and empowered to make the decision they feel is appropriate for their family.

14. In what ways was the evaluation used to support changes in practice? What changes were made based on evaluation findings? (Your response is optional)

The CAC will continue to offer paper surveys to parents to assess parent satisfaction due to the increase return rate. The CAC staff will make sure each parent/child knows that the CAC is a safe place at the beginning of their first visit to the center

Utilization Data Narrative –

The utilization data chart is to be completed at the end of each quarter (including quarter 4) using the online reporting system.

Comparative yearly totals (i.e. reporting estimates and actual numbers) and the narrative section described below are to be completed at end of year only.

Here, you will report on the different types of service categories specified in your program plan application. Please remember that programs **do not** need to collect and report on every category- instead, you are to report only the ones that are most useful for understanding program impact.

1. Please copy and paste the definitions of service categories your program specified in your program plan application in the sections below**. You will report the actual numbers of clients/contacts/community events for each reported service category in the Part II Utilization/Production data form (located on the online system).** If your estimated number of clients/contacts/community events for reported service categories significantly differ from your actual numbers, you may give a narrative explanation for that discrepancy here.

Treatment Plan Clients (TPC):

Treatment Plan clients will include those children or youth who:
1. reside in Champaign County (including residential treatment facilities), AND
2. have been interviewed as a potential victim regarding allegations of child sexual abuse or physical abuse, AND/OR
3. fit our Protocol to receive case management services and/or crisis counseling services from the CAC.

Non-treatment Plan Clients (NTPC):

Non-Treatment Plan Clients will include those children or youth who:
1. reside in Champaign County (including residential treatment facilities), AND
2. have been interviewed as potential non-victim witnesses to child sexual abuse or physical abuse OR are considered at risk of harm for child sexual or physical abuse, AND who did not

disclose being victimized during the interview. (If the child discloses abuse, they become a treatment plan client), OR **3. Are over the age of 18 and have an intellectual, developmental, or behavioral disability, OR** **4. participated in courtesy usage of the Champaign County CAC for out-of-county or federal investigations.**
Community Service Events (CSE): **Community Service Events include the annual Child Abuse Prevention Month activities each April, public presentations (e.g., television and radio appearances, interviews for newspaper articles), consultations with community groups (e.g., presentations to other service providers, classroom presentations), and meetings with small groups to publicize or promote the program.**
Service Contacts (SC): **Screening/Service contacts will be the sum of the Treatment Plan Client and Non-Treatment Plan Client categories. This total will reflect Champaign County resident children only.**
For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

Champaign Co. Regional Planning Commission – Community Services
Justice Diversion Program
Performance Outcome Report PY19

Agency name: Regional Planning Commission
Program name: Justice Diversion Program
Submission date: 8/19/2019

Consumer Access – *complete at end of year only*
Eligibility for service/program
1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application) *Individuals and families in Rantoul, Illinois who have had Crisis Intervention Team (CIT) or domestic offense police contact are eligible for Justice Diversion Program services.*
2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)? *The Rantoul Police Department contact logs and crisis intervention team (CIT) referrals forms are used to determine this criteria.*
3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.) *If the person met the criteria, then the Justice Diversion Program Coordinator contact them via phone or a home visit.*
4. a) *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application): *60%*
b) *Actual* percentage of individuals who sought assistance or were referred who received services: *30%*

5. a) *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application):
Clients are screened for need of treatment plan within two weeks of referral.

b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application):
60%

c) *Actual* percentage of referred clients assessed for eligibility within that time frame:
100%

6. a) *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application):
Clients deemed eligible for and interested in obtaining services will be enrolled into services immediately. If clients are responsive to staff services, it is estimated that TPC clients will be fully engaged in services within 2-3 weeks.

b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application):
30%

c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame:
13%

7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application):
3 months.

b) *Actual* average length of participant engagement in services:
1 month.

Demographic Information

1. *In your application* what, if any, demographic information did you indicate you would collect beyond those required (i.e. beyond race/ethnicity, age, gender, zip code)? (Demographic Information, question #1 in the Program Plan application)
No other Demographics were collected.

2. Please report here on all of the extra demographic information your program collected.
N/A

Consumer Outcomes – *complete at end of year only*

During the application process, you identified participant outcomes that your program activities would impact. Here, report the actual participant outcomes achieved as a result of your program activities

1. *From your application,* what impact on consumers did you expect your program activities to have? That is, what outcome(s) did you want your program to have on the people it is serving? (Consumer Outcomes, question #1 in the Program Plan application). Please number each outcome.
Preventing formal justice system involvement and diverting domestic disturbances and behavioral health issues away from law enforcement are primary goals of the program activities. Providing follow up services and linkage to resources should decrease the number of repetitive CIT calls, allowing law enforcement to focus resources in other areas such as preventing and addressing criminal behavior. Services employing strategies that are both developmentally appropriate and trauma-informed into law related interventions will lead to increased cooperation and decrease the probability of victimization, arrest, incarceration, while ensuring public safety. Rates of engagement in services will be tracked as well as the number of CIT calls. The goal will be to see at least 20% decrease in the percentage of households with repeat CIT/ domestic contacts in the first quarter compared to the last quarter of the program year.

2. For each outcome, please indicate the specific survey or assessment tool you used to collect information on this outcome in the chart below. (Please remember that the tool used should be evidence-based or empirically validated.)

Additionally, in the chart below, please indicate who provided this information (e.g. participant, participant's guardian(s), clinician/service provider, other program staff(if other program staff, indicate their role).) Please report all sources of information that apply for each assessment tool (e.g. the XYZ survey may be completed by both a youth client and their caregiver(s).

Outcome:	Assessment Tool Used:	Information Source:
Needs assessment	Adult Needs and Strengths Assessment (ANSA)	Client

3. Was outcome information gathered from every participant who received service, or only some?

Outcome information was gathered from every participant who was a Treatment Plan Client.

Repeat police contacts were also tracked from TPC and NTPC clients.

4. If only some participants, how did you choose who to collect outcome information from?

N/A

5. How many total participants did your program have?

43 NTPCs and 36 TPCs

6. How many people did you *attempt* to collect outcome information from?

36 (ANSA)

79 participants police contacts were tracked

7. How many people did you *actually* collect outcome information from?
35
79 participants police contacts were tracked

8. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc.)
ANSA was completed at the beginning of the services and at closing.
Police contacts were tracked over the course of the grant year.

Results

9. What did you learn about your participants and/or program from this outcome information? Please be specific when discussing any change or outcome, and give appropriate quantitative or descriptive information when possible.

The clients served during Qtr 1 had no repeat police contacts throughout the remainder of the year. During Qtr 2, 20% of the clients served had repeat police contacts During Qtr 3, 14% of clients served had repeat police contacts.

TPC participants had a higher incidence of repeat contacts, believed to be reflective of greater service needs.

53% of the TPC participants had components of the ANSA ratings of 2 or 3, indicating the need for action in these areas. Of the TPC participants having areas in need of action, 25% of these participants ratings in the action areas were reduced to ratings of 0 or 1.

10. Is there some comparative target or benchmark level for program services? Y/N
No

11. If yes, what is that benchmark/target and where does it come from?

12. If yes, how did your outcome data compare to the comparative target or benchmark?

(Optional) Narrative Example(s):

13. Describe a typical service delivery case to illustrate the work (this may be a "composite case" that combines information from multiple actual cases) (Your response is optional)

14. In what ways was the evaluation used to support changes in practice? What changes were made based on evaluation findings? (Your response is optional)

Utilization Data Narrative –

The utilization data chart is to be completed at the end of each quarter (including quarter 4) using the online reporting system.

Comparative yearly totals (i.e. reporting estimates and actual numbers) and the narrative section described below are to be completed at end of year only.

Here, you will report on the different types of service categories specified in your program plan application. Please remember that programs **do not** need to collect and report on every category- instead, you are to report only the ones that are most useful for understanding program impact.

1. Please copy and paste the definitions of service categories your program specified in your program plan application in the sections below**. You will report the actual numbers of clients/contacts/community events for each reported service category in the Part II Utilization/Production data form (located on the online system).** If your estimated number of clients/contacts/community events for reported service categories significantly differ from your actual numbers, you may give a narrative explanation for that discrepancy here.

Treatment Plan Clients (TPC): Individuals and families who have had Crisis Intervention Team (CIT) or domestic offense police contact whom are provided a needs assessment, soft handoff to services and follow up, or ongoing JDP case management services.

The actual number of TPC participants was approximately 48% of target. This was impacted by a lower number of eligible contacts during the second half of the year and low levels of participant engagement.

Non-treatment Plan Clients (NTPC): Individuals and families who have had Crisis Intervention Team (CIT) or domestic offence police contact, whether initiated by the family or due to a police response, where crisis is resolved during initial contact.

The actual number of NTPC participants was 40% of target. This was impacted by a lower number of eligible contacts during the second half of the year and low levels of participant engagement.

Community Service Events (CSE): Staff presentations; service provider facilitation meetings; meeting with providers, schools, community members, public officials to provide information and education about the Justice Diversion Program; and community meetings/events. *The annual target was met.*
Service Contacts (SC): Individuals and families who have had Crisis Intervention Team (CIT) or domestic offence police contact, whether initiated by the family of due to a police response, who the JDP Coordinator was unable to contact or engage in services. *This number nearly 50% higher than projected. The number of families that did not engage in the services offered by JDP was significantly higher than anticipated and correlates to the lower TPC and NTPC numbers.*
For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

Champaign Co. Regional Planning Commission – Community Services
Youth Assessment Center
Performance Outcome Report PY19

Agency name: Champaign County Regional Planning Commission
Program name: Youth Assessment Center (FY19)
Submission date: August 30, 2019

Consumer Access – *complete at end of year only*
Eligibility for service/program
1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application) Youth ages 10-17 who are exhibiting behavioral issues, including having had police contact are eligible for YAC services. CCMHB funding will specifically target youth assessed as moderate to high risk on the Youth Assessment and Screening Instrument (YASI), and referred two or more times to the YAC, by police departments, school districts, community agencies, and families in Champaign County. Funding will also support YAC staff working with school and community-based referrals.
2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)? Youth referred to the YAC are assessed using the Youth Assessment Screening Instrument (YASI), those scoring moderate-high risk will be provided services.
3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.) The YAC has operations agreements with juvenile justice stakeholders and local schools to support program referrals. Additionally, YAC staff provide community presentations to inform the pubic about the services. Outreach includes social service agencies, public forums and meetings, schools, local police departments, etc. The YAC program is also listed on the Champaign County Regional Planning Commission website.

4. a) *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application):

100% of youth from Champaign County who seek assistance through YAC will be provided assistance.

b) *Actual* percentage of individuals who sought assistance or were referred who received services:

99.5% of individuals who sought assistance were referred and received services. Of those individuals, .05% who met the criteria, declined services.

5. a) *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application):

The amount of time for engagement for youth who are referred to the YAC to when they are assessed for eligibility occurs within three weeks of receipt of the referral.

b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application):

It is estimated that 75% of clients referred who are engaged within the three-week time frame will be assessed for eligibility.

c) *Actual* percentage of referred clients assessed for eligibility within that time frame:

80 % of youth eligible for the services were able to be engaged in services.

6. a) *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application):
Estimated length of time from referral date to engagement: three weeks.

Station adjustments last for up to four months and Court Diversion Services (CDS) restorative options are scheduled within two weeks. Referrals to services, based on the results of the full YASI and trauma screening will be completed within one week of the completed assessments. Follow-up and monitoring of engagement in these service connections will continue throughout YAC enrollment. When youth/families are not able to immediately enroll in recommended treatment, case managers continue to provide support, meeting face-to-face with youth until enrollment in treatment/services takes place. Ongoing YAC CM support/monitoring occurs for an average of three months.

b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application):

It is anticipated that 60% of youth eligible for the services will be able to be engaged in services.

c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame:
70% of youth eligible for services were engaged.

7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application):

The estimated average length of service engagement is 3 – 6 months.

b) *Actual* average length of participant engagement in services:

The average length of engagement time is 3.5 months.

Demographic Information

1. *In your application* what, if any, demographic information did you indicate you would collect beyond those required (i.e. beyond race/ethnicity, age, gender, zip code)? (Demographic Information, question #1 in the Program Plan application)

Demographic statistics are maintained for program participants, including age, race, gender, ethnicity, geographic distribution, and household income. Additionally, the household Median Family Income (MFI) was tracked.

2. Please report here on all of the extra demographic information your program collected.

Demographic information for household income for participants in as follows: 63% were at the 30% MFI level, 17% at the 50% MFI level and 8% at the 80% MFI level. 12% of participants declined to provide MFI level information.

Consumer Outcomes – *complete at end of year only*

During the application process, you identified participant outcomes that your program activities would impact. Here, report the actual participant outcomes achieved as a result of your program activities

1. *From your application,* what impact on consumers did you expect your program activities to have? That is, what outcome(s) did you want your program to have on the people it is serving? (Consumer Outcomes, question #1 in the Program Plan application). Please number each outcome.

A. The YAC aims to divert youth from the justice system, both youth who have had police contact and been referred for station adjustment services and youth exhibiting behavioral issues.
B. Decrease in the level of the Youth Assessment Screening Inventory (YASI) risk score.
C. Increase of resiliency within the youth referred. Service connection based on needs assessment will support individualized, meaningful services.

2. For each outcome, please indicate the specific survey or assessment tool you used to collect information on this outcome in the chart below. (Please remember that the tool used should be evidence-based or empirically validated.)

Additionally, in the chart below, please indicate who provided this information (e.g. participant, participant's guardian(s), clinician/service provider, other program staff(if other program staff, indicate their role).) Please report all sources of information that apply for each assessment tool (e.g. the XYZ survey may be completed by both a youth client and their caregiver(s).

Outcome:	Assessment Tool Used:	Information Source:
A. Comparison of juvenile court records tracked through court services with client list for YAC to determine how many have been adjudicated during the fiscal year.	Court Records	State's Attorney Office
B. Decrease in the level of the Youth Assessment Screening Inventory (YASI) risk score.	YASI – Youth Assessment and Screening Instrument	Client
C. Increase of resiliency within the youth referred. Service connection based on needs assessment will support individualized, meaningful services.	YAC Services specific EXCEL program to track client data and service connections.	Case managers record progress and outcome data for each individual client.

3. Was outcome information gathered from every participant who received service, or only some?

Outcome information is gathered for each participant who receives services.

4. If only some participants, how did you choose who to collect outcome information from? N/A

5. How many total participants did your program have?

FY19 the YAC had 385 unduplicated participants of which 77 were assessed at moderate/high with 38 of those matching the eligibility criteria of having two or more referrals.

6. How many people did you *attempt* to collect outcome information from?

The YAC attempted to collect outcome information from 385 participants.

7. How many people did you *actually* collect outcome information from?

The YAC collected outcome information from 385 participants.

8. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc.)

Information was collected at client intake and exit.

Results

9. What did you learn about your participants and/or program from this outcome information? Please be specific when discussing any change or outcome, and give appropriate quantitative or descriptive information when possible. For example, you could report the following:

i. Means (and Standard Deviations if possible)
ii. Change Over Time (if assessments occurred at multiple points)
iii. Comparison of strategies (e.g., comparing different strategies related to recruitment; comparing rates of retention for clients of different ethnoracial groups; comparing characteristics of all clients engaged versus clients retained)

During FY 2019, the YAC saw a decrease in target participants with two or more law enforcement contacts assessed at a moderate to high level. However, the non-target participants assessed at a moderate to high level was nearly double that of the targeted participant.
We noticed during FY 2019, that 65% of those target participants and 52% of the non-target participants where late teens (15-17) indicating that many of the participants assessed at a moderate to high level (target/non) are simply aging out. Even with this potential aging out factor, 85% of the non-target participants were engaged in services showing that the need for services is a priority for clients.

10. Is there some comparative target or benchmark level for program services? Y/N

No

11. If yes, what is that benchmark/target and where does it come from?

N/A

12. If yes, how did your outcome data compare to the comparative target or benchmark?

N/A

(Optional) Narrative Example(s):

13. Describe a typical service delivery case to illustrate the work (this may be a "composite case" that combines information from multiple actual cases) (Your response is optional)

14. In what ways was the evaluation used to support changes in practice? What changes were made based on evaluation findings? (Your response is optional)

Utilization Data Narrative –

The utilization data chart is to be completed at the end of each quarter (including quarter 4) using the online reporting system.

Comparative yearly totals (i.e. reporting estimates and actual numbers) and the narrative section described below are to be completed at end of year only.

Here, you will report on the different types of service categories specified in your program plan application. Please remember that programs **do not** need to collect and report on every category- instead, you are to report only the ones that are most useful for understanding
program impact.

1. Please copy and paste the definitions of service categories your program specified in your program plan application in the sections below**. You will report the actual numbers of clients/contacts/community events for each reported service category in the Part II Utilization/Production data form (located on the online system).** If your estimated number of clients/contacts/community events for reported service categories significantly differ from your actual numbers, you may give a narrative explanation for that discrepancy here.

Treatment Plan Clients (TPC):
These clients are re-referred youth who are assessed to be moderate to high risk and provided service referral and linkage.

Proposed: 75
Actual:38

Explanation: There were fewer youth referred to services in FY19 in the moderate to high risk category with two or more referrals.

Non-treatment Plan Clients (NTPC):
These clients are youth with two or more referrals, who are assessed to be no to low risk, indicating structured treatment services are not necessary.

Proposed: 30
Actual:20

Explanation: There were fewer youth in the no to low risk category re-referred to services in FY19.

Community Service Events (CSE):
These are activities related to program outreach, networking, staff development and program management, including staff presentations, trainings, partner meetings/activities, volunteer recruitment/training events and community meetings/events.

Proposed: 50
Actual:60

Service Contacts (SC):
These are repeat referrals that the YAC team makes attempts to engage but is unable to contact and/or engage in services.

Proposed: 50
Actual:40

Explanation: The number of actual repeat referrals is lower because more participants were willing to engage in services.

Other:
Referrals made to the YAC by non-law enforcement/ juvenile justice entities. These will include referrals from schools, community, self/ family, etc.

Proposed: 50 Actual:57 Explanation: The increase in referrals made to the YAC by non-law enforcement/ juvenile justice entities has grown.
For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

Champaign Co. Regional Planning Commission – Head Start
Early Childhood Mental Health Services
Performance Outcome Report PY19

Agency name: Regional Planning Commission – Head Start
Program name: Early Childhood Mental Health Assistants
Submission date: 8/30/19

Consumer Access – *complete at end of year only*
Eligibility for service/program
1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application) Children are eligible for services funded by this grant if they score above the cut-off on the ASQ-SE screening and/or the Social-Emotional Development Specialist (SEDS) child observation indicates the child needs additional support with an Support Plan.
2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)? The Social-Emotional Development Specialist identifies children for services funded by this MHB grant. She then assigns the child's services to the Early Childhood Mental Health Assistant at the child's site or program option (center-based, home-based, family childcare) for services.
3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.) CCHS recruits throughout Champaign County at local libraries, elementary schools, door to door, grocery/convenience stores, town/village events, community agencies, and many other locations. CCHS has outreach at community events such as the annual Champaign County Disability Expo, Read Across America, Week of the Young Child and local school district early childhood program child-find activities. CCHS shares information with families about the social-emotional services provided by the Early Childhood Mental Health (ECMH) Assistants at parent

meetings, and through brochures and the parent handbook. Further, the Assistants trainings that pertain to trauma informed care, social-emotional development, and strategies to reduce challenging behaviors and increase social-emotional skills.

4. a) *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application):

All children needing individualized social-emotional lesson plan goals due to a high ASQ-SE score automatically receive services. For children identified for a Support Plan CCHS will provide services to 100% of these children for whom it has parent permission to write such a plan.

b) *Actual* percentage of individuals who sought assistance or were referred who received services:

During FY19 a total of 190 children were served by the ECMHA's. This includes NTPC and TPC.

5. a) *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application):

Teachers refer a child to the Social-Emotional Development Specialist (SEDS) within one week after screening yields an ASQ-SE score indicating eligibility for services. The SEDS will determine eligibility and assign children to the appropriate Early Childhood Mental Health Assistant within two working days of receiving referral from the child's teacher.
Within two weeks of obtaining parent permission to observe a child with challenging behaviors, the SEDS conducts the child observation in the classroom and determines the child's eligibility for an Individual Success Plan. The SEDS then assigns the child to the appropriate Early Childhood Mental Health Assistant within two working days of making the determination.

b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application):

An estimated 90% of children will be assessed for eligibility within the timeframes identified above and in CCHS procedures.

c) *Actual* percentage of referred clients assessed for eligibility within that time frame:

100% of children needing support at 3 of our four sites received immediate support because the 3 ECMHA we hired with the grant are based on site.

6. **a)** *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application):

Children with a high ASQ-SE score: Within two weeks of receiving assignment of a child for services, the Early Childhood Mental Health (ECMH) Assistant arranges a meeting for a child's parent(s), teachers and the ECMH Assistant to develop social-emotional goals for weekly classroom lesson plans. Teachers begin implementation of the goals within one day.
Children referred for challenging behaviors: Within two weeks of receiving assignment of a child for services, the ECMH Assistant facilitates a meeting for a child's parent(s), teachers and the ECMH Assistant to share the observation and develop a home-classroom Individual Success Plan for addressing the child's challenging behavior. Teachers begin implementation of the plan within one day.

b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application):

CCHS estimates 80% of children eligible for Early Childhood Mental Health services will receive them within the timeframe described above and in CCHS procedures.

c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame:

100% of children who needed support throughout the day received support from the onsite ECMHA's with supervision from the SEDS. In total the three staff members provided 2,340 instances of service contacts throughout the FY.

7. a) *From your application,* estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application):

CCHS anticipates the average length of Early Childhood Mental Health services will be 9 months.

b) *Actual* average length of participant engagement in services:

The actual average length of participant engagement in services was 9 months.

Demographic Information

1. *In your application* what, if any, demographic information did you indicate you would collect beyond those required (i.e. beyond race/ethnicity, age, gender, zip code)? (Demographic Information, question #1 in the Program Plan application)

No other demographic information is collected by CCHS

2. Please report here on all of the extra demographic information your program collected.

N/A

Consumer Outcomes – *complete at end of year only*

During the application process, you identified participant outcomes that your program activities would impact. Here, report the actual participant outcomes achieved as a result of your program activities

1. *From your application,* what impact on consumers did you expect your program activities to have? That is, what outcome(s) did you want your program to have on the people it is serving? (Consumer Outcomes, question #1 in the Program Plan application). Please number each outcome.

CCHS anticipates that at least 90% of enrolled children entering kindergarten, including children with a disability, will leave the program ready for kindergarten. CCHS anticipates that at least 85% of all enrolled children will make age-appropriate progress in social-emotional development.

2. For each outcome, please indicate the specific survey or assessment tool you used to collect information on this outcome in the chart below. (Please remember that the tool used should be evidence-based or empirically validated.)

Additionally, in the chart below, please indicate who provided this information (e.g. participant, participant's guardian(s), clinician/service provider, other program staff (if other program staff, indicate their role).) Please report all sources of information that apply for each assessment tool (e.g. the XYZ survey may be completed by both a youth client and their caregiver(s).

Outcome:	Assessment Tools Used:	Information Source:
1. Age appropriate Social-Emotional Readiness for kindergarten	Ages and Stages Questionnaire-Social Emotional (ASQ-SE) GOLD Teaching Strategies	Teachers and Parents
2. Age appropriate Social-Emotional improvement over the course of the school year.	ASQ-SE GOLD Teaching Strategies	Teachers and Parents
3. Reduction in teacher turn-over.	Hiring data from HR	HR department

3. Was outcome information gathered from every participant who received service, or only some?

All children who received services were evaluated using GOLD 3 times a year, fall, winter, and spring.

All children are screened within the first 45 days of attendance using the ASQ-SE

HR maintains a database of staff employment changes.

4. If only some participants, how did you choose who to collect outcome information from?

5. How many total participants did your program have?

60 Students were referred for social emotional evaluations.

6. How many people did you *attempt* to collect outcome information from?

All students had data collected using GOLD.
All staff employment changes are tracked.
All Students who are scored above the cut-off on the ASQ-SE are supposed to be rescreened within 6 months.

7. How many people did you *actually* collect outcome information from?

All students had data collected using GOLD.
All staff employment changes are tracked.

8. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc)

GOLD: 3 times a year, fall, winter, and spring
ASQ-SE: at enrollment and then ideally every six months after.

Results

9. What did you learn about your participants and/or program from this outcome information? Please be specific when discussing any change or outcome, and give appropriate quantitative or descriptive information when possible. For example, you could report the following:

i. Means (and Standard Deviations if possible)
ii. Change Over Time (if assessments occurred at multiple points)
iii. Comparison of strategies (e.g., comparing different strategies related to recruitment; comparing rates of retention for clients of different ethnoracial groups; comparing characteristics of all clients engaged versus clients retained)

Meeting age appropriate social-emotional milestones.
In the fall of 2018 61% of 3-5 year old's and 85% of 6 week to 3 year old's were meeting or exceeding the social-emotional milestones anticipated at their stage of development.

In the spring of 2019; 86% of 3-5 year old's and 89% of 6 week to 3 year old's were meeting or exceeding the social-emotional milestones anticipated at their stage of development.

Teacher retention:

Last year between Jan 2018 to June 2018 the turn over rate for teachers was 11%.
This year between January 2019 and June 2019 the turn over rate had reduced to 6%.

ASQ-SE:
96 Children were screened this year for social-emotional concerns. Out of those 96, 17 scored above the cut off by parents. 3 showed improvement during re-screening, 2 scored the same, 3 received a referral for further evaluation, 8 need to be rescreened in the fall, 1 was referred for medical intervention and needs to be rescreened after recovery

10. Is there some comparative target or benchmark level for program services? Y/N

Not yet, Early Childhood Mental Health Consultation is still a developing profession. Luckily, Illinois is leading the way in providing this service.

11. If yes, what is that benchmark/target and where does it come from?

12. If yes, how did your outcome data compare to the comparative target or benchmark?

(Optional) Narrative Example(s):

13. Describe a typical service delivery case to illustrate the work (this may be a "composite case" that combines information from multiple actual cases) (Your response is optional)

14. In what ways was the evaluation used to support changes in practice? What changes were made based on evaluation findings? (Your response is optional)

Utilization Data Narrative –

The utilization data chart is to be completed at the end of each quarter (including quarter 4) using the online reporting system.

Comparative yearly totals (i.e. reporting estimates and actual numbers) and the narrative section described below are to be completed at end of year only.

Here, you will report on the different types of service categories specified in your program plan application. Please remember that programs **do not** need to collect and report on every category- instead, you are to report only the ones that are most useful for understanding program impact.

1. Please copy and paste the definitions of service categories your program specified in your program plan application in the sections below**. You will report the actual numbers of clients/contacts/community events for each reported service category in the Part II Utilization/Production data form (located on the online system).** If your estimated number of clients/contacts/community events for reported service categories significantly differ from your actual numbers, you may give a narrative explanation for that discrepancy here.

   Since this was a new position we were not sure what numbers to expect from the services we provided.

Treatment Plan Clients (TPC):

Treatment Plan clients are new clients who have been referred for social emotional services, have a new support plan, or have new individual social emotional goals written for them.

Non-treatment Plan Clients (NTPC):

Non-Treatment clients are children who have received support, services, or have warranted consultation but do not have a treatment plan or a formal referral for services.

Community Service Events (CSE):

Attending and contributing to community meetings and training events.

Service Contacts (SC):

is defined as face to face services and supports given to NTP clients, TP Clients; consultation provided to teachers, and or parents related to NTPC/TPC; social-emotional skill building small groups in classrooms; large group guidance lessons in classrooms.

Other:

Meetings with classrooms to facilitate Practice Based Coaching or Social-Emotional Mentoring for teachers based on the Pyramid Model of social-emotional development, conscious discipline and Trauma informed care practices provided in two-week cycles to increase teacher knowledge and self-efficacy when working with challenging behaviors. Also includes psycho-social education for families during family site meetings.

For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

Champaign Co. Regional Planning Commission – Head Start
Social-Emotional Disabilities Services
Performance Outcome Report PY19

Agency name: Regional Planning Commission – Head Start
Program name: Social Emotional Development Services
Submission date: 8/30/19

Consumer Access – *complete at end of year only*
Eligibility for service/program
1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application) Children are eligible for services funded by this grant if they score above the cut-off on the ASQ-SE screening and/or the Social-Emotional Development Specialist (SEDS) child observation indicates the child needs additional support.
2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)? The Social-Emotional Development Specialist identifies children for services evaluating whether a child's ASQ-SE score or an individual classroom observation indicate a need for services.
3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.) CCHS recruits throughout Champaign County at local libraries, elementary schools, door to door, grocery/convenience stores, town/village events, community agencies, and many other locations. CCHS has outreach at community events such as the annual Champaign County Disability Expo, Read Across America, Week of the Young Child and local school district child-find activities. CCHS shares information with families about the social-emotional services provided by the Social-Emotional Development Specialist (SEDS) at parent meetings, and through brochures and the parent handbook. Further, the SEDS provides parent education trainings that pertain to trauma informed care, social-emotional development, and strategies to reduce challenging behaviors and increase social-emotional skills.

4. **a)** *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application):

All children needing individualized social-emotional lesson plan goals due to a high ASQ-SE score automatically receive services. For children identified for an Support Plan CCHS will provide services to 100% of these children for whom it has parent permission to write such a plan.

b) *Actual* percentage of individuals who sought assistance or were referred who received services:

During FY19 Consents were signed by parents for 60 students receive Social Emotional Evaluation. Out of 60:

- 16 were identified to receive intensive interventions and had a support plan developed in collaboration between staff and family.
- 4 were observed by the SEDS and a decision was made that services were not needed.
- 30 were evaluated, consultation was provided to teachers and or parents, and goals were set for social skills to be learned in the classroom.
- 6 students were withdrawn by parents or guardians before the evaluation process could be completed.
- 10 referrals were made for students to one or more of the following external providers. Early Intervention, Special Education, Mental Health, Occupational Therapy, or Developmental Pediatrician.

5. **a)** *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application):

Teachers refer a child to the SEDS within one week after screening. The SEDS confirms/denies the child's eligibility for specific social-emotional development goals for lesson plans within one week of receiving the teacher's referral.
Parents or teachers concerned about a child's behavior can refer the child to the SEDS for an individual observation at any point throughout the school year. Within two weeks of obtaining parent permission to observe, the SEDS conducts the child observation in the classroom and determines the child's eligibility for either intensive intervention; individualized social skills support; or general classroom support.

b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application):

An estimated 90% of children will be assessed for eligibility within the timeframes identified above and in CCHS procedures.

c) *Actual* percentage of referred clients assessed for eligibility within that time frame:

Response time of SEDS to engage in the social emotional evaluation process depended largely on how many referrals were received within the same time frame. There is only one person in this position and the initial evaluation process takes approx. 2-3 weeks with ongoing follow up and support lasting between 2 weeks to 6 months depending on the intensity of the concern/behavior. Average response time was closer to a month. During the wait time, staff, parents, and child is receiving support directly from the Early Childhood Mental Health Assistants under the supervision of the SEDS.

6. **a)** *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application):

Children with a high ASQ-SE score: Within two weeks of determining a child is eligible for services, the SEDS arranges a meeting for a child's parent(s), teachers and the SEDS to develop social-emotional goals for weekly classroom lesson plans. Teachers begin implementation of the goals within one day.

Children referred for challenging behaviors: Within two weeks following the determination of eligibility, the SEDS meets with the parent and classroom teachers to share the observation and develop a home-classroom Support Plan for addressing the child's challenging behavior. Teachers and Early Childhood Mental Health Assistants begin implementation of the plan within one day.

b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application):

CCHS estimates 90% of children eligible for Social-Emotional Development services will receive them within the timeframe described above and in CCHS procedures.

c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame:

100% of children who scored above the cut off on the ASQ-SE were engaged in services within the time frame suggested.

50% of children evaluated by the SEDS for Social Emotional strengths and concerns received plans within the time frame suggested. The gap between the estimation and actual was due to several factors. Parent availability to meet within that time frame, intensity of behavior (the more unsafe the behaviors, the shorter the time frame); Teacher availability to meet during that time frame. Implementation of strategies to support child's success in the classroom was implemented between day and 1 week of the goal setting depending on materials needed to implement plan (ex visual aids, weighted blankets, sensory materials).

7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application):

The average length of services by the SEDS is 9 months.

b) *Actual* average length of participant engagement in services:

The actual average length of participant engagement in services was 9 months.

Demographic Information

1. *In your application* what, if any, demographic information did you indicate you would collect beyond those required (i.e. beyond race/ethnicity, age, gender, zip code)? (Demographic Information, question #1 in the Program Plan application)

No other demographic information is collected by the SEDS

2. Please report here on all of the extra demographic information your program collected.

N/A

Consumer Outcomes – *complete at end of year only*

During the application process, you identified participant outcomes that your program activities would impact. Here, report the actual participant outcomes achieved as a result of your program activities

1. *From your application,* what impact on consumers did you expect your program activities to have? That is, what outcome(s) did you want your program to have on the people it is serving? (Consumer Outcomes, question #1 in the Program Plan application). Please number each outcome.

CCHS anticipates that at least 90% of enrolled children entering kindergarten, including children with a disability, will leave the program ready for kindergarten. CCHS anticipates that at least 85% of all enrolled children will make age-appropriate progress in social-emotional development.

2. For each outcome, please indicate the specific survey or assessment tool you used to collect information on this outcome in the chart below. (Please remember that the tool used should be evidence-based or empirically validated.)

Additionally, in the chart below, please indicate who provided this information (e.g. participant, participant's guardian(s), clinician/service provider, other program staff (if other program staff, indicate their role).) Please report all sources of information that apply for each assessment tool (e.g. the XYZ survey may be completed by both a youth client and their caregiver(s).

Outcome:	Assessment Tools Used:	Information Source:
1. Age appropriate Social-Emotional Readiness for kindergarten	Ages and Stages Questionnaire-Social Emotional (ASQ-SE) GOLD Teaching Strategies	Teachers and Parents
2. Age appropriate Social-Emotional improvement over the course of the school year.	ASQ-SE GOLD Teaching Strategies	Teachers and Parents

3. Reduction in teacher turn-over.	Hiring data from HR	HR department

3. Was outcome information gathered from every participant who received service, or only some?

All children who received services were evaluated using GOLD 3 times a year, fall, winter, and spring.

All children are screened within the first 45 days of attendance using the ASQ-SE

HR maintains a database of staff employment changes.

4. If only some participants, how did you choose who to collect outcome information from?

5. How many total participants did your program have?

60 Students were referred for social emotional evaluations.

6. How many people did you *attempt* to collect outcome information from?

All students had data collected using GOLD.

All staff employment changes are tracked.

All Students who are scored above the cut-off on the ASQ-SE are supposed to be rescreened within 6 months.

7. How many people did you *actually* collect outcome information from?

All students had data collected using GOLD.

All staff employment changes are tracked.

8. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc)

GOLD: 3 times a year, fall, winter, and spring

ASQ-SE: at enrollment and then ideally every six months after.

Results

9. What did you learn about your participants and/or program from this outcome information? Please be specific when discussing any change or outcome, and give appropriate quantitative or descriptive information when possible. For example, you could report the following:

i. Means (and Standard Deviations if possible)
ii. Change Over Time (if assessments occurred at multiple points)
iii. Comparison of strategies (e.g., comparing different strategies related to recruitment; comparing rates of retention for clients of different ethnoracial groups; comparing characteristics of all clients engaged versus clients retained)

Meeting age appropriate social-emotional milestones.
In the fall of 2018 61% of 3-5 year old's and 85% of 6 week to 3 year old's were meeting or exceeding the social-emotional milestones anticipated at their stage of development.

In the spring of 2019; 86% of 3-5 year old's and 89% of 6 week to 3 year old's were meeting or exceeding the social-emotional milestones anticipated at their stage of development.

Teacher retention:
Last year between Jan 2018 to June 2018 the turn over rate for teachers was 11%.
This year between January 2019 and June 2019 the turn over rate had reduced to 6%.

ASQ-SE:
96 Children were screened this year for social-emotional concerns. Out of those 96, 17 scored above the cut off by parents. 3 showed improvement during re-screening, 2 scored the same, 3 received a referral for further evaluation, 8 need to be rescreened in the fall, 1 was referred for medical intervention and needs to be rescreened after recovery

10. Is there some comparative target or benchmark level for program services? Y/N

Not yet, Early Childhood Mental Health Consultation is still a developing profession. Luckily, Illinois is leading the way in providing this service.

11. If yes, what is that benchmark/target and where does it come from?

12. If yes, how did your outcome data compare to the comparative target or benchmark?

(Optional) Narrative Example(s):

13. Describe a typical service delivery case to illustrate the work (this may be a "composite case" that combines information from multiple actual cases) (Your response is optional)

14. In what ways was the evaluation used to support changes in practice? What changes were made based on evaluation findings? (Your response is optional)

Utilization Data Narrative –

The utilization data chart is to be completed at the end of each quarter (including quarter 4) using the online reporting system.

Comparative yearly totals (i.e. reporting estimates and actual numbers) and the narrative section described below are to be completed at end of year only.

Here, you will report on the different types of service categories specified in your program plan application. Please remember that programs **do not** need to collect and report on every category- instead, you are to report only the ones that are most useful for understanding program impact.

1. Please copy and paste the definitions of service categories your program specified in your program plan application in the sections below**. You will report the actual numbers of clients/contacts/community events for each reported service category in the Part II Utilization/Production data form (located on the online system).** If your estimated number of clients/contacts/community events for reported service categories significantly differ from your actual numbers, you may give a narrative explanation for that discrepancy here.

   Numbers looked different than anticipated because of the addition of supervisory responsibilities to the position after the hiring of the Early Childhood Mental Health Assistants.

Treatment Plan Clients (TPC):

Treatment Plan clients are new clients who have been referred for social emotional services, are being seen individually for counseling, have a new support plan, or have new individual social emotional goals written for them.

Non-treatment Plan Clients (NTPC):

Non-Treatment clients are children or parents who have received support, services, or have warranted consultation but do not have a treatment plan or a formal referral for services.

Community Service Events (CSE):

Community Service events are Birth to 6 Council meetings, Mental Health Advisory Committee, Health Advisory meetings, and Infant Mental Health meetings, Champaign Community Coalition meetings, and collaboration with other agencies including Mindful Teachers, Mindful kids; Hope Springs, CU Trauma and Resilience Initiative workgroup and board. Community oriented events, workshops, or trainings.

Service Contacts (SC):

Service/Screening contacts consist of Social Emotional Room Observations (TPOT), ASQ-SE goal setting, and individual child observations, parent and/or teacher meetings to discuss concerns of a child, individual and group counseling sessions, functional behavior assessment interviews, support plan meetings, positive behavior coaching, teacher mentoring, contact to support outside referrals, advocacy, reflective consultation, reflective supervision of SSPC's, parent support groups, and parent trainings.

Other:

Other consists of staff capacity building and psycho-education, SE news blips for parent newsletters, Practice Based Coaching meetings, and other staff related support.

For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

Champaign Urbana Area Project
CU Neighborhood Champions
Performance Outcome Report PY19

Agency name: CUAP
Program name: CUNC
Submission date: 9/6/2019

Consumer Access – *complete at end of year only*

Eligibility for service/program

1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application)

RESPONDERS/CHAMPIONS:
Anyone affected by community violence is eligible for this support, which will be available to victims as well as family members of individuals identified as perpetrators (contributors to community violence).

The approach is designed to be restorative and acknowledge the universality of trauma. Based on our feedback, families of individuals who have been accused of being perpetrators of community violence feel especially stigmatized and isolated. This has resulted in a lack of willingness to connect to and utilize existing resources, which leads to further social isolation and additional adverse behaviors.

When possible, we want to support the families and extended kinship networks of everyone involved in every incident.

EDUCATORS:
Anyone can attend a trauma educational event. However some activities are designed to improve provider/community capacity. Other activities are designed for caregivers and families; and some activities are designed to address the needs of individuals directly impacted by community violence and trauma.

2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)?

RESPONDERS/CHAMPIONS:
We rely on self reports or the referral sources to determine eligibility for our services and supports. We do not require any documentation of additional proof.

EDUCATIONAL EFFORTS also rely on self-selection and self-referral. We do regularly ask 'How did you hear about us" on sign in sheets and during introductions. We also ask their role/group/or organizational affiliation on most sign in sheets.

3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.)

RESPONDER/CHAMPIONS & EDUCATORS
Currently, referrals for our services come from law enforcement, TRUCE, the City of Champaign, and/or other community partners/members (schools and community members). Additionally, we:

- consistently market and educate potential referrals sources about our program/services.
- participate at events designed to reach our targeted audience: health fairs, resource fairs, and a variety of community events.
- regularly distribute information about our educational events and our responder effects at the Champaign County Community coalition, to our partner organizations, through the listserv for the Trauma and Resilience effort and through other community partners.

4. a) *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application): 100% of individuals who wanted to reserve a service or attend a training would be able to do so. (We would not deny services or supports to anyone)

b) *Actual* percentage of individuals who sought assistance or were referred who received services: 100% of those referred to CUNC for either a service, support or who wanted to attend an educational activity were able to receive the requested service.

5. a) *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application):

RESPONDER SUPPORT: Requests for support are addressed within 24 to 48 hours from referral. Knowing that families in crisis can be busy, we gently (once or twice a week) continue to reach out by phone or text. If the family is unavailable or unresponsive after a week of contact, then we will return to the referral source for engagement tips (or for assistance in making the connection).

EDUCATORS: Not affected by the remaining questions.

b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application):

(From our application) All those (100%) of referred to the program will be accessed for eligibility would be assessed.

c) *Actual* percentage of referred clients assessed for eligibility within that time frame:

We did reach out and make contact with 100% of families/individuals referred for services during the 24-48 hour window. However, it generally takes at least 2 weeks to make face to face contact with the family/individual and about 4 weeks to fully be able access - in a comprehensive way- the families full needs. Generally, we spend 2-6 weeks addressing their immediate needs. Since no one is turned down, everyone receives some level support who is referred to services.

6. a) *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application):
Through our responder effort, most referrals are engaged and provided a service or support within one week.

b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application):
If a family or individual agrees to a face-to-face meeting, 100% are open to receiving services and support.

c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame:

Two referrals received services within the 24-48-hour time frame. 13/15 received some service or support within 8-12 weeks from the initial point of contact.

7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application):

Individuals and families receive formal support for 9-12 weeks. However, because the effort is relational and every situation is different, some individuals or families may participate for longer periods.

In an effort to put closure on the formal part of our process, closing meetings are scheduled at the 9-12 week marks to ensure that families are connected to any needed formal or long-term resources even after formal arrangements have ended.

b) *Actual* average length of participant engagement in services:

- 7/15 families served were involved with services/supports for 16-20 weeks.
- 3/15 families were involved with our support only through their crisis 4-8 weeks.
- 5 families have been involved with our services for more than 6 months.
- They have been referred to other programs/services but continue to use CUNC as the primary service provider.

Demographic Information

1. *In your application* what, if any, demographic information did you indicate you would collect beyond those required (i.e. beyond race/ethnicity, age, gender, zip code)? (Demographic Information, question #1 in the Program Plan application)

did not agree to collect additional demographic information.

2. Please report here on all of the extra demographic information your program collected.

Consumer Outcomes – *complete at end of year only*

During the application process, you identified participant outcomes that your program activities would impact. Here, report the actual participant outcomes achieved as a result of your program activities

1. *From your application,* what impact on consumers did you expect your program activities to have? That is, what outcome(s) did you want your program to have on the people it is serving? (Consumer Outcomes, question #1 in the Program Plan application). Please number each outcome.

CUNC agreed to collect various outcome measures and evaluative data including:

a. Comprehensive demographic data.
b. Referrals and contact data.
c. Training event data.
d. Basic training satisfaction survey data.

In addition, we are creating an evaluation tool to measure the collaboration of the group that is coordinating the effort.

RESPONDERS:

- Individuals or families who receive more intensive services complete strength-based needs assessments and wraparound plans; both tools are evidence-informed. . The

training is based on the Youth-CAN model, which is an evidence-based practice from the National Child Traumatic Stress Network.

- Wraparound plans are individualized—approximately 90% of a family's or individual's short-term needs are addressed.

- We are working on collecting data concerning referrals to services and support made by community-based Champion leaders.

- We will try to collect narrative data through photo stories, art projects, and other nontraditional, noninvasive strength-based methods.

We anticipate reduction in signs of depression, aggression, anxiety, and trauma symptomology. We also expect improvement in resiliency scores and outcomes. Part of the working group's goal is to identify a strategy that could be used widely to measure the impact of our community's trauma-informed care efforts.

- We continue to work with our community partners to create a tool for determining a community-impact score. This was a goal from FY18 that has not yet been realized.

- As a part of our advocacy and work with the Coalition, we anticipate assisting with the following:

- Adopting and utilizing a piloted effort of the Healing Justice Alliance's Screening and Tool for Awareness and Relief of Trauma (START intervention model).

- Working with the Coalition to identify a broader measure for examining the impact of our community's move to be more trauma informed. (No tool or measurement has yet been identified.)

2. For each outcome, please indicate the specific survey or assessment tool you used to collect information on this outcome in the chart below. (Please remember that the tool used should be evidence-based or empirically validated.)

Additionally, in the chart below, please indicate who provided this information (e.g. participant, participant's guardian(s), clinician/service provider, other program staff (if other program staff, indicate their role).) Please report all sources of information that apply for each assessment tool (e.g. the XYZ survey may be completed by both a youth client and their caregiver(s).

Outcome:	Assessment Tool Used:	Information Source:

E.g. . Increased empowerment in advocacy clients	Measure of Victim Empowerment Related to Safety (MOVERS) survey		
We did not use an empirically supported tool to assist with evaluating our outcomes in 2019.			

3. Was outcome information gathered from every participant who received service, or only some? No

4. If only some participants, how did you choose who to collect outcome information from? We attempted to collect outcome data for every client served.

5. How many total participants did your program have?

We had 869 individuals participate in an educational event in total (this number includes people who attended more than one educational event.) 46 individuals were served representing 15 enrolled families.

6. How many people did you *attempt* to collect outcome information from?

We only collected evaluation data from individuals who attended a training event – 869.

7. How many people did you *actually* collect outcome information from?

We collected evaluation data from 768 participants.

8. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc)

At trainings/educational events participants complete surveys. We collected information at 76 of the 90 training/educational events. We did lose a few sign in sheets.

Results

9. What did you learn about your participants and/or program from this outcome information? Please be specific when discussing any change or outcome, and give appropriate quantitative or descriptive information when possible. For example, you could report the following:

i. Means (and Standard Deviations if possible)
ii. Change Over Time (if assessments occurred at multiple points)
iii. Comparison of strategies (e.g., comparing different strategies related to recruitment; comparing rates of retention for clients of different ethnoracial groups; comparing characteristics of all clients engaged versus clients retained)

RESPONDER: As previously mentioned we did not collect pre/post or outcome data for the families we worked with/served. However, 6 had full wraparound plans and those families achieved 75% of their planned goals. *It is important to note that we achieved our service goals without much volunteer support.* Only 2 of the 15 families served had volunteers on their teams. We were understaffed the entire program year.

ADVOCACY: We also did not complete our goal of identifying measures to evaluate our collective impact although it was discussed multiple times in our working groups. What we could not foresee was the Coalition launching the Community Violence Response working group in which we have played an integral role in the organization thereof as well as the planning and operation of.

TRAINING/EDUCATION: We did not agree to report outcomes in this area but achieved the following: (Evaluation rankings from 1 (not at all) to 5 (highly likely).

1. *Did today's event help you increase your understanding of trauma/trauma informed care?* (91 % answered this as a 5)
2. *Did the training provide you information you can use in your workplace?* (92% answered this with a 5)
3. *Did today's event meet your expectations?* (98 % answered this with a 5)
4. *Would you be interested in attending future events, trainings, etc?* (96% answered this with a 5)

Most frequent comments were about the need for longer sessions, more materials or about others voices that should be 'in the room' – funders, board members, other providers, and when trainings were aimed at providers there were comments about the absence of consumers and consumer focused presentations frequently suggested providers be included.

This feedback will be integrated into this year's educational/training events.

10. Is there some comparative target or benchmark level for program services? Y/N
Not yet. Eventually we hope to have the capacity to meet the needs of everyone directly impacted by gun violence by providing at least some basic information, resources, and support. Yet the infrastructure needed to develop this capacity has to be built.

11. If yes, what is that benchmark/target and where does it come from?

We plan to establish benchmarks based on anecdotal data from previous year's work. However, we hope to have more volunteers and informal supports to assist with the effort which should result in better engagement, better outcomes (and increase our ability to collect outcome data).

12. If yes, how did your outcome data compare to the comparative target or benchmark?

Not available at this time (see above).

(Optional) Narrative Example(s):

13. Describe a typical service delivery case to illustrate the work (this may be a "composite case" that combines information from multiple actual cases) (Your response is optional)

Currently, the family who is typically referred to CUNC is one that has multiple system involvement (schools, mental health, other services) but is having challenges navigating those systems after they have been affected by community violence.

The typical family is a mom, a stepparent/male paramour and at least one adolescent male child. Additionally, the mom and the child(ren) typically have experienced multiple traumatic experiences prior to being impacted by local community violence. Frequently, they have 'chosen Champaign' because they assumed they would be safe here. Their experience of violence is extremely dysregulating.

Our typical call is from a community person who is aware of our program and is asking us to assist the family in obtaining resources or navigating a system. We engage in a lot of coaching, assisting the family in self advocacy, connecting them to resources (and helping them navigate a system) and most importantly, helping the formal supports better understand the family's needs and the impact of the trauma on the family's life.

In addition to the families being connected to multiple systems, they frequently have informal connections (friends, extended family) that have also been adversely impacted by their current crisis. This means, in turn, that resources they would typically be able to rely upon have diminished capacity for support at this time of crisis.

When helping a family navigate systems we frequently learn about the inflexibility of systems and how the can unintentionally retraumatize the family. Families that stay engaged with us are ones that we help navigate through systems successfully. When we cannot immediately provide the assistance or supports needed these families these families tend to disengage until the next crisis arises. This has taught us that families need to experience some type of an immediate 'win' when they are working with us in order to trust our process. Therefore, we work diligently to provide a robust and immediate response to address their needs.

14. In what ways was the evaluation used to support changes in practice? What changes were made based on evaluation findings? (Your response is optional)

Utilization Data Narrative –

The utilization data chart is to be completed at the end of each quarter (including quarter 4) using the online reporting system.

Comparative yearly totals (i.e. reporting estimates and actual numbers) and the narrative section described below are to be completed at end of year only.

Here, you will report on the different types of service categories specified in your program plan application. Please remember that programs **do not** need to collect and report on every category- instead, you are to report only the ones that are most useful for understanding program impact.

Please copy and paste the definitions of service categories your program specified in your program plan application in the sections below**. You will report the actual numbers of clients/contacts/community events for each reported service category in the Part II Utilization/Production data form (located on the online system).** If your estimated number of clients/contacts/community events for reported service categories significantly differ from your actual numbers, you may give a narrative explanation for that discrepancy here.

Treatment Plan Clients (TPC): 0

Non-treatment Plan Clients (NTPC):

15 projected/15 reached (we served 46 people) and formally provided support to

NTPC =Number of families who received some support from the family. Each family is enrolled under the primary point of contact/person referend's demographic information:

Community Service Events (CSE): 70 projected/ 90 held
Educational and training events
We had a total of 869 participants. However, an estimated 1/3 of the educational participants attended more than one educational event so approximately 580 discrete individuals.

Service Contacts (SC): 50 projected/ 73 held

SC: Contacts made on behalf or with a client: these are service coordination contacts. Wraparound meetings, school meetings, service coordination meetings/calls, and even referrals could be included in this category.

For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

Champaign Urbana Area Project
TRUCE
Performance Outcome Report PY19

Agency name: Champaign Urbana Area Project
Program name: TRUCE
Submission date: September 11, 2019

Consumer Access – *complete at end of year only*
Eligibility for service/program
1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application) **TRUCE Peace Seekers will concentrate their work in the focus areas of Garden Hills, Beardsley Park Neighborhood, North End, and East Urbana neighborhoods. [Individuals and families who have been impacted by community or gun-related violence]**
2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)? **Referrals came from schools, family members, self-referrals, and word of mouth. There was not a formal assessment, and most individuals who self-referred were accepted.**
3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.) **Most individuals learned of the CUAP/TRUCE activities through outreach, referral by other individuals, and word of mouth. During the school year, CUAP/TRUCE Outreach workers worked directly with students who had been involved in community or school-based violence.**
4. a) *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application):

It is estimated that 80% of the individuals who sought assistance would receive services.

b) *Actual* percentage of individuals who sought assistance or were referred who received services:

This number is not available, because the TRUCE/CUAP Outreach Workers did not have a data tracking or case management tool during the FY19 period.

5. a) *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application):

Because there was no formal assessment, the estimated time between the referral and the services was dependent more on staff capacity and individual/family interest.

b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application):

See 5 a.

c) *Actual* percentage of referred clients assessed for eligibility within that time frame:

See 5 a.

6. **a)** *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application):

Estimated length of time between referral and engagement in services varied widely based on staff and client availability. If the client was motivated, the engagement could start almost immediately. Limited funding and limited number of trained outreach workers were the two largest obstacles.

b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application):

c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame:

7. **a)** *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application):

It is estimated that the average length of participant engagement was between 4 to 16 weeks.

b) *Actual* average length of participant engagement in services:

There is no accurate Actual data for length of participant engagement. See 7 a for an estimate.

Demographic Information

1. *In your application* what, if any, demographic information did you indicate you would collect beyond those required (i.e. beyond race/ethnicity, age, gender, zip code)? (Demographic Information, question #1 in the Program Plan application)

No additional demographic information was collected.

2. Please report here on all of the extra demographic information your program collected.

No Additional demographic information was collected.

Consumer Outcomes – *complete at end of year only*

During the application process, you identified participant outcomes that your program activities would impact. Here, report the actual participant outcomes achieved as a result of your program activities

1. *From your application,* what impact on consumers did you expect your program activities to have? That is, what outcome(s) did you want your program to have on the people it is serving? (Consumer Outcomes, question #1 in the Program Plan application). Please number each outcome.

1. **Reduce Community Gun-Related Violence**
2. **Increase community understanding of the impact of gun-related violence**
3. **Reduce retalitations**
4. **Repair harm in affected communities**

2. For each outcome, please indicate the specific survey or assessment tool you used to collect information on this outcome in the chart below. (Please remember that the tool used should be evidence-based or empirically validated.)

Additionally, in the chart below, please indicate who provided this information (e.g. participant, participant's guardian(s), clinician/service provider, other program staff (if other program staff, indicate their role).) Please report all sources of information that apply for each assessment tool (e.g. the XYZ survey may be completed by both a youth client and their caregiver(s).

Outcome:	Assessment Tool Used:	Information Source:
Reduce Community Gun-Related Violence	Paper and pencil data tracking	News reports and updates from local law enforcement at Coalition Meetings
Increase community understanding of the impact of gun-related violence	Survey was developed but not administered. The survey was not evidenced based or validated.	None
Reduce retalitations	No tool developed to measure this goal.	No tool developed to measure this goal.
Repair harm in affected communities	No tool developed to measure this goal.	No tool developed to measure this goal.

3. Was outcome information gathered from every participant who received service, or only some?

For FY19, only some information was gathered from some participants.

4. If only some participants, how did you choose who to collect outcome information from? **The information and data gathering was random, and often based on which outreach worker was working with a participant. There was no formal decision tree or policy regarding the collection of data. Moving forward, we have worked with the two graduate students from UIUC who have helped CUAP develop a data tracking tool.**
5. How many total participants did your program have? **17 NTPC and Other Clients. We had 75 Screening Contacts.**
6. How many people did you *attempt* to collect outcome information from? **Not recorded. Estimated to be 10 of the 17 NTPC and Other Clients**
7. How many people did you *actually* collect outcome information from? **None**
8. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc) **Information was collected, or collection was attempted at client intake. There was no formal policy or procedure in place for exiting or discharging a participant, therefore, there was no method to collect data about the services provided or satisfaction.**
Results

9. What did you learn about your participants and/or program from this outcome information? Please be specific when discussing any change or outcome, and give appropriate quantitative or descriptive information when possible. For example, you could report the following:

    i. Means (and Standard Deviations if possible)
    ii. Change Over Time (if assessments occurred at multiple points)
    iii. Comparison of strategies (e.g., comparing different strategies related to recruitment; comparing rates of retention for clients of different ethnoracial groups; comparing characteristics of all clients engaged versus clients retained)

One of the biggest lessons learned from the FY2019 grant period is that CUAP as an organization needed to work on data tracking, data collection, and aligning activities to goals. The work we did with the graduate students from UIUC helped create a new logic model that aligned Goals with Activities, and eventually developed a data tracking system. However, that work did not get started with earnest until near the end of the Third Quarter. The data tracking tool still has not been rolled out to Outreach Workers yet.

10. Is there some comparative target or benchmark level for program services? Y/N

    No

11. If yes, what is that benchmark/target and where does it come from?

12. If yes, how did your outcome data compare to the comparative target or benchmark?

(Optional) Narrative Example(s):

13. Describe a typical service delivery case to illustrate the work (this may be a "composite case" that combines information from multiple actual cases) (Your response is optional)

14. In what ways was the evaluation used to support changes in practice? What changes were made based on evaluation findings? (Your response is optional)

Formative evaluation was not documentmented. Moving forward, policies, procedures and tools are being developed to shift the organizational culture to more of a data driven system.

Utilization Data Narrative –

The utilization data chart is to be completed at the end of each quarter (including quarter 4) using the online reporting system.

Comparative yearly totals (i.e. reporting estimates and actual numbers) and the narrative section described below are to be completed at end of year only.

Here, you will report on the different types of service categories specified in your program plan application. Please remember that programs **do not** need to collect and report on every category- instead, you are to report only the ones that are most useful for understanding program impact.

1. Please copy and paste the definitions of service categories your program specified in your program plan application in the sections below**. You will report the actual numbers of clients/contacts/community events for each reported service category in the Part II Utilization/Production data form (located on the online system).** If your estimated number of clients/contacts/community events for reported service categories significantly differfrom your actual numbers, you may give a narrative explanation for that discrepancy here.

Treatment Plan Clients (TPC):

0

Non-treatment Plan Clients (NTPC):

3 + 14 other clients who were followed on an irregular basis.

Community Service Events (CSE):

90

Service Contacts (SC):

75

For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

Community Service Center of Northern Champaign County
Resource Connection
Performance Outcome Report PY19

Agency name: Community Service Center of Northern Champaign County
Program name: The Resource Connection
Submission date: 8/28/19

Consumer Access – *complete at end of year only*

Eligibility for service/program

1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application)

Residents of the nine northernmost townships of Champaign County, with focus on low income households and people with disabilities. No restriction on clients seen by other programs using our offices.

2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)?

We verify residence thru an ID card and another current document such as a utility bill. Income information and other demographics are collected at time of intake.

3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.)

Word of mouth, referral from other agencies, outreach events, publicity in local paper.

4. a) *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application): Given the nature of our services it is not often that people are not served in one way or another, but we donot track that data. Based on our count of unmet needs from information and referral inquiries, only about 6.8% are classified as unmet needs.

b) *Actual* percentage of individuals who sought assistance or were referred who received services: See 4a.

5. a) *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application): N/A
b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application): N/A
c) *Actual* percentage of referred clients assessed for eligibility within that time frame: N/A
6. a) *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application): N/A
b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application): N/A
c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame: N/A
7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application): N/A
b) *Actual* average length of participant engagement in services: N/A
Demographic Information

1. *In your application* what, if any, demographic information did you indicate you would collect beyond those required (i.e. race/ethnicity, age, gender, zip code)? (Demographic Information, question #1 in the Program Plan application) None

2. Please report here on all of the extra demographic information your program collected.

N/A

Consumer Outcomes – *complete at end of year only*

During the application process, you identified participant outcomes that your program activities would impact. Here, report the actual participant outcomes achieved as a result of your program activities

1. *From your application,* what impact on consumers did you expect your program activities to have? That is, what outcome(s) did you want your program to have on the people it is serving? (Consumer Outcomes, question #1 in the Program Plan application)
The program's impact is its ability to enhance access to a variety of services, whether directly or through another agency's services. Basic needs and related services are provided directly thru the program and others are referred or given information about services available elsewhere. More specific outcomes will be determined once the new needs assessment form and the annual consumer satisfaction survey have been implemented for at least 1 year.

2. For each outcome, what specific survey or assessment tool did you use to collect information on this outcome? (Please remember that the tool used should be evidence-based or empirically validated.)
We used a consumer satisfaction survey developed several years ago. This September we will implement the new evidence based survey developed by the U of I outcome evaluation staff. We will also use a client needs assessment form every 6 months.

3. Who provided the information about participant outcome(s)?

(Participant, participant guardian, clinician/service provider, other program staff (if other program staff, who? The participants))

4. Was outcome information gathered from every participant who received service, or only some?
Only some, usually about 8%. With the new document we hope to survey closer to 10% of participants.

5. If only some participants, how did you choose who to collect outcome information from? Random choice

6. How many total participants did your program have?
1357 households

7. How many people did you *attempt* to collect outcome information from?
Up to 120

8. How many people did you *actually* collect outcome information from?
100 participants

9. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc)
Annually from now on.

Results

10. What did you learn about your participants and/or program from this outcome information? Please be specific when discussing any change or outcome, and give appropriate quantitative or descriptive information when possible. For example, you could report the following:

i. Means (and Standard Deviations if possible)
ii. Change Over Time (if assessments occurred at multiple points)
iii. Comparison of strategies (e.g., recruitment, retention, treatment, intervention)

Considering the type of services we provide and that we use a satisfaction survey, what we can report is that all but two respondents were either extremely satisfied or moderately satisfied with how they were treated by our staff and by staff from other agencies using our facility. 60% of respondents learned about our services thru word of mouth. 89% indicated that no additional services were needed, but single responses included help with energy assistance, more food, and Spanish speaking staff. With the new survey document we expect a wider range and more detailed information regarding client needs, their sense of well-being, and overall provision of services.

11. Is there some comparative target or benchmark level for program services? Y/N
N

12. If yes, what is that benchmark/target and where does it come from?

13. If yes, how did your outcome data compare to the comparative target or benchmark?

(Optional) Narrative Example(s)

14. Describe a typical service delivery case to illustrate the work (this may be a "composite case" that combines information from multiple actual cases)

A client comes in needing help with payment for utilities. In the interview process we find out they also need help with food and substance abuse counseling. Our intake staff provides information about the LIHEAP program, help set up an appointment and give information about Rosecrance services in Rantoul. Assistance with food is provided immediately and the client returns the following week for an appointment with a counselor. He further informs us that he's being helped by the LIHEAP program and his housing is stabilized as a result. Because he's underemployed, the client returns monthly to get food assistance. He receives information about a local job fair.

15. In what ways was the evaluation used to support changes in practice? What changes were made based on evaluation findings?
The evaluation process will begin in PY20.

Utilization Data Narrative – *complete at the end of each quarter using the online reporting system. Complete this section at end of year only.*

Here, you will report on the different types of service categories specified in your program plan application. Please remember that programs **do not** need to collect and report on every category- instead, you are to report only the ones that are most useful for understanding program impact.

1. Please copy and paste the definitions of service categories your program specified in your program plan application in the sections below**. You will report the actual outcomes of service categories in the Part II Utilization/Production data form (located on the online system).** If your estimated service category outcome significantly differs from your actual service category outcome, you may give a narrative explanation for that discrepancy here.
We over-estimated the number of new and continuing NTPCs for PY18. The new NTPC count is significantly lower than expected. We don't have any specific reason for this except perhaps that the population of Rantoul has been quite stable and that most of the people in need of services are already receiving them. The economy also seems to be doing better and we're seeing less demand for basic needs services as well.

Treatment Plan Clients (TPC):
N/A

Non-treatment Plan Clients (NTPC):
Clients served directly by the program but without a specific treatment plan.

Community Service Events (CSE):
Informational and educational events sponsored or hosted by the agency/program.

Service Contacts (SC):
Phone call and walk in inquiries regarding human services and other needs.

For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

Courage Connection
Courage Connection Program
Performance Outcome Report PY19

Agency name: Courage Connection
Program name: Courage Connection
Submission date: 8/30/2019

Consumer Access – *complete at end of year only*

Eligibility for service/program

1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application)

Individuals who are interested in accessing services with our domestic violence programs do so through walk-in or by contacting our 24/7 domestic violence hotline. Through our hotline we have access to interpretation services, and can receive/make calls through services for the hard-of-hearing. Eligibility is based upon self-report of domestic violence, as required by best practice and the accreditation from the Illinois Coalition Against Domestic Violence (ICADV).

2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)?

Individuals go through an intake process with a Client Advocate.

3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.)

Our target population learns of services through first responders, referrals from court, outreach events, educational events, social media, and word-of-mouth.

4. a) *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application):
100% of individuals who are seeking counseling services will be able to contact the 24/7 domestic violence hotline and speak with a client advocate immediately. This is made possible by policy that ensures the hotline is accessible by staff at all times, and with practices to ensure back-up staff in the case of primary staff being occupied with assisting a client.

b) *Actual* percentage of individuals who sought assistance or were referred who received services:

100% of individuals who contacted our hotline for any reason were able to speak to an advocate immediately. The hotline is directed as the primary responsibility of all who work within our domestic violence program. In the rare case of our phone lines going down, the hotline is forwarded to the National Domestic Violence Hotline. This did not occur during the reporting period of FY19.

5. a) *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application):

86% of individuals who are eligible for services will be contacted by a Counselor to set up an intake assessment within 72 hours.

b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application):

We attempt to contact 100% of referred clients in this timeframe.

c) *Actual* percentage of referred clients assessed for eligibility within that time frame:

86% of individuals who are eligible for service will be contacted by a Counselor within 72 hours.

6. a) *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application):

Depending upon the need, access to services can be immediate if the client indicates s/he is in immediate danger. Legal advocacy and counseling occurs within 24-72 hrs of initial call.

b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application):

We attempt to engage 100% of eligible clients in services within the estimated timeframe.

c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame:

In FY19, we successfully engaged 98% of eligible clients in services.

7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application):

For clients residing in the emergency shelter for three or more days, we estimated 100% would receive three or more services.

For non-residential clients, we estimated 100% would receive three or more services.

b) *Actual* average length of participant engagement in services:

Clients residing in the emergency shelter for three or more days; 91% received three or more services.

Non-residential clients; we estimated 98% received three or more services.

Demographic Information

1. *In your application* what, if any, demographic information did you indicate you would collect beyond those required (i.e. beyond race/ethnicity, age, gender, zip code)? (Demographic Information, question #1 in the Program Plan application)

We do not collect demographic information beyond what is described above

2. Please report here on all of the extra demographic information your program collected.

N/A

Consumer Outcomes – *complete at end of year only*

During the application process, you identified participant outcomes that your program activities would impact. Here, report the actual participant outcomes achieved as a result of your program activities

1. *From your application,* what impact on consumers did you expect your program activities to have? That is, what outcome(s) did you want your program to have on the people it is serving? (Consumer Outcomes, question #1 in the Program Plan application). Please number each outcome.

Ensuring survivors of domestic violence achieve an improved sense of safety and self-empowerment as a result of receiving services from our programs is achieved by providing the survivors with tools and education to ensure they are able to live independently, as well as skills and confidence to prevent a return to a dangerous situation (or a more rapid removal from one). At a community level, increasing the understanding around domestic violence, as well as how to best assist victims, is best achieved through targeted education of the general public, professional

institutions (such as police or hospitals), and accurate media representations. (Education to stop abusers' behavior is also critical, but cannot be provided by Courage Connection directly, as assisting both victims and abusers would represent a significant conflict of interest.)

For ensuring survivors achieve an improved sense of safety and self-empowerment, we will measure the degree to which residential clients, both emergency and transitional, discharge into improved, safer environments. Based on exit data, we will measure "Reason for Leaving", using the categories "Completed program", "Left for housing opportunity before completing program", and "Needs could not be met by project" as positive indicators of an improved, safer environment. (The latter category because in each case this is marked it represents a referral to a living environment that better suits the client's immediate and/or most pressing needs. Other categories include negative or questionable discharges such as rule violations or unknown destinations.)

We expect 60% positive discharge indicators, with no more than 15% of discharges to be "Unknown" or "Unassigned".

It is worth noting that the dynamics that lead to unknown departure locations (if we include the category “Disappeared”, the percentage rises to 11%) are almost always examples like a client returning to live with an abuser and (incorrectly) assuming our staff will be unhappy with this, so they do not tell us they are leaving out of shame, or fear, or concern they will be disappointing staff. Indeed, those who flee domestic violence often return to abusers, and need to leave on average 7 times before they leave permanently. (An excellent resource that summarizes why this is can be found at: http://womensfreedomcenter.net/get-informed/barriers-to-leaving/) Courage Connection’s role is to provide a safe space that people can feel they return to, and to ensure that no matter where they leave to, they have learned more ways to keep themselves safe (so that they *can* return when/if the abuse continues).

To measure a survivor's skills and confidence to move to a more positive situation (or a more rapid removal from a dangerous one), we will use survey responses generated by IDHS and the Illinois Coalition Against Domestic Violence (ICADV) as recorded in the InfoNet reporting system. Survey questions asked are in accordance with IDHS and ICADV standards, and vary slightly depending on the service (e.g. Legal Advocacy or Counseling). We endeavor to ensure that 75% of eligible surveys will be administered, when not including Legal Advocacy. (We do collect surveys for Legal Advocacy, but the often singular nature of this service, often provided exclusively in court, makes administering the survey particularly challenging, and often irrelevant given the brief nature of the service.) Surveys are not administered to small children who do not have the capacity to answer these questions. For most services, the survey is administered at or near the end of the service. For more ongoing services, such as Counseling, the survey is administered at least yearly.

We expect 90% of survey responses to be positive, reflecting an improved understanding of safety planning, community resources, legal rights, and the effects of abuse, as well as an improved sense of safety and knowledge that abuse is not their fault. As any particular service drops below 90%, we will review service provision accordingly to explore potential improvements or to identify reasonable explanations for the lower score.

2. For each outcome, please indicate the specific survey or assessment tool you used to collect information on this outcome in the chart below. (Please remember that the tool used should be evidence-based or empirically validated.)

Additionally, in the chart below, please indicate who provided this information (e.g. participant, participant's guardian(s), clinician/service provider, other program staff (if other program staff, indicate their role).) Please report all sources of information that apply for each assessment tool (e.g. the XYZ survey may be completed by both a youth client and their caregiver(s).

Outcome:	Assessment Tool Used:	Information Source:
I know more ways to plan for my safety **98%**	Survey	Client
I know more about community resources 99%	Survey	Client
I feel safer from abuse by getting out of the abusive environment while in shelter 92%	Survey	Client
I feel more hopeful about my future 94%	Survey	Client
I have a better understanding of the effects of abuse on my life 100%	Survey	Client
I have a better understanding of the effects of abuse on my children's lives **100%**	Survey	Client

[children only] The abuse in my family is not my fault 100%	Survey	Client
[children only] I know two things to do when I don't feel safe 100%	Survey	Client

3. Was outcome information gathered from every participant who received service, or only some?

We attempt to survey every participant

4. If only some participants, how did you choose who to collect outcome information from?

N/A

5. How many total participants did your program have?

1,030

6. How many people did you *attempt* to collect outcome information from?

100%

7. How many people did you *actually* collect outcome information from?

80%

8. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc)

Immediately after a client received services.

Results

See above

9. What did you learn about your participants and/or program from this outcome information? Please be specific when discussing any change or outcome, and give appropriate quantitative or descriptive information when possible. For example, you could report the following:

i. Means (and Standard Deviations if possible)
ii. Change Over Time (if assessments occurred at multiple points)
iii. Comparison of strategies (e.g., comparing different strategies related to recruitment; comparing rates of retention for clients of different ethnoracial groups; comparing characteristics of all clients engaged versus clients retained)

N/A

10. Is there some comparative target or benchmark level for program services? Y/N

Yes

11. If yes, what is that benchmark/target and where does it come from?

We are guided by state and national averages of exit survey data.

12. If yes, how did your outcome data compare to the comparative target or benchmark?

Our outcome data exceeded our targets in FY19.

(Optional) Narrative Example(s):

13. Describe a typical service delivery case to illustrate the work (this may be a "composite case" that combines information from multiple actual cases) (Your response is optional)

14. In what ways was the evaluation used to support changes in practice? What changes were made based on evaluation findings? (Your response is optional)

Utilization Data Narrative –

The utilization data chart is to be completed at the end of each quarter (including quarter 4) using the online reporting system.

Comparative yearly totals (i.e. reporting estimates and actual numbers) and the narrative section described below are to be completed at end of year only.

Here, you will report on the different types of service categories specified in your program plan application. Please remember that programs **do not** need to collect and report on every category- instead, you are to report only the ones that are most useful for understanding program impact.

1. Please copy and paste the definitions of service categories your program specified in your program plan application in the sections below**. You will report the actual numbers of clients/contacts/community events for each reported service category in the Part II Utilization/Production data form (located on the online system).** If your estimated number of clients/contacts/community events for reported service categories significantly differ from your actual numbers, you may give a narrative explanation for that discrepancy here.

Treatment Plan Clients (TPC):

Treatment Plan Client (TPC): A residential client who has opened a new case in the quarter and has been in shelter for at least 3 days, or a non-residential client who has opened a new case in the quarter and has received at least 3 services in the quarter. "New" means the client has not been previously engaged as a client in the operating FY.

Non-treatment Plan Clients (NTPC):

Continuing Non Treatment Plan Client (CNTPC): A residential client who was in shelter for less than 3 days on the first day of the operating FY *and* had less than 3 non-residential services on the first day of the operating year, or a non-residential client who has received less than 3 services on the first day of the operating year. While this number can vary significantly, on any particular day, it is likely to be low.

Community Service Events (CSE):

Domestic Violence impacts every member of our community, regardless of age and other demographics. We are proud to have engaged with more than 10,000 unique individual members of the community in FY19.

Service Contacts (SC):

For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

Crisis Nursery
Beyond Blue – Champaign
Performance Outcome Report PY19

Agency name: Crisis Nursery
Program name: Beyond Blue
Submission date: 8/30/19

Consumer Access – *complete at end of year only*

Eligibility for service/program

1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application)

Beyond Blue serves mothers who have or are at risk of developing perinatal depression (PD), targeting 33 mothers annually who demonstrate PD risk factors and have a child under age one. Mothers are provided individual and group support and education to facilitate healthy parent-child engagement.

Research shows that PD risk factors include: poverty, personal/family history of depression, limited social supports, and marital discord. The program is voluntary and open to all mothers in Champaign County who have a child or children under the age of 1 and who have been identified to be "at risk" of PD. "At risk" is determined by the presence of CDC-identified risk factors and/or a score of 10 or higher on an Edinburgh Postnatal Depression Scale (EPDS).

2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)?

Crisis Nursery identifies Champaign County mothers (expectant and post-natal) who are "at risk" via the following sources:

- Mothers/babies identified by Crisis Nursery staff as "at risk"
- Mothers/babies identified by CUPHD's WIC/Family Case Management units
- Mothers/babies identified by area healthcare providers
- Mothers/babies identified by Beyond Blue participants

Referrals of expectant mother or fathers identified as "at risk" can also be accepted.

"At risk" is determined by the presence of CDC-identified risk factors and/or a score of 10 or higher on an Edinburgh Postnatal Depression Scale (EPDS).

3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.)

Crisis Nursery Family Specialists, working in the Beyond Blue program, made numerous connections with agencies and service providers in the rural and Champaign/Urbana communities during fiscal year 2019. Staff members spoke at several community and agency events about the Beyond Blue program and distributed brochures and program materials at social service agencies throughout the community. Presentations about the program were also made at WIC offices and to Carle and OSF's Labor and Delivery nurses, as well as nurses in the OBGYN Department of Christie Clinic. Community members and agencies were also invited for tours of Crisis Nursery, where information about Beyond Blue was shared. These activities supported the robust partnerships we have with many community agencies, enabling us to better serve our clients.

Thanks to the program's longevity in the community we have established solid working relationships and protocols with referrals sources based in and serving both urban and rural Champaign County, including CUPHD's WIC/Family Case Management program (Rantoul/Champaign), Carle, Christie, OSF Heart of Mary Medical Center, and Promise Healthcare. Beyond Blue's Family Specialists keep in regular contact with WIC/Family Case Management in both Champaign and Rantoul to gather referrals. Ongoing outreach occurs to reach Carle, OSF Heart of Mary Medical Center, and other healthcare providers. We provide program information and materials for Carle and OSF Heart of Mary Medical Center's Labor and Delivery patient packets. Appropriate social service agencies and community organizations, such as Community Service Center of Northern Champaign County, Head Start, community churches, and medical professionals that also serve rural and urban Champaign County also receive program information.

4. a) *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application):

Crisis Nursery estimated 33 Treatment Plan Clients will be served: 17 rural and 16 Champaign-Urbana mothers deemed at risk of PD**.**

b) *Actual* percentage of individuals who sought assistance or were referred who received services:

In FY19, Family Specialists fully engaged a total of 31 new clients; 22 CU and 9 rural. Both a Parent-Infant Interaction group as well as a parent support group were offered in Rantoul with no attendees for six weeks. As a recruitment strategy beginning in July of FY20, Crisis Nursery is providing a regular presence through program materials and through the weekly presence of a Family Specialist at the Community Service Center of Northern Champaign County to reestablish a stronger rapport within the Rantoul community. Groups will be held during times identified by the Rantoul community through parent feedback surveys.

5. a) *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application):

Since Crisis Nursery is open 24/7, critical telephone referrals can be made and are responded to within 24 hours. Clients often receive their first home visit within 3 days. Supervisory staff monitors the speed of consumer access by reviewing Crisis Nursery response data.

b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application):

An estimate 90-95% of clients are assessed for eligibility within this time frame.

c) *Actual* percentage of referred clients assessed for eligibility within that time frame:

Crisis Nursery's program director assigns new referrals to a Family Specialist the same day they are received. Families are contacted within 48 hours of the referral excluding weekends. An immediate initial visit is scheduled based on client interest. Eligibility is determined upon initial visit which takes place no later than one week from the initial contact.

Nearly 90% of families were contacted within 48 hours and assessed for eligibility within this time frame**.**

6. a) *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application):

Clients often receive their first home visit within 3 days of referral.

b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application):

An estimated 85-90% of referred clients receive their first home visit within this time frame.

c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame:

Interested clients are offered a home visit within the first week of initial contact.

Approximately 92% of families referred to the Beyond Blue program were offered a home visit within the first three days of contacting the client. The remaining families were offered visits within seven days.

7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application):

Families are able to engage in the program until their child turns 1 year.

b) *Actual* average length of participant engagement in services:

The majority of families engage in some capacity until their child turns 1 year.

Demographic Information

1. *In your application* what, if any, demographic information did you indicate you would collect beyond those required (i.e. beyond race/ethnicity, age, gender, zip code)? (Demographic Information, question #1 in the Program Plan application)

N/A

2. Please report here on all of the extra demographic information your program collected.

N/A

Consumer Outcomes – *complete at end of year only*

During the application process, you identified participant outcomes that your program activities would impact. Here, report the actual participant outcomes achieved as a result of your program activities

1. *From your application,* what impact on consumers did you expect your program activities to have? That is, what outcome(s) did you want your program to have on the people it is serving? (Consumer Outcomes, question #1 in the Program Plan application). Please number each outcome.

Objectives identified included the following:

- Mothers will have a decrease in depressive symptoms, as indicated by the client's quarterly EDPS scores

- Mothers will develop greater understanding of their child's developmental needs and an ability to meet those in positive and growth producing interactions
- Mothers will learn to reduce their stress, seek resources, and broaden networks which would prevent them from becoming overwhelmed
- Mothers will improve their capacity to engage fully in a reciprocal relationship with their babies, resulting in optimal development of the baby, more successful and satisfying parenting, and a greater security for both.

2. For each outcome, please indicate the specific survey or assessment tool you used to collect information on this outcome in the chart below. (Please remember that the tool used should be evidence-based or empirically validated.)

Crisis Nursery tracks outcomes using evidence-based tools: The Edinburgh Postnatal Depression Scale (EPDS), the Ages and Stages Questionnaire (ASQ), and the ARCH CR1 Survey.

The EPDS is given to mothers quarterly to assess progress re: depressive symptoms. While the EPDS can be a strong indicator of client improvement we recognize that scores can be impacted by more factors than the program alone.

The Ages and Stages Questionnaire (ASQ), which assesses child developmental progress (physical and socio-emotional), is administered upon entry into the program if it has not been done elsewhere. It also serves as an educational tool to assist a mother's understanding of her infant's development. If delays are identified, then the ASQ is administered again to assess progress and appropriate referrals will be made.

The ARCH CR1 is used by 7 Crisis Nurseries across the state to evaluate outcomes for adult clients. Developed by ARCH, a national resource center for crisis and respite care, it measures a client's sense of well-being and his/her acquisition of parenting skills. The scale is based on a client's reported level of stress, risk of maltreatment, and parenting skills. It is administered interview style and clients are surveyed annually.

Additionally, in the chart below, please indicate who provided this information (e.g. participant, participant's guardian(s), clinician/service provider, other program staff (if other program staff, indicate their role).) Please report all sources of information that apply for each assessment tool (e.g. the XYZ survey may be completed by both a youth client and their caregiver(s).

Outcome:	Assessment Tool Used:	Information Source:
E.g. 1. Increased empowerment in advocacy clients	Measure of Victim Empowerment Related to Safety (MOVERS) survey	Client

Improved depressive symptoms	Edinburgh Postnatal Depression Scale (EPDS)	Parent
Improved developmental progress	Ages and Stages Questionnaire (ASQ),	Family Specialist & Parent
Decreased parental stress	ARCH CR1	Parent
Reduced risk of maltreatment	ARCH CR1	Parent
Improved parenting skills	ARCH CR1	Parent

3. Was outcome information gathered from every participant who received service, or only some?

Information for the EDPS is gathered on every client, the ARCH CR1 survey is attempted with every client but they have the right to decline the survey, and the ASQ is offered as a need is identified case by case.

4. If only some participants, how did you choose who to collect outcome information from?

Families have a choice whether or not to participate in the ARCH CR1 and the ASQ is provided as needed. The EDPS is provided to every participant.

5. How many total participants did your program have?

31

6. How many people did you *attempt* to collect outcome information from?

31 (See parameters above)

7. How many people did you *actually* collect outcome information from?

EDPS: 27
ARCH: 25
ASQ: 26

8. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc)

ARCH is collected once per FY, EPDS is collected at least every quarter and the ASQ is offered at least once per client. If any concerns are present or follow up is needed, Family Specialists can follow up with another ASQ as often as every 2 months through age 1.

Results

9. What did you learn about your participants and/or program from this outcome information? Please be specific when discussing any change or outcome, and give appropriate quantitative or descriptive information when possible. For example, you could report the following:

i. Means (and Standard Deviations if possible)
ii. Change Over Time (if assessments occurred at multiple points)
iii. Comparison of strategies (e.g., comparing different strategies related to recruitment; comparing rates of retention for clients of different ethnoracial groups; comparing characteristics of all clients engaged versus clients retained)

Crisis Nursery and the other six Illinois crisis nurseries use a program outcome survey developed by ARCH, a national resource center for crisis and respite care. This survey is used to measure the impact our programming has on the stress levels of our clients, how our services have impacted their parenting skills, and to what degree they feel our services reduce the risk of harm to children. Of our Beyond Blue clients who completed the survey in FY19:

- 80% showed a decrease in their level of stress after using services,
- 80% felt there was an improvement in their parenting skills, and
- 84% believed that our services reduced the risk of harm to children.

Groups continue to be one of the most impactful ways we work with clients in the Beyond Blue program. Based on the evidenced-based intervention *Parents Interacting With Infants*, our Infant Parent-Child Interaction groups provide Family Specialists with the opportunity to model and support positive parenting interactions Throughout FY19 we held 32 successful Infant Parent-Child Interaction Groups. While marketed to our Beyond Blue clients, our Infant Parent-Child Interaction Groups are open to any community member with a child under the age of 1. We believe this strategy benefits Beyond Blue mothers, as they can witness non-depressive mothers model positive interactions with their infant.

We also offer a Beyond Blue Support Group, which provides the space for our Beyond Blue clients to connect with their peers, share their experiences, and expand their support network. In FY19, we offered 31 Beyond Blue support groups. Beyond Blue Support Groups were well attended by CU-based clients. Unfortunately, we had a lack of response from the Rantoul area this past year. Rantoul is now being surveyed more frequently in an effort to reengage families in that area for FY20. Transportation remains a challenge for rural families wanting to access services at the Nursery.

10. Is there some comparative target or benchmark level for program services? Y/N
No

11. If yes, what is that benchmark/target and where does it come from?
N/A

12. If yes, how did your outcome data compare to the comparative target or benchmark?
N/A

(Optional) Narrative Example(s):

13.
"I have been working with Deanna as a Beyond Blue participant for 5 months. When I first began visiting this mother in her home in Rantoul, she had a 1-month old baby and was struggling with symptoms of anxiety and depression. This mother was struggling with not experiencing happiness, high anxious/scared thoughts, and not connecting with her baby. We began with talking about her newborn. Deanna was breast feeding, talking and singing to baby, and providing skin to skin contact. By highlighting this parental mastery, began realizing during our visit, over time, that she was doing everything she wanted to do to connect with her baby.

Months in, things shifted and we focused on what mom would like to do to improve how she felt, personally. Mom didn't want to reach out to family and friends due to feeling like a burden however we had identified together that social support is an area where this mother really felt she was lacking. Deanna began spending more time on the phone with her mother and one friend which helped her mood greatly. Reflecting on these simple steps with encouragement helped Deanna to feel confident in reaching out to the loved ones in her life. At this time, mom and I were able to move on to looking at what present issues or environments were making mom anxious.

Deanna was experiencing high anxiety due to going back to 60-hour work weeks, which had been going on for three months. The pressure of figuring out safe childcare with a newborn was creating a lot of worry for this mama. It was at this time that I was able to provide a referral to childcare resource service. This additional resource helped mom find a daycare in her town that would provide care for her baby. We also discussed healthy coping strategies that would help mom get through the long 60 hour weeks. I had a visit with mom recently after her work schedule slowed down and her demeanor and affect had completely shifted! Deanna shared feeling happy and relieved that she successfully got through the hard months. Baby Jane is now 8 months and I witnessed a wonderful connection between them. Based on the progress of mom's mood and the age of Jane, we will now be able to transition alongside

mom into our Prevention Initiative program where we can follow this family all the way until little Jane is three years old. " ~*Beyond Blue Family Specialist*

14. In what ways was the evaluation used to support changes in practice? What changes were made based on evaluation findings? (Your response is optional)

The evaluation of the deficit in rural recruitment and the change in Crisis Nursery as the preferred meeting place for rural clients has supported the need for a change in the approach of recruiting within northern Champaign County. In response to this evaluation, a client friendly survey has been mailed to all potential Rantoul families with preferred group times, dates and locations.

Our Beyond Blue Family Specialist particularly focusing in on rural outreach has discovered a benefit in allowing families the ability to text a Family Specialist. This is now an option for retrieving information about Beyond Blue programming even as a new incoming client. Finally, group surveys are being given to every client utilizing Safe Children emergency childcare, as well.

Finally, recruitment documents have been edited to reflect neutral terms inviting both mothers and fathers to participate.

Utilization Data Narrative –

The utilization data chart is to be completed at the end of each quarter (including quarter 4) using the online reporting system.

Comparative yearly totals (i.e. reporting estimates and actual numbers) and the narrative section described below are to be completed at end of year only.

Here, you will report on the different types of service categories specified in your program plan application. Please remember that programs **do not** need to collect and report on every category- instead, you are to report only the ones that are most useful for understanding program impact.

1. Please copy and paste the definitions of service categories your program specified in your program plan application in the sections below**. You will report the actual numbers of clients/contacts/community events for each reported service category in the Part II Utilization/Production data form (located on the online system).** If your estimated number of clients/contacts/community events for reported service categories significantly differ from your actual numbers, you may give a narrative explanation for that discrepancy here.

Between Quarters 1 and 4 of FY19, two Family Specialists serving Beyond Blue clients resigned to move on to alternate careers or out of the area. An additional newer Family Specialist who began in Quarter 2 reigned near end of Quarter 4, to become a professor at a local university. Two new Family Specialists have joined the team within the last six months of FY 19 and have recruited new families, transitioned to continue serving engaged families and have begun deepening rapport and level of service with all involved families. With a team established and committed to serving those mainly in areas of isolation, our team is confident that the program need is present o transportation, employment, housing, education, healthcare,

Treatment Plan Clients (TPC):

33 Treatment Plan Clients will be served: 17 rural and 16 Champaign-Urbana mothers deemed "at risk" of PD.

31 Treatment Plan Clients were served: 9 rural and 22 Champaign-Urbana mothers were deemed "at risk" of PD.

Non-treatment Plan Clients (NTPC):

77 Non-Treatment Plan Clients will be served (39 rural and 38 Champaign-Urbana). Non Treatment Plan clients include the following: 33 infants and expected infants of the mothers participating in the program and other family members.

93 Non-Treatment Plan Clients were served (29 rural and 64 Champaign-Urbana). Non-Treatment Plan Clients include the following: 31 infants and expected infants of the mothers participating in the program and other family members.

Community Service Events (CSE):

128 Community Service Events are projected. Community Service Events include: 30 Parent Child Interaction groups for the mother/baby dyads (6 rural, 24 Champaign-Urbana) and 30 perinatal depression support group meetings (6 rural, 24 Champaign-Urbana). Other events include: 20 meetings with referral sources (11 rural and 9 Champaign-Urbana); 46 presentations to community groups (24 rural and 22 Champaign-Urbana); 2 media contacts resulting in an article or participation in a program; and a Beyond Blue page on the Crisis Nursery website with a link to Facebook with over 2,800 followers and growing. Each quarter, a new story will be featured on the website to chronicle the growth of the program (4 stories).

320 Community Service Events occurred. Community Service events include: 32 Parent-Child Interaction groups for the mother/baby dyads and 31 perinatal depression support group meetings. Other events include: 254 outreach events including meetings with referrals sources; presentations to community groups; media contacts; and a Beyond Blue page on the Crisis Nursery website with a link to Facebook with nearly 3,700 followers and growing.

Service Contacts (SC):

522 service contacts are projected (270 rural and 252 Champaign-Urbana). Service contacts include screenings, home visits, referral contacts for both Treatment Plan Clients and Non-Treatment Plan

Clients. This number is significantly reduced for FY19 as a result of a recommendation that came out of our CCMHB site visit. Phone calls for Treatment Plan Clients have previously been counted but are not entered into our database due to programming limitations. These quarterly phone calls are a hand count of calls tracked by Family Specialists that will no longer be included in the count of service contacts.

503 service contacts occurred through service contacts include screenings, home visits, referral contacts for both Treatment Plan Clients and Non Treatment Plan Clients.

Other:

The Other category is the number of hours of crisis and respite care provided to families. An estimated 2,275 hours crisis care and respite care will be provided: 1,160 for rural mothers and 1,115 for Champaign-Urbana mothers. Actual service usage varies depending on family need and wants.

1101 hours of crisis care and respite care were provided to Beyond Blue participants. Actual service usage varies depending on family needs and wants.

For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

Cunningham Children's Home
ECHO Housing & Employment Support
Performance Outcome Report PY19

Agency name: Cunningham Children's Home
Program name: ECHO (Empowering Connections through Hope and Opportunities) Housing and Employment Support Program
Submission date: 08/29/19

Consumer Access – *complete at end of year only*

Eligibility for service/program

1. *From your* application, what are the eligibility criteria for your services? (i.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application)

ECHO serves individuals and families considered homeless or at risk of homelessness as defined as:

- **Lacking permanent housing including those with residence in a shelter ortransitional housing program.**
- **Living on the streets, abandoned building/vehicle, or in any other unstable/non-permanent situation.**
- **Considered "doubled-up", referring to a situation where individuals are unableto maintain housing and are forced to stay with a series of friends and/or extended family members.**
- **Previously homeless individuals released from prison or hospital if they do not have a stable housing situation to which they can return.**
- **Individuals and families at imminent risk of becoming homeless.**

2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)?

Most referrals to the ECHO program are through Centralized Intake at Regional Planning Commission (RPC). This referral stream provides a gatekeeping function to ensure that appropriate clients are referred to our program.
We also have some referrals that come from individuals and community agencies that serve homeless individuals. We rely on self-report information as well as information from the referring agency (when applicable) that verifies their homeless status. We obtain documentation of SSI/SSDI eligibility when available.

When the program was implemented at the beginning of FY19, we were accepting many more self-referrals. As we have become more knowledgeable of the agencies involved in providing services to the homeless population, we have begun to intentionally direct clients

to the centralized intake process at RPC. We are, however, also evaluating whether we need to limit the number of clients we serve who have shelter + care vouchers to ensure that we are able to accommodate at least some self and/or community-based referrals.

There have been a few clients who are at risk of homelessness at the time of referral and as a result (not currently homeless), were not eligible for centralized intake. For clients at risk of homeless, we follow the process we described above for self-referrals.

3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.)

We have participated in a number of community service events to ensure that our community partners are aware of the services offered by the ECHO program. We believe these events have been instrumental in facilitating our referrals. During FY19, we participated in 20 community service events regarding the ECHO program. An example of a few of these stakeholders/events included the Human Services Council, Continuum of Care Council, CU One Winter Night and CIRRPS (landlord committee).

4. a) *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application):

50%

b) *Actual* percentage of individuals who sought assistance or were referred who received services:

50% (24 of 48)

Note: there has been a question about the number of clients served in the ECHO program who were former Cunningham clients. In FY19, we served four clients who had previously been served in Cunningham programs.

- **One client was served in our residential program – discharged in 1994;**
- **One client was served in our residential and foster care programs – discharged in 2007;**
- **Two clients were served in our independent living programs. Both had been discharged in 2017.**

One additional client was a student in our educational program at the time of referral/program enrollment. This was a very short-term program enrollment of less than two weeks.

5. a) *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application): **30 days**
b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application): **80%**
c) *Actual* percentage of referred clients assessed for eligibility within that time frame: **92% (22 of 24 clients)**
6. a) *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application): **30 days**
b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application): **50%**
c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame: **50% (12 of 24 clients)**
7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application): **Estimated length of service is one year with a follow-up contact one year post-discharge.**
b) *Actual* average length of participant engagement in services: **2.74 months (11 clients)** **While the length of stay was much shorter than anticipated during the first year of operation, it would not have been possible for any discharged client to reach a 12**

month length of stay. As of 08/23/19, the length of program participation for current clients is approximately 8.5 months. Due to this being ECHO's first year, no follow-up contact attempts were made in FY19.

Demographic Information

1. *In your application* what, if any, demographic information did you indicate you would collect beyond those required (i.e. beyond race/ethnicity, age, gender, zip code)? (Demographic Information, question #1 in the Program Plan application)

Demographic information beyond those required by the grant may include: other system involvement (e.g., DCFS, DOC, Medicaid, Social Security), grade level completed, marital status, language, religion, and disability type (if applicable).

2. Please report here on all of the extra demographic information your program collected.

Additional demographic information was incorporated into the database sheet we created to set up clients in our Service Documentation System. Not all information was completed for every client and follow-up will be done to strengthen our procedures:

- **Six (6) of our 24 ECHO clients receive SSI/SSDI – some became eligible during program enrollment**
- **Language was recorded for all 24 clients: all were English-speaking**
- **Marital status was recorded for 23 of 24 clients: 16 were single, 2 were married, 5 were divorced and 1 was widowed**
- **Religion was recorded for all 24 clients: 8 reported Protestant, 1 reported Jewish, 1 reported Catholic, 3 reported other and 11 reported none.**
- **Grade level completed was reported for 23 of 25 clients: 7 clients did not complete high school (2 were currently enrolled in high school), 7 graduated from high school, 1 had earned a GED, 3 had completed some college coursework, 2 had obtained bachelor/associate degrees and 2 had completed graduate degrees.**
- **Disability information was collected for 15 clients: 5 reported no disability, 1 reported a physical disability, 8 reported a mental disability and 1 client reported both a mental and physical disability. This information is based on individual self-report of disabilities vs. disabilities documented by other systems.**
- **Clients reported a variety of other system involvement to include: Regional Planning Commission, Medicaid, DHS, social security, DOC, Rosecrance, Urban Ministries, WIC, Courage Connection, Crisis Pregnancy and drug court.**

Consumer Outcomes – *complete at end of year only*

During the application process, you identified participant outcomes that your program activities would impact. Here, report the actual participant outcomes achieved as a result of your program activities

1. *From your application,* what impact on consumers did you expect your program activities to have? That is, what outcome(s) did you want your program to have on the people it is serving? (Consumer Outcomes, question #1 in the Program Plan application). Please number each outcome.

We expect the impact of this program to be that people secure and maintain stable housing and employment, as well as other basic supports, creating hope for a better future. Expected outcomes include:

1. Length of Housing Stability: At least 80% of individuals will be housed within 90 days of assessment with at least 50% achieving housing stability for more than 90 days.

2. Length of Employment: At least 80% of individual will be employed within 90 days of assessment with at least 60% achieving employment stability for more than 90 days. Individuals eligible for social security are excluded from this outcome although part-time employment goals may still be relevant.

3. Life Skills Mastery: At least 90% of clients receiving both pre- and post- life skills assessment will show improvement in life skill mastery.

4. Participant Surveys: At least 60% of individuals will complete a participant satisfaction survey upon discharge. 95% of survey responses will agree or strongly agree with positive service quality statements.

2. For each outcome, please indicate the specific survey or assessment tool you used to collect information on this outcome in the chart below. (Please remember that the tool used should be evidence-based or empirically validated.)

Additionally, in the chart below, please indicate who provided this information (e.g. participant, participant's guardian(s), clinician/service provider, other program staff (if other program staff, indicate their role).) Please report all sources of information that apply for each assessment tool (e.g. the XYZ survey may be completed by both a youth client and their caregiver(s).

Outcome:	Assessment Tool Used:	Information Source:

E.g. 1. Increased empowerment in advocacy clients	Measure of Victim Empowerment Related to Safety (MOVERS) survey	Client
Length of Housing Stability	**Service Documentation System (agency MIS) – track housing via placement screen**	**Staff observation, client reports and collateral reports of changes in housing status**
Length of Employment	**Service Documentation System (agency MIS) – track employment via events screen**	**Staff observation, client reports and collateral reports of changes in employment status**
Life Skills Mastery	**ECHO Life Skills Assessment (developed by program)**	**Client self-report**
Participant Survey	**ECHO Client Satisfaction Survey (developed by program)**	**Client**

3. Was outcome information gathered from every participant who received service, or only some?

Housing stability was tracked for every client.

Length of Employment (including SSI/SSDI status) was tracked for every client.

Life Skills Mastery – goal was to collect assessment data from each client, but not all clients were assessed.

Participant Surveys – no surveys were completed by discharged clients.

4. If only some participants how did you choose who to collect outcome information from?

N/A – our goal was to collect outcomes information for all clients.

5. How many total participants did your program have?

25

6. How many people did you *attempt* to collect outcome information from?

We were successful in collecting housing and employment information on all 25 clients.

We attempted to collect Life Skills Assessment information on 21 of 24 clients. Three (3) clients did not complete a Life Skills Assessment at admission. No clients completed the Life Skills Assessment at discharge. In most cases, the client ended services unexpectedly and contact ended abruptly. In addition, none of the discharged clients had reached a length of stay of 6 month to provide a second measure on the Life Skills Assessment (that might be used in lieu of a discharge measure).

Participant surveys. While we have a satisfaction survey, there was some miscommunication with our case managers in the intent to distribute the survey at discharge. In addition, as was noted above, of the clients that discharged in FY19 (n = 11), approximately half (5) ended services and contact unexpectedly. There would not have been an opportunity to complete a survey as we were unable to establish contact.

7. How many people did you *actually* collect outcome information from?

We were successful in collecting housing and employment information on all 24 clients.

We attempted to collect Life Skills Assessment information on 21 of 24 clients. Three (3) clients did not complete a Life Skills Assessment at admission.

No participant surveys were completed.

8. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc)

Housing and employment data was evaluated through ongoing contacts with documentation of status made during monthly supervision contacts. This data was incorporated into a program dashboard that was developed in the second half of FY19 and is now distributed monthly.

The Life Skills Assessment is completed by clients during first 30 days of enrollment, every 6 months and at discharge.

The satisfaction survey is to be completed at discharge.

Results

9. What did you learn about your participants and/or program from this outcome information? Please be specific when discussing any change or outcome, and give appropriate quantitative or descriptive information when possible. For example, you could report the following:

i. Means (and Standard Deviations if possible)
ii. Change Over Time (if assessments occurred at multiple points)
iii. Comparison of strategies (e.g., comparing different strategies related to recruitment; comparing rates of retention for clients of different ethnoracial groups; comparing characteristics of all clients engaged versus clients retained)

1. Length of Housing Stability: At least 80% of individuals will be housed within 90 days of assessment with at least 50% achieving housing stability for more than 90 days.

Of the 24 clients served, 11 (46%) obtained permanent housing during program enrollment. The average length of time to secure permanent housing was 50 days (range of 1 to 138 days).

- Nine of the 11 (82%) were housed within 90 days of program enrollment.
- Six of the 11 (55%) maintained permanent housing for 90+ days. One client was evicted after approximately 9 months, but has since re-secured permanent housing. The remaining 5 clients were either discharged prior to reaching the 90 day mark or are continuing to build successful housing placement toward that benchmark.

Of the 24 clients served, 10 clients (42%) were in temporary housing either at the close of the fiscal year or at the point of discharge.

Four clients were homeless throughout program enrollment and/or at the point of discharge.

Lessons learned/Strategies:

- Some clients are difficult to house quickly (90 day timeframe) due to their criminal record (n = 2), eviction history (n = 3) and/or not meeting income requirements (n = 17). These are barriers that limit the number of landlords willing to rent to clients.
- A small number of clients (n = 2) are "unhouseable." Due to significant mental illness and/or developmental functioning issues, they refuse or are simply unable to meet the expectations of landlords to successfully live in an apartment setting (e.g., too many guests in and out of the apartment, noise, etc.). While housing can be obtained, the ability to maintain housing is challenging;
- The client needs to want the program services for himself/herself. Early in program implementation, we accepted referrals for young people referred by family members, social workers, etc. We learned quickly that unless the client is

fully committed to the goals of the program, we are unlikely to be successful in providing services.

2. Length of Employment: At least 80% of individual will be employed within 90 days of assessment with at least 60% achieving employment stability for more than 90 days. Individuals eligible for social security are excluded from this outcome although part-time employment goals may still be relevant.

Six (6) of 24 clients (25%) were eligible/receiving for SSI/SSDI during program enrollment. Four additional clients are either in the process of applying for SSI/SSDI or are appealing an initial denial.

Of the 19 clients for whom employment outcomes are tracked, 9 of 19 (47%) are or have been employed during FY19. Five (5) of those 9 (56%) maintained employment for 90+ days. The remaining four (4) clients remained employed at discharge (n = 3) or are employed and continuing to build toward the 90 day benchmark (n = 1).

Lessons learned/Strategies:

- Several clients have very significant mental health issues that interfere with their ability to maintain any type of employment. Despite sometimes obvious mental illness, clients are being denied SSI/SSDI. We have been consistent in helping clients to apply for these benefits and appeal denials, as applicable;
- Substance abuse issues are a significant barrier to a client's ability to maintain employment. We recognize that substance abuse is often the primary treatment need that must be met before the individual can successfully obtain housing and maintain a job.

3. Life Skills Mastery: At least 90% of clients receiving both pre- and post- life skills assessment will show improvement in life skill mastery.

We have no outcome to report regarding the Life Skills Assessment tool.

We attempted to complete the Life Skills Assessment tool with 21 of 24 clients. Due to some initial errors in implementation of the form (page 2 of double-sided form was incomplete), we did not receive complete assessment scores on 4 additional clients. Of the 18 clients who successfully completed the initial Life Skills Assessment, the average score was 166.5 out of a possible 186 (89.5%).

None of our 11 discharged clients completed the Life Skills Assessment tool and all were discharged prior to 6 months of enrollment (i.e., no second measure had been completed).

Lessons learned/Strategies:

- Due to the large number of adult clients, many have significant experience with the life skills included in our assessment. The assessment is most appropriate for young adults who have limited experience living on their own. As a result, the average score of clients at admission was 89.5% which allows limited room for improvement as a program outcome.
- We also recognize that while clients report knowing how to perform many of these basic life skills, their ability to implement these skills to obtain/maintain housing and employment has not been effective. We're still grappling with how we can capture client improvement in use of these skills in a demonstrable way.

4. Participant Surveys: At least 60% of individuals will complete a participant satisfaction survey upon discharge. 95% of survey responses will agree or strongly agree with positive service quality statements.

No outcomes data is available related to the participant satisfaction surveys.

Lessons learned/Strategies:

- Ensuring assigned case managers understand the expectation of completing a satisfaction survey at discharge. We are also planning to implement a point in time survey (e.g., survey all clients during a single month in of the year). This will ensure that we are receiving some feedback about services during client enrollment. As we work with clients with shelter + care vouchers (who may receive services for up to 5 years), it will be important that we request feedback more frequently than discharge.
- We discussed that while we typically administer surveys to clients in a manner that allows confidential responses (e.g., clients seal completed surveys in an envelope that is routed directly to QI staff), we have the flexibility to offer the survey via phone. Even if a client requests discharge from the program unexpectedly, they may still be willing to complete the survey via phone.
- We will be updating our closing summary to include an indicator about completion of a satisfaction survey at the point of discharge. This will help serve as a prompt to the case manager, but will also help us more effectively track client refusal and/or lack of client contact as reasons that the survey could not be completed.

10. Is there some comparative target or benchmark level for program services? Y/N

No

11. If yes, what is that benchmark/target and where does it come from?

N/A

12. If yes, how did your outcome data compare to the comparative target or benchmark?

N/A

(Optional) Narrative Example(s):

13. Describe a typical service delivery case to illustrate the work (this may be a "composite case" that combines information from multiple actual cases) (Your response is optional)

14. In what ways was the evaluation used to support changes in practice? What changes were made based on evaluation findings? (Your response is optional)

Utilization Data Narrative –

The utilization data chart is to be completed at the end of each quarter (including quarter 4) using the online reporting system.

Comparative yearly totals (i.e. reporting estimates and actual numbers) and the narrative section described below are to be completed at end of year only.

Here, you will report on the different types of service categories specified in your program plan application. Please remember that programs **do not** need to collect and report on every category- instead, you are to report only the ones that are most useful for understanding program impact.

1. Please copy and paste the definitions of service categories your program specified in your program plan application in the sections below**. You will report the actual numbers of clients/contacts/community events for each reported service category in the Part II Utilization/Production data form (located on the online system).** If your estimated number of clients/contacts/community events for reported service categories significantly differ from your actual numbers, you may give a narrative explanation for that discrepancy here.

Treatment Plan Clients (TPC):

New Treatment Plan Clients (TPC) are defined as those individual actively accepting services and meeting with a case manager to develop a service plan. Service Contacts is defined as the number of TPC (24) multiplied by using an assumption of an estimated weekly service contacts for the first six months and monthly for the second six months which is an estimated 768 Service Contacts provided by the program to TPC at a minimum. Service Contacts include both direct service provision and collateral contacts (e.g., originating referral source, family member). With a target of 80% engagement outcomes (based on a targeted number of unduplicated clients of 30), it is estimated this this project will have 24 TPC.

Narrative:
We served fewer than anticipated TPC clients in FY19. While our target was 24 TPC, we actually served 18 TPC. The lower than expected number of TPC clients was largely due to the intensity of the needs of the clients served. While we projected a more intensive service period during the initial 6 months of service followed by a less intensive period, this did not hold true for many of the clients served. As noted in question 9 (outcomes 1 and 2), the severity of mental illness experienced by some clients required a high level of case management that has continued throughout program enrollment. Alternatively, we had some clients that we were unable to locate and/or they did not maintain contact.

We anticipate that we will serve fewer than 30 clients in FY20 as well. We had projected the average length of stay to be one year. While we expect that we will continue to have some short-term enrollments, we anticipate that clients served under shelter + care voucher requirements will have more intensive needs that may require services for 24+ months. The intensity of client service needs may impact caseload capacity. This will be monitored as part of our grant application considerations for FY21.

Non-treatment Plan Clients (NTPC):

Non-Treatment Plan clients (NTPC) are defined as those individuals that are referred for services or are identified through street engagement efforts as eligible or likely eligible but never actively accept service engagement. Due to the unique engagement challenges of the target population, it is expected that substantial services may be provided through engagement efforts which may not result in a TPC. With a target of 80% engagement outcomes (based on a targeted number of unduplicated clients of 30), it is estimated this this project will have 6 NTPC.

Six (6) NTPC clients were enrolled in the ECHO program and participated in services.

An additional 11 individuals had contact with the ECHO program, but did not enroll in the program.

Community Service Events (CSE):

There is an estimated 24 Community Service Events (CSE) for outreach and referral development to temporary housing resources, food kitchens, other potential referral sources, and homeless advocacy efforts, as well as distribution of materials to promote the program.

Service Contacts (SC):

Service Contacts is defined as the number of TPC (24) multiplied by using an assumption of an estimated weekly service contacts for the first six months and monthly for the second six months which is an estimated 768 Service Contacts provided by the program to TPC at a minimum. Service Contacts include both direct service provision and collateral contacts (e.g., originating referral source, family member). The number of NTPC (6) uses an assumption of on-going weekly attempts at engagement either directly or via collateral for these individuals resulting in an additional 108 Service Contacts provided to NTPC. This results in a combined 876 service contacts.

Based on our conceptualization of contacts for TPC clients, we would have expected that, if prorated, 18 TPC clients would have had 576 contacts. Our case managers documented a total 560 contacts and/or attempted contacts (97% of expected). These broke down as follows:

- 493 contacts with clients/collaterals (86% of expected)
- 10 missed appointments (excluded from screening contacts)
- 57 attempted contacts (excluded from screening contacts)

For 6 NTPC clients, we projected 108 service contacts. We enrolled 6 NTPC clients to the ECHO program and the number of service contacts for these clients was 27 (25% of expected). This was much lower than the number of expected contacts is based on relatively short periods of engagement (about 2 months) and discharge from services due to lack of contact (n = 2), client re-location (1) and client choice to terminate services (n = 3). Eleven (11) individuals were reflected in our service contacts as NTPC clients, but did not enroll in ECHO. There were 19 service contacts with these individuals. We had a total of 46 service contacts with 17 NTPC clients. While contacts were much lower than expected, it seems reasonable to believe that NTPC clients will typically be engaged for shorter periods of time. We will re-evaluate the level of NTPC contacts in the FY21 grant application. As we have moved through the first year of the grant, we have served fewer NTPC clients across the course of the year as a result of accepting more clients through the centralized intake process.

For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

Dreaam House
Dreaam
Performance Outcome Report PY19

Agency name: DREAAM Opportunity Center
Program name: DREAAM
Submission date: September 5, 2019

Consumer Access – *complete at end of year only*

Eligibility for service/program

1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application)

• Boys, with a targeted focus on marginalized boys, between ages of 5-12 in Champaign, Urbana, and Rantoul who are experiencing emotional, academic and behavioral challenges; living in high crime neighborhoods; and/or have or at risk of involvement with the special education, mental health, and/or child welfare systems.

• Parents/caregivers of boys aged 5-12 experiencing and/or at-risk of developing challenging behavior and/or with a diagnosed mental health disorder.

● Boys in grades 3rd-6th will be involved in targeted early gang prevention/pro-social skills building after-school and Saturday programming activities.

2. *How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)?*

Eligibility was determined to target boys ages 5-12:
1.) with challenging behavior or suspected ADHD indicators based on parent and school reports
2.) with an incarcerated or formerly incarcerated parent
3.) with low literacy skills (last quarter report card is collected as part of enrollment)
Eligibility was determined through a several methods. For two years, we have used the Strength & Difficulties Questionnaire (SDQ) to screen for challenging behavior. SDQ is completed by the parent and/or teacher. We used a cut-off score of above 2 for behavioral difficulties and difficulties getting along with other children, above 5 for hyperactivity, and above 3 for emotional distress. This instrument measured social, emotional and behavioral development at home and school.

Parent incarceration history or status was self-reported. Report cards were collected on a quarterly basis to assess for literacy skills. In addition, parent responded to essay questions to collect the parent perspective on the child's needs. Parent voice was and will always be essential to determining eligibility.

3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.)

Social media combined with parent referrals played a major role in the community awareness of DREAAM. Parent referrals increased during FY19. Referrals from Unit 4 Schools reduced, due to the relocation of DREAAM from Unit 4 School to churches on the campus of the University of Illinois. In Rantoul, there was a balance between school referrals and community outreach.

4. **a)** *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application):

In the application, we estimated 90% of families who sought assistance receive services.

b) Actual percentage of individuals who sought assistance or were referred who received services:

In FY19, the actual percentage was 95% received services.

5. *a) From your application, estimated length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application):*

In the application, we estimated it would take less than a week or 5 days from referral to assessment of eligibility/need.

b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application):

We estimated that 85% of referred clients would be assessed within that timeframe.

c) *Actual* percentage of referred clients assessed for eligibility within that time frame:

The actual percentage was 75%. The estimated length of time to determine eligibility/need increased to 5-7 days. Collecting information from schools was easier when the program was located in schools. Due to the relocation, we had challenges with communication with schools and teacher and that delayed the eligibility timeline, particularly for new TPCs.

6. **a)** *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application):

An estimate of 1-4 weeks to engage clients in services after eligibility/need was determined.

b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application):

In the application, we stated an estimate of 100% of eligible program participants are engaged in services during that time frame.

c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame:

We achieved 100% engagement within that time frame.

7. **a)** *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application):

Program participant are expected to engage at least a year in services.

b) *Actual* average length of participant engagement in services:

Due to our pipeline model, program participants are engaged at least 10-11 months out of the year. Services are offered September – May and June – July.

Demographic Information

1. *In your application* what, if any, demographic information did you indicate you would collect beyond those required (i.e. beyond race/ethnicity, age, gender, zip code)? (Demographic Information, question #1 in the Program Plan application)

In the application, we stated we would collect additional demographic date on income, literacy levels, and system involvement.

2. Please report here on all of the extra demographic information your program collected.

Unfortunately, this information was not collected systemically and/or was under-reported by parents. The goal in FY20 is to improve in the collection and analysis of extra demographic data.

Consumer Outcomes – *complete at end of year only*

During the application process, you identified participant outcomes that your program activities would impact. Here, report the actual participant outcomes achieved as a result of your program activities

1. *From your application,* what impact on consumers did you expect your program activities to have? That is, what outcome(s) did you want your program to have on the people it is serving? (Consumer Outcomes, question #1 in the Program Plan application). Please number each outcome.

The expected impact was:
1. Increase in positive friendship skills
2. Increase in emotional literacy
3. Increase in academic skills and resiliency to overcome risk factors
4. At least twenty-five (25) boys who participate 4 days per week in the program for at least 20 weeks will acquire 5 or more Developmental Assets ™ in these particular areas: Adult Role Models, Positive Peer Influence, Achievement Motivation, Responsibility, Interpersonal Competence, and Positive View of Personal Future.
5. Due to the multiple layers of support and services, it is estimated that 100% of program participants will acquire assets in Adult Role Models, Interpersonal Competence, and Achievement Motivation.

2. For each outcome, please indicate the specific survey or assessment tool you used to collect information on this outcome in the chart below. (Please remember that the tool used should be evidence-based or empirically validated.)

Additionally, in the chart below, please indicate who provided this information (e.g. participant, participant's guardian(s), clinician/service provider, other program staff (if other program staff, indicate their role).) Please report all sources of information that apply for each assessment tool (e.g. the XYZ survey may be completed by both a youth client and their caregiver(s).

Outcome:	Assessment Tool Used:	Information Source:
E.g. 1. Increased empowerment in advocacy clients	Measure of Victim Empowerment Related to Safety (MOVERS) survey	Client
1. Increase in positive friendship skills	*Strengths and Difficulties Questionnaire (SDQ)*	*Parent* *Teacher*

2. Increase in emotional literacy	*No evidence-based assessment tool was used. An online tool and observations were used to measure emotional literacy over time.*	*Participant*
3. Increase in academic skills and resiliency to overcome risk factors	*Strengths and Difficulties Questionnaire (SDQ) and school report cards; Non-evidence-based tools were staff case notes and tracking of homework completion while at DREAAM*	*Participant* *Parent* *Teacher*
4. At least twenty-five (25) boys who participate 4 days per week in the program for at least 20 weeks will acquire 5 or more Developmental Assets ™	*Development Assets Survey*	*Client* *Parent*
5. 100% of program participants will acquire assets in Adult Role Models, Interpersonal	*Development Assets Survey*	*Client* *Parent*

3. Was outcome information gathered from every participant who received service, or only some?

No, the outcome information was not gathered from every participant.

4. If only some participants, how did you choose who to collect outcome information from?

Participants who were enrolled in the after-school program and services during the school year participated in all the data collection.

5. How many total participants did your program have?

A total of 91 participants were in DREAAM.

6. How many people did you *attempt* to collect outcome information from?

N/A

7. How many people did you *actually* collect outcome information from?

Outcome data were collected from 65 participants.

8. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc.)

Data were collected at minimum twice a year (enrollment in September and in May when school ended) and in some cases three times during the program year from in September, January and May.

Results

9. What did you learn about your participants and/or program from this outcome information? Please be specific when discussing any change or outcome, and give appropriate quantitative or descriptive information when possible. For example, you could report the following:

i. Means (and Standard Deviations if possible)
ii. Change Over Time (if assessments occurred at multiple points)
iii. Comparison of strategies (e.g., comparing different strategies related to recruitment; comparing rates of retention for clients of different ethnoracial groups; comparing characteristics of all clients engaged versus clients retained)

Outcomes of the Developmental Asset Survey indicated a significant increase in assets in the following areas: adult role models, positive peer influence, and responsibility. In addition, the program continues to have success in developing positive friendship skills. The program focuses on friendship skills (brotherhood) as an intervention to address bullying and potential gang involvement.

The program continues to show progress in the asset of Positive View of Personal Future.
These outcomes were assessed through parent self-report, participants' self-report, observations, and teachers' feedback.

10. Is there some comparative target or benchmark level for program services? Y/N

No, the development of a comparative target or benchmark level is the goal as more evaluation systems are constructed.

11. If yes, what is that benchmark/target and where does it come from?

12. If yes, how did your outcome data compare to the comparative target or benchmark?

(Optional) Narrative Example(s):

13. Describe a typical service delivery case to illustrate the work (this may be a "composite case" that combines information from multiple actual cases) (Your response is optional)

14. In what ways was the evaluation used to support changes in practice? What changes were made based on evaluation findings? (Your response is optional)

Utilization Data Narrative –
The utilization data chart is to be completed at the end of each quarter (including quarter 4) using the online reporting system.

Comparative yearly totals (i.e. reporting estimates and actual numbers) and the narrative section described below are to be completed at end of year only.

Here, you will report on the different types of service categories specified in your program plan application. Please remember that programs **do not** need to collect and report on every category- instead, you are to report only the ones that are most useful for understanding program impact.

1. Please copy and paste the definitions of service categories your program specified in your program plan application in the sections below**. You will report the actual numbers of clients/contacts/community events for each reported service category in the Part II Utilization/Production data form (located on the online system).** If your estimated number of clients/contacts/community events for reported service categories significantly differ from your actual numbers, you may give a narrative explanation for that discrepancy here.

Treatment Plan Clients (TPC):

Participants who are continuing enrollment in program services, including summer, after-school, and social emotional programs.

Non-treatment Plan Clients (NTPC):

Participants enrolled in kindergarten and will receive program services to develop healthy social emotional skills.

Community Service Events (CSE):

This category includes the number of parent meetings/support groups, outreach events, and community presentations.

Service Contacts (SC):

This category includes number of program activities, screenings, and family engagement events.

For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

Developmental Services Center
Family Development Center
Performance Outcome Report PY19

Agency name: **DSC**
Program name: **Family Development**
Submission date: **FY 19**

Consumer Access – *complete at end of year only*

Eligibility for service/program

1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application)

Children between birth and six years, with or at risk for developmental delay and disability are eligible for services. Children and families receiving services under CCDDB reside in Champaign County.

2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)?

Young children are assessed for eligibility in a variety of ways. Children are eligible for the developmental screening program when they are between the ages of three months and three years and live in Champaign County. Children who fail the developmental screening are referred to Child and Family Connections for further assessment. The state of Illinois' criteria for state-funded services is a score of 30% delay in one or more developmental area and/or a qualifying condition. Children eligible for PLAY Project have delays as identified by the Greenspan Functional Emotional Assessment Scale.

3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.)

Referrals for services come from a variety of sources including parents, physicians, child care centers, public health, the Multicultural Community Center, Crisis Nursery, Community Elements, DCFS and Parent Wonders.

4. a) *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application):

100%

b) *Actual* percentage of individuals who sought assistance or were referred who received services:

100% of children were screened and assessed.

5. a) *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application):

It is estimated that initial assessments are scheduled within seven days of initial contact.

b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application):

100%

c) *Actual* percentage of referred clients assessed for eligibility within that time frame:

100% of children referred were screened within the given timeframe of seven days.
100% of children were assessed within the timeframe of the authorization received by CFC, usually within 14 days of receiving a child's Intake Packet.

6. a) *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application):

It is estimated that children will be engaged in services within seven days of the eligibility assessment.

b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application):

100% will engage in services within seven days.

c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame:

100% of children screened and assessed qualified for services through Early Intervention.

7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application):

Children may participate for a one-time screening or for up to three years in the therapy program, depending on the age of child at entry.

b) *Actual* average length of participant engagement in services:

24 months.

Demographic Information

1. *In your application* what, if any, demographic information did you indicate you would collect beyond those required (i.e. beyond race/ethnicity, age, gender, zip code)? (Demographic Information, question #1 in the Program Plan application)

None

2. Please report here on all of the extra demographic information your program collected.
n/a

Consumer Outcomes – *complete at end of year only*

During the application process, you identified participant outcomes that your program activities would impact. Here, report the actual participant outcomes achieved as a result of your program activities

1. *From your application,* what impact on consumers did you expect your program activities to have? That is, what outcome(s) did you want your program to have on the people it is serving? (Consumer Outcomes, question #1 in the Program Plan application). Please number each outcome.

Outcome 1: Families will successfully access appropriate community services for their children.
Outcome 2: Families will identify progress in child functioning in everyday life routines, play and interactions with others.
Outcome 3: Children will progress in goals identified by families on the IFSP.

2. For each outcome, please indicate the specific survey or assessment tool you used to collect information on this outcome in the chart below. (Please remember that the tool used should be evidence-based or empirically validated.)
Additionally, in the chart below, please indicate who provided this information (e.g. participant, participant's guardian(s), clinician/service provider, other program staff (if other program staff, indicate their role).) Please report all sources of information that apply for each assessment tool (e.g. the XYZ survey may be completed by both a youth client and their caregiver(s).

Outcome:	Assessment Tool Used:	Information Source:
E.g. 1. Increased empowerment in advocacy clients	Measure of Victim Empowerment Related to Safety (MOVERS) survey	Client
Outcome 1: Families accessed community services for their children.	**Referrals and whether accessed will be documented.**	**Program staff** **Quarterly file reviews** **Service Notes**
Outcome 2: Families will identify progress in child functioning.	**Quarterly file review of parent report regarding the child's functional skills, play skills, and interactions as recorded**	**Families** **Quarterly file reviews** **Service Notes** **Family Surveys**

	on the home visit contact note. **Family surveys**	
Outcome 3: Progress in IFSP goals.	**Review of assessments quarterly.**	**Program staff reviews of developmental assessments.** **IFSP notes** **Quarterly File Reviews**

3. Was outcome information gathered from every participant who received service, or only some? **Only some**

4. If only some participants, how did you choose who to collect outcome information from?

By random selection of those receiving services each quarter.

5. How many total participants did your program have? **655**

6. How many people did you *attempt* to collect outcome information from?

100 children's progress was reviewed over the fiscal year.

7. How many people did you *actually* collect outcome information from?

100 children's progress was reviewed over the fiscal year.

8. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc)

Progress is assessed every quarter.

Results

9. What did you learn about your participants and/or program from this outcome information? Please be specific when discussing any change or outcome, and give appropriate quantitative or descriptive information when possible. For example, you could report the following:

i. Means (and Standard Deviations if possible)
ii. Change Over Time (if assessments occurred at multiple points)
iii. Comparison of strategies (e.g., comparing different strategies related to recruitment; comparing rates of retention for clients of different ethno racial groups; comparing characteristics of all clients engaged versus clients retained)

Parents reported progress toward developmental goals (98 out of 100 files reviewed) and learning strategies to support their child's development. Parents (96 out of 100) identified progress in child functioning in everyday life routines, play and interactions with others. Parents noted improvement in children's skills in motor, communication, problem-solving, socialization, and confidence. Parents report appreciation for therapists' flexibility in scheduling, in-home therapy sessions, therapeutic techniques shared, communication, understanding, relationship-based styles, and patience. Additionally, parents' value the educational information provided that is tailored to their individual child.

10. Is there some comparative target or benchmark level for program services? **Yes**

11. If yes, what is that benchmark/target and where does it come from?

The comparative targets were established from averaging past results.

12. If yes, how did your outcome data compare to the comparative target or benchmark?

Outcome 1: Target of 90% was met with outcome of 94%.
Outcome 2: Target of 90% was met with outcome of 96%.
Outcome 3: Target of 90% was met with outcome of 98%.

(Optional) Narrative Example(s):

13. Describe a typical service delivery case to illustrate the work (this may be a "composite case" that combines information from multiple actual cases) (Your response is optional)

Typical service delivery case involves weekly visits usually in the child's home with a parent or other caregiver present. Occasionally a child is seen at daycare. Depending on evaluation results child may be eligible for developmental therapy, feeding therapy, occupational therapy, physical therapy, speech therapy, developmental therapy – vision and/or developmental therapy – auditory. Some children are eligible for services based on diagnoses like spina bifida, hydrocephalus and Down syndrome. Weekly visits include checking in with parent/caregiver regarding child's health, new developments, regression and child's response to activities/skills practiced at home. Activities targeting skills outlined on child's plan are then used to model the activity, have the parent model how they are using the activity at home, gauge child's response to the activity, provide modifications to activity as needed and coach parent on using/tailoring the activity within daily routines for maximum effectiveness. For example, a child with Down syndrome may be learning new words so an animal puzzle is used to teach new words as well as elicit simple consonant-vowel sounds like "moo." Puzzle pieces are presented one at a time holding the puzzle piece by one's mouth to provide a clear visual/verbal model of the word. Then the puzzle piece is given to the child to explore. Parent/service provider may take puzzle piece back after exploration modeling the sound and "running" the puzzle piece up the child's leg to encourage participation handing the piece back to the child for play engagement. Puzzle pieces are introduced one at a time in this manner. When child

tires of play, parent/caregiver wraps the play up singing the "clean-up" song and one by one placing the puzzle pieces back in the puzzle saying/waving "bye". Parent is then coached about how to use this activity in different ways like providing two puzzle pieces to the child while seated in his high chair as meals are being prepared. Child plays with the puzzle pieces as sounds, signs and words are modeled as he plays. Puzzle pieces can be introduced at bath time marching, jumping, running, sliding the animals across the edge of the bathtub to emphasize action words. Puzzle pieces can be used during diaper changes again modeling names/sounds as pieces are given to child. The session is completed by reviewing the plan of action for the week and answering parent/caregiver questions.

14. In what ways was the evaluation used to support changes in practice? What changes were made based on evaluation findings? (Your response is optional)

Evaluation findings drive the outcomes that are developed at the initial evaluation. Annual evaluation findings are then used to develop new outcomes if needed at the annual review once outcomes have been reviewed to see what child has accomplished since the initial evaluation. Changes based on evaluation findings are made to outcomes and thus practice at the annual review of the child's plan.

Utilization Data Narrative –

The utilization data chart is to be completed at the end of each quarter (including quarter 4) using the online reporting system.

Comparative yearly totals (i.e. reporting estimates and actual numbers) and the narrative section described below are to be completed at end of year only.

Here, you will report on the different types of service categories specified in your program plan application. Please remember that programs **do not** need to collect and report on every category-instead, you are to report only the ones that are most useful for understanding program impact.

1. Please copy and paste the definitions of service categories your program specified in your program plan application in the sections below**. You will report the actual numbers of clients/contacts/community events for each reported service category in the Part II Utilization/Production data form (located on the online system).** If your estimated number of clients/contacts/community events for reported service categories significantly differ from your actual numbers, you may give a narrative explanation for that discrepancy here.

Treatment Plan Clients (TPC):

All children receiving services, living in Champaign County. FY target is 655.

Non-treatment Plan Clients (NTPC): **n/a**

Community Service Events (CSE):

Community service events provide opportunities to increase awareness of the importance of early identification and early intervention, reduce stigma, and promote community-based solutions. The FDC regularly participates in the Down Syndrome Network Buddy Walk, the DisAbility Expo, Read Across America, Ready Set Grow, Latino Partnership Events, and the CUPHD fair. In addition, consultation to child-care centers and preschools for children enrolled in FDC services continues. Presentations to UIUC and Parkland

College classes provide opportunities to increase community awareness, recruit possible volunteers, and educate future professionals. The FDC director is active in a number of community groups including the Birth-to-Three council and the Kindergarten Readiness group of Champaign Urbana Cradle to Career, working to build a better system of care for young children in Champaign County, including coordinated intake and referral. Target is 300 community service events.

Service Contacts (SC):

Screening contacts are the number of developmental screenings conducted by the screening coordinator. The screening coordinator continually builds new and maintains ongoing relationships with agencies serving underrepresented groups, including the Rantoul Multicultural Community Center, the Champaign Urbana Public Health District, DCFS, the Center for Youth and Family Solutions Intact Families program, Illinois State Board of Education Prevention Initiative Programs, and others. While the screening coordinator may screen children at a large resource event, the majority of developmental screenings are conducted in the child's home with the parent present. Target is 200 developmental screenings.

For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

Don Moyer Boys and Girls Club
C-U Change
Performance Outcome Report PY19

Agency name: Don Moyer Boys & Girls Club
Program name: C-U Change
Submission date: August 30, 2019

Consumer Access – *complete at end of year only*

Eligibility for service/program

1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application)

The C-U Change program is open to all youth and families in Champaign County. Eligibility criteria for services are:

- Residents of Champaign County as shown by address;
- Have evidence of a need or service based upon an assessment;
- Have limited financial resources to meet the cost of their care.
- Youth referred will have 3 or more risk factors identified in the Target Population section.

Referrals are accepted from Juvenile Probation, Local School Districts, Champaign County Youth Assessment Center, and other community organizations serving youth at risk. Program Staff meet with families, in their home when necessary. The program is inclusive of all child serving systems, social agencies, family support organizations, faith-based organizations, civic/social groups and community-based entities that have a vested interest to improve outcomes for youth and families, including those located in rural areas.

2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)?

With the program being based upon referrals, many of the programs referrals come from Champaign Youth Probation Services, the Youth Assessment Center, the READY Program, Champaign County School Representatives (i.e. administration, social workers, counselors, school resource officers, etc.) and other community organizations that may serve youth-at-risk from Mahomet, Rantoul, Urbana and Champaign. With the programs referral base coming from a variety of community based sources throughout Champaign County, CU Change is inclusive of all youth-at-risk serving systems and entities.

The program admissions process is as follows:

Step 1 - The Referral

Referral Forms will be distributed to agencies via program presentations, school meetings and community events. Referral based programs will complete the CU Change Referral Form for prospective youth and submit to the CU Change Coordinator.

Step 2 - The Family Contact and Conference

Upon receiving referral, the CU Change Coordinator contacts the parent/guardian of the prospective youth to schedule a family conference. During the conference the CU Change coordinator discusses the dynamics of the referral to the program. Youth and the parent/guardian have the opportunity to describe challenges at home, school, peers and/or social issues. Throughout this process risk factors are identified and determined. The CU Change Coordinator then explains the program expectations and parameters which include the following:

- Youth must be a resident of Champaign County as shown by address
- Must show need for services by assessment, income and/or referral
- Have limited financial resources to meet the cost of their care.
- Youth must have 3 or more risk factors identified in the Target Population section.
- Youth must be between the ages of 11-18.
- Youth must engage and participate in required classes throughout the school day.
- Youth must be involved in required programs (i.e., counseling sessions, classes, groups, etc.)
- Youth must follow all respective school rules and the DMBGC Code of Conduct
- Parents/Guardians or Caring Adult Mentor are required to attend a quarterly student progress meetings with CU Change Coordinator throughout the year
- Parents/Guardians or Caring Adult Mentor are required to participate in at least 3 parent engagement activities throughout the year.

Upon agreement, the CU Change Coordinator administers the Screening Instrument , finalizing this step.

Step 3 - The Advisory Team Discussion

Referrals to the CU Change Program are approved by the CU Change Advisory Team which consists of the CU Change Coordinator and the Director of Teen Services. The team reviews the information collected from the Family Contact and Conference and determine admission into the program. Upon admission the family is contacted for Intake and Orientation.

While the CU Change program is designed for youth-at-risk, the safety of all youth at Don Moyer Boys & Girls Club is of the utmost importance. The CU Change Program and Don Moyer Boys & Girls Club cannot service youth referred with violent or aggressive tendencies or offenses.

Step 4 – Intake and Orientation

Before program support services begin, program families are required to attend a group or individual orientation meeting with the CU Change Coordinator. Orientations are held on a case-by-case basis to provide access. This orientation covers and reiterates

expectations, the Club's core ideals, programming, discipline procedures, case management, etc.

Step 5 - Placement
After completion of the Intake and Orientation, is placed in the program and assigned a caring adult (mentor) within the Club for the duration of the program. The goal of the mentor is to develop a healthy relationship with the youth to focus on grade promotion and graduating high school on time with a plan for the future. New students are admitted as graduation occurs or as open slots become available.

3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.)

To assure consumer access, Don Moyer Boys & Girls Club works with the Local School Districts (Champaign, Urbana, Rantoul and the Regional Planning Commission), Police Departments (Champaign, Urbana, Rantoul and University of Illinois), Champaign County Youth Assessment Center, Champaign County Juvenile Court Services and Juvenile Probation, Community Services Center of Northern Champaign County, as well as community organizations to build awareness of the program and its services. A major focus of the services are to meet the needs of the youth and families in their respective schools, homes and community environments. The program uses community engagement events (fairs, workshops, etc.) as a mechanisms for referrals.

Referral Forms will be distributed to agencies via program presentations, school meetings and community events. Referral based programs will complete the CU Change Referral Form for prospective youth and submit to the Director of Teen Program Services.

4. a) *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application):

80%

b) *Actual* percentage of individuals who sought assistance or were referred who received services:

74%

5. a) *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application):

1 Week

b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application): 95%
c) *Actual* percentage of referred clients assessed for eligibility within that time frame: 96%
6. a) *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application): 1-2 weeks
b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application): 100%
c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame: 96%
7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application): 2 Years
b) *Actual* average length of participant engagement in services: 96%
Demographic Information
1. *In your application* what, if any, demographic information did you indicate you would collect beyond those required (i.e. beyond race/ethnicity, age, gender, zip code)? (Demographic Information, question #1 in the Program Plan application) *N/A*

2. Please report here on all of the extra demographic information your program collected.

Household Income

Consumer Outcomes – *complete at end of year only*

During the application process, you identified participant outcomes that your program activities would impact. Here, report the actual participant outcomes achieved as a result of your program activities

1. *From your application,* what impact on consumers did you expect your program activities to have? That is, what outcome(s) did you want your program to have on the people it is serving? (Consumer Outcomes, question #1 in the Program Plan application). Please number each outcome.

C-U CHANGE Staff, Mentors and Youth Leaders, will be trained to implement three Boys & Girls Clubs of America; OJJDP (Office of Juvenile Justice and Delinquency Programs) evidence-based and approved programs: Project Learn, Positive Action, and SMART Leaders. These programs will provide youth with individualized case management across four areas (law enforcement/juvenile justice, school, family, and Club involvement); engage youth with trained, culturally competent staff and mentors; provide youth with access to academic support, and with various experiences to increase their life opportunities. The program will strive to build strong parent involvement, community support and provide youth with college and career awareness, field trips and activities.

A. To Promote and Develop Life Skills Education.

- Outcome: 65% of all youth are expected to show Improved Social-Emotional Skills
- Outcome: 65% of all youth are expected to show Improved Self-Esteem and Self Efficacy
- Outcome: 85% of all youth are expected to show Improved Future Orientation (Goal-Setting)
- Outcome: 70% of youth enrolled demonstrating Disciplinary Problems are expected to show Reduced Disciplinary Problems
- Outcome: 80% of youth enrolled in the program demonstrating Acts of Violence are expected to show Reduced Acts of Violence
- Outcome: 70% of all youth are expected to show Improved Health Behaviors

B. To provide Case Management that will assist youth to successfully address behavior issues.

- Outcome: 70% of all youth are expected to show Improved Self-Management
- Outcome: 70 % of all youth are expected to show Improved Self-Concept
- Outcome: 60% of all youth are expected to maintain or show Improved Leadership and Relationships among School Administrators, Teachers and Parents
- Outcome: 95% of all youth are expected to demonstrate an Increased Sense of Positive Influence from Parent/Guardian/Caring Adult

C. To improve educational achievement and progress of youth enrolled in the program.

- Outcome: 75% of all youth are expected to maintain or show Improved School Attendance
- Outcome: 60% of all youth are expected to maintain or show Improved Grades and Test Scores
- Outcome: 65% of all youth are expected to maintain or show Improved Classroom Behavior
- Outcome: 70 % of all youth are expected to maintain or show Improved Learning/Study Skills

2. For each outcome, please indicate the specific survey or assessment tool you used to collect information on this outcome in the chart below. (Please remember that the tool used should be evidence-based or empirically validated.)

Additionally, in the chart below, please indicate who provided this information (e.g. participant, participant's guardian(s), clinician/service provider, other program staff (if other program staff, indicate their role).) Please report all sources of information that apply for each assessment tool (e.g. the XYZ survey may be completed by both a youth client and their caregiver(s).

Outcome:	Assessment Tool Used:	Information Source:
Outcome: 65% will demonstrate Improved Social-Emotional Skills	Intake, Assessment Survey and Case Management	Case Manager/Client
Outcome: 65% will demonstrate Improved Self-Esteem and Self Efficacy	Intake, Assessment Survey and Case Management	Case Manager/Client

Outcome: 85% will demonstrate Improved Future Orientation (Goal-Setting)	Intake, Assessment Survey and Case Management	Case Manager/Client
Outcome: 70% will demonstrate Reduced Disciplinary Problems	Case Management	Report Cards/Parent-teacher Conference/IEP Meetings and Client
Outcome: 80% will demonstrate Reduced Acts of Violence	Case Management	Report Cards/Parent-teacher Conference/IEP Meetings
Outcome: 70% will demonstrate Improved Health Behaviors	Case Management and Pre/Post Survey	Case Manager/Client
Outcome: 70% will demonstrate Improved Self-Management	Case Management and Pre/Post Survey	Case Manager/Client
Outcome: 70 % will demonstrate Improved Self-Concept	Case Management and Pre/Post Survey	Case Manager/Client
Outcome: 60% Improved Leadership and Relationships among School Administrators, Teachers and Parents	Case Management	Report Cards/Parent-teacher Conference/IEP Meetings
Outcome: 95% will develop an Increased Sense of Positive Influence from Parent/Guardian/Caring Adult	Case Management	Parent Update Meetings, Client, Case Manager
Outcome: 75% will demonstrate Improved School Attendance	Case Management and Report Cards	Report Cards/Progress Reports

Outcome: 60% will demonstrate Improved Grades and Test Scores	Case Management and Report Cards	Report Cards/Progress Reports
Outcome: 65% will demonstrate Improved Classroom Behavior	Case Management and Report Cards	Report Cards/Parent-teacher Conference/IEP Meetings
Outcome: 70 % will demonstrate Improved Learning/Study Skills	Case Management and Report Cards	Report Cards/Progress Reports

3. Was outcome information gathered from every participant who received service, or only some?

- Outcome information was only collected from youth with whom the outcome fit based upon Referral, Intake and Family Contact and Conference. Therefore outcome information was only collected for some.

4. If only some participants, how did you choose who to collect outcome information from?

- Outcome information was only collected from youth with whom the outcome fit based upon Referral, Intake, Family Contact and Conference.

5. How many total participants did your program have?

- We had a total of 76 Clients for the year.

6. How many people did you *attempt* to collect outcome information from?

76 Clients were contacted in an attempt to collect outcome information from.

7. How many people did you *actually* collect outcome information from?

- Outcome information was collected from 57 clients.

8. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc).

- This information was collected at intake and family conference, weekly via case management, quarterly via report cards and progress reports, at parent/teacher conferences and at discharge.

Results

9. What did you learn about your participants and/or program from this outcome information? Please be specific when discussing any change or outcome, and give appropriate quantitative or descriptive information when possible. For example, you could report the following:

i. Means (and Standard Deviations if possible)
ii. Change Over Time (if assessments occurred at multiple points)
iii. Comparison of strategies (e.g., comparing different strategies related to recruitment; comparing rates of retention for clients of different ethnoracial groups; comparing characteristics of all clients engaged versus clients retained)

By comparison of FY 18 'Performance Outcome Report' to FY 19 'Performance Outcome Report' there are some significant differences that occurred:

- In section A of the Program Outcomes report there was a difference is the mean of Life Skills Education of 76% in FY 19 compared to 70% in FY 18.

- In section 'A' of the program outcome the contact of mentor to mentee, intervention, parental contact, and school contact, increased to 81% of participants improving in Life skills. The reduced acts of violence – 9 of 11 was significant.

- 49 out of 57 (81%) CU Change members showed improvement in Health Behaviors.

- Increase in over servicing due to the lack consistency with following the program expectations and parameters, lack parental buy-in, we had to discharge an inordinate amount of youth this year.

- In order for change over time that each youth admitted to the program will need 36-48 months to exhibit one year of sustained improvement in individual/fami.ly risk factors, on-time grade promotion and on track for high school graduation with a plan for the future.

- Due to the changing social environment and comparing the rates of retention, for clients of ethnoracial groups, we have found the parental involvement and engagement is a strategical necessity to create change over time. .

FY19 Results

A. To Promote and Develop Life Skills Education.

- Outcome: 65% of all youth are expected to show Improved Social-Emotional Skills

40 out of 57 (70%) of all youth showed Improved Social-Emotional Skills.

- Outcome: 65% of all youth are expected to show Improved Self-Esteem and Self Efficacy

41 out of 57 (72%) demonstrated Improved Self-Esteem and Self Efficacy.

- Outcome: 85% of all youth are expected to show Improved Future Orientation (Goal-Setting)

50 out of 57% (88%) if all youth demonstrated improvement in Future Orientation.

- Outcome: 70% of youth enrolled demonstrating Disciplinary Problems are expected to show Reduced Disciplinary Problems

13 out of 17 (76%) demonstrated reduced Disciplinary Problems.

- Outcome: 80% of youth enrolled in the program demonstrating Acts of Violence are expected to show Reduced Acts of Violence

9 out of 11 (82%) significantly reduced Acts of Violence.

- Outcome: 70% of all youth are expected to show Improved Health Behaviors

49 out of 57 (86%) of all youth showed improvement in Health Behaviors and Skills Mastery.

B. To provide Case Management that will assist youth to successfully address behavior issues.

- Outcome: 70% of all youth are expected to show Improved Self-Management

46 out of 57 (81%) of all youth showed Improved Self-Management skills.

- Outcome: 70 % of all youth are expected to show Improved Self-Concept

46 out of 57 (81%) of all youth demonstrated Improved Concept of Self.

- Outcome: 60% of all youth are expected to maintain or show Improved Leadership and Relationships among School Administrators, Teachers and Parents

38 out of 57 (67%) of all youth demonstrated improved relationships among School Administrators, Teachers and Parents.

- Outcome: 95% of all youth are expected to demonstrate an Increased Sense of Positive Influence from Parent/Guardian/Caring Adult

53 of 57 (93%) of all youth demonstrated and increased Sense of Positive Influence from Parent/Guardian/Caring Adult.

C. To improve educational achievement and progress of youth enrolled in the program.

- Outcome: 75% of all youth are expected to maintain or show Improved School Attendance

48 out of 57 (84%) of all youth maintained or improved School Attendance.

- Outcome: 60% of all youth are expected to maintain or show Improved Grades and Test Scores

35 out of 57 (61%) of all youth showed improved Grades and Test Scores since enrolling into the program.

- Outcome: 65% of all youth are expected to maintain or show Improved Classroom Behavior

40 out of 57 (70%) of all youth maintained or improved Classroom and School Behavior since enrolling into the program.

- Outcome: 70 % of all youth are expected to maintain or show Improved Learning/Study Skills

44 out of 57 (77%) of all youth are demonstrating improved learning/study skills through Power Hour/Project Learn program.

10. Is there some comparative target or benchmark level for program services? Y/N

Yes

11. If yes, what is that benchmark/target and where does it come from?

Based upon the last years areas of need and outcomes of individuals in our program. Improvement of educational goals has been revealed through report cards and attendance reports and compared to previous year. The goal for CU Change program is for each youth admitted into the program to fully participate in the program for 12-24 months to show sustained improvement and change.

12. If yes, how did your outcome data compare to the comparative target or benchmark?

The outcome describe show that the program is successfully making change, but the participants need additional time (i.e. additional 12-24 months) to show sustainability in change.

(Optional) Narrative Example(s):

13. Describe a typical service delivery case to illustrate the work (this may be a "composite case" that combines information from multiple actual cases) (Your response is optional)

14. In what ways was the evaluation used to support changes in practice? What changes were made based on evaluation findings? (Your response is optional)

Utilization Data Narrative –

The utilization data chart is to be completed at the end of each quarter (including quarter 4) using the online reporting system.

Comparative yearly totals (i.e. reporting estimates and actual numbers) and the narrative section described below are to be completed at end of year only.

Here, you will report on the different types of service categories specified in your program plan application. Please remember that programs **do not** need to collect and report on every category- instead, you are to report only the ones that are most useful for understanding program impact.

1. Please copy and paste the definitions of service categories your program specified in your program plan application in the sections below**. You will report the actual numbers of clients/contacts/community events for each reported service category in the Part II Utilization/Production data form (located on the online system).** If your estimated number of clients/contacts/community events for reported service categories significantly differ from your actual numbers, you may give a narrative explanation for that discrepancy here.

Treatment Plan Clients (TPC): Unduplicated Number of Youth Enrolled in Program.

- Estimated – 40
- Actual - 76

Non-treatment Plan Clients (NTPC): Total Unduplicated Number of Parents, Family Members or Individuals connected to the Treatment Plan Client and involved in program related activities.

- Estimated – 48
- Actual - 78

Community Service Events (CSE): Number of meetings between agencies, public presentations, school presentations and/or school staff meetings (i.e., referral meetings/conversations, meeting with School Social Worker/Teacher/Dean/SRO/Counselor, presentations to Champaign County Juvenile Probation Department, Community Resource Fairs, Youth Assessment Follow-Ups, Probation Officer Check-Ins, Etc.).

- Estimated – 150
- Actual – 182

Discrepancy occurred due to program slots filling quickly and program focus became case management and service contacts.

Service Contacts (SC): Number of case management sessions, counseling sessions. Unduplicated Participation in Programs (i.e., Positive Action, Passport to Manhood, SMART Girls, CareerLaunch, diplomas2Degrees, Power Hour, SMART Moves, etc.), Field Trips (i.e., college tours, team-building trips, family outings, etc.), and Mentor Meetings.

- Estimated – 1000
- Actual - 833

For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

Don Moyer Boys and Girls Club
Community Coalition Summer Youth Initiatives
Performance Outcome Report PY19

Don Moyer Boys & Girls Club/Champaign County Community Coalition – Summer Initiative Program

Performance Outcome Report
Summer 2018 (May 1 –September 30)

Don Moyer Boys and Girls Club served as Administrative Agent to support the efforts of the Champaign County Community Coalition to create a unified community effort to address youth and community violence by providing the following: youth unemployment, structured and adult led youth activities, and activities and training to assist community members in developing neighborhood support groups and dealing with trauma.

Twelve community organizations formed a partnership to provide a range of services and activities over a five month period. Outcomes from the variety of partner programs and activities include:

- 623 youth participated in partnership programming
- 40 High school youth provided with 8 weeks of employment and employment skills training
- 41 youth participated STEM focused "street college" learning activities and robotics development
- 214 teens participated in weekly midnight basketball and adult mentoring
- 110 youth participated in a PEACE Project program developed in cooperation with the University of Illinois Krannert Center for the Performing Arts
- 45 youth participated in weekly fine arts and music related activities
- 17 Youth participated in "Girls Only" program focusing on social and emotional skill development and reading comprehension and fluency skills
- 30 Rantoul youth participated in leadership development daily recreation activities, field trips and youth development activities
- 15 Youth participated in an intensive trauma training, de-escalation training, college exploration, and academic enhancement activities
- 111 youth participated in daily sports and mentoring activities through the First String program
- 1,400 community members viewed and discussed Racial Taboo film to promote racial understanding
- Trauma Training was provided to multiple coalition partners and community members
- Racial Taboo film and community discussion activities were provided
- Walk as One neighborhood community events were organized
- Multiple youth and community members participated in weekly open programs and activities

Don Moyer Boys and Girls Club
Youth and Family Services
Performance Outcome Report PY19

Agency name: Don Moyer Boys & Girls Club
Program name: Youth & Family Services
Submission date:

Consumer Access – *complete at end of year only*

Eligibility for service/program

1. From your application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application)

The Youth & Family Services program serves youth, families and child-serving organizations, in Champaign County.

- School-aged youth who have or are: experiencing social, emotional orbehavioral challenges; have a history of trauma; involved with the juvenile justice, mental health, child welfare or school systems (i.e. special education)
- Parents and caregivers of youth who are: experiencing social, emotional, and behavioral challenges; have a history of trauma; involved with the juvenile justice, mental health or child welfare systems
- Child-serving systems, social service agencies, family support organizations, faith-based organizations, civic/social groups and other community-based entities interested in improving outcomes for youth with emotional and behavioral challenges

The Youth & Family Services program is committed to extending consumer access to our target population. To assist with the challenges inherent in expecting our target population to "come into the office," we will offer most of our services and programs in the community. Youth Advocacy and Peer Support will primarily occur in the youth/families natural setting including the home, schools, other youth development programs, churches and other safe community spaces. Public Education activities will be inclusive of all child-serving systems, social service agencies, family support organizations, faith-based organizations, civic/social groups, and other community-

based entities that have a vested interest in improving outcomes for youth and families in Champaign County and surrounding rural areas.

2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)?

A particular person's eligibility criteria is determined by self-report of multiple system involvement in conjunction with assessment scores.

3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.)

Our target population learned about our services through our community partnerships with other service providers such as CU Neighborhood Champions, DREAM Academy, Regional Planning Commission Justice Diversion Program, Youth Assessment Center, and Champaign County Juvenile Probation. Others heard about us through word mouth from other caregivers and self-referred themselves for services.

4. a) *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application):

We did not provide an estimate for the percentage of persons who sought assistance or were referred who would receive services in our application.

b) *Actual* percentage of individuals who sought assistance or were referred who received services:

44% of individuals who sought assistance or were referred received services.

5. a) *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application):

We did not provide an estimate regarding length of time from referral/assistance seeking to assessment of eligibility/need in our application.

b) From your application, estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application):

We did not provide an estimate for percentage of referred clients who would be assessed for eligibility within a specific time frame in our application. Our services with treatment plan clients can last between 12-18 months. It takes longer to for some families to engage. The families we typically serve tend to be more open for help and "services" when in crisis only. Therefore, it may not be until the next crisis occurs before we are able to completely engage them in services.

c) *Actual* percentage of referred clients assessed for eligibility within that time frame:

We are unable to provide the actual percentage of referred clients assessed for eligibility within a specific timeline because that data information was not collected during this program year.

6. a) *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application):

We did not provide an estimate regarding estimated length of time from assessment of eligibility/need to engagement in services in our application.

b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application):

We did not provide an estimate percentage of eligible clients who would be engaged in services within a specific time frame in our application.

c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame:

We are unable to provide the actual percentage of clients assessed as eligible who were engaged in services within a specific timeline because that data information was not collected during this program year.

7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application):

We did not provide an estimate regarding the average length of participant engagement in services in our application.

b) *Actual* average length of participant engagement in services:

We are unable to provide the actual length of participant engagement in services because that data information was not collected during this program year.

Demographic Information

1. *In your application* what, if any, demographic information did you indicate you would collect beyond those required (i.e. race/ethnicity, age, gender, zip code)? (Demographic Information, question #1 in the Program Plan application)

We did not indicate we would collect any demographic information beyond those required.

2. Please report here on all of the extra demographic information your program collected.

There is no extra demographic information to report on our program.

Consumer Outcomes – *complete at end of year only*

During the application process, you identified participant outcomes that your program activities would impact. Here, report the actual participant outcomes achieved as a result of your program activities

1. *From your application,* what impact on consumers did you expect your program activities to have? That is, what outcome(s) did you want your program to have on the people it is serving? (Consumer Outcomes, question #1 in the Program Plan application)

The Youth & Family Services program had the following shared goals and intended systems of care outcomes for youth/families and community organizations in Champaign County and surrounding rural areas:

Purposeful peer to peer support
• 80% of parents/caregivers receiving peer parent support will report that it is "very important" to work with another parent that has the same or similar experiences navigating systems
• 75% of parents/caregivers will report they feel able to voice their ideas to professionals "most of the time."
• 75% of parents/caregivers will "agree" they can handle things when things get tough because they know what I can do to make it better

• 50% of parents/caregivers will "agree" they can strategically share their story (lived experience) with purpose at the community, county, and state level

Youth Advocacy
• 60% of transitioned-aged youth will complete the Ansell-Casey Life Skills Assessment
• 40% of transitioned-aged youth will participate in at least one (1) Public Education activity/event
Promote self-care, health-seeking behaviors, SOC Values
• 100% of Public Education topics and presentations will promote self-care, health-seeking behavior, SOC values and principles

Educate families about consumer rights and feedback process
• 80% of parents/caregivers receiving Youth & Family services will be educated about consumer rights and feedback processes as it relates to their specific system involvement

2. For each outcome, what specific survey or assessment tool did you use tocollect information on this outcome? (Please remember that the tool used should be evidence-based or empirically validated.)

We utilized 2 assessment tools to collect information regarding the progress of the youth and caregivers served as it relates to each of our program's outcomes.

Purposeful peer to peer support
- Family Assessment Tool (FAST) - The purpose of the FAST is to determine theright match and fit of support. support effective interventions when the focuses of those efforts are on entire families rather than single individuals. The most common use of the FAST is in efforts to address the needs of families who are involved with one or more systems of care. Parent provides key insight and final agreement on the array of support needed for their family. Peer Parent Support Partners can use this tool to manage their time spent out in the field. Scoring should be documented with agreement of amount of support from parent noted in documentation.

Youth Advocacy
- Casey Life Skills Tool and Life Skills Guidebook - Curriculum designed and intended to match developmental levels of youth and/or adult. The learner is youth or adult that is learning life skills content in-group, individual, or self-instructions formats. All the Learning goals for a skill area are listed together experience has shown that individuals do not learn skills in a chronological sequence. The competency-based curriculum design provides outcome measures from competency achieved. The learner is provided a scaffold of four levels beginning with Level 1- Awareness and Level 2 Knowledge and Understanding. The learner is gathering data and

information and the purpose of this part of the process is for the learner to identify, describe, or explain information about subject matter being taught. Level 3 the learner "knows how" and is demonstrating in observable and measurable ways the skill level capacity of the task. The capacity of the skill is tested in simulated or real-life learning settings. Level 4 the learner has successfully integrated the knowledge and skill set into a learned behavior and has reached the "can or is able to" plateau for independent living. The tool and guidebook encompass all domains for successful integration into and the community while increasing capacity for independent living that matches the learner's aptitudes. The guidebook design when matched with our model of Parent Peer Support Partner (PPSP) and/or youth to peer (Y2P) increases the capacity for engagement of skill set development.

3. Who provided the information about participant outcome(s)?
(Participant, participant guardian, clinician/service provider, other program staff (if other program staff, who?_____)

Information regarding participant outcome(s) was provided by the participants themselves as well as the Parent Peer Support Partner or Youth Peer to Peer Support Partner.

4. Was outcome information gathered from every participant who received service, or only some?

Outcome information was gathered from every participant who received service.

5. If only some participants, how did you choose who to collect outcome information from?

6. How many total participants did your program have?

Our program had a total of 37 participants (18 TPC and 19 NTPC).

7. How many people did you *attempt* to collect outcome information from?

We attempted to collect outcome information on all 37 participants.

8. How many people did you *actually* collect outcome information from?

We actually collected outcome information from 7 participants.

9. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc)

Information was collected at client intake and throughout length of service. Each participant engaged in services differently (frequency of contacts, length of time, level of intensity) therefore assessment administration varied at the individual client level based on need and progress.

Results

10. What did you learn about your participants and/or program from this outcome information? Please be specific when discussing any change or outcome, and give appropriate quantitative or descriptive information when possible. For example, you could report the following:

i. Means (and Standard Deviations if possible)
ii. Change Over Time (if assessments occurred at multiple points)
iii. Comparison of strategies (e.g., recruitment, retention, treatment, intervention)

Purposeful peer to peer support

- 0% of parents/caregivers receiving peer parent support will report that it is "very important" to work with another parent that has the same or similar experiences navigating systems- This is because the assessment tool we use to get this information was eliminated from our assessment process at the start of the year.
- 39% of parents/caregivers will report they feel able to voice their ideas to professionals "most of the time."
- 39% of parents/caregivers will "agree" they can handle things when things get tough because they know what I can do to make it better
- 39% of parents/caregivers will "agree" they can strategically share their story (lived experience) with purpose at the community, county, and state level

Youth Advocacy

- There were no direct youth advocacy services provided this program year due to the inability to fill staff vacancies. Youth were served indirectly through support provided to their caregivers
- 0% of transitioned-aged youth will complete the Ansell-Casey Life Skills Assessment
- 0% of transitioned-aged youth will participate in at least one (1) Public Education activity/event

Promote self-care, health-seeking behaviors, SOC Values

- 100% of Public Education topics and presentations promoted self-care, health-seeking behavior, SOC values and principles
- 26 opportunities to make presentations, training, facilitate
    - 09/06/18 – Crisis Nursery: presentations on FRO
    - 09/26/18 – Presented Probation "Focus on Building Youth One Selfie ata Time"
    - 10/03/18 – Community Schools presentation on peer support, FRO
    - 10/11/18 – Panel participation Healing Neen; (trauma)
    - 10/17/18 – 10/18/18 - Provide training: Facing Family Engagement Challenges & Useful Ways to Solve the Challenges
    - 11/9/18-11/10/18 - Presentation on Emotional Health & Trauma (AA/Black women Champaign, Springfield, Chicago)
    - 11/12/18 - Provided training: "The Basics of Effective Engagement"
    - 12/04/18 – Presentation WIOA – Presented on FRO, SOC and PeerSupport
    - 02/08/19 & 03/04/19 – Facilitated Group – Self-care Stress Management
    - 02/25/19 – Training – Trauma and Families: Family Resilience
    - 03/25/19 – Peer Support and the Juvenile Justice System
    - 03/29/19 – Novak Academy – Presentation to college students about my organization and setting goals for the future and seeking supportsystems.
    - 04/04/19 – Presentation for 708: Parenting with the end in mind
    - 05/07/19– Facebook Live Discussion – Suicide and Mental Health
    - 05/10/19 – Children Mental Health Awareness Dinner & Dance
    - 05/17/19 – Lunch & Learn – Raising Awareness and Breaking Silence
    - 05/28/19 – Panel Participation – WILL News & Brews: Mental Health by YPSA Staff & Peers.

Educate families about consumer rights and feedback process

- 80% of parents/caregivers receiving Youth & Family services will beeducated about consumer rights and feedback processes as it relates to their specific system involvement

11. Is there some comparative target or benchmark level for program services? Y/N

No there is no comparative target or benchmark level for program services.

12. If yes, what is that benchmark/target and where does it come from?

13. If yes, how did your outcome data compare to the comparative target or benchmark?

(Optional) Narrative Example(s)

14. Describe a typical service delivery case to illustrate the work (this may be a "composite case" that combines information from multiple actual cases)

15. In what ways was the evaluation used to support changes in practice? What changes were made based on evaluation findings?

Utilization Data Narrative – *complete at the end of each quarter using the online reporting system. Complete this section at end of year only.*

Here, you will report on the different types of service categories specified in your program plan application. Please remember that programs **do not** need to collect and report on every category- instead, you are to report only the ones that are most useful for understanding program impact.

1. Please copy and paste the definitions of service categories your program specified in your program plan application in the sections below**. You will report the actual outcomes of service categories in the Part II Utilization/Production data form (located on the online system).** If your estimated service category outcome significantly differs from your actual service category outcome, you may give a narrative explanation for that discrepancy here.

Treatment Plan Clients (TPC):

Treatment Plan Clients are youth and parents who have completed our intake and enrollment process with the development of a treatment plan.

We served 18 treatment plan clients during this program year. Our goal was 70. We have been working on strengthening relationships with partner organizations. We signed MOU's with 4 organizations that receive funding under the System of Care funding. The purpose of the MOU's was to identify the roles and responsibilities of each organization as they relate to "Champaign County Mental Health Board's focus on youth with serious emotional disturbance and multi-system involvement. What we have learned is that the actual relationship and building true authentic and reciprocal partnerships take time. Had we taken this into consideration, we would have set our target numbers much lower. For next year we

plan on continuing to be strategic about referral sources and the services we provide to our treatment plan clients.

Non-treatment Plan Clients (NTPC):

Non-treatment Plan Clients are youth and parents who may have completed our intake and enrollment process, but haven't developed a treatment plan; these families will still have access to linkage and engagement services this includes short-term community support services (ie. attend IEP meetings; court hearings; review IEP's; apply for public assistance etc.); youth and parents who contact us via phone or the website for linkage and engagement information).

We served 19 non-treatment plan clients during this program year. Our target was 115. Again, we did not get the referral we anticipated getting from partner agencies. For next year we plan on continuing to be strategic about referral sources and the services we provide to our treatment plan clients.

Community Service Events (CSE):

Community Service events refer to the number of events held in the community (workshops, training's, support groups, webinairs).

We held 33 community service events this program year. Our target was 50. We believe there were more and recognize we need to tighten up on our data collection methods to ensure all of our efforts are recorded to allow us to truly represent our impact with caregivers in Champaign County.

Service Contacts (SC):

Service contacts are the number of times a staff member makes contact with TPC and NTPC via phone, face-to-face or the mechanism decided upon by the youth or parent that best suit their needs.

A total of 332 service contacts were made this program year. Our goal was 1500. Due to the fact that we did not get our anticipated number of referrals, our service contacts were significantly lower than expected. For next year we plan on continuing to be strategic about referral sources and the services we provide to our treatment plan clients.

For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

East Central Illinois Refugee Mutual Assistance Center
Family Support and Strengthening
Performance Outcome Report PY19

Agency name: East Central Illinois Refugee Mutual Assistance Center (The Refugee Center)
Program name: Family Support & Strengthening
Submission date: 8/30/2019

Consumer Access – *complete at end of year only*

Eligibility for service/program

1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application)

a. The goal of the program is to work with the natural support networks within the different ethnic communities (i.e., Vietnamese, Cuban, Russian, Chinese, DRC, Cameroon, Algeria, Liberia, Congo, Guatemala, Honduras, El Salvador, Peru, Mexico, Iraqi, etc.). Special attention is given to 1) Families at highest risk for mental health problems (newly arrived refugee/immigrants who have fled war/genocide and are facing and/or experiencing culture shock). 2) Families, with young children, that lack a family support network. 3) Families who have a child/children identified by the schools as having special needs. 4) Unaccompanied minors. 5) The elderly, the illiterate, and relocated migrants 6) Leaders and identified potential leaders of the ethnic communities for development of volunteer mutual assistance efforts. 7) Community agencies that serve refugee, asylee, and immigrant community or organizations with whom the targeted population needs to interact.

b. Required Eligibility criteria for funded services. (This statement must be retained in all plans submitted). CCMHB will contract with the AGENCY for services to individuals/families who meet the following criteria: (a) are residents of Champaign County as shown by address; (b) have evidence of a need for service based on an assessment; (c) have limited financial resources to meet the cost of their care.

2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)?

We fill out an Intake Form for every new client with that information included. We document proof of income when we begin services.

3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.)

Services are accessed by referrals from social service providers like the IL Department Human Services and IL Department of Children and Family Services, clients and former clients, local churches, employers, schools, Adult Diversion Program or by bilingual outreach to refugee/immigrant populations through mass outreach events, flyers, newsletters, public benefit sessions, workshops, and other community service events.

4. a) *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application):

While we did not provide a percentage on our application, we predicted we would serve 2,100 unduplicated persons.

b) *Actual* percentage of individuals who sought assistance or were referred who received services:

We actually served 2,250 unduplicated persons in FY19.

5. a) *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application):

Appointments to work with families in crisis are always given a priority and there are no delays in setting meetings to work on family problems. We work with mental health providers to get clients help as soon as possible. Clients who come in needing other services, ie, a friendly ear, help at the schools, help with paperwork, is all done within a week of the request.

b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application):

We do not have corresponding percentage from our application. Since most of our clients are seeking assistance applying for social service benefits, they are almost always qualify for assistance based on assessment, having very limited financial resources.

c) *Actual* percentage of referred clients assessed for eligibility within that time frame:

n/a

6. a) *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application):

We do not have corresponding answer from our application.

b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application):

We do not have corresponding answer from our application.

c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame:

n/a

7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application):

We do not have corresponding answer from our application.

b) *Actual* average length of participant engagement in services:

n/a

Demographic Information

1. *In your application* what, if any, demographic information did you indicate you would collect beyond those required (i.e. beyond race/ethnicity, age, gender, zip code)? (Demographic Information, question #1 in the Program Plan application)

n/a

2. Please report here on all of the extra demographic information your program collected.

n/a

Consumer Outcomes – *complete at end of year only*

During the application process, you identified participant outcomes that your program activities would impact. Here, report the actual participant outcomes achieved as a result of your program activities

1. *From your application,* what impact on consumers did you expect your program activities to have? That is, what outcome(s) did you want your program to have on the people it is serving? (Consumer Outcomes, question #1 in the Program Plan application). Please number each outcome.

1. Clients receive the benefits they are eligible for.

2. Clients will retain jobs and switch from temporary positions to permanent ones.

3. The Refugee Center mediation helps service providers work with and understand better their clients from different cultural backgrounds, especially when the providers are dealing with mentally ill clients.

4. Clients who have successfully completed workshops expressed an interest in having more sessions and have recommended the workshops to others.

5. Individual oral pre- and post-surveys as well as collection of comments and suggestions demonstrate clients' satisfaction and the overall effectiveness of the program.

6. Through the analysis of case notes the most common suggestions are used to reformat the program.

7. We have seen several clients with domestic violence issues in FY19. We will continue to offer workshops and attend community meetings to address this issue. While there have been positive results due to Mrs. Ho's involvement, we hope that the future planned re-organization of the Congolese community will help educate more members of this particular community about how to combat domestic violence.

8. Direct feedback from clients showing improved adjustment. Most of our new families have reported that they are making plans for their future and starting to put those plans into action.

9. Preparation for participation in the Trafficking Victims Assistance Program, a program that provides individuals seeking T Visas with assistance while they wait to qualify for public benefits. One great benefit of the program is cash assistance for the T Visa applicant to pay for a mental health evaluation, which is a critical piece of evidence in any T Visa application. Staff has received training and is prepared to accept referrals to this program in FY20.

10. Saturday Morning Tutoring Program: The school liaisons are active in the Champaign/Urbana school districts. The staff member who goes weekly to Rantoul

helps facilitate communications between the schools and the families. (This help is also available to other districts within the county if requested). The number of contacts being initiated by Champaign & Urbana School Districts and Rantoul has increased. They are experiencing a large number of unaccompanied minors from Central America in the schools. We visited Central HS three times in FY 19 to address issues regarding this population. Not including the students served directly in the schools, the Saturday Morning Tutoring Program attendance averages between 35 -40 students a week. The children are exposed to various enrichment activities and close to one-to-one tutoring by volunteers from the University of Illinois.

2. For each outcome, please indicate the specific survey or assessment tool you used to collect information on this outcome in the chart below. (Please remember that the tool used should be evidence-based or empirically validated.)

Additionally, in the chart below, please indicate who provided this information (e.g. participant, participant's guardian(s), clinician/service provider, other program staff (if other program staff, indicate their role).) Please report all sources of information that apply for each assessment tool (e.g. the XYZ survey may be completed by both a youth client and their caregiver(s).

Outcome:	Assessment Tool Used:	Information Source:
1. Clients receive the benefits they are eligible for.	Intake & Encounter Forms	Bilingual Counselor & Client
2. Clients will retain jobs and switch from temporary positions to permanent ones.	Intake & Encounter Forms	Bilingual Counselor & Client
3. Refugee Center mediation helps mainstream service providers work with and understand better their clients from different cultural backgrounds; especially when the providers are dealing with mentally ill clients.	Intake & Encounter Forms	Bilingual Counselor & Client

4. Clients who have successfully completed workshops expressed an interest in having more sessions and have recommended the workshops to others.	Intake & Encounter Forms	Bilingual Counselor & Client
5. Individual pre- and post-surveys as well as collection of comments and suggestions demonstrate clients' satisfaction and the overall effectiveness of the program.	Post program survey given to student volunteers in the Saturday Morning Program	Student volunteers
6. Through the analysis of exit questionnaires the most common suggestions are used to reformat the program.		[Surveys not implemented]
7. Decrease in domestic violence cases and culturally inappropriate behavior among clients who have attended sessions on this problem. Clients referred by Adult Diversion had a better understanding of the American Justice and have avoided repeat contact with the police.	Intake & Encounter Forms	Bilingual Counselor & Client
8. Direct feedback from clients showing improved adjustment.	Intake & Encounter Forms	Bilingual Counselor & Client
9. Individuals filing for LPR (green card) under VAWA.	Intake & Encounter Forms	Bilingual Counselor & Client

10. Saturday Morning Tutoring Program: improved comfort and performance of k-5 students enrolled in the local schools.	Interviews with parents and school staff. Survey completed at end of Spring session by student volunteers that worked with students.	School liaisons, teachers, volunteers and parents.

3. Was outcome information gathered from every participant who received service, or only some?

a. Intake forms and encounter forms are filled out for every client.
b. Saturday Morning Tutoring Program: We get information about progress of school children in general, about the group. Teachers cannot share information about individual children with the school liaisons due to privacy concerns. Parents tell us when children are not doing well. Student volunteers report progress to the Saturday Morning Program Supervisor(s) and answered a survey at the end of the school year.

4. If only some participants, how did you choose who to collect outcome information from?

Saturday Morning Tutoring Program: With children we rely on parents to let us know when children need extra or different kinds of help. Survey newly implemented at end of school year for volunteers that worked with students. Parent surveys in development. Difficult due to the number of languages spoken by participants.

5. How many total participants did your program have?

2,250 participants

6. How many people did you *attempt* to collect outcome information from?

Through oral survey and written case notes, we record outcomes of all our clients.

7. How many people did you *actually* collect outcome information from?

2,250 participants

8. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc)

a. Client Intake
b. Each client encounter, every time we interacted with a client.

Results

9. What did you learn about your participants and/or program from this outcome information? Please be specific when discussing any change or outcome, and give appropriate quantitative or descriptive information when possible. For example, you could report the following:

i. Means (and Standard Deviations if possible)
ii. Change Over Time (if assessments occurred at multiple points)
iii. Comparison of strategies (e.g., comparing different strategies related to recruitment; comparing rates of retention for clients of different ethnoracial groups; comparing characteristics of all clients engaged versus clients retained)

Change over time:

- We are serving more Latinos; more of them are from Central America, especially Guatemala, and fewer are from Mexico.
- We are encountering more Latinos who are not literate in any language.
- We are serving more people from Democratic Republic of the Congo as well as West African peoples (Togo, Cameroon, etc). Most of the clients speak French and Swahili or Lingala.
- We are serving more clients from the DRC who are having contact with law enforcement. Domestic violence and sexual abuse is a growing problem.

Comparison of strategies (ethnoracial differences):

- Mayans: increased help to unify families through unification process, particularly for unaccompanied minors. We have seen an increase in requests for reunification.
- Congolese: Work mostly with community leaders fostering ways that they can help each other, collect funds for families in need, etc. Attended several meetings to try to bring the Congolese community together though their different Pastors. Helping different members of the Congolese community find common ground. We are helping the community members to be more involved and aware of the needs in their community.
- Work with mosque to serve new immigrant families from middle-east (Afghanistan) get settled into the community. These families required standard support: help applying for/using public benefits, help with paperwork for government services, enrolling children in school, accessing ESL classes, finding jobs, etc…

10. Is there some comparative target or benchmark level for program services? Y/N
No.

11. If yes, what is that benchmark/target and where does it come from?

12. If yes, how did your outcome data compare to the comparative target or benchmark?

(Optional) Narrative Example(s):

13. Describe a typical service delivery case to illustrate the work (this may be a "composite case" that combines information from multiple actual cases) (Your response is optional)

Case 1: In December of 2018, a family of five people (2 parents, 3 children) arrived from Afghanistan on Special Immigrant Visas (SIV). They were placed with us through the United States Conference of Catholic Bishops' Remote Placement Program. We rented a furnished apartment for them though money received from a private grant specifically for this purpose. They received all the benefits entitled to them and were issued Social Security numbers and green cards. We spent a great deal of time making sure that this family received their benefits. SIV cases are not typical for our local IDHS office, and there has been some confusion as to what benefits they are qualified to receive. We addressed this situation when we met with the staff of the local DHS office to explain what an SIV is and what benefits they are entitled to by law.

The father has been attending ESL and worked part time until his hours were reduced. He is currently seeking other employment or volunteer work to meet requirements to receive TANF. His wife just gave birth to another child. The school aged children attend King Elementary in Urbana. Their counselor, Mrs. Ho, has spent countless hours with this family at school, in their home and accompanying them to social service and medical appointments. Since they speak Pashto and Dari, communication was difficult at first. Through the help of the Afghan families that we previously settled in the area and Mrs. Ho's unique ability to communicate with people of many nations and cultures, they are finding their way in their new home. They are grateful for the assistance, advocacy, and support provided by our staff.

Case 2: A blended family of five arrived from Honduras, also in December of 2018. Ms. K arrived with one child from a previous relationships and two children that she shares with Mr. D. They are not married, but were granted refugee status as a family through the US Catholic Conference of Bishops. They came to Champaign –Urbana to join Mr. D's mother, who is an asylee. They originally lived in a trailer in Rantoul, but soon moved to a trailer in Champaign. We helped them get settled and applied for Social Security cards and benefits. One of the children tested positive for latent TB and received treatment. The entire family received their green cards. Mr. D found work in construction soon after his arrival and continues to work. Ms. K has worked as a few different part time jobs, but is currently out of work. Ms. K became dissatisfied and left Mr. D, leaving all three children with him. The situation between the parents is pretty volatile. We have referred the family to counseling. Appointments for the children were made, but not kept. We plan to meet with the parents to discuss the issues that they are having and how to solve them peacefully. The entire family is under a great deal of stress.

14. In what ways was the evaluation used to support changes in practice? What changes were made based on evaluation findings? (Your response is optional)

We have discussed hiring another part–time French interpreter to assist Mrs. Ho serving the expanding French speaking African community, which would allow her to reduce her hours

worked. The demand for her French interpretation services continues to increase. French speakers need more documents translated for schools, work, and legal processes as the documentation from their home countries can differ vastly from what is considered adequate documentation in the American system. In addition, many of these immigrants have been traveled through or lived in many different countries before arriving in the US. Their documentation is difficult to trace.

We continue to see an increase in asylum seekers. Additional pro bono legal help is expected in FY20, and we hope to refer more of these cases to legal providers so we can concentrate on delivery of public benefits and social services to these clients. Asylum seekers can now apply for benefits at the beginning of the legal process. This is because the asylum process is taking so long and the government has changed its policies in order to make it possible for people to receive benefits. So, we are seeing a need to hire more Spanish speakers and identify Spanish/Konjobal (Mayan native language) interpreters. In addition, there has been confusion about what constitutes proof of an asylum pending case for public benefits purposes. USCIS often does not issue a letter or stamp to indicate that a client has asylum pending. A notice of filing is sent, but many clients discard the notice. We met with our local IDHS office to discuss this issue and came up with some procedures.

Mental health is a big concern. We are seeing so many clients, both adult and children, who have experienced trauma. The need for mental health professionals who are bilingual Spanish and French is critical. We have seen a rise in teen pregnancy in the Latinx community, and plan to hold workshops about teen sex in a culturally appropriate manner. In the Congolese community we see domestic violence and sexual misconduct, often with minors. We continue to meet with the Pastors of the Congolese community in order to address these difficult issues. We are very glad that we will have an opportunity to receive Trauma Informed Care training through the CU Trauma & Resilience Initiative in FY20.

It seems that as divorce is being destigmatized in the Vietnamese and Mexican communities, we are assisting with more divorces, referring clients to therapists and divorce lawyers. In some cases, the families see it as a solution, instead of a stigma to avoid. However, we are seeing an increase in mental health issues in the children of both these communities. The Mexicans more that the Vietnamese are experiencing stress due to family composition and immigration status.

Our Mayan clients need more verbal interpreting than written because they are not literate in any language. We have received many requests for Konjobal interpretation. The issue is that since most of those people who speak Konjobal are from the same small area and know each other, there is a privacy issue when it comes to interpretation.

Our Arabic speaking population has increased a little, but not enough to warrant hiring an interpreter. The Central Illinois Mosque is a very organized and supportive community that works on outreach within our larger C-U community, serving this demographic. Currently, we have several volunteers that speak Arabic that have assisted us when needed. Same can be said for our Afghan population, who speak Pashto and Dari. The also attend the Mosque and have found others from their home country that they have bonded with. We will be cognizant of this group and we will make adjustments to the organization as needed.

Utilization Data Narrative –

The utilization data chart is to be completed at the end of each quarter (including quarter 4) using the online reporting system.

Comparative yearly totals (i.e. reporting estimates and actual numbers) and the narrative section described below are to be completed at end of year only.

Here, you will report on the different types of service categories specified in your program plan application. Please remember that programs **do not** need to collect and report on every category-instead, you are to report only the ones that are most useful for understanding program impact.

1. Please copy and paste the definitions of service categories your program specified in your program plan application in the sections below**. You will report the actual numbers of clients/contacts/community events for each reported service category in the Part II Utilization/Production data form (located on the online system).** If your estimated number of clients/contacts/community events for reported service categories significantly differ from your actual numbers, you may give a narrative explanation for that discrepancy here.

Treatment Plan Clients (TPC): n/a

Non-treatment Plan Clients (NTPC): n/a

Community Service Events (CSE):

From our FY19 application: In our proposal for FY19, the Refugee Center intends to provide for our grant, 75 "Community Service Events" and a minimum of 25 Smart Money and Promoting Better Health to Fight Obesity and Diabetes in Adults workshops.

In FY 19, we actually provided a total of 103 CSE's, and 31 hours of workshops, including support groups that discussed mental health in children, overcoming stigma and receiving treatment, reviewing rules for citizenship applications, identifying local services for senior citizens, answering questions about the proposed Public Charge rule, meeting with unaccompanied minor students, etc…

The support group activities for families are well attended. Specific youth support group activities are offered through the Saturday Morning Program.

Two newsletter issues published articles pertaining to mental health issues. There was also an article in the News Gazette publicizing the Refugee Center and it's relocation. Posting on the Center's Facebook page continues.

Linkage with Courage Connection, RACES, Child Advocacy Center, DCFS, local hospitals, police and the courts continue. Home visits are being made to Afghan, Vietnamese, Chinese, Spanish, Iraqi, Russian, Lao, and African homes. Case notes, encounter forms, newsletter, attendance lists, and mailing list provide documentation of services.
Service Contacts (SC): n/a
For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

Family Service of Champaign County
Counseling
Performance Outcome Report PY19

Agency name: Family Service of Champaign County
Program name: Counseling
Submission date: August 30, 2019

Consumer Access – *complete at end of year only*

Eligibility for service/program

1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application)

People over the age of 5 who live in Champaign County and who have a need for our services are eligible. A sliding fee scale provides low income and/or uninsured clients access to affordable mental health services. In general, there are no limits to the number of sessions available to a client. The fee is reduced or waived for Drug Court clients if requested by a representative of the assessment team or Judge Ford. This allows access to service for a group of individuals who may not have insurance or income to pay for counseling. During FY19 we were unable to accept clients who receive Medicaid benefits.

2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)?

Eligibility is determined during the intake interview. Information is requested at that time regarding county of residence and other eligibility factors. A potential client is asked if they receive Medicaid. During FY19, if the individual was a Medicaid recipient, a referral was made to other mental health providers who accept Medicaid. The potential client is also asked several questions about their presenting issue and mental health needs. The answers provided by the client will determine if our counselors are able to appropriately address the potential client's needs. If their needs are beyond our scope of services, we refer to other professionals.

3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.)

Many individuals who seek our services are referred from outside sources, such as Drug Court. Information about our Counseling program has been distributed to school social workers and guidance counselors and church pastors. An informational flyer is posted on the bulletin boards of community libraries and community centers in the rural Champaign County communities. The program director represents the Counseling program as a member of the Human Services Council that meets monthly. The Counseling program is also promoted on the Family Service website and Face Book page. Any outreach event that Family Service participates in also promotes the Counseling program. This includes the DisAbility Expo, Jettie Rhodes Community Day and health fair events held at Parkland College.

4. a) *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application): **85%**

b) *Actual* percentage of individuals who sought assistance or were referred who received services:

65% of the individuals for which a phone intake was completed received services. A phone intake was not completed with individuals who stated that they had Medicaid as their insurance. These individuals were referred to other providers automatically since Family Service was not approved to accept Medicaid clients. No log was kept of these calls. 11% of the callers were referred elsewhere. 21% were left voicemails and never called back to schedule an appointment. 3% of the callers received appointments for services but no showed their appointments.

5. a) *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application): **1-2 business days**

b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application): **85%**

c) *Actual* percentage of referred clients assessed for eligibility within that time frame: **100%**
Referred clients are assessed for eligibility to receive services when the phone intake is completed with a therapist.

6. a) *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application):

Once a therapist is assigned to a potential client, the therapist makes diligent efforts to contact the potential client and schedule an appointment. The therapists document each contact attempt made with potential clients. This usually takes 1-2 business days.

b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application):

The individual may have an appointment scheduled as quickly as during the initial intake interview, depending on when the individual contacted Family Service and if the person conducting the phone intake will be the assigned therapist. Approximately 85% of eligible clients will have an appointment within the 1-2 business days' time frame. The remaining 15% of eligible clients are those individuals who are difficult to reach after the initial intake.

c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame:
40% of clients were scheduled for appointments within the 1-2 business days timeframe. The remaining 60% of eligible clients were scheduled for appointments within a week of their phone intake. Clients made the decisions determining when they wanted their counseling appointments as it matched the availability of the counselors.

7 a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application):

The average length of participant engagement in counseling services is difficult to quantify as length of engagement can vary greatly from client to client. The purpose of our Counseling program is to improve or maintain an individual's ability to function. Some individuals feel better after a few sessions and discontinue service at that time. Some clients engage in service for several months to address all their treatment goals. Some clients, after initial improvement and stabilization, need the ongoing support of periodic contact with their therapist to maintain their level of functioning and may receive services for a year or longer.

b) *Actual* average length of participant engagement in services:
N/A
In general, there are no limits to the number of sessions available to a client.

Demographic Information

1. *In your application* what, if any, demographic information did you indicate you would collect beyond those required (i.e. beyond race/ethnicity, age, gender, zip code)? (Demographic Information, question #1 in the Program Plan application)

We indicated in our application that we would collect demographic data regarding race, ethnicity, age, gender and zip code.

2. Please report here on all of the extra demographic information your program collected.
N/A

Consumer Outcomes – *complete at end of year only*

During the application process, you identified participant outcomes that your program activities would impact. Here, report the actual participant outcomes achieved as a result of your program activities

1. *From your application,* what impact on consumers did you expect your program activities to have? That is, what outcome(s) did you want your program to have on the people it is serving? (Consumer Outcomes, question #1 in the Program Plan application). Please number each outcome.

For FY19
The goal of counseling is to improve the client's level of functioning. Depending on the client and the presenting problem, this may include reducing stress, depression or anxiety; reducing relationship conflicts; improving parenting or communication skills or ending an abusive relationship.

Outcome 1: Individuals receiving our services will report improvement in four areas of functioning (individual, relational, social and overall) as measured using the Outcome Rating Scale (ORS). This tool will be given to clients quarterly when the individual treatment plan is reviewed and revised. The ORS uses a gradient scale rating range of 0 (doing poorly) to 10 (doing very well) with a total potential score of 40.

Outcome 2: Individuals receiving our services will meet the treatment goals that they established with their therapist. Individual treatment plans are reviewed at least quarterly with the client. Clients determine with the therapist success in meeting treatment objectives, outcomes and goals. When a client terminates services, the therapist uses the most recent treatment plan to determine the client's success with goal completion.

Outcome 3: Individuals receiving our services will have an improvement in their functioning over the course of treatment as measured using the Global Assessment of Functioning (GAF). A GAF score is determined by the therapist during the mental health assessment. A new GAF score is determined whenever a plan is reviewed or the case is closed. A comparison will note changes in a client's functioning. The scale ranges from 0 (inadequate information) to 100 (superior functioning).

2. For each outcome, please indicate the specific survey or assessment tool you used to collect information on this outcome in the chart below. (Please remember that the tool used should be evidence-based or empirically validated.)

Additionally, in the chart below, please indicate who provided this information (e.g. participant, participant's guardian(s), clinician/service provider, other program staff (if other program staff, indicate their role).) Please report all sources of information that apply for each assessment tool (e.g. the XYZ survey may be completed by both a youth client and their caregiver(s).

Outcome:	Assessment Tool Used:	Information Source:
E.g. 1. Increased empowerment in advocacy clients	Measure of Victim Empowerment Related to Safety (MOVERS) survey	Client
1. Individuals will report improvement in four areas of functioning (individual, relational, social and overall functioning)	**Outcome Rating Scale (ORS)**	**Client**
2. Individuals will meet the treatment goals that they established with their therapist.	**Treatment plan review**	**Client and therapist**
3. Individuals will have an improvement in their functioning over the course of treatment.	**Global Assessment of Functioning (GAF)**	**Therapist**

3. Was outcome information gathered from every participant who received service, or only some? **Only some.**

4. If only some participants, how did you choose who to collect outcome information from? **Outcome information was only collected on those clients who had a developed treatment plan.**

5. How many total participants did your program have? **60**

6. How many people did you *attempt* to collect outcome information from?

Fifty-five (55) of our clients had the opportunity to become treatment plan clients including 19 Drug Court clients. These Drug Court clients chose to only complete the relationship assessment and declined counseling services.
Five (5) clients received mental health assessments for the Probation Department.

7. How many people did you *actually* collect outcome information from?
Outcome information was collected from 21 of 21 treatment plan clients.

8. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc.)
For Outcome 1, the ORS information is obtained when the treatment plan is reviewed. This typically occurs quarterly. It is also requested that the client complete the ORS at completion of services.
For Outcome 2, treatment plans are typically reviewed and revised quarterly. When a client terminates services, the therapist uses the most recent treatment plan to determine the client's success with goal completion.
For Outcome 3, the GAF is assessed during the initial mental health assessment. A new GAF score is determined whenever a plan is reviewed or the case is closed.

Results

9. What did you learn about your participants and/or program from this outcome information? Please be specific when discussing any change or outcome, and give appropriate quantitative or descriptive information when possible. For example, you could report the following:

i. Means (and Standard Deviations if possible)
ii. Change Over Time (if assessments occurred at multiple points)
iii. Comparison of strategies (e.g., comparing different strategies related to recruitment; comparing rates of retention for clients of different ethno racial groups; comparing characteristics of all clients engaged versus clients retained)

With all of our outcomes, we hope to observe client change over time.
Our therapists want to see the ORS scores move closer to 40 over time.
Our therapists want to see on-going progress made on the client's identified objectives and goals.
Our therapists want to see improvement of the GAF scores from the initial assessment at each treatment plan review and at case closure with more treatment plan clients reaching GAF scores above 91 at case closure.

10. Is there some comparative target or benchmark level for program services? Y/N
Yes

11. If yes, what is that benchmark/target and where does it come from?

Outcome 1: The benchmark for the ORS is a total score of 35-40. This means that a client is feeling that they are doing very well in all areas of their life. This benchmark is established by those who developed the tool.

Outcome 2: The treatment goals benchmark is that progress has been made on objectives and treatment goals have been met at time of case closure. This is an internal benchmark developed by our program.

Outcome 3: The benchmark for the GAF is a score of 91-100 at time of case closure. This score represents superior functioning in a wide range of activities. This benchmark is established by those who developed the tool.

12. If yes, how did your outcome data compare to the comparative target or benchmark?

Outcome 1: As assessed at the end of the fiscal year: 100% of treatment plan clients who had both an initial and subsequent ORS score showed at least some improvement in their score during their treatment. Two clients reached the ORS benchmark score of 35-40. Four clients have not yet completed the ORS since they have not yet had their first treatment plan review. Four treatment plan clients were minors and minors are not asked to complete the ORS.

Outcome 2: For treatment plan clients whose case was closed during FY19, eighty percent (80%) made progress with at least 75% of their objectives and met at least 60% of their treatment goals at the time their case was closed. For treatment plan clients whose case was still open as of 6/30/19, fifty-eight (58%) made progress on at least sixty percent (60%) of their objectives and goals. The remaining forty-two percent (42%) of treatment plan clients whose case was still open as of 6/30/19 will have their first treatment plan review during the first quarter of FY20 to evaluate their progress with their objectives and goals.

Outcome 3: As assessed at the end of the fiscal year based on the most current or final (if case closed) GAF score for treatment plan clients: Thirty-six percent (36%) of clients increased their GAF scores by 5 points or more. Thirty-two percent (32%) of clients had no change in their GAF scores. No clients reached the GAF benchmark score of 91-100 when their case was closed; the highest score achieved prior to case closure was a score of 75. Fourteen percent (14%) of clients will have their treatment plan reviewed for the first time in the first quarter of FY20 at which time the GAF will be reassessed, so we are not yet able to report on any change from their initial GAF score. Four treatment plan clients were minors and GAF is not assessed on minors.

(Optional) Narrative Example(s):

13. Describe a typical service delivery case to illustrate the work (this may be a "composite case" that combines information from multiple actual cases) (Your response is optional)

14. In what ways was the evaluation used to support changes in practice? What changes were made based on evaluation findings? (Your response is optional)

The program director noted that our current evaluation did not adequately capture the Drug Court participants who chose to only complete the relationship assessment and were non-treatment plan clients since they only see a therapist for one visit. Changes were made in the Family Service FY20 Counseling application to better reflect and evaluate the activity of this specific client group.

Utilization Data Narrative –

The utilization data chart is to be completed at the end of each quarter (including quarter 4) using the online reporting system.

Comparative yearly totals (i.e. reporting estimates and actual numbers) and the narrative section described below are to be completed at end of year only.

Here, you will report on the different types of service categories specified in your program plan application. Please remember that programs **do not** need to collect and report on every category- instead, you are to report only the ones that are most useful for understanding program impact.

1. Please copy and paste the definitions of service categories your program specified in your program plan application in the sections below**. You will report the actual numbers of clients/contacts/community events for each reported service category in the Part II Utilization/Production data form (located on the online system).** If your estimated number of clients/contacts/community events for reported service categories significantly differ from your actual numbers, you may give a narrative explanation for that discrepancy here.

Treatment Plan Clients (TPC):

Clients counted in this category are unduplicated cases with a case record and a developed treatment plan. Their case record will include an intake, a fee agreement, a mental health assessment/social history, a treatment plan and case notes.

In FY 19, our target was to serve 55 treatment plan clients.
We had 21 treatment plan clients in FY 19.

Non-treatment Plan Clients (NTPC):

Clients counted in this category are unduplicated cases with a case record but no developed treatment plan. This includes clients who receive only a mental health assessment, such as for Probation. This also includes clients who come for only a couple of sessions and discontinue therapy before a treatment plan is completed. Their case record will include an intake, a fee agreement, a mental health assessment and case notes.

In FY 19, our target was to serve 5 non-treatment plan clients.
We had 39 non-treatment plan clients in FY19. Of those 39 NTPC, five received a mental health assessment for the Probation Department and 19 received a Drug Court relationship assessment.

Community Service Events (CSE): **N/A**
Service Contacts (SC): **N/A**
For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

Family Service of Champaign County
Self Help Center
Performance Outcome Report PY19

Agency name: Family Service of Champaign County
Program name: Self-Help Center
Submission date: August 30, 2019

Consumer Access – *complete at end of year only*

Eligibility for service/program

1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application)

Those seeking the services of the Self-Help Center are not required to meet any eligibility criteria. The demographics for persons contacting the Self-Help Center are not available because information provided is confidential and anonymous. A log is kept to record the date of all phone calls and responses given. Consumers are also able to access information and services online through the Family Service webpage. All services are free except for a small registration fee to attend the biennial conference or the workshops.

2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)?

Since there are no eligibility criteria there is no determination of eligibility.

3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.)

Individuals learn about the Self-Help Center and its resources from extensive outreach efforts made by the coordinator and the program director. The Self-Help Center Coordinator is an active participant with several area coalitions and partnerships such as the Alliance for the Promotion of Acceptance, Inclusion and Respect, the Birth to Six Council and the Disability Expo Steering Committee. This involvement and leadership with creating, planning and participating in events assists the Self-Help Center to ensure that information relevant to the needs of diverse populations is delivered to those who can most benefit. A Support Group Directory is published every other year and is distributed to professionals, group leaders and members on an ongoing basis. The 16th Edition was distributed this year and the 17th edition was published at the end of the fiscal year, with distribution beginning in FY20. It contains information about more than 200 local and regional self-help and support groups. The online edition of the support group directory is continually updated as information about groups frequently changes. A quarterly newsletter is published for group leaders, support group members and community professionals. The Self-Help Center posts information on bulletin boards in numerous human service agency lobbies, public libraries and counseling offices. The Self-Help Center phone number is published in the Sunday News-Gazette Community calendar and

the SHC mailing list includes the rural libraries and churches for distribution of the directory and other meeting notices.

4. a) *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application):

The Self-Help Center provides assistance to all individuals seeking its services. We did not estimate a percentage in our application.

b) *Actual* percentage of individuals who sought assistance or were referred who received services:
N/A

5. a) *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application):

The speed of consumer access is generally within 24 hours if a call or email occurs during business hours (in most instances response is sooner than 24 hours). Internet access is immediate. A log is kept to record the date of all phone calls and responses given.

b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application):
N/A: The Self-Help Center does not have any eligibility criteria.

c) *Actual* percentage of referred clients assessed for eligibility within that time frame:
N/A

6. a) *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application):

The Self-Help Center serves as an information clearinghouse. It links individuals to resources. There is no assessment for eligibility or time frame for engagement of services. We do gather information from those individuals who participate in the workshops or conferences as to what topics are relevant for group leaders.

b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application): **N/A**

c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame: **N/A**

7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application):

When someone consults the Self-Help Center for assistance, the length of engagement varies depending on individual need. A person seeking to start a new group may require more technical assistance and support compared to an experienced group leader who is having issues of maintaining membership. The coordinator may spend a few minutes with an individual or could have several meetings that last an hour or more.

b) *Actual* average length of participant engagement in services: **N/A**

Demographic Information

1. *In your application* what, if any, demographic information did you indicate you would collect beyond those required (i.e. beyond race/ethnicity, age, gender, zip code)? (Demographic Information, question #1 in the Program Plan application)

Due to confidentiality and anonymity issues, limited information is collected on the information and referral calls except for the topic and if the person is a professional or a lay person. Data is collected from the conference registration form as it applies to gender, lay or professional registrant and zip code. This information lets us know how successful our outreach efforts are for participant needs.

2. Please report here on all of the extra demographic information your program collected. **N/A**

Consumer Outcomes – *complete at end of year only*

During the application process, you identified participant outcomes that your program activities would impact. Here, report the actual participant outcomes achieved as a result of your program activities

1. *From your application,* what impact on consumers did you expect your program activities to have? That is, what outcome(s) did you want your program to have on the people it is serving? (Consumer Outcomes, question #1 in the Program Plan application). Please number each outcome.

For FY19

Outcome 1: Through the Self-Help Center, individuals and families will be made aware of the existence of self-help groups and will be provided information and/or referral to a group(s) appropriate to address their needs (when one is available).

****Participation in public awareness activities, which include informational fairs, conferences, public education presentations, media events, and publications.**

****Continual update of the on-line version of the Support Group Directory, the Specialized Lists and the website.**

****Publication of the Self-Help Center phone number in the Sunday News-Gazette**

Community Calendar.
****The rural libraries and churches in Champaign County will receive hard copies of the directory and other meeting notices.**

Outcome 2: Through the Self-Help Center, individuals wanting to start a group and group leaders experiencing difficulties will be able to effectively start and lead groups and group visibility will increase.
****Consultation services will be available to individuals wanting to start a group or to group leaders experiencing difficulties.**
****Training opportunities will be provided through the biennial Self-Help Conference and the workshops.**

Outcome 3: Through the Self-Help Center, professionals will be able to locate self-help groups to which they can refer their clients and will know how to work effectively with groups.
****Distribution of the printed Support Group Directories, Specialized Lists, quarterly newsletter and website information to group leaders and professionals.**

2. For each outcome, please indicate the specific survey or assessment tool you used to collect information on this outcome in the chart below. (Please remember that the tool used should be evidence-based or empirically validated.)

Additionally, in the chart below, please indicate who provided this information (e.g. participant, participant's guardian(s), clinician/service provider, other program staff (if other program staff, indicate their role).) Please report all sources of information that apply for each assessment tool (e.g. the XYZ survey may be completed by both a youth client and their caregiver(s).

Outcome:	Assessment Tool Used:	Information Source:
E.g. 1. Increased empowerment in advocacy clients	Measure of Victim Empowerment Related to Safety (MOVERS) survey	Client
1. Increased awareness of the existence of self-help groups and provision of information and/or referral to a group(s) appropriate to	**Participation in public awareness activities; continual update of the on-line version of the Support Group Directory, the Specialized Lists and the website; publication of the Self-help Center phone number in the Sunday News-Gazette Community Calendar;**	**Self-Help Center Coordinator**

address their needs (when one is available).	and rural libraries and churches provided with a hard copy of the directory and other meeting notices.	
2. Increased ability for individuals wanting to start a group and group leaders experiencing difficulties to find and receive training to be able to effectively start and lead groups for their group visibility to improve.	Consultation services available; training opportunities provided through the biennial Self-Help Conference Support Group Needs survey	Self-Help Center Coordinator; Self-Help Center Advisory Council members
3. Through the Self-Help Center, professionals will be able to locate self-help groups to which they can refer their clients and will know how to work effectively with groups.	Distribution of the printed Support Group Directory, Specialized Lists, quarterly newsletter and website information to group leaders and professionals; Post-event evaluation of conference from attendees.	Self-Help Center Coordinator; Attendees at conference

3. Was outcome information gathered from every participant who received service, or only some?

Not all attendees at the biennial conference chose to complete the evaluation surveys.

4. If only some participants, how did you choose who to collect outcome information from? **The attendees chose to complete the surveys. We did not choose.**

5. How many total participants did your program have?

In FY2019, there were 33 consultations, 337 information and referral calls, 10,342 website views, 1748 emails, 102 printed directories distributed, 7 health and/or information fairs that the SHC staff participated at, 4 presentations given by SHC staff, 4 newsletters distributed to the SHC mailing list, and the biennial Self-Help Center conference with 34 attendees (with 4.5 CE credits available). The SHC staff served as members on several different service organizations or committees including the Human Services Council and the DisAbility Expo committee. The SHC maintained information on approximately 210 support groups available to Champaign County residents. The 16th edition of the hard copy of the Support Group Directory was updated in January. The 17th edition of the hard copy of the Support Group Directory was updated and submitted to the printer in June 2019.

6. How many people did you *attempt* to collect outcome information from?

- **34 participants who attended the biennial conference (conference evaluation form)**
- **200 support group leaders (Support Group Needs survey)**

7. How many people did you *actually* collect outcome information from?

- **28 participants from the biennial conference but not all responded to every survey question (Conference evaluation form)**
- **24 support group leaders (Support Group Needs survey)**

8. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc.) **Conference evaluation data was collected from the Spring 2019 biennial Self-Help Center conference attendees. Support group data was collected in a survey conducted by the Self-Help Center in August/September 2018.**

Results

9. What did you learn about your participants and/or program from this outcome information? Please be specific when discussing any change or outcome, and give appropriate quantitative or descriptive information when possible. For example, you could report the following:

i. Means (and Standard Deviations if possible)
ii. Change Over Time (if assessments occurred at multiple points)
iii. Comparison of strategies (e.g., comparing different strategies related to recruitment; comparing rates of retention for clients of different ethnoracial groups; comparing characteristics of all clients engaged versus clients retained)

The low return rate of the Support Group Needs survey was a disappointment but some valuable information was obtained. Respondents were asked to describe the demographics of their groups, services offered within their groups, and challenges faced. In addition, facilitators were asked to rate current SHC services and suggest additional services that the SHC could provide that would be helpful.
Here are some of the results obtained from the 24 respondents:

a) Twenty-one of the respondents were group leaders/facilitators.

b) Ten of the respondents had been group leaders for more than 5 years.

c) The topics most commonly addressed within their groups (with rates of 50% or higher) were those addressing health and parenting issues. Following closely were issues related to mental health and caregiving.

d) The majority of the reporting groups had an average attendance of up to ten or more members per meeting, closely followed by meetings with an average attendance of up to 20 members per meeting.

e) The majority of reporting facilitators had a wide age range within their group from young adult to mature adult (67%).

f) Group membership was comprised mostly of Caucasians (83%) and African-Americans (79%), followed by Latino/a (54%) members.

g) Of the reporting group facilitators, the most frequently provided services besides the face to face meetings were on-line communication (46%) and phone support (42%).

h) The top five ways in which people found out about a group according to the reporting facilitators were: 1) by a family/friend 2) by a group member, both tied at 79%, 3) by a professional referral(75%), 4) information gleaned from the internet (50%) and 5) from a bulletin board flyer (46%).

i) Of the reporting facilitators, the majority of their groups utilized professionals in capacities such as facilitators (63%) and as guest speakers (50%). In addition, some groups utilized professionals in an advisor/planner capacity (38%).

j) As identified by the reporting facilitators, the top five issues presenting challenges to the group as a whole and affecting the group's ability to function smoothly were:
Attracting new members: 16 or 67%
Retaining members: 11 or 46%
Difficulty arranging transportation to the meeting for members: 10 or 42%

Getting members involved in sharing the work of the group: 8 or 33%
Having disorganized or uninteresting meetings: 5 or 21%

k) Of the reporting facilitators, English was primarily spoken in 21 or 88% of groups and Spanish primarily spoken in 2 or 8% of the groups.

l) One of the lessons learned from this process for future surveys is to use an on-line tool, such as Survey Monkey, to increase facilitator participation/survey response. This survey will be repeated in FY20.

The title of the 2019 biennial conference was "Collaboration in Times of Need" with Karen Simms providing the keynote address. Ann Vermilion was the closing speaker and presented on one community's effective collaborative response to the opioid epidemic. Three additional presenters had breakout sessions: Rev. Dr. Sheryl Palmer – breakout session on effective community collaboration with the faith communities;
Joel Sanders from the Urbana Police Department – breakout session on effective community collaboration within crisis services; and Shandra Summerville, CCMHB – breakout session on culturally informed and sensitive approaches to community collaboration.

a) 96% of the participants who submitted an evaluation found the conference subject level to be just right (not too elementary or too advanced).

b) 96% of the participants who submitted an evaluation found the keynote address effective.

c) 96% of the participants who submitted an evaluation found the closing presentation of the conference effective.

10. Is there some comparative target or benchmark level for program services? Y/N
Yes, for our workshops and conference.

11. If yes, what is that benchmark/target and where does it come from?

We set a benchmark in 2005 to obtain a good or excellent rating from all attendees of the workshops or conference regarding acquisition of skills, knowledge, satisfaction, networking opportunities and implementation of information presented by the speaker(s). This means we need to achieve 100% to meet that benchmark.

12. If yes, how did your outcome data compare to the comparative target or benchmark?
From the biennial conference, we obtained the following results from the 28 respondents:

- **100% of the participants rated the conference as excellent or good.**
- **100% of the attendees liked the venue of Round Barn Centre.**

(Optional) Narrative Example(s):

13. Describe a typical service delivery case to illustrate the work (this may be a "composite case" that combines information from multiple actual cases) (Your response is optional)

14. In what ways was the evaluation used to support changes in practice? What changes were made based on evaluation findings? (Your response is optional)

Utilization Data Narrative –

The utilization data chart is to be completed at the end of each quarter (including quarter 4) using the online reporting system.

Comparative yearly totals (i.e. reporting estimates and actual numbers) and the narrative section described below are to be completed at end of year only.

Here, you will report on the different types of service categories specified in your program plan application. Please remember that programs **do not** need to collect and report on every category- instead, you are to report only the ones that are most useful for understanding program impact.

1. Please copy and paste the definitions of service categories your program specified in your program plan application in the sections below**. You will report the actual numbers of clients/contacts/community events for each reported service category in the Part II Utilization/Production data form (located on the online system).** If your estimated number of clients/contacts/community events for reported service categories significantly differ from your actual numbers, you may give a narrative explanation for that discrepancy here.

Treatment Plan Clients (TPC): **N/A**

Non-treatment Plan Clients (NTPC): **N/A**

Community Service Events (CSE): Community Service Events (CSE): Number of contacts (meetings) to promote the program, including public presentations (including mass media shows and articles), consultations with community groups and/or caregivers, school class presentations, and small group workshops. DO NOT count things like individual participants who attended an event, or number of pamphlets passed out, as a count of CSEsThe focus of a CSE is on activities that promote the program or educate a targeted audience about the program. Units of measurement are the following:

- Public presentations – Each presentation is 1 CSE
- School class presentations- Each class presentation is 1 CSE
- Small group workshop sessions to promote healthy lifestyles- Each workshop is 1 CSE
- Meetings between agencies to plan community service events
- Interviews with reporters or the articles, programs or shows that result (do not count number of people, stations, or newspapers to which items are distributed)- Each unique interview or article, program, show that results is 1 CSE.

Distribution of public service announcements, newsletters, and pamphlets: Each distribution event is 1 CSE, or each unique PSA is 1 CSE. Note that attending or participating in a regularly scheduled meeting where you do not give a presentation on your program or participate in planning an event related to the program is not a CSE.

- A total target number of Community Service Events might be comprised of the number of parent education meetings to be held, the number of community/public meetings planned, and the number of planning meetings to organize an event. Or you may only be counting the parent meetings under your program, so you reference the total number of parent meetings to be held and reported as CSEs.

  301 Community Service Events were completed by the Self-Help Center in FY2019. We exceeded our goal of 280 CSEs as a result of meeting the needs of many people searching for groups and making active use of the webpage for seeking information. Conference attendees provided great ideas for the workshops that will be held in the fall and spring 2020.

Service Contacts (SC): **N/A**

For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

Family Service of Champaign County
Senior Counseling & Advocacy
Performance Outcome Report PY19

Agency name: Family Service of Champaign County
Program name: Senior Counseling & Advocacy (2019)
Submission date: 08/28/19

Consumer Access – *complete at end of year only*

Eligibility for service/program

1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application)

Senior Counseling and Advocacy (C&A) services are available to any Champaign County resident age 60 or older living in a domestic setting. Many services are available to adults with disabilities. Services are also available to family or friends providing direct care to seniors in their homes. All clients must have one or more of the needs addressed by the program: anxiety, depression, isolation, grief, or other mental health issues; family concerns; neglect, abuse, or exploitation; and/or the need to access financial or material services or benefits. There are no fees charged for the services so that income does not become a barrier to receive services.

2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)?

Eligibility is determined by interview (address, birth date, statement of presenting need) at the time service is requested. Assessment for particular benefits or programs may be supplemented by standardized assessment as needed.

3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.)

Staff do concerted outreach in the rural areas of the county and in residential areas of the county that have a large concentration of lower income seniors. They also participate in community events that allow us to highlight our services and to provide on-the-spot information and referral. In FY 19, Staff participated in 39 community events. Family Service also has a web page which describes our services with contact information for each and a Facebook page to highlight service events.

4. a) *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application):

All people eligible for services receive services.

b) *Actual* percentage of individuals who sought assistance or were referred who received services:

100%: All Treatment Plan Clients who sought assistance received services. Some Non-Treatment Plan Clients were waitlisted but all received services.

5. a) *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application):

All potential clients will be assessed for eligibility during the initial call or contact. No one is put on the waiting list who does not qualify for service. Those who are not eligible (out of county, not a senior or an adult with a disability) can still receive referral to other possible service agencies that may be able to help them.

b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application):

All potential clients will be assessed for eligibility during the initial call or contact.

c) *Actual* percentage of referred clients assessed for eligibility within that time frame:

100%: All potential clients were assessed for eligibility during initial contact.

6. a) *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application):

New treatment plan clients are generally opened within a week with assessments completed within 2-3 weeks.

b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application):

60 percent of clients will receive service in 15 working days or less and 20 percent will receive service in 5 working days or less

c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame:

Due to an unanticipated reduction in staff, 38% of clients received services in 15 working days. Seven percent received service in 5 working days or less.

7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application):

Non-treatment plan clients are those receiving and completing service within 2-3 contacts in 2-3 months. Treatment plan and Other (caregiver clients) can remain active clients for several years if necessary.

b) *Actual* average length of participant engagement in services:

Non-Treatment Plan Clients engaged in services for an average of 29 days.
Treatment Plan Clients engaged in service an average of 85 days for Adult Protective Services (APS) participants and an average of 2.6 years for counseling clients.

Demographic Information

1. *In your application* what, if any, demographic information did you indicate you would collect beyond those required (i.e. beyond race/ethnicity, age, gender, zip code)? (Demographic Information, question #1 in the Program Plan application)

Percentage of clients served who are low income, rural, and minority compared to census data for Champaign County seniors.

2. Please report here on all of the extra demographic information your program collected.
7.67% of our clients are rural compared to East Central Illinois Area Agency on Aging (ECIAAA) estimates of 16% rural seniors (60 years old or older) in Champaign County.
27.2% are minorities compared to the ECIAAA estimates of 12.59% senior minorities in Champaign County.
53.7% are Low Income compared to the ECIAAA estimates of 11.84% low income seniors in Champaign County.

Consumer Outcomes – *complete at end of year only*

During the application process, you identified participant outcomes that your program activities would impact. Here, report the actual participant outcomes achieved as a result of your program activities

1. *From your application,* what impact on consumers did you expect your program activities to have? That is, what outcome(s) did you want your program to have on the

people it is serving? (Consumer Outcomes, question #1 in the Program Plan application). Please number each outcome.

Outcome 1: People will be referred to needed services for anxiety, depression, and/or social isolation.

Outcome 2: People will have reduced anxiety, depression, and social isolation scores.

Outcome 3: Seniors and adults with disabilities receiving protective services will have reduced risk scores.

Outcome 4: The clients served by the program will reflect the demographics of senior residents in Champaign County.

Outcome 5: People will have information about benefits and services available.

2. For each outcome, please indicate the specific survey or assessment tool you used to collect information on this outcome in the chart below. (Please remember that the tool used should be evidence-based or empirically validated.)

Outcome 1: People will be referred to needed services for anxiety, depression, and/or social isolation.
*Geriatric Anxiety Scale, Geriatric Depression Scale, Geriatric Perceived Social Isolation Scale, PEARLS PHQ-9, and IADL's.

Outcome 2: People will have reduced anxiety, depression, and social isolation scores.
*Geriatric Anxiety Scale, Geriatric Depression Scale, Geriatric Perceived Social Isolation Scale, PEARLS PHQ-9, and IADL's.

Outcome 3: Seniors and adults with disabilities receiving protective services will have reduced risk scores.
*State of Illinois risk assessment tool.

Outcome 4: The clients served by the program will reflect the demographics of senior residents in Champaign County.
*Census data and zip codes of clients.
*Percentage of clients served who are low income, rural, and minority compared to census data for Champaign County seniors.

Outcome 5: People will have information about benefits and services available.
*Information and referral logs, client satisfaction surveys, and number of PR events.

Additionally, in the chart below, please indicate who provided this information (e.g. participant, participant's guardian(s), clinician/service provider, other program staff (if other program staff, indicate their role).) Please report all sources of information that apply for each assessment tool (e.g. the XYZ survey may be completed by both a youth client and their caregiver(s).

Outcome:	Assessment Tool Used:	Information Source:
People will be referred to needed services for anxiety, depression, and/or social isolation.	*Geriatric Anxiety Scale, Geriatric Depression Scale, Geriatric Perceived Social Isolation Scale, PEARLS PHQ-9 and IADL's.	Client
People will have reduced anxiety, depression, and social isolation scores.	*Geriatric Anxiety Scale, Geriatric Depression Scale, Geriatric Perceived Social Isolation Scale, PEARLS PHQ-9 and IADL's.	Client
Seniors and adults with disabilities receiving protective services will have reduced risk scores.	*State risk assessment tool.	Client
The clients served by the program will reflect the demographics of senior residents in Champaign County.	*Census data and zip codes of clients.	Client
People will have information about benefits and services available.	*Information and referral logs, client satisfaction surveys. Number of PR events	Client

3. Was outcome information gathered from every participant who received service, or only some?

Outcome information was gathered for all Treatment Plan clients; demographics information was gathered for Non-Treatment Plan clients.

4. If only some participants, how did you choose who to collect outcome information from?

Due to the brevity of the interaction with non-treatment plan clients, there is little opportunity to measure accurate change over time. Treatment Plan Clients have long enough casework involvement to accurately measure change.

5. How many total participants did your program have?

Our program has 392 Non-Treatment Plan Clients and 334 Treatment Plan Clients.

6. How many people did you *attempt* to collect outcome information from?

We attempted to collect information from all Treatment Plan Clients. We also attempted to collect demographic information for all non-treatment plan clients.

7. How many people did you *actually* collect outcome information from?

Risk Assessment information was collected from all Protective Service clients.
At least initial Anxiety, Depression, and Isolation scales were collected from 35% of the non-APS Clients.
Demographics information was gathered from all clients.

8. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc.)

Risk assessment scores are collected at intake, at 30 days, at 90 days, and every 90 days after that for 15 months or until closure.
Depression, anxiety, and social isolation scales are to be completed every 6 months.
Demographic information is gathered once at intake.

Results

9. What did you learn about your participants and/or program from this outcome information? Please be specific when discussing any change or outcome, and give appropriate quantitative or descriptive information when possible. For example, you could report the following:

i. Means (and Standard Deviations if possible)
ii. Change Over Time (if assessments occurred at multiple points)
iii. Comparison of strategies (e.g., comparing different strategies related to recruitment; comparing rates of retention for clients of different ethnoracial groups; comparing characteristics of all clients engaged versus clients retained)

Looking at Change over Time of PHQ-9 PEARLS assessments, we began our sessions of PEARLS (an evidence-based depression management program) with an average baseline score of 14.8, indicating moderate depression. At the end of our sessions we had an average score of 8, indicating mild depression. This change is due to the intervention our caseworker provided, as there is a 4% probability this reduction is due to chance. (two-tailed t=.0309). All of our participants saw some positive change.

On a similar note, we had a significant reduction in Geriatric Social Isolation Scores, falling from an average of 15.5 to 8.3, with there being a 2% probability this is due to chance.

There is not enough data to measure statistically valid changes in Geriatric Anxiety, but there is a practical change from an average score of 5.6 to 3.9 on the Geriatric Anxiety Scale.

In terms of Geriatric Depression for clients not in the PEARLS Program, there was no significant reduction in GDS scores but there were practical reductions of and average of 1 point per client.

These significant changes demonstrate the need for our services in the community, particularly in reducing the social isolation and depression of seniors.

10. Is there some comparative target or benchmark level for program services? Y/N

No

11. If yes, what is that benchmark/target and where does it come from?

N/A

12. If yes, how did your outcome data compare to the comparative target or benchmark?
N/A

(Optional) Narrative Example(s):

13. Describe a typical service delivery case to illustrate the work (this may be a "composite case" that combines information from multiple actual cases) (Your response is optional)

Mrs. A is a legally blind client who was referred for services by her family. At intake, we asked her what her perceived needs were and completed assessments of other needs she may not have considered. We conducted the Geriatric Depression, Anxiety, and Social Isolation Scales, to determine what barriers and strengths she had in her life. After assessment it was clear that Mrs. A was socially isolated. Due to the continued contact with the caseworker, Mrs. A was empowered to start forming relationships with several different neighbors. At this point in time, Mrs. A goes on day outings with them and meets with them on her patio during the week.

14. In what ways was the evaluation used to support changes in practice? What changes were made based on evaluation findings? (Your response is optional)

We have begun to focus more on evidence-based programs in our every day practice. This change was made due to the evaluation that PEARLS was successful at significantly reducing depression scores in our clients. We have also begun to gather significant data to determine the efficacy of our programs through statistical analysis. We have shown the caseworkers the value of the assessments and subsequent referrals to their clients, encouraging and validating their

efforts; their success is getting clients to agree to the assessments has gone up as they, themselves can relate the value of the assessment process to the clients.

Utilization Data Narrative –

The utilization data chart is to be completed at the end of each quarter (including quarter 4) using the online reporting system.

Comparative yearly totals (i.e. reporting estimates and actual numbers) and the narrative section described below are to be completed at end of year only.

Here, you will report on the different types of service categories specified in your program plan application. Please remember that programs **do not** need to collect and report on every category- instead, you are to report only the ones that are most useful for understanding program impact.

1. Please copy and paste the definitions of service categories your program specified in your program plan application in the sections below**. You will report the actual numbers of clients/contacts/community events for each reported service category in the Part II Utilization/Production data form (located on the online system).** If your estimated number of clients/contacts/community events for reported service categories significantly differ from your actual numbers, you may give a narrative explanation for that discrepancy here.

Treatment Plan Clients (TPC):

Clients counted in this category are those who require help with long term and/or complex needs including mental health issues. Their case records include a comprehensive assessment and other assessments for depression, anxiety, social isolation, cognitive functioning and/or unmet needs. Each client has a treatment plan addressing assessed needs. These clients need extensive contact and can be open from several months to several years.

Non-treatment Plan Clients (NTPC):

Clients counted in this category are those who require interventions to address needs that can be resolved in no more than two or three months, typically in 2-3 contacts. Their case records include a comprehensive assessment, but no formal treatment plan is developed.

There is a major difference between our projected numbers and our actual numbers in non-treatment plan clients. This is due to the loss of a major grant and corresponding loss of staff hours resulting in less Information and Referral and short-term casework services for seniors in Champaign County. Most, if not all, interactions with seniors under the lost grant qualify as Non-Treatment Plan Clients. As the community adjusts to the new level of service provision, we expect our Non-Treatment Plant client numbers to increase.

Community Service Events (CSE):

N/A
Service Contacts (SC): Activities counted in this category include information, referral and assistance provided by telephone or computer to seniors, those with disabilities, their families, service providers and the community regarding resources and services that are pertinent to aging. We did not meet our projected number. See above in Non-Treatment Plan clients for explanation.
For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

First Followers
Peer Mentoring for Re-entry
Performance Outcome Report PY19

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Agency name: FirstFollowers
Program name: Peer Mentoring
Submission date: August 29, 2019

Consumer Access – *complete at end of year only*
Eligibility for service/program
1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application) All those with criminal justice system involvement in need of services.
2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)? Intake form answers and personal interview
3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.) Word of mouth, outreach events, referrals.
4. a) *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application): 80%
b) *Actual* percentage of individuals who sought assistance or were referred who received services: 80% **5. a)** *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application): A few minutes to a day
b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application): 100%

c) *Actual* percentage of referred clients assessed for eligibility within that time frame: 100%
6. a) *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application): A few minutes to a day, depending on what services were needed
b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application): 100%
c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame: 100%
7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application): Very difficult to determine an average. About 50% come to drop-in center once, receive services and leave. About 20% will return once or twice to follow up. About 30% will develop a longer-term participation in our programs (e.g. Workforce Development which is 19 weeks) or become peer mentors.
b) *Actual* average length of participant engagement in services: Can't determine
Demographic Information
1. *In your application* what, if any, demographic information did you indicate you would collect beyond those required (i.e. beyond race/ethnicity, age, gender, zip code)? (Demographic Information, question #1 in the Program Plan application) None
2. Please report here on all of the extra demographic information your program collected. None

Consumer Outcomes – *complete at end of year only*

During the application process, you identified participant outcomes that your program activities would impact. Here, report the actual participant outcomes achieved as a result of your program activities

1. *From your application,* what impact on consumers did you expect your program activities to have? That is, what outcome(s) did you want your program to have on the people it is serving? (Consumer Outcomes, question #1 in the Program Plan application). Please number each outcome.

1. Anti-Stigma-This outcome was more qualitative than quantitative. Through our public education of employers and services agencies we secured a working contract with the City of Champaign to provide paid training to their Fresh Start participants and built a partnership with the Housing Authority of Champaign County to provide a transitional house for people coming home from prison. Both the City and the Housing Authority are providing job opportunities for our Workforce Development participants. In addition, we have one participant who obtained his Commercial Driver's License through our program and he now is driving full-time; another who has begun a law care business

2. Workforce Development: 10 of 12 original participants completed the course. Every one of them increased their TABE scores as measured before and after.

Five completed the Fork Lift Driver's certificate at Parkland College. One of them has been employed full-time.

2. For each outcome, please indicate the specific survey or assessment tool you used to collect information on this outcome in the chart below. (Please remember that the tool used should be evidence-based or empirically validated.)

Additionally, in the chart below, please indicate who provided this information (e.g. participant, participant's guardian(s), clinician/service provider, other program staff (if other program staff, indicate their role).) Please report all sources of information that apply for each assessment tool (e.g. the XYZ survey may be completed by both a youth client and their caregiver(s).

Outcome:	Assessment Tool Used:	Information Source:
1. Improved academic skills	TABE test	WIOA
2. Expanded employer contact list	Numbers in our data base	Our interview results

3. Improved work skills	Certificates obtained;	Parkland College
4. Improved work skills (2)	Evaluation of construction production	Internal assessment of construction skills and outcomes

3. Was outcome information gathered from every participant who received service, or only some? Only some.

4. If only some participants, how did you choose who to collect outcome information from? We collected information from all those who remained in the Workforce Development Program.

5. How many total participants did your program have? 28

6. How many people did you *attempt* to collect outcome information from? 10

7. How many people did you *actually* collect outcome information from? 10

8. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc) Once per month through focus group discussions

Results

9. What did you learn about your participants and/or program from this outcome information? Please be specific when discussing any change or outcome, and give appropriate quantitative or descriptive information when possible. For example, you could report the following:

i. Means (and Standard Deviations if possible)
ii. Change Over Time (if assessments occurred at multiple points)
iii. Comparison of strategies (e.g., comparing different strategies related to recruitment; comparing rates of retention for clients of different ethnoracial groups; comparing characteristics of all clients engaged versus clients retained)

i. We do not use statistical analysis of this sort.

ii. We were able to assess academic progress through TABE testing at the beginning and end of the Workforce Development course; on the building site we could assess change by the quantity, type and quality of work course participants were able to produce. (e.g. 8 out of 10 could hang dry wall by the end of the course-only 2 could do it at beginning; similar numbers with painting patching; none of them did any gardening work at the beginning but by the end all were looking after a part of the garden they themselves had planted)

iii. This course we began every session with a check-in exercise which was targeted at a specific outcome or emotion. We ensured that everyone participated in this "circle." Examples of prompts were: what is your goal in life? Who is the most important person in your life and why? Who is your idol or role model? These check-in broke the ice and built participants' capacity to express feelings and opinions in a safe space. This connection increased the enthusiasm for the course and improved attendance and punctuality a great deal over the first course. A second innovation was that se kept detailed records of every class session, highlighting the exercises, activities and content that resonated the best with the participants. This was an advance over our previous course where note-taking was sporadic only done by some facilitators. This time we had someone who took notes every minute of every class. They did not facilitate. We will use these notes, along with the records from the previous GoMAD course to plan our future curriculum.

Another innovation which we learned from our last course was the use of near peers in our classes, people who were slightly older than the target cohort but younger than the peer mentors of FirstFollowers. We found this strategy was very useful in communicating with the participants as well as learning how the participants were responding to our efforts. In planning our next course we will review all these notes, interview the near peers and adjust our learning content and process accordingly.

Finally we shared out experience with other organizations in different parts of the country who do similar work. We connected with people in our Chicago visit but also built ties with other organizations by attending national conferences organized for formerly incarcerated people.

10. Is there some comparative target or benchmark level for program services? Y/N

N

11. If yes, what is that benchmark/target and where does it come from?

12. If yes, how did your outcome data compare to the comparative target or benchmark?

(Optional) Narrative Example(s):

13. Describe a typical service delivery case to illustrate the work (this may be a "composite case" that combines information from multiple actual cases) (Your response is optional)

A composite: A Black man of twenty years joins our Workforce Development course. He has not completed high school, has a short arrest record, no job skills and no clear career goals. When asked if he could be an expert on anything in the world, what would it be, he answers "marijuana." By week five he is totally engaged with all the content of the course. He arrives on time every day, participates actively in all class sessions. During one of our check-in sessions, he tells us that his best friend was shot dead two year earlier, that he has avoided talking about this all this time but now he feels free in

this group to reveal that story and how he felt about it. He says it was a big trauma that he still has not dealt with. At the end of the class he says he liked everything about it, that he always thought he was "stupid" because his teachers never paid any attention to him and taught him things that weren't interesting. He says that our course is different, that we listen to what the participants say that we respect them. He says he wished school was like that. By the end of the class he is thinking of enrolling at Parkland.

Second case: A Black man of 40 comes to the drop-in center. His sister told him about it. He has been out of prison for two years and has just quit his job at Plastipak and is looking for something else. We ask him what he wants to do. He replies by saying he hopes to get a job in a restaurant as a cook. We ask him again what he wants to do. He again speaks about cooking. When we press him a third time, he says what he really wants to do is learn car mechanics. We give him an aptitude test and he scores very high in mechanical areas. We help him investigate car mechanic courses at Parkland. We drive him to Parkland to meet with the director of the car mechanic program. Our client leaves very inspired. The deadline for applications is ten days away. We tell him to come back the following week and we will help him fill out the online application and support him with the fees. We don't see him for five weeks. Our phone calls tell us his line is not working. We drive by his address but the people there don't know him. Finally he comes back and tells us since he left us the last time, his mother died from cancer and he was diagnosed with degenerative disc disease. He wants us to help him apply for SSI. We begin the process with him, then he disappears for a couple weeks. We are not sure if he will come back. His phone is dead. This is a case that contrasts the first case above which ends on a positive note. Many of our cases do end up that way but a good number also end up unresolved. The lives of our clients are works in progress, often disrupted by forces that are beyond their control. We try to help them deal with those forces. Many times we succeed. Many times when we do succeed we never find out. Life moves on for our clients and maybe they remember us with a post on our Facebook page or a Xmas card. Reentry is indeed a challenging world and not everyone has a passion for it but we at FirstFollower do-one hundred per cent

14. In what ways was the evaluation used to support changes in practice? What changes were made based on evaluation findings? (Your response is optional)
Answered in 9. above

Utilization Data Narrative –

The utilization data chart is to be completed at the end of each quarter (including quarter 4) using the online reporting system.

Comparative yearly totals (i.e. reporting estimates and actual numbers) and the narrative section described below are to be completed at end of year only.

Here, you will report on the different types of service categories specified in your program plan application. Please remember that programs **do not** need to collect and report on every category- instead, you are to report only the ones that are most useful for understanding program impact.

1. Please copy and paste the definitions of service categories your program specified in your program plan application in the sections below**. You will report the actual numbers of clients/contacts/community events for each reported service category in the Part II Utilization/Production data form (located on the online system).** If your estimated number of clients/contacts/community events for reported service categories significantly differ from your actual numbers, you may give a narrative explanation for that discrepancy here.

   "Individuals who participate in our drop-in center are classified as NTPCs. Those clients who participate in FirstFollowers activities and/or become peer mentors along with those who participate in Workforce Development and Family Support Group will be classified as TPCs. We will continue to build our employer network with employer contacts being classified as SCs. We will participate in public events to present our work and network with other agencies. These will include Job Fairs, the Expungement Summit, and other reentry related activities. These will be classified as CSEs."

Treatment Plan Clients (TPC):
Target: 30
Actual: 18

Non-treatment Plan Clients (NTPC):
Target:200
Actual: 86

Community Service Events (CSE):
Target: 6
Actual: 12

Service Contacts (SC):
Estimated:35
Actual: 30

For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

GROW in Illinois
Peer-Support
Performance Outcome Report PY19

Agency name: GROW In Illinois
Program name: Growth to Maturity
Submission date: August 30, 2019

Consumer Access – *complete at end of year only*

Eligibility for service/program

1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application)

We serve anyone 18 years or older, while participation by anyone under 18 years old would need a parent's approval. There is no other criteria needed to attend GROW's Program of Growth to Maturity

2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)?

Phone call and discussion with parent for those under 18 years of age.

3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.) From the recent survey taken July 2019, we found that 4.5% of participants heard about GROW through orientations, 43.5% through family and friends, 13% through professional referral, and 39% through other means (Satellite Jail, did not remember or did not provide a response).

4. a) *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application):

In the application for this year, we did not estimate the percentage of people seeking assistance who received services.

b) *Actual* percentage of individuals who sought assistance or were referred who received services: 100%

5. a) *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application):

In the application for this year, we did not estimate the length of time from referral/assistance seeking to assessment of eligibility/need.

b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application):

There is no time between referral/assistance seeking (phone call) an assessment of eligibility (no eligibility besides age). In other words, assessment of eligibility occurs immediately following referral/assistance seeking.

c) *Actual* percentage of referred clients assessed for eligibility within that time frame: **100%**

6. a) *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application):

In the application for this year, we did not estimate the length of time from assessment of eligibility to engagement in services.

b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application):

In the application for this year, we did not estimate the percentage of eligible participants engaged in services within a specified time frame.

c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame:

GROW does not currently collect this data; however, we are looking to collect this data in the future.

7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application):
In the last application, we did not estimate an average length of participant engagement.

b) *Actual* average length of participant engagement in services:

At the time of the most recent survey taken July 2019, 16.7% of participants had attended GROW for less than 1 month, 16.7% attended for 1 to 3 months, 8.3% attended between 3-6 months, 8.3% attended between 6 months to 1 year, 8.3% attended between 1-2 years, 16.7% attended between 2-5 years, and 25% attended for 5 years or longer.

Demographic Information

1. *In your application* what, if any, demographic information did you indicate you would collect beyond those required (i.e. beyond race/ethnicity, age, gender, zip code)? (Demographic Information, question #1 in the Program Plan application)

Our survey sample, collected demographic information on religion in addition to race/ethnicity, age, gender, and zip code.

2. Please report here on all of the extra demographic information your program collected.

We found that 8.3% of participants identified as agnostic, 37.5% as spiritual, 45.8% as religious, and 0% identified as atheist.

Consumer Outcomes – *complete at end of year only*

During the application process, you identified participant outcomes that your program activities would impact. Here, report the actual participant outcomes achieved as a result of your program activities

1. *From your application,* what impact on consumers did you expect your program activities to have? That is, what outcome(s) did you want your program to have on the people it is serving? (Consumer Outcomes, question #1 in the Program Plan application). Please number each outcome.

We did not include all of these outcomes in our application. However, we created a theory of change logic model that included the following outcomes of interest:

1. decreased hospitalization frequency
2. decreased medication use
3. increased social resources
4. increased personal growth
5. increased wellbeing
6. number of participants in leadership roles

2. For each outcome, please indicate the specific survey or assessment tool you used to collect information on this outcome in the chart below. (Please remember that the tool used should be evidence-based or empirically validated.)

Additionally, in the chart below, please indicate who provided this information (e.g. participant, participant's guardian(s), clinician/service provider, other program staff (if other program staff, indicate their role).) Please report all sources of information that apply for each assessment tool (e.g. the XYZ survey may be completed by both a youth client and their caregiver(s).

Outcome:	Assessment Tool Used:	Information Source:

1.decreased hospitalization frequency	GROW survey	GROWERs
2.decreased medication use	“”	“”
3.increased social resources	GROW Survey (2-Way Social Support Scale and the NIH Toolbox Emotional Support Survey	“”
4.increased personal growth	internal (using guidelines from GROW book	Fieldworker
5.increased wellbeing	GROW Survey (Personal Wellbeing Index)	GROWERs
6.high number in leadership roles	GROW Survey	GROWERs

3. Was outcome information gathered from every participant who received service, or only some?

Outcomes 1-3 and 5-6 were collected from only those who consented to the GROW survey and were present at a survey collection session. Outcome 4 was collected from everyone.

4. If only some participants, how did you choose who to collect outcome information from?

The GROW survey was administered only to GROWERs who were present at the meeting in which surveys were collected and who gave their consent.

5. How many total participants did your program have?

Our program had 54 participants in FY19. We started with 19 continuing GROWers, and had 35 new comers to groups.

6. How many people did you *attempt* to collect outcome information from?

In FY19, we attempted to collect data for outcome 4 from all 54 participants, while we attempted to collect data from outcomes 1-3 and 5-6 from 16 participants who were present at the survey administration meetings who consented to the GROW survey.

7. How many people did you *actually* collect outcome information from? Outcome 4 was collected from all 54 participants, while outcomes 1-3 and 5-6 were collected from 16 participants who were present at the survey administration meetings who consented to the GROW survey.

8. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc) The survey is being administered at the end of the fiscal year. We are having some trepidation concerning new members of GROW being administered a baseline survey after 3 weeks of continuing GROW meetings. It is tough to maintain confidentiality with only a couple people able to administer and collect the data, and then have the data remain confidential when only one survey is being administered. We will continue to administer the survey yearly.

Results

9. What did you learn about your participants and/or program from this outcome information? Please be specific when discussing any change or outcome, and give appropriate quantitative or descriptive information when possible. For example, you could report the following:

i. Means (and Standard Deviations if possible)
ii. Change Over Time (if assessments occurred at multiple points)
iii. Comparison of strategies (e.g., comparing different strategies related to recruitment; comparing rates of retention for clients of different ethnoracial groups; comparing characteristics of all clients engaged versus clients retained)

1. decreased hospitalization frequency

On average, GROWERs reported 0.2 hospitalizations in the past year. Across their lifetimes, GROWERs reported an average of 4.8 hospitalizations.

2. decreased medication use

36% of GROWERs reported currently taking 0 medications, 12% reported taking 1 medication, 28% reported taking 2 medications, 8% reported taking 3 medications, 12% reported taking 4 medications, and 4% reported taking 5 or more medications.

3. increased social resources

The mean score for emotional support received on scale of 1 to 5 was 3.71 (with a standard deviation of 1.14). The mean score for emotional support provided on a scale of 1 to 5 was 4.05 (with a standard deviation of 0.89). Emotional support provided is of particular interest, as past research has indicated that this may be a key mechanism of change in mutual help groups like GROW. For example, one paper found that providing support and help to others improved psychosocial adjustment for GROW members (Roberts, Salem, Rappaport, Toro, Luke, & Seidman, 1999).

4. increased personal growth

It has been observed at the GROW Satellite Jail group that the 'mature' inmates are more likely to actively participate in the program and seem to encourage the younger inmates to participate in the program [and their own recovery]. The GROW Rantoul Group leader has been helpful with all aspects organizing and recording activities at GROW meetings and is starting CRSS training and looking forward to becoming a GROW Fieldworker. Another long-time GROWer is starting with CRSS training with the intention of

finding work in the community. One GROWer at group is now smiling, participating in the group, improving hygiene, and walking around the town and sometimes into stores.
Two other GROWers have rejoined group meetings to work on problems and improve their mental health.

5. increased wellbeing

The average wellbeing score from the Personal Wellbeing Index was 64.68 on a scale of 0 to 100 (with a standard deviation of 28.39)

6. number of participants in leadership roles

52% of participants had leadership role in GROW.

10. Is there some comparative target or benchmark level for program services? Y/N
Note: we did not set benchmarks in our FY19 application; however, we did in our FY20 application and we would like to use benchmarks going forward, so we will use the benchmarks from FY20 when applicable.

1. Yes
2. Yes
3. No
4. No
5. Yes
6. Yes

11. If yes, what is that benchmark/target and where does it come from?

1. Ideally, we would like to compare incoming GROWers at baseline to 1 year follow-up to see if hospitalization in the past year decreased from time 1 to time 2. Because we do not have enough baseline data, for now we set a target of 1 or less hospitalizations in the past year.
2. A 2001 report from the National Association of State Mental Health Program Directors describes some of the risks of taking multiple psychiatric medications at the same time, such as risks of interactions, side effects, and costs. For this reason, we aimed for less than 10% of participants to be taking 5 or more medications for mental health reasons.
3. No benchmark.
4. No benchmark.
5. As we described in our FY20 application, the normative range for adults in Western nations [whole population] is between 70 and 80 points (International Wellbeing Group, 2013). Our benchmark is for GROWers to score within 10 points of the average wellbeing score collected on data from the International Wellbeing Group, with an aim for a score of 70. While the International Wellbeing Group surveyed adults at random, because participants coming to GROW are often living with mental health problems in living, we expected lower baseline wellbeing scores, with the expectation that participation in GROW would increase wellbeing scores to within a 10 point range of normative data. Similarly, a 2012 study by Shirli Werner in Israel found that adults living with serious mental illness had an average wellbeing score of 61.6, about 15 points lower than the average score in the general population.

6. As described in our FY20 application, we aimed to add at least 1 leadership role per group to FY2018's leadership roles, which were held by 5 out of 7 members who took the survey.

12. If yes, how did your outcome data compare to the comparative target or benchmark?

1. The average number of hospitalizations in the past year was 0.2, which meets our target.
2. We met our benchmark, as only 4% of participants were taking 5 or more medications.
3. no benchmark.
4. no benchmark
5. GROWERs scored 65 on average, compared to 75 on the International Wellbeing Group's survey, which is just within the 10 point range, although it still falls below a score of 70.
6. In FY19, 3 out of 12 first time survey takers reported having a leadership role (in addition to 3 of 4 follow-up survey takers who also reported having a leadership role). Thus, more than 1 leadership role was added per group, which met our benchmark.

(Optional) Narrative Example(s):

13. Describe a typical service delivery case to illustrate the work (this may be a "composite case" that combines information from multiple actual cases) (Your response is optional)

14. In what ways was the evaluation used to support changes in practice? What changes were made based on evaluation findings? (Your response is optional)

Utilization Data Narrative –

The utilization data chart is to be completed at the end of each quarter (including quarter 4) using the online reporting system.

Comparative yearly totals (i.e. reporting estimates and actual numbers) and the narrative section described below are to be completed at end of year only.

Here, you will report on the different types of service categories specified in your program plan application. Please remember that programs **do not** need to collect and report on every category- instead, you are to report only the ones that are most useful for understanding program impact.

1. Please copy and paste the definitions of service categories your program specified in your program plan application in the sections below**. You will report the actual numbers of clients/contacts/community events for each reported service category in the Part II Utilization/Production data form (located on the online system).** If your estimated number of clients/contacts/community events for reported service categories significantly differfrom your actual numbers, you may give a narrative explanation for that discrepancy here.

Treatment Plan Clients (TPC):
Non-treatment Plan Clients (NTPC): all clients in GROW are non-TPC because they all receive services but do not receive individualized treatment plans to treat a specific diagnosed condition.
Community Service Events (CSE): Events including orientations, expo events, and talks given to organizations like the VFW. GROW Presented "Mental Health& Social Stigma Awareness on 11/14/18 in Rantoul. GROW held a Vendor table at the Disability Expo on 3/30/19 and Animarvels on 6/1/19. Two grow members from September 2018 to December 2018 volunteered at the Rantoul Food pantry on Thursdays and discussed the GROW program with persons receiving assistance.
Service Contacts (SC): clients who have called and been assessed for eligibility
For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

Mahomet Area Youth Club
BLAST
Performance Outcome Report PY19

Agency name: Mahomet Area Youth Club
Program name: Bulldogs Learning & Succeeding Together (BLAST)
Submission date: 8/30/19

Consumer Access – *complete at end of year only*

Eligibility for service/program

1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application)

BLAST is in its fifth year, and we have made consumer access a priority. All youth between the ages of 6 and 12 are eligible for our BLAST programming in the Mahomet schools, and space is held open in each course for those youth in-need financially. As a result, those youth that are recommended for the program based on socio-economic needs are given preferential placement. Economic need is based on the free and reduced lunch federal guidelines.

2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)?

Basic criteria for participation is determined by grade level and being in the district which is on the application for every student and scholarship qualification is determined through student's eligibility for free or reduced lunch qualification through the district.

3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.)

Outreach to eligible participants (all students in first grade - fifth grade) is accomplished through several avenues. Primary dissemination of information is completed by sending outthe information and sign up packet home with all students. In addition, School Reach, the district-wide communication platform, school websites, and the MAYC website and Facebook page are utilized to provide information.

4. a) *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application):

All students referred to the program are given access to the program, and 100% of the students are given their 1st or 2nd choice in terms of enrichment courses.

b) *Actual* percentage of individuals who sought assistance or were referred who received services:

100% of students who sought assistance/scholarships for or were referred to BLAST were given access to the program and assistance

5. a) *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application):

The length of time from registration to participation is approximately 1 week. Participants have approximately 1 week to return BLAST registration. Upon receiving registration information, students are placed into classes by the BLAST coordinator. It takes approximately 1 week, overlapping with the registration period, to place all students in the BLAST classes including referred and target population clients.

b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application):

The eligibility assessment happens within this same one week time frame, and 100% of eligible clients will be engaged within the one week time frame.

c) *Actual* percentage of referred clients assessed for eligibility within that time frame: 100% of students who sought assistance/scholarships for or were referred to BLAST were given access to the program and assistance within the time frame

6. a) *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application):

The length of time from registration to participation is approximately 1 week. Participants have approximately 1 week to return BLAST registration. Upon receiving registration information, students are placed into classes by the BLAST coordinator. It takes approximately 1 week, overlapping with the registration period, to place all students in the BLAST classes including referred and target population clients. The eligibility assessment happens within this same one week time frame, and 100% of eligible clients will be engaged within the one week time frame.

b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application):

100%

c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame:

100%

7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application):

We can expect five years of enrollment if a student starts in first grade. All BLAST information is tracked with BLAST registration packets, attendance by class and target population in spreadsheet documents.

b) *Actual* average length of participant engagement in services:

Although many students have participated the full 5 years, the program has not been available for all students this long (example if a student was in 5th grade when the program started). Additionally, data for students year to year has not been tracked formally, only session to session within a school year. At this time, we can only estimate that the average length of participant engagement is 2.5 years- based on the number of students participating, the average age of participation and the parent surveys.

Demographic Information

1. *In your application* what, if any, demographic information did you indicate you would collect beyond those required (i.e. beyond race/ethnicity, age, gender, zip code)? (Demographic Information, question #1 in the Program Plan application)

2. Please report here on all of the extra demographic information your program collected.

Consumer Outcomes – *complete at end of year only*

During the application process, you identified participant outcomes that your program activities would impact. Here, report the actual participant outcomes achieved as a result of your program activities

1. *From your application,* what impact on consumers did you expect your program activities to have? That is, what outcome(s) did you want your program to have on the people it is serving? (Consumer Outcomes, question #1 in the Program Plan application). Please number each outcome.

1. Number of participants
2. Attendance in program
3. Satisfaction with program
4. School attendance

2. For each outcome, please indicate the specific survey or assessment tool you used to collect information on this outcome in the chart below. (Please remember that the tool used should be evidence-based or empirically validated.)

Additionally, in the chart below, please indicate who provided this information (e.g. participant, participant's guardian(s), clinician/service provider, other program staff (if other program staff, indicate their role).) Please report all sources of information that apply for each assessment tool (e.g. the XYZ survey may be completed by both a youth client and their caregiver(s).

Outcome:	Assessment Tool Used:	Information Source:
Number of participants	Database	Registration forms/School & Program leader
Attendance in program	Attendance logs	School/program leaders
Satisfaction with the program	Parent survey	Parents who complete the post survey
School Attendance	Parent survey & School records	Parents who complete the post survey along with school records for students receiving scholarships/assistance

3. Was outcome information gathered from every participant who received service, or only some?

Outcome information for all students receiving scholarships/assistance is gathered related to attendance but satisfaction information received from parents is voluntary and anonymous, so no way to track this related to specific students.

4. If only some participants, how did you choose who to collect outcome information from?

Parent surveys are voluntary and anonymous

5. How many total participants did your program have?

75 received scholarships/assistance

6. How many people did you *attempt* to collect outcome information from?

MAYC only tracked students receiving scholarships/assistance, but the district did attempt to collect parent surveys from all participants.

7. How many people did you *actually* collect outcome information from?

75 student level info

8. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc)

Twice throughout the school year, after Sessions 1 & 2 and again after Sessions 3 & 4 (Mid-year and end of year)

Results

9. What did you learn about your participants and/or program from this outcome information? Please be specific when discussing any change or outcome, and give appropriate quantitative or descriptive information when possible. For example, you could report the following:

i. Means (and Standard Deviations if possible)
ii. Change Over Time (if assessments occurred at multiple points)
iii. Comparison of strategies (e.g., comparing different strategies related to recruitment; comparing rates of retention for clients of different ethnoracial groups; comparing characteristics of all clients engaged versus clients retained)

Special Ed or 504 plan %:

District has 13% of total students (including Jr. High and High School) included in Special Ed or with a 504 plan

BLAST participants (elementary only) receiving assistance/scholarships were 7% this year

Attendance:

In BLAST Sessions 1 & 2, participants receiving assistance/scholarship: 65% missed 3 days or more of school

In BLAST Sessions 3 & 4, participants receiving assistance/scholarship: 50% missed 3 days or more of school

**participation in BLAST increases number of interactions with classmates and other students outside of the classroom leading to possible development of friendships and could lead to improved overall school attendance.*

Parent survey (results from all parents who anonymously responded):

50% said "B.L.A.S.T. made my child more excited to come to school."

46% said "Yes, my child made new friends as a result of attending BLAST."

Awareness about MAYC scholarships availability

74% said "Yes, I am aware that MAYC provides B.L.A.S.T. scholarships to students in financial need."

10. Is there some comparative target or benchmark level for program services? Y/N
N

11. If yes, what is that benchmark/target and where does it come from?

12. If yes, how did your outcome data compare to the comparative target or benchmark?

(Optional) Narrative Example(s):

13. Describe a typical service delivery case to illustrate the work (this may be a "composite case" that combines information from multiple actual cases) (Your response is optional)

14. In what ways was the evaluation used to support changes in practice? What changes were made based on evaluation findings? (Your response is optional)

Utilization Data Narrative –

The utilization data chart is to be completed at the end of each quarter (including quarter 4) using the online reporting system.

Comparative yearly totals (i.e. reporting estimates and actual numbers) and the narrative section described below are to be completed at end of year only.

Here, you will report on the different types of service categories specified in your program plan application. Please remember that programs **do not** need to collect and report on every category- instead, you are to report only the ones that are most useful for understanding program impact.

1. Please copy and paste the definitions of service categories your program specified in your program plan application in the sections below**. You will report the actual numbers of clients/contacts/community events for each reported service category in the Part II Utilization/Production data form (located on the online system).** If your estimated number of clients/contacts/community events for reported service categories significantly differ from your actual numbers, you may give a narrative explanation for that discrepancy here.

Treatment Plan Clients (TPC): defined as number of participants referred to other providers for services
3 was the goal and 3 clients were referred to other providers for services including school social worker and school food pantry

Non-treatment Plan Clients (NTPC): defined as number of participants in BLAST program
116 is the goal- only 75 participants applied for assistance/scholarship

Community Service Events (CSE): defined as number of contacts with participants throughout course of the program as well as with the community at large about upcoming events and activities
828 is the goal which we exceeded with 1152 CSE's due to the large number of participants as well as the community events and activities MAYC staff participated in and hosted

Service Contacts (SC): defined as number of enrichment opportunities, the number of meetings each week, and the length of the program. The events are also kept in a database for review.
2595 is the goal which we almost met with a total of 2445.

For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

Mahomet Area Youth Club
MAYC Members Matter!
Performance Outcome Report PY19

Agency name: Mahomet Area Youth Club
Program name: MAYC Members Matter!
Submission date: 8/29/19

Consumer Access – *complete at end of year only*

Eligibility for service/program

1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application)

Eligibility criteria for entry into our program is based on age and/or grade level of the student as well as location of residency. If they student falls between the ages of 6-18 and lives in the Mahomet area including rural Champaign County, they are eligible for out of school programming. If the student is enrolled in middle school at MSCUSD, they are also eligible for the Jr. High Program during the school year. Priority is given to low income families.

2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)?

Student's parent/guardian completes an application for membership and enrollment requiring information about their family address and student info related to grade level in school and birthday. Income information is also a part of the application and if a family seeks financial assistance in our program (scholarship or reduced rates) there is an additional application requiring proof of income for this.

3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.)

MAYC's target population learns about our services through information shared through word of mouth from existing members as well as online through websites and social media (both school the district's and MAYC's). Additionally, MAYC participates in and hosts many community events which provides opportunities to share information about our services.

4. a) *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application):

Over 90% of families who register end up attending the club at some point. For our core participants in summertime programming, we expect that membership will continue from age 6 until age 18. For middle school after-school programming, we expect three years of participation (6th, 7th, and 8th grades).

b) *Actual* percentage of individuals who sought assistance or were referred who received services:

90% of kids enrolled in the out of school programs attended.

5. a) *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application):

100% of client's paperwork is reviewed within 24 hours of submission. Approval of scholarship-level occurs within a week of request, but child continues services for free if necessary while financials are reviewed.

b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application):

100% of client's paperwork is reviewed within 24 hours of submission. Approval of scholarship-level occurs within a week of request, but child continues services for free if necessary while financials are reviewed

c) *Actual* percentage of referred clients assessed for eligibility within that time frame:

100% of client's paperwork is reviewed within 24 hours of submission.

6. a) *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application):

Approval of scholarship-level occurs within a week of request, but student is able to continue services for free if necessary while financials are reviewed.

b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application):

Once a member's parent has read, signed, and returned the membership application, the child may begin attending the club, and members can and have been enrolled on the same day the blank paperwork is given to parents. The fee can be paid at a later date if necessary. 100% of client's paperwork is reviewed within 24 hours of submission. Approval of scholarship-level occurs within a week of request, but child continues services for free if necessary while financials are reviewed.

c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame:

90% of families who register attend the club

7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application):

For our core participants in summertime programming, we expect that membership will continue from age 6 until age 18. For middle school after-school programming, we expect three years of participation (6th, 7th, and 8th grades).

b) *Actual* average length of participant engagement in services:

For summertime programming, many participants begin at different ages and end earlier than 18. Average length of participant engagement is 5 years. For the Jr. High afterschool program, the average length of participation is 2 years because some start late or don't attend their 8th grade year

Demographic Information

1. *In your application* what, if any, demographic information did you indicate you would collect beyond those required (i.e. beyond race/ethnicity, age, gender, zip code)? (Demographic Information, question #1 in the Program Plan application)

2. Please report here on all of the extra demographic information your program collected.

Consumer Outcomes – *complete at end of year only*

During the application process, you identified participant outcomes that your program activities would impact. Here, report the actual participant outcomes achieved as a result of your program activities

1. *From your application,* what impact on consumers did you expect your program activities to have? That is, what outcome(s) did you want your program to have on the people it is serving? (Consumer Outcomes, question #1 in the Program Plan application). Please number each outcome.

The MAYC Members Matter! Programs provides activities in five value areas. Membership at MAYC, participation at the club and interaction with staff is designed to:

1. Teach members to be self-sufficient in school and in age-appropriate life skills
2. Discuss and seek out educational or vocational opportunities
3. Develop skills to make appropriate behavioral decisions
4. Learn and share information about the importance of community service
5. Expand parental involvement through the MAYC Parents' Club

These activities are not directly tied to outcome data collected by MAYC. But, the Members Matter! program does track outcomes, and we have a 94% passing grade rate within the Jr. High after-school program, and 75% of the students in the program have held their math or reading grades steady or improved their grades during their time in the program. That data is collected via grade cards at the end of each semester and compared against previous semesters. The ACT Now Coalition for After-School programs is working on standards and benchmarks but none exist across various programs currently to our knowledge. We will target 75% of students holding or improving grades in math and reading for next year and a 90% passing grade rate for promotion to the next grade as our baseline outcomes.

1) Promotion to next grade
2) Maintaining/Improving math & reading grades

2. For each outcome, please indicate the specific survey or assessment tool you used to collect information on this outcome in the chart below. (Please remember that the tool used should be evidence-based or empirically validated.)

Additionally, in the chart below, please indicate who provided this information (e.g. participant, participant's guardian(s), clinician/service provider, other program staff (if other program staff, indicate their role).) Please report all sources of information that apply for each assessment tool (e.g. the XYZ survey may be completed by both a youth client and their caregiver(s).

Outcome:	Assessment Tool Used:	Information Source:
Promotion to the next grade	Report card/online student system (Skyward)	School district and/or student
Maintaining/Improving math & reading grades	Report card/online student system (Skyward)	School district and/or student & parent

3. Was outcome information gathered from every participant who received service, or only some?

Outcome information was gathered for all Jr. High after school participants which is only some of the total Members Matter! participants

4. If only some participants, how did you choose who to collect outcome information from? Those who participated in the Jr. High after school program.

5. How many total participants did your program have?

204 (NTPC's)

6. How many people did you *attempt* to collect outcome information from?

31

7. How many people did you *actually* collect outcome information from?

31

8. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc)

Twice- once at the end of the first quarter and then again at the end of the fourth quarter.

Results

9. What did you learn about your participants and/or program from this outcome information? Please be specific when discussing any change or outcome, and give appropriate quantitative or descriptive information when possible. For example, you could report the following:

i. Means (and Standard Deviations if possible)
ii. Change Over Time (if assessments occurred at multiple points)
iii. Comparison of strategies (e.g., comparing different strategies related to recruitment; comparing rates of retention for clients of different ethnoracial groups; comparing characteristics of all clients engaged versus clients retained)

Information gathered:
18 of 31 on Free/Reduced Lunch
Grades collected in English/Language Arts & Math
1st Quarter:
2 students failing 1 of these classes and 2 students with a D in one of these classes
4th Quarter:
2 students failing 2 of these classes, 2 students failing 1 class, 1 student with a D in two classes and 6 students with a D in one of the classes

Overall 90% of the students were passing all of their courses at the end of the year, guaranteeing promotion to the next grade and 87% maintained or improved their reading and math grades.

10. Is there some comparative target or benchmark level for program services? Y/N

N

11. If yes, what is that benchmark/target and where does it come from?

12. If yes, how did your outcome data compare to the comparative target or benchmark?

(Optional) Narrative Example(s):

13. Describe a typical service delivery case to illustrate the work (this may be a "composite case" that combines information from multiple actual cases) (Your response is optional)

14. In what ways was the evaluation used to support changes in practice? What changes were made based on evaluation findings? (Your response is optional)

Utilization Data Narrative –

The utilization data chart is to be completed at the end of each quarter (including quarter 4) using the online reporting system.

Comparative yearly totals (i.e. reporting estimates and actual numbers) and the narrative section described below are to be completed at end of year only.

Here, you will report on the different types of service categories specified in your program plan application. Please remember that programs **do not** need to collect and report on every category- instead, you are to report only the ones that are most useful for understanding program impact.

1. Please copy and paste the definitions of service categories your program specified in your program plan application in the sections below**. You will report the actual numbers of clients/contacts/community events for each reported service category in the Part II Utilization/Production data form (located on the online system).** If your estimated number of clients/contacts/community events for reported service categories significantly differ from your actual numbers, you may give a narrative explanation for that discrepancy here.

Treatment Plan Clients (TPC): defined as number of participants referred to other providers for services.
4 was the goal. We ended up referring 12 participants to various other providers including services related to food insecurity, ILHEAP, counseling, IEP help and school social workers.

Non-treatment Plan Clients (NTPC): defined as number of participants in Members Matter!
136 was the goal and we ended up serving 204 as the membership grew tremendously over the summer and other out of school day programs.

Community Service Events (CSE): defined as number of attendance days, days the club is open for summer programming, and the total number of events that are available to the youth for the Jr. High After School Program and the summer program.
200 was the goal & the goal was met

Service Contacts (SC): defined as number of contacts with participants throughout course of the program as well as about upcoming events and activities. Contacts with parents and community members are also tracked. 1380 was the goal. Due to the increase in TPC's and NTPC's, the SC's increased as well and resulted in a total of 1709.
For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

Promise Healthcare
Mental Health Services with Promise
Performance Outcome Report PY19

Agency name: Promise Healthcare
Program name: Mental Health Services with Promise Healthcare
Submission date: 8/30/19

Consumer Access – *complete at end of year only*

Eligibility for service/program

1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application)

We will integrate physical health and behavioral health care--which includes mental health counseling and psychiatry for established patients of Promise Healthcare who have been referred by our medical providers or Rosecrance case managers and crisis counselors due to emotional distress or mental health issues. Promise will offer limited availability for those not already patients of Promise or participating in Rosecrance services. Patients will be supported by nurses, primary care providers, and by enabling services.

2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)?

Provider referral, collaborator referral or self-referral to services

3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.)

Referrals by our medical providers for mental/behavioral health services or Rosecrance case managers and crisis counselors for both counseling and psychiatry.

4. a) *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application):

100% of patients who sought assistance or were referred would receive a screening (to identify actual need or desire for counseling or psychiatry), Mental Health Assessment or Psychiatric Evaluation.

b) *Actual* percentage of individuals who sought assistance or were referred who received services:

Actual percentage is 100%. No one is turned away who is seeking assistance or referred for counseling or psychiatry.

5. a) *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application):

Patients referred for counseling will complete a Mental Health Assessment and Patient Stress Questionnaire within three weeks of referral.

Patients referred to a psychiatrist will be scheduled within 30 days of referral.

b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application):

85% of patients referred for counseling will complete a Patience Stress Questionnaire and Mental Health Assessment within three weeks of referral.

90% of patients referred to a psychiatrist will be scheduled within 30 days of referral.

c) *Actual* percentage of referred clients assessed for eligibility within that time frame:

Over 85% of patients referred for counseling completed a Mental Health Assessment within three weeks of referral. Reporting on the Patient Stress Questionnaire from our electronic health record failed, and we are unable to report.

Over 90% of Promise patients were scheduled with a psychiatrist within 30 days of referral. The average time from referral to first appointment was 16 days.

6. a) *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application):

The estimated length of time from assessment of eligibility/need to engagement in service for counseling is 2 weeks. Clients are immediately scheduled with the counselor that completes the Mental Health Assessment.

The estimated length of time from evaluation of eligibility/need to engagement in service for psychiatry is 1 month.

b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application):

85% is an estimated percentage of eligible clients who would who would be engaged in counseling within 2 weeks of the Mental Health Assessment.

85% is an estimated percentage of eligible clients who would who would be engaged in psychiatry within 1 month of the Psychiatric Evaluation.

c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame:

Promise Healthcare maintained strong access and was able to meet or exceed the estimated 85% of eligible clients engaged in counseling and psychiatry within 2 weeks of the Mental Health Evaluation or Psychiatric Evaluation.

7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application):

(not in 2019 application)
The estimated average length of engagement in counseling services is 12-15 months.

The estimated average length of engagement in psychiatric services is ongoing as needed for medication management to maintain health.

b) *Actual* average length of participant engagement in services:

not available.

Demographic Information

1. *In your application* what, if any, demographic information did you indicate you would collect beyond those required (i.e. race/ethnicity, age, gender, zip code)? (Demographic Information, question #1 in the Program Plan application)

In FY 2019, we will continue to collect race/ethnicity, age, gender and zip code for both counseling and psychiatry services.

2. Please report here on all of the extra demographic information your program collected.

None

Consumer Outcomes – *complete at end of year only*

During the application process, you identified participant outcomes that your program activities would impact. Here, report the actual participant outcomes achieved as a result of your program activities

1. *From your application,* what impact on consumers did you expect your program activities to have? That is, what outcome(s) did you want your program to have on the people it is serving? (Consumer Outcomes, question #1 in the Program Plan application)

We hope that clients in counseling and psychiatry will have a decrease in emotional distress or mental health symptoms.

2. For each outcome, what specific survey or assessment tool did you use to collect information on this outcome? (Please remember that the tool used should be evidence-based or empirically validated.)

Currently, consumer outcomes are measured for adults and children through the Global Assessment of Functioning (GAF) scale or the Children's Global Assessment of Scale (C-GAS) at the start and cessation of treatment. In FY 2019, we would like to integrate the use of the Patient Stress Questionnaire at the start and cessation of treatment and at regular intervals throughout treatment. Based on the CBT approach, intermittent evaluation of progress i.e. Depression Scale, Anxiety Scale, GAF, and goal achievement will be assess at regular intervals.

Psychiatry uses a medical model and patient interviews for assessment.

3. Who provided the information about participant outcome(s)? (Participant, participant guardian, clinician/service provider, other program staff (if other program staff, who?_____))

Our counselors measure outcomes for adults and children through the Global Assessment of Functioning (GAF) scale or the Children's Global Assessment of Scale (C-GAS).

Patient Stress Questionnaire will be used to measure consumer outcomes and information will be provided by the consumer.

4. Was outcome information gathered from every participant who received service, or only some?

In FY 2019, the information will be gathered from all clients that engage in counseling.

5. If only some participants, how did you choose who to collect outcome information from?

Non-applicable

6. How many total participants did your program have?

Non-applicable

7. How many people did you *attempt* to collect outcome information from?

Non-applicable

8. How many people did you *actually* collect outcome information from?

Non-applicable

9. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc)

In FY 2019, the information we work to collect at intake and discharge, and regular intervals, every 6 months during treatment. We collected outcome information on 237 patients.

Results

10. What did you learn about your participants and/or program from this outcome information? Please be specific when discussing any change or outcome, and give appropriate quantitative or descriptive information when possible. For example, you could report the following:

i. Means (and Standard Deviations if possible)
ii. Change Over Time (if assessments occurred at multiple points)
iii. Comparison of strategies (e.g., recruitment, retention, treatment, intervention)

Non-applicable

11. Is there some comparative target or benchmark level for program services? Y/N
No

12. If yes, what is that benchmark/target and where does it come from?
Non-applicable

13. If yes, how did your outcome data compare to the comparative target or benchmark?
Non-applicable

(Optional) Narrative Example(s)

14. Describe a typical service delivery case to illustrate the work (this may be a "composite case" that combines information from multiple actual cases)
Non-applicable

15. In what ways was the evaluation used to support changes in practice? What changes were made based on evaluation findings?
Non-applicable

Utilization Data Narrative – *complete at the end of each quarter using the online reporting system. Complete this section at end of year only.*

Here, you will report on the different types of service categories specified in your program plan application. Please remember that programs **do not** need to collect and report on every category- instead, you are to report only the ones that are most useful for understanding program impact.

1. Please copy and paste the definitions of service categories your program specified in your program plan application in the sections below**. You will report the actual outcomes of service categories in the Part II Utilization/Production data form (located on the online system).** If your estimated service category outcome significantly differs from your actual service category outcome, you may give a narrative explanation for that discrepancy here.

Treatment Plan Clients (TPC):
Continuing treatment plan patients and new patients to counseling or seeing a psychiatrist (unduplicated) will be counted in TPCs as Treatment Plan Clients.
Continuing treatment plan clients in counseling for FY 2018 Q2 are 174
Psych?

Non-treatment Plan Clients (NTPC):
Non Treatment Plan Clients will include patients who receive their behavioral health medications from their Promise Healthcare primary care provider due to the support provided by Dr. Chopra—usually tracked in psychiatry. We believe that we have built capacity for serving an additional 800 patients a year through PCPs. When a patient does not complete assessment or choses to not engage in therapy with one of our therapists, this is tracked in NTPC incounseling.

Clients without treatment plans in counseling are for FY 2018 Q2 are 26. 5 of these are Spanish speaking with an interpreter with a limited amount of sessions. We transitioned to an EHR in Oct 2017. Many of those without treatment plans in the EHR have written treatment plans that were scanned into the EHR.
Psych?

Community Service Events (CSE):
Community service events tracked as CSE includes our therapists promoting the mental health program or educating about mental health awareness outside the health center—typically a community event or health fair. For our psychiatrists, CSE is where we track the monthly noon meetings Dr. Chopra has with our other providers and nurses.

0 Community Service Events for FY 2018 Q2 have been attended since a change in counselors. Psych?
Service Contacts (SC): Counseling encounters and medication management encounters by our psychiatrists will be tracked using SC to count each encounter or attended appointment. Counseling Encounter for FY 2018 Q2 are 543. Psych?
For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

Promise Healthcare
Wellness
Performance Outcome Report PY19

Agency name: Promise Healthcare
Program name: Wellness
Submission date: 8/30/19

Consumer Access – *complete at end of year only*
Eligibility for service/program
1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application) Promise Healthcare patients that may need assistance to execute their treatment plan
2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)? Established as a patient of Promise behavioral health, medical or dental services and self-referred or referred by their Promise Healthcare provider.
3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.) The target population is often referred by Promise Healthcare providers and staff.
4. a) *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application): Wellness targeted outcomes will include - Help 510 patients remove barriers to their treatment plan. This will be a count of patients and the issues a patient needs support and assistance addressing to move towards wellness (NTPC + TPC).

- Improve tracking of wellness assists in the electronic health record and implement patient experience surveys for assistance
- Maintain a percentage of mental health visits where patients do not have coverage to under 15% through outreach and enrollment efforts and help 2000 people enroll in coverage (all programs, includes non-Promise patients as well).

b) *Actual* percentage of individuals who sought assistance or were referred who received services:

Percentage not available.

5. a) *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application):

Not available.

b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application):

Not available.

c) *Actual* percentage of referred clients assessed for eligibility within that time frame:

Not available.

6. a) *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application):

Not available.

b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application):

Not available.

c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame:

Not available.

7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application):

Not available.

b) *Actual* average length of participant engagement in services:

Not available.

Demographic Information

1. *In your application* what, if any, demographic information did you indicate you would collect beyond those required (i.e. beyond race/ethnicity, age, gender, zip code)? (Demographic Information, question #1 in the Program Plan application)

In FY 2019, we will continue to collect race/ethnicity, age, gender and zip code

2. Please report here on all of the extra demographic information your program collected.

None

Consumer Outcomes – *complete at end of year only*

During the application process, you identified participant outcomes that your program activities would impact. Here, report the actual participant outcomes achieved as a result of your program activities

1. *From your application,* what impact on consumers did you expect your program activities to have? That is, what outcome(s) did you want your program to have on the people it is serving? (Consumer Outcomes, question #1 in the Program Plan application). Please number each outcome.

From 2020 application:

Promise Healthcare's Adult Wellness Program will work to
1. **Help patients remove barriers to their treatment plan.**
2. **Maintain a percentage of mental health visits where patients do not have coverage to under 15% through outreach and enrollment efforts and help 2000 people enroll in coverage (all programs, includes non-Promise patients as well).**
3. **The program will work to support patients to achieve their optimal health.**

2. For each outcome, please indicate the specific survey or assessment tool you used to collect information on this outcome in the chart below. (Please remember that the tool used should be evidence-based or empirically validated.)

Additionally, in the chart below, please indicate who provided this information (e.g. participant, participant's guardian(s), clinician/service provider, other program staff (if other program staff, indicate their role).) Please report all sources of information that apply for each assessment tool (e.g. the XYZ survey may be completed by both a youth client and their caregiver(s).

Outcome:	Assessment Tool Used:	Information Source:
Help patients remove barriers to their treatment plan.	This will be a count of patients and the issues a patient needs support and assistance addressing to move towards wellness.	Electronic Health Record
Maintain a percentage of mental health visits where patients do not have coverage to under 15% through outreach and enrollment efforts and help 2000 people enroll in coverage (all programs, includes non-Promise patients as well).	Financial reporting shows the percentage of patients seen by therapists and psychiatrists that were uninsured. This will be a ratio of visits and count of people enrolled in coverage.	Practice Management Reporting
The program will work to support patients to achieve their optimal health which can	Clinical care gaps are HRSA and CMS evidence-based standards of care. Patients of the mental health program	Patient

be measured by patients who are also medical patients through tracking clinical care gaps.	can also anonymously report program experience through the annual patient experience survey.	

3. Was outcome information gathered from every participant who received service, or only some?

No, only some.

4. If only some participants, how did you choose who to collect outcome information from?

In FY17 we worked with the Evaluation Capacity Building project to create a system to record the work of the adult wellness program. The system is to create an appointment and log number and types of assists, how patient was assisted and report out in an excel spreadsheet that can be used to determine number of encounters and numbers of assists per patient.

Promise will work to conduct patient experience surveys of adult wellness work in coming year to collect outcome data.

Financial reporting shows the percentage of patients seen by therapists and psychiatrists that were uninsured.

5. How many total participants did your program have?

395

6. How many people did you *attempt* to collect outcome information from?

150

7. How many people did you *actually* collect outcome information from?

0

8. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc)

Results

9. What did you learn about your participants and/or program from this outcome information? Please be specific when discussing any change or outcome, and give appropriate quantitative or descriptive information when possible. For example, you could report the following:

i. Means (and Standard Deviations if possible)
ii. Change Over Time (if assessments occurred at multiple points)
iii. Comparison of strategies (e.g., comparing different strategies related to recruitment; comparing rates of retention for clients of different ethnoracial groups; comparing characteristics of all clients engaged versus clients retained)

We did not collect good data on outcomes due to staff error in recording program assists. They collected info as a narrative in patient charts and failed to provide the coding needed to run reports.

The winter patient surveys were not properly executed. We are updating that to get better information on all programs in Fall 2019.

10. Is there some comparative target or benchmark level for program services? Y/N

No.

11. If yes, what is that benchmark/target and where does it come from?

Not applicable

12. If yes, how did your outcome data compare to the comparative target or benchmark?

Not applicable

(Optional) Narrative Example(s):

13. Describe a typical service delivery case to illustrate the work (this may be a "composite case" that combines information from multiple actual cases) (Your response is optional)

Not available.

14. In what ways was the evaluation used to support changes in practice? What changes were made based on evaluation findings? (Your response is optional)

Not available.

Utilization Data Narrative –

The utilization data chart is to be completed at the end of each quarter (including quarter 4) using the online reporting system.

Comparative yearly totals (i.e. reporting estimates and actual numbers) and the narrative section described below are to be completed at end of year only.

Here, you will report on the different types of service categories specified in your program plan application. Please remember that programs **do not** need to collect and report on every category- instead, you are to report only the ones that are most useful for understanding program impact.

1. Please copy and paste the definitions of service categories your program specified in your program plan application in the sections below**. You will report the actual numbers of clients/contacts/community events for each reported service category in the Part II Utilization/Production data form (located on the online system).** If your estimated number of clients/contacts/community events for reported service categories significantly differfrom your actual numbers, you may give a narrative explanation for that discrepancy here.

<u>Treatment Plan Clients (TPC):</u>

Patients who are engaged with more than one contact or assisted through several barriers are considered case management (TPC).

Non-treatment Plan Clients (NTPC):

NTPC patients are ones who are just helped once in a program year. A service contact may be a referral from their primary care provider, mental health provider, or referring partner.

Community Service Events (CSE):

Promise Healthcare's Wellness Program will participate in at least twelve community service events during the grant year. Promise Healthcare will welcome referrals and seek out outreach events that will help target those involved in the criminal justice system. That could include area church programs, job fairs, and education programs.

The Wellness Program will execute fifteen appropriate collaborations with area agencies. These collaborations are all supported by our Adult Wellness Coordinator. Both events and collaborating agencies are tracked in CSE.

Service Contacts (SC):

Service contacts are encounters with patients assisted either through adult wellness or medication assistance program.

For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

Rape Advocacy, Counseling, & Education Services (RACES)
Sexual Violence Prevention Education
Performance Outcome Report PY19

Agency name: Rape Advocacy, Counseling, & Education Services (RACES)
Program name: Sexual Violence Prevention Education
Submission date: August 2019

Consumer Access – *complete at end of year only*

Eligibility for service/program

1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application)

All of the agency's prevention education programming is provided free of charge, so cost is never a barrier.

Consumer access to our sexual violence prevention education is straightforward. Most program requests are organized by a school or other organization, so the services are easily accessed by participants. In addition, people may hear about prevention programming through RACES' social media or our website and can email us to request a program for their group.

Since each prevention education presentation mentions the entire array of RACES' services, people are also made aware of our free counseling and rape crisis hotline, medical advocacy and court advocacy services.

There is no specific screening or referral required prior to prevention education programming.

2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)?

The nature of our education/prevention services are such that all people are eligible for services; there is a specific focus on the school-age population for the "prevention" aspect of our programming. All schools in Champaign County are contacted with an offer to provide these services, and those interested contact RACES to schedule times. School-age population (ages 5-18) represent the majority of these services provided.

Other groups are provided these services by request. Some are long-standing requests (e.g. groups within the University of Illinois, or the Juvenile Detention Center which asks us to help fulfill a requirement associated with the Prison Rape Elimination Act).

3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.)

We utilized several approaches:

- **We sent a letter to every school principal in Champaign County in mid-summer describing our free services and how to access them.**

- **We followed up two weeks later with an email to the school principal and the school social worker or guidance counselor.**
- **There is a prevention education request tab on our website that can be utilized to request these services.**
- **At outreach events we hand out colorful cards describing prevention education and how to request the service.**
- **Due to long-standing relationships with teachers or school social workers, we are asked back to most of the schools in which we present.**

4. a) *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application):

N/A

b) *Actual* percentage of individuals who sought assistance or were referred who received services:

According to our records, 17 out of 23 requests (73.9%) from schools received services, and this proved instructive for planning for FY20. Of the 6 schools which did not receive services in FY19, 2 failed to follow through with us to set dates, 2 were unable to be served because we were fully booked, and 2 requested a format that was not best practices (i.e. single-session education, or assembly-style audience) and were as a result declined. (5 of these 6 were Champaign County schools.)

5. a) *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application):

N/A

b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application):

N/A

c) *Actual* percentage of referred clients assessed for eligibility within that time frame:

Of the 17 Champaign County schools scheduled and ultimately provided service, it took an average of 11.4 days to schedule (days between requesting the services and scheduling the

services; time before *provision* of services varied widely, as we book for the entire school year, well in advance).
6. a) *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application): **N/A**
b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application): **N/A**
c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame: **N/A**
7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application): **N/A – Presentations are provided for the number of sessions prescribed by the curriculum; curriculum varies by content and target age. Most children and youth receive 3 or 4 presentations spread out over the course of the school year. Research shows that for a prevention program to have significant impact it must be delivered as part of a multi-session curriculum. Single session programs are deemed to have little to no impact.**
b) *Actual* average length of participant engagement in services: **N/A - See above.**
Demographic Information
1. *In your application* what, if any, demographic information did you indicate you would collect beyond those required (i.e. beyond race/ethnicity, age, gender, zip code)? (Demographic Information, question #1 in the Program Plan application) **None.**
2. Please report here on all of the extra demographic information your program collected.

N/A

Consumer Outcomes – *complete at end of year only*

During the application process, you identified participant outcomes that your program activities would impact. Here, report the actual participant outcomes achieved as a result of your program activities

1. *From your application,* what impact on consumers did you expect your program activities to have? That is, what outcome(s) did you want your program to have on the people it is serving? (Consumer Outcomes, question #1 in the Program Plan application). Please number each outcome.

As with most education initiatives, the ultimate desired outcome is to change behaviors and attitudes over a lifetime; the ability to measure such changes over decades is beyond the scope of a small, local agency. we seek to (a)increase participant knowledge about sexual violence causes and effects, and (b)improve local response to victims of sexual violence.

As part of a statewide coalition of rape crisis centers, all Illinois rape crisis centers are moving toward aligning efforts with a nationwide violence prevention initiative spearheaded by the Centers for Disease Control (CDC). Our efforts will be reported in a standardized manner to a national database, there to be bundled with results from programs across the nation (MRS reporting). Because the CDC requires evidence-based or evidence-informed programming, the initiative has the potential to transform how stakeholders think about and evaluate violence prevention programming.

In addition to contributing to the nationwide initiative, we are revamping the measures we use on presentation level. We have started working with the CCMHB Evaluation Consultants to move beyond simple satisfaction surveys and to find or create some meaningful metrics so we can monitor our work. Age-appropriate pre-test/post-test surveys are being developed in association with the Evaluation Consultants.

Our presentations seek to:
(1)increase participant knowledge about sexual violence causes and effects (CDC strategies 1,2,3)
(2)improve local response to victims of sexual violence (CDC strategies 4,5).

In presentations we plan to measure impact in several age-appropriate ways. For Prevention Education for ages middle-school through adults, we use a pre-test/post-test model to measure immediate learning and attitude change. For the younger students, we use teacher assessment to gauge learning.

For training delivered to professionals, we use pre-test/post-test as well.

For a measure of the community's response to victim needs, we plan to enhance our RACES client satisfaction surveys to gather information on victims' experiences with other entities as well as with our own services.

2. For each outcome, please indicate the specific survey or assessment tool you used to collect information on this outcome in the chart below. (Please remember that the tool used should be evidence-based or empirically validated.)

Additionally, in the chart below, please indicate who provided this information (e.g. participant, participant's guardian(s), clinician/service provider, other program staff (if other program staff, indicate their role).) Please report all sources of information that apply for each assessment tool (e.g. the XYZ survey may be completed by both a youth client and their caregiver(s).

Outcome:	Assessment Tool Used:	Information Source:
E.g. 1. Increased empowerment in advocacy clients	Measure of Victim Empowerment Related to Safety (MOVERS) survey	Client
Increase knowledge related to (age-appropriate) risk factors of sexual violence	Pre/Post tests created in coordination with the CCMHB Consultation Bank	Students
Improve responses to survivors of sexual violence	Pre/Post tests created in coordination with the CCMHB Consultation Bank	Students

3. Was outcome information gathered from every participant who received service, or only some?

Some students – if a student was absent on the final day of the sessions, they did not have a post-test completed. There were also unique factors, often related to specific schools, listed below, that contributed to not being able to collect from every participant.

4. If only some participants, how did you choose who to collect outcome information from?

There were a handful of circumstances to precluded full data collection in FY19:

- **One school, through a scheduling error, did not allow us to complete the sessions.**
- **One school we were unable to print the tests due to a flood of our office.**

5. How many total participants did your program have?

8986 (duplicated; see Service Contacts); 17 schools, with multiple classes per schools.

6. How many people did you *attempt* to collect outcome information from?

We attempted to collect outcome information from all schools, save for the one which we were unable to return to, and one where we were unable to due to the flood.

7. How many people did you *actually* collect outcome information from?

We collected 1,973 post-tests in Champaign County schools.

8. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc)

Tests were conducted during the first session (pre-test) and the last session (post-test).

Results

9. What did you learn about your participants and/or program from this outcome information? Please be specific when discussing any change or outcome, and give appropriate quantitative or descriptive information when possible. For example, you could report the following:

i. Means (and Standard Deviations if possible)
ii. Change Over Time (if assessments occurred at multiple points)
iii. Comparison of strategies (e.g., comparing different strategies related to recruitment; comparing rates of retention for clients of different ethnoracial groups; comparing characteristics of all clients engaged versus clients retained)

All data was collected and analyzed with the assistance of the CCMHB Consultation Bank.

"I ♥ Consent" (9th grade)

i. **PRE – Mean 6/10, Std. 2.07; POST – Mean 7.3/10, Std. 2.04**
ii. **Increase of ~1.3 points (improvement)**
iii. **We found that all students improved about the same rate, but that where a student went to school significantly informed a student's initial scores.**

"Safe Dates" (8th grade)

i. **PRE – Mean 7.80/10; POST – Mean 8.67/10 (Standard Deviation not available)**
ii. **Increase of ~0.87 points (improvement)**
iii. **We found that all students improved about the same rate, but that where a student went to school significantly informed a student's initial scores. This curriculum had one school where there was *no* change – this school was unique in that it separated out the participants by gender and had appreciably more classroom management challenges. (These issues have since changed; we anticipate this will positively impact our work with this school in FY20.)**

"Second Step" (K-2nd grade version)

i. **Mean 3.58/4, Std. 0.69**
ii. **N/A – curriculum doesn't have post-test evaluation due to age of the students and type of content**
iii. **We found that all students improved about the same rate, including across schools.**

"Second Step" (3rd-5th grade version)
i. **Mean 4.67/5**
ii. **N/A – curriculum doesn't have post-test evaluation due to age of the students and type of content**
iii. **We found that all students improved about the same rate, including across schools.**

10. Is there some comparative target or benchmark level for program services? Y/N

The evaluations were created for this year in tandem with the CCMHB's Consultation Bank. We will use FY19 data as our benchmark for FY20.

11. If yes, what is that benchmark/target and where does it come from?

N/A

12. If yes, how did your outcome data compare to the comparative target or benchmark?

N/A

(Optional) Narrative Example(s):

13. Describe a typical service delivery case to illustrate the work (this may be a "composite case" that combines information from multiple actual cases) (Your response is optional)

N/A

14. In what ways was the evaluation used to support changes in practice? What changes were made based on evaluation findings? (Your response is optional)

- **In "Second Step", we changed how we taught self-defense from an unsafe or unwanted touch to improve participant comprehension**
- **In "I ♥ Consent", we increased the time allotted to the concept of "consent" (specifically as relates to alcohol use and within established relationships).**
- **In "Safe Dates", we use the qualitative data to integrate additional aspects of healthy/unhealthy relationships taught (e.g. "loyalty", "testing", arguing, jealousy)**
- **Overall, recognizing an initial "ceiling effect", we changed what myths of sexual violence to focus on in programming.**

Utilization Data Narrative –

The utilization data chart is to be completed at the end of each quarter (including quarter 4) using the online reporting system.

Comparative yearly totals (i.e. reporting estimates and actual numbers) and the narrative section described below are to be completed at end of year only.

Here, you will report on the different types of service categories specified in your program plan application. Please remember that programs **do not** need to collect and report on every category- instead, you are to report only the ones that are most useful for understanding program impact.

1. Please copy and paste the definitions of service categories your program specified in your program plan application in the sections below**. You will report the actual numbers of clients/contacts/community events for each reported service category in the Part II Utilization/Production data form (located on the online system).** If your estimated number of clients/contacts/community events for reported service categories significantly differ from your actual numbers, you may give a narrative explanation for that discrepancy here.

Treatment Plan Clients (TPC): **None; prevention education attendees will not have treatment plans and will not be considered clients of the agency for these purposes.**

Non-treatment Plan Clients (NTPC): **None; prevention education attendees will not be considered clients of the agency for these purposes.**

Community Service Events (CSE): **Number of in-person educational presentations presented by RACES staff or specially-trained RACES volunteers.**

Actual CSEs for FY19 (423) was significantly over the estimated 100. We believe this represents an overly-conservative estimate made when coming out of a "rebuilding year", as well as a success in the growth of this program in FY19 – word of mouth as to the quality of our services, combined with a new Coordinator, allowed for significant growth.

Service Contacts (SC): **Number of individuals who attend and participate in one of our sexual violence prevention education presentations. Because many of our presentations are multi-session, and we have no way of tracking attendees between sessions, this number will of necessity be a duplicated number of people. For information tables at fairs or festivals, we count the number of people who stop at our table and say something to the staffers.**

Actual SCs for FY19 (8986) was significantly over the estimated 2000. This number is tied to the CSEs – SCs are the participants in the SCEs, as defined for this application/these services. In the application estimates, this broke down to approximately 20 people (SCs) per class (SCE): 200 / 100 = 20

For FY19 actuals, this ratio is appreciably the same at 21 people per class: 8986 / 423 = 21.2

The FY19 actuals track very closely with the FY20 application targets (400 SCEs and 8,000 SCs). The SCs represent a duplication of individuals, given the multi-class (SCE) nature of the work. For FY20, we will be able to provide a much less-duplicative number, which will therefore be under 8,000, but more accurately reflect the number of individual people in Champaign county impacted by our services.

For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

Rattle the Stars
Youth Suicide Prevention Education
Performance Outcome Report PY19

Agency name: Rattle the Stars
Program name: Youth Suicide Prevention
Submission date: 8/30/2019

Consumer Access – *complete at end of year only*

Eligibility for service/program

1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application)

Our program is available to middle and high school aged youth (ages 12-18) through a school or other organization, and adults that have contact with these youth. We require a minimum group size of 5 and a minimum of 45 minutes to conduct a presentation.

2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)?

Eligibility was determined by self-report. All youth attending a school in Champaign County were considered eligible. All adults who had contact with youth in Champaign County (parent, educator, service provider, coach, mentor, etc.) were eligible.

3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.)

We had information tables at events in the community, including events such as the Disability Resource Expo, the Taste of CU, CU Pride Festival, and Wear Orange Day. We discussed our services in media promotions, and we presented information about our services at community meetings, such as the Community Coalition. We established relationships with key contacts at local schools and agencies that serve youth through direct email. We advertise our services on social media and on our website.

4. a) *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application): 100% of groups who request our service will be served, given that they have a minimum attendance of 5 people.

b) *Actual* percentage of individuals who sought assistance or were referred who received services: 100%

5. a) *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application): Requests/referrals will be assessed for eligibility with 2 business days.

b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application): 100% of clients will be assessed for eligibility within that time frame.

c) *Actual* percentage of referred clients assessed for eligibility within that time frame: 100%

6. a) *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application): The amount of time between assessment and receipt of services will vary, and is difficult to estimate. Services will be guaranteed available within 30 days of request, but may be delivered later due to the scheduling needs of the requesting group.

b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application): 100% of eligible clients will be guaranteed services within 30 days of request.

c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame: 100%

7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application): School/youth group presentations will be planned for 3 45-minute sessions, for a total of 2 hours 15 minutes of engagement. This may be shortened due to the scheduling needs of the group, but will not be less than 45 minutes in total. Adult/community group presentations will be scheduled for an average of 1.5 hours (1 hour - 2 hours depending on the scheduling needs of the group), but will not be less than 1 hour.

b) *Actual* average length of participant engagement in services: We conducted 3 youth presentations for 30 minutes each. This was not a full implementation of the program, but was the amount of time allotted by the requesting school. Our adult/community group presentations averaged 2.5 hours. Our typical program lasts 3 hours, but we had a few groups request shorter presentations of 1-2 hours.

Demographic Information

1. *In your application* what, if any, demographic information did you indicate you would collect beyond those required (i.e. beyond race/ethnicity, age, gender, zip code)? (Demographic Information, question #1 in the Program Plan application)

None

2. Please report here on all of the extra demographic information your program collected.

We did not collect extra demographic information.

Consumer Outcomes – *complete at end of year only*

During the application process, you identified participant outcomes that your program activities would impact. Here, report the actual participant outcomes achieved as a result of your program activities

1. *From your application,* what impact on consumers did you expect your program activities to have? That is, what outcome(s) did you want your program to have on the people it is serving? (Consumer Outcomes, question #1 in the Program Plan application). Please number each outcome.

Our program is designed to (1) increase confidence and competence to intervene with a youth experiencing a mental illness, mental health crisis, or suicidal thoughts. We hope to (2) increase help-encouraging behavior and help-seeking behavior, as well as (3) reducing stigma.

2. For each outcome, please indicate the specific survey or assessment tool you used to collect information on this outcome in the chart below. (Please remember that the tool used should be evidence-based or empirically validated.)

Additionally, in the chart below, please indicate who provided this information (e.g. participant, participant's guardian(s), clinician/service provider, other program staff (if other program staff, indicate their role).) Please report all sources of information that

apply for each assessment tool (e.g. the XYZ survey may be completed by both a youth client and their caregiver(s).

Outcome:	Assessment Tool Used:	Information Source:
1. increased confidence and competence to intervene with youth experiencing a mental illness, mental health crisis, or suicidal thoughts	Evaluation tools designed for this program in conjunction with the Evaluation Team	Client
2. increase help-encouraging behavior and help-seeking behavior	Evaluation tools designed for this program in conjunction with the Evaluation Team	Client
3. reducing stigma	Evaluation tools designed for this program in conjunction with the Evaluation Team	Client

3. Was outcome information gathered from every participant who received service, or only some? Only some.

4. If only some participants, how did you choose who to collect outcome information from? For short presentations (less than 2 hours) surveys were not provided to participants as time did not allow for completion. For presentations of 2 hours or more, all clients were offered evaluation surveys.

5. How many total participants did your program have? 192

6. How many people did you *attempt* to collect outcome information from? 90

7. How many people did you *actually* collect outcome information from? 75

8. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc) Information was collected at the conclusion of each training presentation that lasted for at least 2 hours.

Results

9. What did you learn about your participants and/or program from this outcome information? Please be specific when discussing any change or outcome, and give appropriate quantitative or descriptive information when possible. For example, you could report the following:

i. Means (and Standard Deviations if possible)
ii. Change Over Time (if assessments occurred at multiple points)
iii. Comparison of strategies (e.g., comparing different strategies related to recruitment; comparing rates of retention for clients of different ethnoracial groups; comparing characteristics of all clients engaged versus clients retained)

Clients rated their knowledge and abilities for suicide intervention on a 4-point scale, with 1 indicating low ratings and 4 indicating high ratings.

Clients reported and understanding of suicide (M=3.78, SD=.53), suggesting reduced stigma. Clients reported knowledge of warning signs (M=3.88, SD=.32), knowledge of what to say to intervene (M=3.73, SD=.44), feelings of comfort to intervene (M=3.61, SD=.54), and feelings of competence to intervene (M=3.57, SD=.52), suggesting increased confidence and competence to intervene. Clients reported knowledge of how to access resources (M=3.87, SD=.38), suggesting an increased ability to promote help-seeking.

While these results are promising, we feel they are limited by the structure of our evaluation tool. We have completed the development of new evaluation tools for the next year.

10. Is there some comparative target or benchmark level for program services? Y/N
No

11. If yes, what is that benchmark/target and where does it come from?

12. If yes, how did your outcome data compare to the comparative target or benchmark?

(Optional) Narrative Example(s):

13. Describe a typical service delivery case to illustrate the work (this may be a "composite case" that combines information from multiple actual cases) (Your response is optional)

14. In what ways was the evaluation used to support changes in practice? What changes were made based on evaluation findings? (Your response is optional)

Utilization Data Narrative –

The utilization data chart is to be completed at the end of each quarter (including quarter 4) using the online reporting system.

Comparative yearly totals (i.e. reporting estimates and actual numbers) and the narrative section described below are to be completed at end of year only.

Here, you will report on the different types of service categories specified in your program plan application. Please remember that programs **do not** need to collect and report on every category- instead, you are to report only the ones that are most useful for understanding program impact.

1. Please copy and paste the definitions of service categories your program specified in your program plan application in the sections below**. You will report the actual numbers of clients/contacts/community events for each reported service category in the Part II Utilization/Production data form (located on the online system).** If your estimated number of clients/contacts/community events for reported service categories significantly differ from your actual numbers, you may give a narrative explanation for that discrepancy here.

   Our data will be collected and reported as Community Service Events (CSE). We plan to participate in at least 5 events to distribute pamphlets and materials, and at least 110 presentations. We anticipate giving at least 100 presentations at schools (reaching an estimated 2000 students), and 10 presentations to other groups (reaching an estimated 150 youth/adults).

Treatment Plan Clients (TPC): not applicable

Non-treatment Plan Clients (NTPC): not applicable

Community Service Events (CSE): We participated in 16 events to distribute pamphlets and materials, 42 planning meetings and promotional events, and 29 trainings and presentations for a total of 87 CSEs.

This was significantly lower than our projections. We were not sufficiently prepared to begin offering the program to youth in schools, and we spent the year further developing the program and designing a comprehensive implementation structure to offer to schools. We developed a program to offer consultations for schools to develop suicide crisis response plans to support the training offered for staff and students. We did begin training adults in the community, which has allowed us to gather feedback and further improve the program.

Service Contacts (SC): not applicable

Rosecrance Central Illinois
Criminal Justice PSC
Performance Outcome Report PY19

Agency name: Rosecrance
Program name: Criminal Justice (FY 19)
Submission date: August 28, 2019

Consumer Access – *complete at end of year only*

Eligibility for service/program

1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application)

The Criminal Justice program serves individuals with mental health or co-occurring mental health and substance use disorders that have involvement in the Champaign County criminal justice system. This includes adults who are presently or within the past six months have been charged with a crime, are on some type of community supervision (probation, parole, conditional discharge, or court supervision), have been found unfit to stand trial, or are on conditional release because they were found not guilty by reason of insanity. Individuals may engage in services from a number of entry points, including the Jail, Drug Court, or the community.

2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)?

Justice involvement within the past six months and completed screening/assessment(s) indicating a mental health and/or substance use needs are the criteria for eligibility to the Criminal Justice program.

3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.)

The following list indicates the various methods by which individuals are identified and referred to the program:

a) Jail staff
b) The mental health staff in the jail
c) Self-referrals within the jail
d) Names gained through the Illinois Jail Data Link program
e) Prior clients of Rosecrance who are incarcerated at the Champaign County Jail
f) Individuals that are sentenced to Problem Solving Court

g) Individuals that are referred by local law enforcement, courts, probation or parole
h) Self-referrals from the community

4. a) *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application):

We estimate that 95% of the people who are referred or seeking assistance will receive the initial screenings

b) *Actual* percentage of individuals who sought assistance or were referred who received services:

- 51% of jail clients engaged or received services
- 100 % of clients referred were screened

5. a) *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application): 5 days or less

b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application): 95%

c) *Actual* percentage of referred clients assessed for eligibility within that time frame: 42%

6. a) *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application): 45 days

b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application): 50%

c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame: 81%

7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application): 5 months

b) *Actual* average length of participant engagement in services: 56 days

Demographic Information

1. *In your application* what, if any, demographic information did you indicate you would collect beyond those required (i.e. race/ethnicity, age, gender, zip code)? (Demographic Information, question #1 in the Program Plan application) None

2. Please report here on all of the extra demographic information your program collected.
N/A

Consumer Outcomes – *complete at end of year only*

During the application process, you identified participant outcomes that your program activities would impact. Here, report the actual participant outcomes achieved as a result of your program activities

1. *From your application,* what impact on consumers did you expect your program activities to have? That is, what outcome(s) did you want your program to have on the people it is serving? (Consumer Outcomes, question #1 in the Program Plan application)

It is our intent that participation in the Criminal Justice program will result in reduced recidivism rates, as well as promote improvement in clients' life circumstances and situation.

2. For each outcome, what specific survey or assessment tool did you use to collect information on this outcome? (Please remember that the tool used should be evidence-based or empirically validated.)

Recidivism will continue to be reported on Treatment Plan Clients by researching future offense data from the date of admission into the program (regardless of what year they were actually admitted) to the date the data is drawn.

We will use the Self-Sufficiency Matrix as a case management tool, to document clients' progress in a number of domains (Access to services, Mental Health, Substance Abuse, and Primary Health) and as a measurement tool to articulate program outcomes.

3. Who provided the information about participant outcome(s)?
(Participant, participant guardian, clinician/service provider, other program staff (if other program staff, who? Program staff entered data into a spreadsheet for the Self-Sufficiency Matrix and one staff outside of this program (in our Performance Improvement Department), pulled the data on recidivism.

4. Was outcome information gathered from every participant who received service, or only some? Outcomes are reported on treatment plan clients only

5. If only some participants, how did you choose who to collect outcome information from? We chose treatment plan clients because they would be the population to receive more than just a screening.

6. How many total participants did your program have? 104 New Treatment Plan Clients and 231 New Non-Treatment Plan Clients

7. How many people did you *attempt* to collect outcome information from?

- For recidivism we looked at the treatment plan clients
- For the Self-Sufficiency Matrix we looked at the 88 people who had been discharged from the program in the fiscal year

8. How many people did you *actually* collect outcome information from?

- For recidivism we identified only **one Treatment Plan** client who had an additional arrest during the fiscal year.
- For the Self-Sufficiency Matrix, we found only **one Treatment Plan** client that had been discharged.

9. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc). Recidivism data was collected at fiscal year-end one time and the Self-Sufficiency Matrix data was collected one time at intake and one time at discharge.

Results

10. What did you learn about your participants and/or program from this outcome information? Please be specific when discussing any change or outcome, and give appropriate quantitative or descriptive information when possible. For example, you could report the following:

i. Means (and Standard Deviations if possible)
ii. Change Over Time (if assessments occurred at multiple points)
iii. Comparison of strategies (e.g., recruitment, retention, treatment, intervention)

Through assistance from the U of I Evaluation Team, we were able to collect and analyze a whole other set of data that based on our logic model, provided valuable information regarding the case management services. Here is the summary of this information:

- Individuals under formal supervision (probation, parole, court supervision) were significantly more likely to have linkages met than those who were not under formal supervision.
- The percentage of linkages made to MRT, substance use, and transportation, were significantly greater for individuals under formal supervision than for individuals not under formal supervision.
- Individuals with a stable housing plan were more likely to have linkages met than individuals who did not have a stable housing plan, but the difference was not statistically significant.
- Those with a stable housing plan made linkages to benefit significantly more than those without a stable housing plan.
- Individuals who were linked to MRT were significantly more likely to have other, non-MRT linkages met than those not were not linked to MRT

11. Is there some comparative target or benchmark level for program services? No

12. If yes, what is that benchmark/target and where does it come from?

13. If yes, how did your outcome data compare to the comparative target or benchmark?

(Optional) Narrative Example(s)

14. Describe a typical service delivery case to illustrate the work (this may be a "composite case" that combines information from multiple actual cases)

15. In what ways was the evaluation used to support changes in practice? What changes were made based on evaluation findings?

None at this time as this if the time we have had the data organized in a way that it can be analyzed. We could not have gotten to this point without the U of I Evaluation Team's assistance. Data reported in 10 above is what we will begin looking at to determine next possible steps. Since most of the rest of our data does not have benchmarks, it's hard to draw any conclusions about programing. We also need to take

a closer look at ALL of the data that is being collected as I question if it is providing any valuable/useful information. I don't believe the recidivism data or the Self-Sufficiency Matrix is/will produce any data of value. We would like to use the Consultation Bank to help us focus on improving our methods of collecting and analyzing data that has value to program improvements.

Utilization Data Narrative – *complete at the end of each quarter using the online reporting system. Complete this section at end of year only.*

Here, you will report on the different types of service categories specified in your program plan application. Please remember that programs **do not** need to collect and report on every category-instead, you are to report only the ones that are most useful for understanding program impact.

1. Please copy and paste the definitions of service categories your program specified in your program plan application in the sections below**. You will report the actual outcomes of service categories in the Part II Utilization/Production data form (located on the online system).** If your estimated service category outcome significantly differs from your actual service category outcome, you may give a narrative explanation for that discrepancy here.

Treatment Plan Clients (TPC):
TPCs will represent all clients engaged in case management services.

Non-treatment Plan Clients (NTPC):
Non-treatment Plan Clients (NTPC) will represent everyone who receives screening and referral information.

Community Service Events (CSE): n/a

Service Contacts (SC): n/a

For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

Rosecrance Central Illinois
Crisis, Access, and Benefits
Performance Outcome Report PY19

Agency name: Rosecrance Central Illinois
Program name: Crisis, Access, & Benefits
Submission date: 8/1/2019

Consumer Access – *complete at end of year only*

Eligibility for service/program

1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application)

Any individuals seeking and in need of behavioral health services are eligible for services.

2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)?

Through direct referrals, first responder requests, phone referrals, and walk-ins, individuals will be screened and assessed by a clinician to determine current behavioral health needs and to provide linkage to appropriate services and needed levels of care.

3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.)

The Crisis Line Coordinator and Supervisor of Access/Crisis/Crisis Residential will provide information through local outreach events. There is also local advertisement through radio ads and billboards. Rosecrance also has membership on Continuum of Care, the I-Plan committee, Mental Health Agency Council, and the Community Coalition, etc.

4. a) *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application):

It is estimated that 100% of those seeking information, screening, or referral will receive those services.

b) *Actual* percentage of individuals who sought assistance or were referred who received services:

Actual percentage of individuals seeking information, screening, or referral services who received this service was 100%.

5. a) *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application):

It is estimated that clients seeking services will be screened the same day they are referred, call, or walk-in.

b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application):

It is estimated that 100% of referred clients will be assessed for eligibility.

c) *Actual* percentage of referred clients assessed for eligibility within that time frame:
Actual percentage of clients assessed for eligibility same day they were referred, called, or walked-in was 100%.

6. a) *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application):
If it is determined the individual is in crisis, services are provided same day. For all other services, such as psychiatric, case management, counseling/therapy, capacity will dictate the length of time from assessment to engagement.

b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application):
It is estimated that 100% of eligible clients experiencing a crisis situation will be engaged in services same day. For internal referrals, the estimated percentage of eligible clients who will be engaged in services within that time frame is estimated to be less than 50%. This estimate comes from the knowledge that for those referred for full mental health assessments, typically only 50% follow through. For all referrals outside the organization, this information is not available.

c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame:
Actual percentage of eligible clients engaged in crisis services same day was 100%.
For internal referrals, we are unable to capture this data in our medical record as we do not have an internal referral form that would capture this information in our data base.

7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application):
For Crisis, Crisis Line, or Access, the average length of engagement is 1-3 days with most individuals being served same day. The exception to this is Benefits Case Management engagement which could take several months for benefits determination and/or acquisition.

b) *Actual* average length of participant engagement in services:
Actual average length of participant engagement in Crisis services is 1.45 days.
Actual average length of participant engagement in Crisis Line is not able to be tracked based on the electronic health record tracking.
Actual average length of participant engagement in Benefits Case Management is not able to be tracked as these clients are grouped in with all Community Support clients in the electronic health record.

Demographic Information

1. *In your application* what, if any, demographic information did you indicate you would collect beyond those required (i.e. beyond race/ethnicity, age, gender, zip code)? (Demographic Information, question #1 in the Program Plan application)
There was no other demographic information collected beyond the requirement.

2. Please report here on all of the extra demographic information your program collected.
Not applicable

Consumer Outcomes – *complete at end of year only*

During the application process, you identified participant outcomes that your program activities would impact. Here, report the actual participant outcomes achieved as a result of your program activities

1. *From your application,* what impact on consumers did you expect your program activities to have? That is, what outcome(s) did you want your program to have on the people it is serving? (Consumer Outcomes, question #1 in the Program Plan application). Please number each outcome.

Through the Access department, individuals will be screened and referred to appropriate services to meet their behavioral health needs. Through the Crisis department, individuals presenting with a mental health crisis will be assessed by a trained clinician to determine and facilitate the needed level of care to mitigate the crisis. Through the Benefits Case Managers, individuals will be assisted with obtaining benefits.

2. For each outcome, please indicate the specific survey or assessment tool you used to collect information on this outcome in the chart below. (Please remember that the tool used should be evidence-based or empirically validated.)

Additionally, in the chart below, please indicate who provided this information (e.g. participant, participant's guardian(s), clinician/service provider, other program staff (if other program staff, indicate their role).) Please report all sources of information that apply for each assessment tool (e.g. the XYZ survey may be completed by both a youth client and their caregiver(s).

Outcome:	Assessment Tool Used:	Information Source:
1. Determine level of care	Suicide Assessment Five-Step Evaluations and Triage (SAFE-T)	Client, Collaterals

3. Was outcome information gathered from every participant who received service, or only some?

For every client assessed in crisis, a disposition regarding level of care was determined, in part, based on the SAFE-T.

4. If only some participants, how did you choose who to collect outcome information from?

Not applicable

5. How many total participants did your program have?

We assessed 1,174 clients in crisis.

6. How many people did you *attempt* to collect outcome information from?

We attempted to collect outcome information from 100% of clients assessed in crisis.

7. How many people did you *actually* collect outcome information from?

We actually collected outcome information from 100% of clients assessed in crisis.

8. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc)

This information was collected during every crisis assessment.

Results

9. What did you learn about your participants and/or program from this outcome information? Please be specific when discussing any change or outcome, and give appropriate quantitative or descriptive information when possible. For example, you could report the following:

i. Means (and Standard Deviations if possible)
ii. Change Over Time (if assessments occurred at multiple points)
iii. Comparison of strategies (e.g., comparing different strategies related to recruitment; comparing rates of retention for clients of different ethnoracial groups; comparing characteristics of all clients engaged versus clients retained)

Not applicable

10. Is there some comparative target or benchmark level for program services? Y/N

No

11. If yes, what is that benchmark/target and where does it come from?

Not applicable

12. If yes, how did your outcome data compare to the comparative target or benchmark?

Not applicable

(Optional) Narrative Example(s):

13. Describe a typical service delivery case to illustrate the work (this may be a "composite case" that combines information from multiple actual cases) (Your response is optional)

14. In what ways was the evaluation used to support changes in practice? What changes were made based on evaluation findings? (Your response is optional)

Utilization Data Narrative –

The utilization data chart is to be completed at the end of each quarter (including quarter 4) using the online reporting system.

Comparative yearly totals (i.e. reporting estimates and actual numbers) and the narrative section described below are to be completed at end of year only.

Here, you will report on the different types of service categories specified in your program plan application. Please remember that programs **do not** need to collect and report on every category- instead, you are to report only the ones that are most useful for understanding program impact.

1. Please copy and paste the definitions of service categories your program specified in your program plan application in the sections below**. You will report the actual numbers of clients/contacts/community events for each reported service category in the Part II Utilization/Production data form (located on the online system).** If your estimated number of clients/contacts/community events for reported service categories significantly differfrom your actual numbers, you may give a narrative explanation for that discrepancy here.
Treatment Plan Clients (TPC):
Non-treatment Plan Clients (NTPC):
Community Service Events (CSE):
Service Contacts (SC):
For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

Rosecrance Central Illinois
Fresh Start
Performance Outcome Report PY19

Agency name: Rosecrance Central Illinois
Program name: C-U Fresh Start
Submission date: 08/30/2019

Consumer Access – *complete at end of year only*

Eligibility for service/program

1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application)

The Eligibility criteria are that participants be 18 or older; be currently on probation or parole; have a prior felony arrest; have a prior gun arrest or a violent crime conviction; law enforcement must have credible information of recent involvement in violent crime; have NO current unresolved case(s).

2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)?

Law Enforcement submits a list of individuals who meet the 6 criteria. A meeting is held between Law enforcement and a subset of MDT members to review packets of information on each potential participant. Once the packets are reviewed and questions asked the 3 MDT members select the individuals that will be invited to the call-in. Law enforcement officials notify probation/parole officers of the selections.

3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.)

The target population learns about the program through their probation/parole officer. The C-U Fresh Start case manager coordinate with the selected individuals' probation/parole officer to schedule a meeting to do introductions, give a description of the C-U Fresh Start program, explain what the call-in is, call-in expectations, and issue an invitation.

4. a) *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application):

The estimated % of individuals referred who received services for FY19 is 60%. This is based on FY18 results as follows: Call In #1: 7 out of 9 (78%); Call In #2: 5 out of 11 (45%); FY19: Call In #1: 2 out of 11 (18%)

b) *Actual* percentage of individuals who sought assistance or were referred who received services:
100% of participants who were referred received services this would include information on community resources and services given at the post call in to all attendees even those who eventually chose not to sign up for the program.

5. a) *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application):
The estimated length of time from referral to assessment for FY19 is 2 weeks. This is based on FY17 results of 3 week average from call-in to ANSA administration (reminder there was a 1 year gap in call ins during FY18).

b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application): The estimated % of referred clients who will be assessed within 2 weeks.

c) *Actual* percentage of referred clients assessed for eligibility within that time frame:
1 out of 2 participants were assessed for eligibility within 2 weeks. FY19 Actual: 50%

6. a) *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application):
The estimated length of time from assessment (ANSA) to engagement in services for FY19 is 3 weeks. This is an estimate due to this criteria being added during FY17 and not being outlined in the inaugural grant application plus the difficulty of engaging this high risk population.

b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application):
The estimated % of call in participants who sign up for services engaging within 3 weeks is 60% FY19. This estimate is based on results for FY17: Engaged: Call In #1 7: of 9 and Call In #2: 5 of 11= Total: 12 of 20 (60%)

c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame:
1 out of 2 participants engaged in services within 3 weeks. FY 19 Actual: 50%

7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application):

The estimated average length of participant engagement in services for FY19 is 9 months. This estimate is based on FY17 results: Total for all engaged participants: 119 months/12 participants= 9.92 months average. As long as offenders remain actively engaged in the program, are approved by the Steering Committee, and are working towards individual goals, they may continue to participate in the program. Therefore, the projected length of involvement in the program will vary by individual.

b) *Actual* average length of participant engagement in services:

FY19 Target: 9 months

FY19 Actual: 6 months

Demographic Information

1. *In your application* what, if any, demographic information did you indicate you would collect beyond those required (i.e. beyond race/ethnicity, age, gender, zip code)? (Demographic Information, question #1 in the Program Plan application)

Other demographic information collected (from ANSA): Crisis/Safety Issues; Living Situation; Family Makeup; Basic Needs/Financial; Mental Health history; Alcohol or Other Drug Abuse; Social and Recreational; Education/Vocational; Legal; Medical/Dental; and Independent Living Skills.

2. Please report here on all of the extra demographic information your program collected.

Data collected from the Adult Needs and Strengths Assessment (ANSA): (3 of participants needing case management assistance in each domain of life)

2 Crisis/Safety Issues; 6 Living Situation; 3 Family Makeup; 4 Basic Needs/Financial; 2 Mental Health history; 4 Alcohol or Other Drug Abuse; 3 Social and Recreational; 5 Education/Vocational; 6 Legal; 3 Medical/Dental; and 0 Independent Living Skills.

Consumer Outcomes – *complete at end of year only*

During the application process, you identified participant outcomes that your program activities would impact. Here, report the actual participant outcomes achieved as a result of your program activities

1. *From your application,* what impact on consumers did you expect your program activities to have? That is, what outcome(s) did you want your program to have on the people it is serving? (Consumer Outcomes, question #1 in the Program Plan application). Please number each outcome.

Decrease gun violence and violent crimes by assisting those who decide to move away from a life of crime and violence to make a fresh start via referrals/linkages to services. According to a report submitted by Champaign Chief of Police Anthony Cobb:

- Champaign: 71 shooting incidents, 3 deaths
- Urbana: 32 shooting incidents, 2 deaths
- Champaign County Sheriff (outside city limits/rural areas): 23 shooting incidents, 0 deaths
- U of I PD: 0 shooting incidents, 0 deaths

In FY 19, Champaign County saw 126 shooting incidents, a 19.04 % increase from FY 18's 102 shooting incidents.

a) Estimated percentages for 3 target areas listed below with benchmark data reported for FY19: a) % of those who agree to engage in the program will receive case management services from the Case Manager. FY18 Target: 100%; FY18 Actual: 100%; FY19 Target: 100%; FY19 Actual: 100%

b) % of the participants successfully linked to at least one identified community service (especially substance use disorder and mental health treatment services), housing, employment, education, benefits enrollment, or vocational support and/or resources.
FY18 Target: 100%; FY18 Actual: 100%
FY19 Target: 100%; FY19 Actual: 100%

2. For each outcome, please indicate the specific survey or assessment tool you used to collect information on this outcome in the chart below. (Please remember that the tool used should be evidence-based or empirically validated.)

Additionally, in the chart below, please indicate who provided this information (e.g. participant, participant's guardian(s), clinician/service provider, other program staff (if other program staff, indicate their role).) Please report all sources of information that apply for each assessment tool (e.g. the XYZ survey may be completed by both a youth client and their caregiver(s).

Outcome:	Assessment Tool Used:	Information Source:
Decrease gun violence	Tracked & Calculated by Champaign and Urbana police departments	Champaign Chief of Police Anthony Cobb and Mary Roberson (City of Champaign)
Participants receive case management services	Adults Needs and Strengths Assessment (ANSA)	Participants and Case Manager

Participants referred/linked to community service resource	N/A (Tracked by Case Manager in Excel Spreadsheet) (Documented in electronic health record as a progress note)	Case Manager

3. Was outcome information gathered from every participant who received service, or only some?
No

4. If only some participants, how did you choose who to collect outcome information from? N/A

5. How many total participants did your program have? 6

6. How many people did you *attempt* to collect outcome information from? 6

7. How many people did you *actually* collect outcome information from? 0. Surveys were mailed out to participants but none were returned.

8. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc.). The ANSA is collected at intake and updated every 90 days. The gun violence data is collected by law enforcement throughout the year. The case manager tracks contact and service linkage data through use of an excel spreadsheet daily and submits the data to the clinical coordinator quarterly.

Results

9. What did you learn about your participants and/or program from this outcome information? Please be specific when discussing any change or outcome, and give appropriate quantitative or descriptive information when possible. For example, you could report the following:

i. Means (and Standard Deviations if possible)
ii. Change Over Time (if assessments occurred at multiple points)
iii. Comparison of strategies (e.g., comparing different strategies related to recruitment; comparing rates of retention for clients of different ethno-racial groups; comparing characteristics of all clients engaged versus clients retained)

Per discussions in the MDT with law enforcement, city officials, probation/parole officers, and representatives of the States Attorney's Office the reasons for the continue rise in shootings despite a concerted unified effort of all parties involved are overwhelming contributing factors such as the following: gang activity, the availability of firearms, normalizing violence, a lack of parenting (parents work long hours or have health/poverty issues themselves, or the fact that many parents grew up without role models themselves, systemic poverty and continued issues with access to and utilization

of local and state government programs. The Champaign Coalition and the MDT remain committed to continuing to chip away at the issues that contribute to gun violence. The groundwork has been laid to add two additional routes of entry into the C-U Fresh Start Program in addition to the Call-In (which will continue) including referral/self-referral and custom notification. Both of which other cities with gun violence deterrence programs have been utilizing.

10. Is there some comparative target or benchmark level for program services? Y/N

Rosecrance benchmarks against previously reported client survey data year by year for quality of services provided, client satisfaction, and client report of outcomes. Additional client demographic is collected and entered into the electronic health record on each individual client, ability to aggregate data for total clients would take a considerable amount of time, however this information is available in the electronic health record and can be reviewed during the annual site visit conducted by CCMHB staff.

11. If yes, what is that benchmark/target and where does it come from?
N/A

12. If yes, how did your outcome data compare to the comparative target or benchmark?
N/A

(Optional) Narrative Example(s):

13. Describe a typical service delivery case to illustrate the work (this may be a "composite case" that combines information from multiple actual cases) (Your response is optional)
At-risk offender is referred to the C-U Fresh Start call-in. The participant is required to attend the call-in but not required to sign up for the program. The participant is signed up for the program during the post call-in meeting on the same night as the call-in or within 2 weeks. The case manager completes the Adults Needs and Strengths Assessment (ANSA) and a service plan with the client at intake. The assessment determines what areas of life the participant needs assistance in. Typical areas include: finding full-time employment, securing housing, obtaining

medical coverage through the Affordable Care Act (ACA), and providing transportation for court and probation meetings. The case manager has telephone and/or face-to-face contact with the participant several times per week to assist them in following through with referrals and service linkage. With the support of intensive case management services the participant is able to make improvements in their daily living skills, employment, housing, education, and health with the goal of deterring them from activities that may result in gun violence. Participant may be in the program anywhere from 2 months to 1 year depending on their needs, motivation, and legal outcomes. Participants can be involved in the program as long as needed.

14. In what ways was the evaluation used to support changes in practice? What changes were made based on evaluation findings? (Your response is optional)

Even though no surveys were returned by participants there has been feedback given by them to the case manager and also in public forums like the Champaign City Council meeting. This feedback included wanting more tangible support with clothing, housing items, transportation and incentives for participating in the program. Due to this feedback the MDT sought out and secured a collaboration with First Followers which will provide mentoring, stipends, vocational/employment skill building, and other supports. Also, Rosecrance utilized funds to purchase bus tokens, bus passes, and gift cards to support clients needing transportation, work clothes/work boots, or items for their apartments when they secure independent housing and incentives/congratulations for any achievements while in the program. We will continue to look for ways to improve the access to the program and the services to the participants to increase the numbers. Although the numbers are small there has been successes including securing full-time employment, securing independent housing, acquiring important documents (DL, birth certificates, social security cards, etc.) needed to secure employment/housing, and enrollment in apprenticeship and educational programs.

Utilization Data Narrative –

The utilization data chart is to be completed at the end of each quarter (including quarter 4) using the online reporting system.

Comparative yearly totals (i.e. reporting estimates and actual numbers) and the narrative section described below are to be completed at end of year only.

Here, you will report on the different types of service categories specified in your program plan application. Please remember that programs **do not** need to collect and report on every category-instead, you are to report only the ones that are most useful for understanding program impact.

1. Please copy and paste the definitions of service categories your program specified in your program plan application in the sections below**. You will report the actual numbers of clients/contacts/community events for each reported service category in**

the Part II Utilization/Production data form (located on the online system). If your estimated number of clients/contacts/community events for reported service categories significantly differ from your actual numbers, you may give a narrative explanation for that discrepancy here.

Treatment Plan Clients (TPC): Number of unduplicated persons identified by the Fresh Start Steering Committee who engage in the program and develop a strengths-based individualized services plan with the Case Manager.
FY18 Estimated TPC: 20
FY18 Actual: 0 (No call ins were held)
FY19 Target: 20
FY19 Actual: 6

Non-treatment Plan Clients (NTPC): Number of persons identified by the Fresh Start Steering Committee who choose not to engage in the program.
FY18 Estimated NTPC: 10
FY18 Actual: 0 (No call ins have been held. Next Call in scheduled for March 8, 2018)
FY19 Target: 10
FY19 Actual: 16

Community Service Events (CSE): Number of MDT (formerly Steering) Committee and other service coordination/planning meetings attended by Case Manager, Supervisor, and/or Administrator. For example, Rosecrance RCI Administrator currently participates in the Specialty Court Steering Committee, Champaign County Re-entry Council, and Crisis Response Planning Committee. The collaboration which results from participation on all of these committees/councils results in more coordinated care for individuals served by Rosecrance RCI Killarney and other organizations.
FY18 Target: 150
FY18 Actual: 60
FY19 Target: 130
FY19 Actual: 190

Service Contacts (SC): SC: Number of Screenings completed.
FY18 Target: 20
FY18 Actual: 0 (No call ins have been held.)
FY19 Target: 20
FY19 Actual: 3

Other: Number of linkages (to transportation, employment, housing, education, healthcare, and behavioral health treatment) which the Case Manager helps develop while working with

Fresh Start participants who engage in the program and develop a strengths-based individualized services plan with the Case Manager. FY18 Estimated Other: 30 FY18 Q1 and Q2: 33 FY19 Target: 30 FY 19 Actual: 29
For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

Rosecrance Central Illinois
Prevention
Performance Outcome Report PY19

Agency name: Rosecrance Central Illinois
Program name: Prevention Program
Submission date: 8/30/19

Consumer Access – *complete at end of year only*

Eligibility for service/program

1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application)

2.

Youth at schools throughout the county are eligible to participate. Afterschool sessions are based on the request of the school/youth-based organization making the request and may include sessions on life skills, substance abuse education and violence prevention. Parents and communities in Champaign County interested in Prevention services or resources may also request special presentations.

3. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)?

Prevention services are available to any student, parent, or community in Champaign County wishing to partner with the Rosecrance Prevention Department.

4. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.)

Outreach to schools, youth-serving organizations, parents, and communities are ongoing. Outreach activities include face-to-face interactions, correspondence, community events, and communication campaigns. Our Prevention Team continues to increase involvement in our community to help our program reach more students, parents, and community members.

5. a) *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application):

Unless there is a scheduling conflict, all persons seeking resources from our Prevention Department will receive prevention services. This is a collaborative effort in which the Prevention staff work directly with schools, youth-serving organizations, parents, and communities to provide the requested services. Every effort is made to find an available Prevention Team member to cover requests for presentations and other services.

b) *Actual* percentage of individuals who sought assistance or were referred who received services:

100% of individuals seeking resources from the Prevention Department received prevention services.

6. a) *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application):

The length of time from request for services to the services being performed is variable and dependent upon the type of request, as some services require more preparation than others.

b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application):

Unless there is a scheduling conflict, all schools and community partners wishing to receive prevention services will receive the requested services as jointly planned.

c) *Actual* percentage of referred clients assessed for eligibility within that time frame:

100% of individuals seeking resources from the Prevention Department received prevention services.

7. a) *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application):

The length of time from request for services to the services being performed is variable and dependent upon the type of request, as some services require more preparation than others.

b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application):

Unless there is a scheduling conflict, all schools, youth and community partners wishing to receive prevention services will receive the requested services as jointly planned.

c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame:

100% of individuals seeking resources from the Prevention Department received prevention services.

8. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application):

The 10-session Too Good for Drugs curriculum is presented weekly on a quarterly basis. The Too Good for Violence curriculum is a 7-session series also presented weekly during a quarter. After school programming is also coordinated on a quarterly basis. Community events and other presentations are generally a one-time engagement.

b) *Actual* average length of participant engagement in services:

The participants in the 10-session Too Good for Drugs curriculum attended, on average, weekly on a quarterly basis. The participants Too Good for Violence curriculum attended the 7-session series also, on average, weekly during a quarter. After school program participants also, on average, attended weekly on a quarterly basis. Community events and other presentations are generally a one-time engagement.

Demographic Information

1. *In your application* what, if any, demographic information did you indicate you would collect beyond those required (i.e. beyond race/ethnicity, age, gender, zip code)? (Demographic Information, question #1 in the Program Plan application)

N/A

2. Please report here on all of the extra demographic information your program collected.

N/A

Consumer Outcomes – *complete at end of year only*

During the application process, you identified participant outcomes that your program activities would impact. Here, report the actual participant outcomes achieved as a result of your program activities

1. *From your application,* what impact on consumers did you expect your program activities to have? That is, what outcome(s) did you want your program to have on the people it is serving? (Consumer Outcomes, question #1 in the Program Plan application). Please number each outcome.

It is the intent of the Prevention services offered to youth, parents, and communities to improve Champaign County youth knowledge and attitudes about alcohol, drugs and/or violence.

2. For each outcome, please indicate the specific survey or assessment tool you used to collect information on this outcome in the chart below. (Please remember that the tool used should be evidence-based or empirically validated.)

Additionally, in the chart below, please indicate who provided this information (e.g. participant, participant's guardian(s), clinician/service provider, other program staff (if other program staff, indicate their role).) Please report all sources of information that apply for each assessment tool (e.g. the XYZ survey may be completed by both a youth client and their caregiver(s).

Outcome:	Assessment Tool Used:	Information Source:
E.g. 1. Increased empowerment in advocacy clients	Measure of Victim Empowerment Related to Safety (MOVERS) survey	Client
Improve Champaign County youth knowledge and attitudes about alcohol, drugs and/or violence	**Too Good for Drugs and Too Good for Violence pre and post-tests**	**Youth (Students)**

3. Was outcome information gathered from every participant who received service, or only some?

All Too Good for Drugs participants take the pre and post-tests evaluations.

4. If only some participants, how did you choose who to collect outcome information from?

Data on the youth knowledge and attitudes about alcohol, drugs and/or violence is only compiled from eligible students at participating schools.

5. How many total participants did your program have?

850

6. How many people did you *attempt* to collect outcome information from?

All students participating in Too Good for Drugs

7. How many people did you *actually* collect outcome information from?

850

8. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc)

Too Good For Drugs pre-test is given at the first day of the program at the beginning of each quarter, and the post-test is give on the last day of the program at the end of each quarter.

Results

9. What did you learn about your participants and/or program from this outcome information? Please be specific when discussing any change or outcome, and give appropriate quantitative or descriptive information when possible. For example, you could report the following:

i. Means (and Standard Deviations if possible)
ii. Change Over Time (if assessments occurred at multiple points)
iii. Comparison of strategies (e.g., comparing different strategies related to recruitment; comparing rates of retention for clients of different ethno-racial groups; comparing characteristics of all clients engaged versus clients retained)

From our pre/post test results we can see an average of about 14 % increase in knowledge from the beginning of the program to the end of the program for all grades. There is also a 10% increase in knowledge between 6th and 7th grade pre-test scores, and a 6% increase in knowledge from 7th grade to 8th grade pre-test scores. This shows that there is an initial improvement in knowledge during a single school year, and retained knowledge through the grade levels.

10. Is there some comparative target or benchmark level for program services? Y/N

There is no national or state benchmark for the Too Good For Drugs/Too Good For Violence pre/post-test results. The intent of the program is to provide an improvement from pre-test to post-test. These improvements are tracked and measured.

11. If yes, what is that benchmark/target and where does it come from?

N/A

12. If yes, how did your outcome data compare to the comparative target or benchmark?

N/A

(Optional) Narrative Example(s):

13. Describe a typical service delivery case to illustrate the work (this may be a "composite case" that combines information from multiple actual cases) (Your response is optional)

N/A

14. In what ways was the evaluation used to support changes in practice? What changes were made based on evaluation findings? (Your response is optional)

N/A

Utilization Data Narrative –

The utilization data chart is to be completed at the end of each quarter (including quarter 4) using the online reporting system.

Comparative yearly totals (i.e. reporting estimates and actual numbers) and the narrative section described below are to be completed at end of year only.

Here, you will report on the different types of service categories specified in your program plan application. Please remember that programs **do not** need to collect and report on every category- instead, you are to report only the ones that are most useful for understanding program impact.

1. Please copy and paste the definitions of service categories your program specified in your program plan application in the sections below**. You will report the actual numbers of clients/contacts/community events for each reported service category in the Part II Utilization/Production data form (located on the online system).** If your estimated number of clients/contacts/community events for reported service categories significantly differ from your actual numbers, you may give a narrative explanation for that discrepancy here.

Treatment Plan Clients (TPC):

Non-treatment Plan Clients (NTPC):

Community Service Events (CSE):

Community Service Events (CSE's) include the number of prevention presentations performed throughout the county. Presentations may be in such places as classrooms, afterschool programs, community-based organizations, and the like. Past year (FY19) projected total for Community Service Events (CSEs) was 950. The actual # of CSEs completed was 1141, which was 120% completion rate.

Service Contacts (SC):

For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

Rosecrance Central Illinois
Recovery Home
Performance Outcome Report PY19

Agency name: ROSECRANCE
Program name: RECOVERY HOME
Submission date: 8/20/2019

Consumer Access – *complete at end of year only*

Eligibility for service/program

1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application)

A licensed recovery home is an alcohol and drug free housing component whose rules, peer-led groups, staff activities and other structured operations are directed toward maintenance of sobriety for persons who exhibit treatment resistance, relapse potential and/or lack of suitable recovery living environments or who recently have completed substance abuse treatment services or who may be receiving such treatment services at another licensed facility.

2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)?

Persons interested in participating in Recovery Home services must complete an application for services. They must meet the American Society for Addiction Medicine (ASAM) criteria for Level II (intensive outpatient) or Level I (outpatient) care, and exhibit treatment resistance, relapse potential and/or lack of suitable recovery living environment.

3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.)

Clients learn about our services from either treatment, completion of residential, court, drug court, AA and NA meetings

4. a) *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application):

The estimated percentage of persons who seek Recovery Home services who receive the services will depend upon program eligibility and bed availability. It is estimated that 80% of those referred will receive a bed.

b) *Actual* percentage of individuals who sought assistance or were referred who received services:

75%

5. a) *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application):

100% of those referred will be assessed prior to/at time of referral

b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application):

100%

c) *Actual* percentage of referred clients assessed for eligibility within that time frame: **100%**

6. a) *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application):

Rosecrance coordinates access to Recovery Home services with the residential treatment provider, to offer a seamless transition at time of discharge from residential to admission to the Recovery Home. If a bed is available at time of referral, access to services will be within 1-2 days

b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application):
5 days

c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame:

7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application):
Rosecrance coordinates access to Recovery Home services with the residential treatment provider, to offer a seamless transition at time of discharge from residential to admission to the Recovery Home. If a bed is available at time of referral, access to services will be within 1-2 days.

b) *Actual* average length of participant engagement in services:
4.5 months

Demographic Information

1. *In your application* what, if any, demographic information did you indicate you would collect beyond those required (i.e. beyond race/ethnicity, age, gender, zip code)? (Demographic Information, question #1 in the Program Plan application)

Demographic information, including residency zip code, race, ethnicity, gender, and date of birth, is tracked in the electronic health record for all Rosecrance services, and will be reported quarterly to CCMHB. Additionally, Rosecrance also collects income level, education level, living arrangement, # of dependents, contact information, primary language, religion, veteran status, marital status, employment status, and legal status.

2. Please report here on all of the extra demographic information your program collected.

Unable to run a report out of our EHR to report on all the information collected

Consumer Outcomes – *complete at end of year only*

During the application process, you identified participant outcomes that your program activities would impact. Here, report the actual participant outcomes achieved as a result of your program activities

1. *From your application,* what impact on consumers did you expect your program activities to have? That is, what outcome(s) did you want your program to have on the people it is serving? (Consumer Outcomes, question #1 in the Program Plan application). Please number each outcome.

One of the foundational principles of lasting recovery is a strong support network and longer engagement in treatment. Recovery home settings provide on-going learning to help decrease the likelihood of relapse and a chance for residents to practice living their new lifestyle in a supportive environment.

2. For each outcome, please indicate the specific survey or assessment tool you used to collect information on this outcome in the chart below. (Please remember that the tool used should be evidence-based or empirically validated.)

Additionally, in the chart below, please indicate who provided this information (e.g. participant, participant's guardian(s), clinician/service provider, other program staff (if other program staff, indicate their role).) Please report all sources of information that apply for each assessment tool (e.g. the XYZ survey may be completed by both a youth client and their caregiver(s).

Outcome:	Assessment Tool Used:	Information Source:
E.g. 1. Increased empowerment in advocacy clients	Measure of Victim Empowerment Related to Safety (MOVERS) survey	Client
Successful linkage to items in individualized plan: affordable housing, vocational/educational resources, medical, dental, psychiatric/counseling services	EHR	EHR
Engagement in 12-step support groups	Client meeting sheet	Client
Step down to less intensive services	Counselor report	Counselor
Secured housing	Lease	Client
Secured employment or engagement in education program	Pay Stub	Client

3. Was outcome information gathered from every participant who received service, or only some?

Only some

4. If only some participants, how did you choose who to collect outcome information from?

Only Champaign County residents

5. How many total participants did your program have?

11

6. How many people did you *attempt* to collect outcome information from?

100%

7. How many people did you *actually* collect outcome information from?

11

8. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc)

Through out services

Results

9. What did you learn about your participants and/or program from this outcome information? Please be specific when discussing any change or outcome, and give appropriate quantitative or descriptive information when possible. For example, you could report the following:

i. Means (and Standard Deviations if possible)
ii. Change Over Time (if assessments occurred at multiple points)
iii. Comparison of strategies (e.g., comparing different strategies related to recruitment; comparing rates of retention for clients of different ethnoracial groups; comparing characteristics of all clients engaged versus clients retained)

We look at the change from admission to discharge, by reviewing their service plan with them, behaviors in the recovery home, engagement in 12 steps, and employment. The clients who is engaged in 12 step and employment have done better than those who have not.

10. Is there some comparative target or benchmark level for program services? Y/N

No

11. If yes, what is that benchmark/target and where does it come from?

12. If yes, how did your outcome data compare to the comparative target or benchmark?

(Optional) Narrative Example(s):

13. Describe a typical service delivery case to illustrate the work (this may be a "composite case" that combines information from multiple actual cases) (Your response is optional)

14. In what ways was the evaluation used to support changes in practice? What changes were made based on evaluation findings? (Your response is optional)

Utilization Data Narrative –

The utilization data chart is to be completed at the end of each quarter (including quarter 4) using the online reporting system.

Comparative yearly totals (i.e. reporting estimates and actual numbers) and the narrative section described below are to be completed at end of year only.

Here, you will report on the different types of service categories specified in your program plan application. Please remember that programs **do not** need to collect and report on every category- instead, you are to report only the ones that are most useful for understanding program impact.

1. Please copy and paste the definitions of service categories your program specified in your program plan application in the sections below**. You will report the actual numbers of clients/contacts/community events for each reported service category in the Part II Utilization/Production data form (located on the online system).** If your estimated number of clients/contacts/community events for reported service categories significantly differ from your actual numbers, you may give a narrative explanation for that discrepancy here.

Treatment Plan Clients (TPC): 11

Non-treatment Plan Clients (NTPC): 0

Community Service Events (CSE): 0

Service Contacts (SC): 93

For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

Rosecrance Central Illinois
Specialty Courts
Performance Outcome Report PY19

Agency name: Rosecrance
Program name: Specialty Courts
Submission date: August 30, 2019

Consumer Access – *complete at end of year only*

Eligibility for service/program

1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application)

Eligibility criteria includes the participant being a convicted felon, not classified as high risk dangerous, not be convicted of a non-probationable offense under 20 ILCS 301/40-5; not have a mental illness or developmental disability which would interfere with completing requirements to graduate from Drug Court; complete a Drug Court Assessment; be willing to engage in and comply with the treatment and supervision requirements of drug court; and be residents of Champaign County at time of assessment and time of offense.

2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)?

Participants must be assessed as MEDIUM-HIGH RISK/HIGH NEEDS on a Validated Risk and Needs Assessment approved by the Champaign County Drug Court. Assessment must show the participant has a drug or alcohol addiction or dependency.

3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.)

Potential participants are identified by defense counsel, state's attorney, law enforcement, family, and friends. Defendants can request to be assessed for drug court through their attorney/counsel.

4. a) *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application): Estimated percentage of persons requesting/referred to drug court who receive services for FY19 is 70%. In 2016, 51% of the individuals that requested an assessment for drug court were found eligible and accepted into the program. In 2017, 70 % of the individuals that requested an assessment for drug court were found eligible and accepted into the program.

b) *Actual* percentage of individuals who sought assistance or were referred who received services: For FY 19 61% of those who applied to drug court were found eligible AND accepted

to the program. 75% assessed were accepted into the program. 26% of all that applied in FY19 were deemed ineligible to be assessed.

5. a) *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application): Consumers who received assessment within three business days of sentencing to Drug Court.
FY18 Target: 90%; FY18 Actual: 63%; FY19 Target: 90% FY19 Actual: Undetermined due to Champaign County Drug Court changing program policy to require substance abuse assessment be completed prior to sentencing date.

b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application): Consumers who received assessment within three business days of sentencing to Drug Court.
FY18 Target: 90%; FY18 Actual: 63%; FY19 Target: 90%; FY19 Actual: Undetermined due to Champaign County Drug Court changing program policy to require substance abuse assessment be completed prior to sentencing date.

c) *Actual* percentage of referred clients assessed for eligibility within that time frame: This measurement is no longer valid due to changes in the drug court program. All individuals requesting drug court are now assessed prior to being considered. A substance abuse assessment is completed at the jail while the individual is still incarcerated and awaiting a court date. Once the individual is assessed then the drug court team will staff the applicant to determine eligibility. If accepted then the individual is scheduled for intake at residential or intensive outpatient services.

6. a) *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application): Clients who began treatment within three business days of assessment.
FY18 Estimate: 95% of clients began treatment within three business days of assessment (excluding clients court-ordered to remain incarcerated). (100% of clients engaging in outpatient services began treatment within three business days. 100% of clients who did not begin treatment within three business days were court-ordered to remain incarcerated until residential services were available.)
FY18Actual: 37%
FY19 Target: 95%

b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application): Clients who began treatment within three business days of assessment.
FY18 Estimate: 95% of clients began treatment within three business days of assessment (excluding clients court-ordered to remain incarcerated). (100% of clients engaging in outpatient services began treatment within three business days. 100% of clients who did not begin treatment within three business days were court-ordered to remain incarcerated until residential services were available.)
FY18 Actual: 37%
FY19 Target: 95%

c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame: FY19 Actual: 67%

7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application):

Estimated average length of participant engagement in services is a minimum 1 year of sobriety, however most participants are in the program for 1.5 years.

b) *Actual* average length of participant engagement in services:

Average length of participant engagement in services is a minimum 1 year of sobriety, however most participants are in the program for 1.5 years. This has not changed from previous fiscal year reports due to the drug court program being set up for participants to progress through phases towards graduation from the program.

Demographic Information

1. *In your application* what, if any, demographic information did you indicate you would collect beyond those required (i.e. beyond race/ethnicity, age, gender, zip code)? (Demographic Information, question #1 in the Program Plan application)

In addition to the required demographic information Rosecrance also collects income level, education level, living arrangement, the number of dependents, contact information, primary language, religion, veteran status, marital status, employment status, and legal status.

2. Please report here on all of the extra demographic information your program collected.

Additional client demographic is collected and entered into the electronic health record on each individual client, ability to aggregate data for total clients would take a considerable amount of time, however this information is available in the electronic health record and can be reviewed during the annual site visit conducted by CCMHB staff.

Consumer Outcomes – *complete at end of year only*

During the application process, you identified participant outcomes that your program activities would impact. Here, report the actual participant outcomes achieved as a result of your program activities

1. *From your application,* what impact on consumers did you expect your program activities to have? That is, what outcome(s) did you want your program to have on the people it is serving? (Consumer Outcomes, question #1 in the Program Plan application). Please number each outcome.

1) Drug court aims to eliminate substance abuse among the participants, decrease recidivism, help participants to achieve and maintain sobriety, and decrease the costs of crimes associated with substance abuse.

2) The Drug Court Coordinator tracks the recidivism rate of the drug court graduates. Recidivism refers to graduates who are convicted of a new charge (excluding minor traffic offenses or ordinance violations) or are returned to court on a revocation of probation. Client charts also are used to track progress in treatment, including admission and discharge data required for SAMHSA National Outcome Measures (NOMs).

3) The Champaign County Drug Court Coordinator provides the data the recidivism rate of the drug court graduates. Clinical staff enter admission and discharge data required for SAMHSA NOMs in the client chart at intake and at time of discharge. Positive changes in substance use, employment/education, and 12-step group involvement are anticipated for those who engage in the program.

4) The Champaign County Drug Court Coordinator provides the data the recidivism rate of the drug court graduates. Clinical staff enter admission and discharge data required for SAMHSA NOMs in the client chart at intake and at time of discharge. Positive changes in substance use, employment, education, and 12-step group involvement are anticipated for those who engage in the program.

5) Rosecrance benchmarks against previously reported data year by year for quality of services provided and NOMs outcomes.

6) a) No. of Graduates: FY18 Target: 20; FY18 Actual: 11; FY19 Target: 20; b) % of Graduates who donot experience recidivism: FY18 Target: 65%; FY18Actual: 64%; FY19 Target: 65%;
b) Individuals with potential barriers who received Case Management services.
FY18 Target: 100%; FY18 Actual: 100%; FY19 Target: 100%

2. For each outcome, please indicate the specific survey or assessment tool you used to collect information on this outcome in the chart below. (Please remember that the tool used should be evidence-based or empirically validated.)

No new recidivism data is available at this time. The last report was through the May 23, 2018 graduating class. This may be due to turnover in the probation department leadership. As soon as new data is provided it will be included in the quarterly report and the next end of year report.

Additionally, in the chart below, please indicate who provided this information (e.g. participant, participant's guardian(s), clinician/service provider, other program staff (if other program staff, indicate their role).) Please report all sources of information that apply for each assessment tool (e.g. the XYZ survey may be completed by both a youth client and their caregiver(s).

Outcome:	Assessment Tool Used:	Information Source:
See #9 below	Rosecrance Client Satisfaction Survey	Clients
6) a) No. of Graduates: 18	Not applicable	Rosecrance Staff /Champaign County Drug Court Staff Report
6) b) Individuals with potential barriers who received Case Management services: 100%	Not applicable	Progress Notes in electronic health record Avatar

3. Was outcome information gathered from every participant who received service, or only some?

Only some, the client satisfaction survey is provided to all clients twice a year, but it is completely voluntary with clients having the option to not participate.

4. If only some participants, how did you choose who to collect outcome information from? Clients chose whether or not to complete the survey.

5. How many total participants did your program have?

For fiscal year 2019, Rosecrance served 48 (24 continuing/24 new) unduplicated Drug Court consumers.

6. How many people did you *attempt* to collect outcome information from?

20

7. How many people did you *actually* collect outcome information from? 8?

8. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc.) The client satisfaction survey is distributed twice a year.

Results

9. What did you learn about your participants and/or program from this outcome information? Please be specific when discussing any change or outcome, and give appropriate quantitative or descriptive information when possible. For example, you could report the following:

i. Means (and Standard Deviations if possible)
ii. Change Over Time (if assessments occurred at multiple points)
iii. Comparison of strategies (e.g., comparing different strategies related to recruitment; comparing rates of retention for clients of different ethno-racial groups; comparing characteristics of all clients engaged versus clients retained)

Sample of some of the Client Satisfaction Survey questions/answers:

1) I am aware of my progress toward the goals of my treatment plan.
    a. Strongly Disagree 0 0%
    b. Disagree 0 0%
    c. Neutral 1 12%
    d. Agree 3 38%
    e. Strongly Agree 4 50%
    f. Total Responses: 8 Mean: 4.38 Standard Deviation: 0.74
2) I am satisfied with the services I receive from Rosecrance.
    a. Strongly Disagree 0 0%
    b. Disagree 0 0%
    c. Neutral 1 12%
    d. Agree 4 50%
    e. Strongly Agree 3 38%
    f. Total Responses: 8 Mean: 4.25 Standard Deviation: 0.71
3) I feel prepared to continue my recovery and wellness outside of Rosecrance.
    a. Strongly Disagree 0 0%
    b. Disagree 0 0%

c. Neutral 1 12%
d. Agree 2 25%
e. Strongly Agree 5 62%
f. Total Responses: 8 Mean: 4.50 Standard Deviation: 0.76

4) I am satisfied with the services I have received overall.
   a. Strongly Disagree 0 0%
   b. Disagree 0 0%
   c. Neutral 1 12%
   d. Agree 4 50%
   e. Strongly Agree 3 38%
   f. Total Responses: 8 Mean: 4.25 Standard Deviation: 0.71
5) I feel better as a result of my experience at Rosecrance.
   a. Strongly Disagree 0 0%
   b. Disagree 0 0%
   c. Neutral 1 12%
   d. Agree 3 38%
   e. Strongly Agree 4 50%
   f. Total Responses: 8 Mean: 4.38 Standard Deviation: 0.74
6) Treatment at Rosecrance helped me deal with my problem/addiction.
   a. Strongly Disagree 0 0%
   b. Disagree 0 0%
   c. Neutral 1 12%
   d. Agree 3 38%
   e. Strongly Agree 4 50%
   f. Total Responses: 8 Mean: 4.38 Standard Deviation: 0.74
7) Rosecrance provides high quality care and services.
   a. Strongly Disagree 0 0%
   b. Disagree 0 0%
   c. Neutral 1 12%
   d. Agree 4 50%
   e. Strongly Agree 3 38%
   f. Total Responses: 8 Mean: 4.25 Standard Deviation: 0.71

10. Is there some comparative target or benchmark level for program services? Y/N

Rosecrance benchmarks against previously reported data year by year for quality of services provided and NOMs outcomes, however this is the first full year as Rosecrance so there is no data to benchmark against/no comparison data.

11. If yes, what is that benchmark/target and where does it come from?

N/A

12. If yes, how did your outcome data compare to the comparative target or benchmark?

N/A

(Optional) Narrative Example(s):

13. Describe a typical service delivery case to illustrate the work (this may be a "composite case" that combines information from multiple actual cases) (Your response is optional)

A typical drug court client is referred to Champaign county drug court by their defense attorney in hopes of deferring a jail/prison sentence in exchange for participation in the drug court treatment program. The client is assessed typically in jail while awaiting court, then the assessment is reviewed and if accepted the client is referred to drug court. The client is admitted into either residential or outpatient treatment services based on the results of the substance abuse assessment. The client will spend 28 days at residential and then be transferred to intensive outpatient treatment services and eventually stepped down to continuing care treatment services as they work through the drug court phases. The client typically is followed from admission to graduation by the same addiction counselor. The client will receive case management (transportation and referral services), individual and group sessions, as well as toxicology testing. Upon completion of all treatment program requirements and drug court phases the client will participate in a graduation ceremony. Also, the client is required to have a sponsor, participate in AA/NA support groups, have a job and return once a month to sit in on a treatment group for the first 6 months following graduation.

14. In what ways was the evaluation used to support changes in practice? What changes were made based on evaluation findings? (Your response is optional)

Utilization Data Narrative –

The utilization data chart is to be completed at the end of each quarter (including quarter 4) using the online reporting system.

Comparative yearly totals (i.e. reporting estimates and actual numbers) and the narrative section described below are to be completed at end of year only.

Here, you will report on the different types of service categories specified in your program plan application. Please remember that programs **do not** need to collect and report on every category- instead, you are to report only the ones that are most useful for understanding program impact.

1. Please copy and paste the definitions of service categories your program specified in your program plan application in the sections below**. You will report the actual numbers of clients/contacts/community events for each reported service category in the Part II Utilization/Production data form (located on the online system).** If your estimated number of clients/contacts/community events for reported service categories significantly differ from your actual numbers, you may give a narrative explanation for that discrepancy here.

   In addition to consumers' court ordered to remain incarcerated, there were also changes to the drug court referral procedure on the court side. Potential participants are now assessed prior to being considered for drug court, therefore most referral to assessment and assessment to treatment times are longer than 3 days due to those two factors. Clients whose assessments recommend residential treatment

are court ordered to remain in jail until a residential bed opens up or to complete jail time prior to entering residential, thus impacting treatment start dates. There was also staff turnover at RCI in FY19: Addictions Counselor Lyssa Barth resigned August 10, 2018 and was eventually replaced by Jason Abrams (start date 11/5/18); RCI Outreach Worker Zachary Dawkins resigned to take a position with the Champaign County Court as the Drug Court Coordinator and therefore remains on the team but in a different role. He was replaced by Mark Dotson on June 24, 2019. Updates and revisions to the drug court program treatment phases also occurred.
Treatment Plan Clients (TPC): Number of Drug Court clients with a strengths-based, individualized Treatment Plan. FY18 Target: 90 (50 Continuing, 40 New) FY 18 Actual: 66 (47 Continuing, 19 New) FY19 Target: 90 (50 Continuing, 40 New) FY 19 Actual: 48 (24 Continuing, 24 New)
Non-treatment Plan Clients (NTPC): Not applicable for this program
Community Service Events (CSE): M = Number of times media reports on Champaign County Drug Court G = Number of Drug Court Graduation Events FY18 Target: 5 total (3 M,2 G) FY18 Actual: 2 total (1 M, 1 G) FY19 Target: 5 total (3 M,2 G) FY19 Actual: 9 total (7 M, 2 G)
Service Contacts (SC): Number of weekly Drug Court reports completed and submitted to Champaign County Drug Court. FY 17 criteria were different therefore not included in this application. FY18 Target: 1700 FY18 Actual: 870 FY19 Target: 1700 FY19 Actual: 1478
For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

The UP Center of Champaign County
Children, Youth, & Families Program
Performance Outcome Report PY19

Agency name: The Uniting Pride (UP) Center of Champaign County
Program name: Children, Youth, and Families Program
Submission date: August 30, 2019

Consumer Access – *complete at end of year only*

Eligibility for service/program

1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application)

The program is available to all LGBTQ+ youth (13-18 years-old) and families with LGBTQ+ youth living in Champaign County.

2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)?

The Youth Coordinator meets with an individual or family referred for the program and has them fill out a demographics form where they report their age, sexual and gender identities, and zip code. This information is used to assess eligibility.

3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.)

During assessment, youth and their families provide feedback on how they learned about our services. A majority of our youth are referred from a health professional (e.g., counselor, doctor). Other sources include our website and social media, community events, and from a family or friend.

4. a) *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application):

It is anticipated that over 90% of consumers who request support group or case management services will be eligible to participate.

b) *Actual* percentage of individuals who sought assistance or were referred who received services:

93% of individuals who sought services or were referred received services.

5. a) *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application):

The Coordinator meets with an individual or family within one week of referral/assistance seeking; individuals or families in immediate need will receive services within 24 hours.

b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application):

c) *Actual* percentage of referred clients assessed for eligibility within that time frame:

100% of referred/assistance seeking clients were assessed for eligibility within that time frame.

6. a) *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application):

Individuals and/or families receive services immediately following assessment since they complete assessment of eligibility at their first program attendance.

b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application):

100%

c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame:

100%

7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application):

Individuals or families engaged in case management are anticipated to be engaged for one month or less. Individuals or families engaged in a support group are anticipated to be engaged for 3 to 6 months, or longer if needed.

b) *Actual* average length of participant engagement in services:

Average length of engagement for case management is 3 weeks.
Average length of engagement for support group is 6 months.

Demographic Information

1. *In your application* what, if any, demographic information did you indicate you would collect beyond those required (i.e. race/ethnicity, age, gender, zip code)? (Demographic Information, question #1 in the Program Plan application)

N/A

2. Please report here on all of the extra demographic information your program collected.

N/A

Consumer Outcomes – *complete at end of year only*

During the application process, you identified participant outcomes that your program activities would impact. Here, report the actual participant outcomes achieved as a result of your program activities

1. *From your application,* what impact on consumers did you expect your program activities to have? That is, what outcome(s) did you want your program to have on the people it is serving? (Consumer Outcomes, question #1 in the Program Plan application)

The UP Center anticipates youth accessing support groups or case management will report an decreased depression, anxiety, and stress. Successful treatment will be benchmarked by any individuals who scored a 2 or 3 on the DASS-21 at baseline who improve to a 1 or 0 by subsequent post-test.

2. For each outcome, what specific survey or assessment tool did you use to collect information on this outcome? (Please remember that the tool used should be evidence-based or empirically validated.)

Depression, anxiety, and stress (DASS-21).

3. Who provided the information about participant outcome(s)? (Participant, participant guardian, clinician/service provider, other program staff (if other program staff, who?_____))

Participant

4. Was outcome information gathered from every participant who received service, or only some?

Every participant filled out the baseline DASS-21. However, because services are not mandatory, some youth did not fill out a follow up assessment.

5. If only some participants, how did you choose who to collect outcome information from?

We collected information from youth who attended multiple quarters.

6. How many total participants did your program have?

7. How many people did you *attempt* to collect outcome information from?

8. How many people did you *actually* collect outcome information from?

9. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc)

Information was collected once every quarter.

Results

10. What did you learn about your participants and/or program from this outcome information? Please be specific when discussing any change or outcome, and give appropriate quantitative or descriptive information when possible. For example, you could report the following:

i. Means (and Standard Deviations if possible)
ii. Change Over Time (if assessments occurred at multiple points)
iii. Comparison of strategies (e.g., recruitment, retention, treatment, intervention)

Quarter 1 (n = 18)

Stress	M = 16.25 (SD = 6.11)	Range = 0 - 32
Anxiety:	M = 15.77 (SD = 7.87)	Range = 0 - 36
Depression:	M = 17.06 (SD = 11.23)	Range = 0 - 38

Quarter 2 (n = 9)

Stress	M = 16.73 (SD = 5.23)	Range = 0 - 30
Anxiety:	M = 14.96 (SD = 8.13)	Range = 0 - 32
Depression:	M = 19.77 (SD = 13.92)	Range = 0 - 42

Quarter 3 (n = 15)

Stress	M = 13.55 (SD = 10.40)	Range = 0 - 36
Anxiety:	M = 11.13 (SD = 6.23)	Range = 0 - 28
Depression:	M = 18.63 (SD = 10.23)	Range = 0 - 38

Quarter 4 (n = 8)

Stress	M = 15.91 (SD = 8.10)	Range = 0 – 30
Anxiety:	M = 10.18 (SD = 8.33)	Range = 0 – 30

Depression:	M = 17.66 (SD = 11.70)	Range = 0 - 38

*** Includes new and returning clients.**

11. Is there some comparative target or benchmark level for program services? Y/N
No

12. If yes, what is that benchmark/target and where does it come from?
N/A

13. If yes, how did your outcome data compare to the comparative target or benchmark?
N/A

(Optional) Narrative Example(s)

14. Describe a typical service delivery case to illustrate the work (this may be a "composite case" that combines information from multiple actual cases)

15. In what ways was the evaluation used to support changes in practice? What changes were made based on evaluation findings?

Utilization Data Narrative – *complete at the end of each quarter using the online reporting system. Complete this section at end of year only.*

Here, you will report on the different types of service categories specified in your program plan application. Please remember that programs **do not** need to collect and report on every category- instead, you are to report only the ones that are most useful for understanding program impact.

1. Please copy and paste the definitions of service categories your program specified in your program plan application in the sections below**. You will report the actual outcomes of service categories in the Part II Utilization/Production data form (located on the online system).** If your estimated service category outcome significantly differs from your actual service category outcome, you may give a narrative explanation for that discrepancy here.

Treatment Plan Clients (TPC):

Treatment Plan Clients (TPC) will be reported as LGBTQ+ adolescents and families in need of case management services. TPCs will provide demographic information, as well as a survey asking about their present needs to help the Program Coordinator or Families Facilitator develop a treatment plan. The UP Center does not directly provide clinical services, however there is an active inter-agency linkage agreement with Rosecrance, in which the UP Center will refer any client in need of clinical services. Case management includes one-on-one meetings between the Program Coordinator and the consumer to create a plan for managing distress, as well as connecting the adolescent to appropriate community resources. New TPCs

are defined as any individual starting case management services for the first time in FY19. Returning TPCs are defined as any individual continuing case management services from FY18 going into FY19. We anticipate 5 new TPCs in FY19.

Non-treatment Plan Clients (NTPC):

Non-Treatment Plan Clients (NTPC) will be reported as LGBTQ adolescents and families attending support groups. NTPCs will be asked to complete a form asking for the same demographic information as TPCs, as well as performance metrics. New NTPCs includes individuals attending the youth or families support groups for the first time in FY19; returning NTPCs includes individuals who attended the youth or families support group in FY18 and returned for FY19. We anticipate at least 15 new NTPCs for the youth support group during FY19 and 15 new NTPCs for the families support group, totaling 30 new NTPCs for FY19.

Community Service Events (CSE):

Community Service Events (CSES) will be reported as events held in the community with the goal of increasing sensitivity and tolerance toward LGBTQ individuals. Community Service Events can include the annual Pride Festival, fundraising events, social gatherings, etc. We currently anticipate 30 CSEs during FY19.

Service Contacts (SC):

Service Contacts will be reported as those individuals who contact The UP Center by email, social media, or phone inquiring about youth or family services. Service Contacts will be tracked only by their reason for contacting The UP Center in a spreadsheet. We currently anticipate 50 service contacts during FY19.

For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

United Cerebral Palsy - Land of Lincoln
Vocational Training and Support
Performance Outcome Report PY19

Agency name: United Cerebral Palsy Land of Lincoln
Program name: Vocational Training and Support MHB
Submission date: 8/28/2019

Consumer Access – *complete at end of year only*

Eligibility for service/program

1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application)

The program will target individuals with a mental health disability, ages 18-55, living in Champaign County who may have substance abuse disorders and require extended support services or vocational training to maintain successful employment, to become job ready and become financially stable. Referrals will come from the Division of Rehabilitation Services, CCRPC, schools and other agencies that serve people with mental illness. Some of the eligible clients may be considered "at risk" and susceptible to abuse, neglect or exploitation because they are not able to access services necessary for their safety, health or welfare or they lack sufficient understanding or capacity to communicate or make responsible decisions. UCP currently holds a contract with CCDDB to provide employment services to people with developmental disabilities. Over the past two years, UCP has had difficulties meeting the projected numbers due to individuals not being eligible for the program because they do not have a developmental disability. Many of the referrals UCP receives are people with a mental health disability. UCP has recognized a need for vocational training and support for people who have a mental health disability.

2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)?

An individual must have medical documentation from a physician that they have a diagnosis of a mental illness to be eligible for the program.

3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.)

Referrals to the program will come from a number of sources - Division of Rehabilitation Services, CCRPC, schools and other community partners who serve people with mental health disabilities. UCP staff also attended community outreach events and networked with other community partners and employers to generate referrals.

4. a) *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application):

100% of the referrals will be assessed for eligibility into the program by meeting with the CCRPC Case Manager to determine whether they meet the eligibility requirements for the program. Only individuals that had felony convictions were refused for services.

b) *Actual* percentage of individuals who sought assistance or were referred who received services:

100% of individuals who sought assistance or were referred were assessed for eligibility. Approximately 96% of persons who sought assistance or were referred received services. 100% of people eligible for services received services. Only individuals that had felony convictions were refused for services.

5. a) *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application):

Program candidates will be contacted by UCP staff within 7 days of receipt of referral and they will set up a schedule for candidates to start the intake process and career assessments and exploration.

b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application):

100% of the referrals will be assessed for eligibility into the program by meeting with the CCRPC Case Manager to determine whether they meet the eligibility requirements for the program. Only individuals that had felony convictions will be refused for services.

c) *Actual* percentage of referred clients assessed for eligibility within that time frame:

100% of the referrals were assessed for eligibility into the program by meeting with the CCRPC Case Manager to determine whether they meet the eligibility requirements for the program. Only individuals that had felony convictions were refused for services.

6. a) *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application):

This was not recorded in the application as it is hard to determine when a client will be able to schedule themselves to come in to start services once they have been deemed eligible for services. Most clients start immediately some start within a week, some within a month; it varies from client to client. The goal is to get a client started as soon as possible but that isn't always possible for this clients circumstances.

b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application):

This was also not recorded in the applications however; the goal is that 100% of clients who were deemed eligible engaged in services as soon as possible. Most clients start services immediately some start within a week, some within a month; it varies from client to client. The goal is to get a client started as soon as possible but that isn't always possible for this clients circumstances.

c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame:

100% of clients who were deemed eligible engaged in services as soon as their schedule deemed them possible. Most clients start services immediately some start within a week, some within a month; it varies from client to client. The goal is to get a client started as soon as possible but that isn't always possible for this clients circumstances.

7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application):

This varies from client to client and was not a number that was recorded in the applications for this reason. Some clients require minimal job supports and others require extensive supports and consistent check ins to maintain successful employment.

b) *Actual* average length of participant engagement in services:

Again, this varies from client to client and was not a number that was recorded in the applications for this reason. Some clients require minimal job supports and others require extensive supports and consistent check ins to maintain successful employment.

Job training curriculum includes: social interaction and communication, resume development, interviewing techniques, filling out applications and job shadowing, appropriate dress and personal hygiene. UCP will provide transportation training if necessary on the bus routes. If individuals have housing needs, UCP will provide information, referral and resources on local community living options. If individuals are interested in the janitorial field, UCP will provide an 8-week janitorial training to program participants. Once they complete the vocational and/or janitorial training, UCP will help participants find a job in the community and provide the job supports necessary for them to be successful. The Employment Specialist/Job Developer will work with local employers on securing jobs, set up interviews and find the right job matches for program participants. Once a job is secured for an individual, the Employment Specialist/Job Developer determines what level of support is needed to maintain the job and a Job Coach is provided to work alongside with the individual at the work site. Money-management training will include developing a budget, paying bills, reducing debt, and savings/checking account information. UCP is partnering with a local bank to provide a representative who will train individuals on these money management skills. Case management will be provided by the Job Development Supervisor to ensure that the individual is maintaining successful employment and financial stability. The Job Development Supervisor will visit job sites, talk to employers, work with individuals on money management maintenance and any job-related issues. Depending on the individual and their illness this process can take very little time or can be very long and require more intensive assistance.

Demographic Information

1. *In your application* what, if any, demographic information did you indicate you would collect beyond those required (i.e. beyond race/ethnicity, age, gender, zip code)? (Demographic Information, question #1 in the Program Plan application)

None.

2. Please report here on all of the extra demographic information your program collected.

None.

Consumer Outcomes – *complete at end of year only*

During the application process, you identified participant outcomes that your program activities would impact. Here, report the actual participant outcomes achieved as a result of your program activities

1. *From your application,* what impact on consumers did you expect your program activities to have? That is, what outcome(s) did you want your program to have on the people it is serving? (Consumer Outcomes, question #1 in the Program Plan application). Please number each outcome.

1. UCP will provide extended job support services to 30 individuals with mental health disabilities.
2. UCP will provide vocational training/self-advocacy skills to 20 individuals with mental health disabilities.
3. 90% of program participants will obtain employment.

2. For each outcome, please indicate the specific survey or assessment tool you used to collect information on this outcome in the chart below. (Please remember that the tool used should be evidence-based or empirically validated.)

Additionally, in the chart below, please indicate who provided this information (e.g. participant, participant's guardian(s), clinician/service provider, other program staff (if other program staff, indicate their role).) Please report all sources of information that apply for each assessment tool (e.g. the XYZ survey may be completed by both a youth client and their caregiver(s).

Outcome:	Assessment Tool Used:	Information Source:
E.g. 1. Increased empowerment in advocacy clients	Measure of Victim Empowerment Related to Safety (MOVERS) survey	Client
UCP will provide extended job support services to 30 individuals with mental health disabilities.	Barriers to Employment Success Inventory, ONET Career Interest Survey, Vocational Assessment, ECDP Plan, Tabe Test	Client, Parent/Guardian, UCP Employment Specialist, Referral source case workers, DRS counselors, job coaches
UCP will provide vocational training/self-advocacy skills to 20 individuals with mental health disabilities.	Barriers to Employment Success Inventory, ONET Career Interest Survey, Vocational Assessment, ECDP Plan, Tabe Test	Client, Parent/Guardian, UCP Employment Specialist, Referral source case workers, DRS counselors, job coaches
90% of program participants will obtain employment	Barriers to Employment Success Inventory, ONET Career Interest Survey, Vocational Assessment, ECDP Plan, Tabe Test, Placement Report	Client, Parent/Guardian, UCP Employment Specialist, Referral source case workers, DRS counselors, job coaches

3. Was outcome information gathered from every participant who received service, or only some?
Outcome information was gathered from every participant.

4. If only some participants, how did you choose who to collect outcome information from? N/A

5. How many total participants did your program have?

25

6. How many people did you *attempt* to collect outcome information from?

25

7. How many people did you *actually* collect outcome information from?

25

8. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc)

At intake, monthly and more often as necessary during services.

Results

9. What did you learn about your participants and/or program from this outcome information? Please be specific when discussing any change or outcome, and give appropriate quantitative or descriptive information when possible. For example, you could report the following:

i. Means (and Standard Deviations if possible)
ii. Change Over Time (if assessments occurred at multiple points)
iii. Comparison of strategies (e.g., comparing different strategies related to recruitment; comparing rates of retention for clients of different ethnoracial groups; comparing characteristics of all clients engaged versus clients retained)

There were many lessons learned in this year of the grant. I believe that one of the biggest lessons learned was that obtaining a job for someone with a mental illness is not necessarily the largest barrier in the process. Maintaining that job when that individual was faced with the added stressors of problems at home or in the workplace proved to be a larger barrier to our participants. These barriers frequently caused clients to have missed shifts, obtain disciplinary actions at work and ultimately quit their jobs without notice causing them to reenter the program. Over time we learned that on the job coaching was not necessarily the best method to making these individuals successful as much as troubleshooting problems prior to them happening or as they were happening. For example, if an individual was experiencing a change in management on the job we found it successful to have them come to the office and discuss strategies regarding change in the workplace and expectations for a new manager or new co-workers. We spent more time preparing and training the individuals for potential workplace stressors.

We also noticed an unusual trend with clients relocating from the area. This was a trend that we not only notice in Champaign county but in all of the areas UCP serves. We noticed that more clients and their families were relocating from the state of Illinois.

10. Is there some comparative target or benchmark level for program services? Y/N
Y

11. If yes, what is that benchmark/target and where does it come from?
The benchmark for the year was to serve 30 individuals. In serving those individuals we want to see successful placements. That is, that the individual is successful and stable in their job without job coaching. Because the definition of successful and stable is different for each individual it is hard to measure this. We look at their individualized goals to see if they are meeting those goals and when they are meeting their goals independently we are able to consider them successful and stable. Because of the nature of our clients some will reenter the program after being considered successful and stable at which point we would reevaluate and start the process over with new individualize goals that line up with their needs at that time.

12. If yes, how did your outcome data compare to the comparative target or benchmark?
Our individuals served was below the number anticipated but only because we were not granted funding for FY20 and started to refer cases out to other agencies, move clients to other programs and stop taking referrals. Had funding been granted for FY20 we would have surpassed our clients served easily. IF funding becomes available for this program again I anticipate that we will once again meet and exceed program capacity.

(Optional) Narrative Example(s):

13. Describe a typical service delivery case to illustrate the work (this may be a "composite case" that combines information from multiple actual cases) (Your response is optional)

14. In what ways was the evaluation used to support changes in practice? What changes were made based on evaluation findings? (Your response is optional)

Utilization Data Narrative –

The utilization data chart is to be completed at the end of each quarter (including quarter 4) using the online reporting system.

Comparative yearly totals (i.e. reporting estimates and actual numbers) and the narrative section described below are to be completed at end of year only.

Here, you will report on the different types of service categories specified in your program plan application. Please remember that programs **do not** need to collect and report on every category-instead, you are to report only the ones that are most useful for understanding program impact.

1. Please copy and paste the definitions of service categories your program specified in your program plan application in the sections below**. You will report the actual numbers of clients/contacts/community events for each reported service category in the Part II Utilization/Production data form (located on the online system).** If your

estimated number of clients/contacts/community events for reported service categories significantly differ from your actual numbers, you may give a narrative explanation for that discrepancy here.

N/A

Treatment Plan Clients (TPC):

UCP expects to serve 30 Treatment Plan Clients for next year - An initial staffing will be held with each program participant during the first month of service to develop an Individual Service Plan that is person-centered and based on the desired employment goals of the individual. At this meeting, UCP staff will address personal, social, financial, and employment issues that may be potential barriers to successfully completing the program. These barriers will be included in the Individual Service Plan with specific goals to address each issue. UCP maintains community resource information booklets in the office that will be available at the time of the staffing. UCP will provide the program participant with information about available services for the person and will link the participant to any other needed services in the community.

Non-treatment Plan Clients (NTPC):

N/A

Community Service Events (CSE):

UCP will provide 40 inservice trainings to the Division of Rehabilitation Services (DRS), CCRPC and other community agencies on how to identify potential candidates for the program. Other public presentations will be held for local disability groups and organizations, colleges and/or universities, high schools and advocacy groups.

Service Contacts (SC):

UCP estimates 90 service contacts/screening contacts for the employment program. Service Contacts/Screening Contacts will include the intake process for all new participants as well as any screenings of potential candidates who do not enter the program.

For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

Urbana Neighborhood Connections Center
Community Study Center
Performance Outcome Report PY19

Agency name: Urbana Neighborhood Connections Center
Program name: Community Study Center
Submission date: 08/30/2019

Consumer Access – *complete at end of year only*
Eligibility for service/program
1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application) In accordance with CCMHB, UNCC continues to provide services to individuals/families who meet the following criteria: (a) are residents of Champaign County as shown by address; (b) have evidence of a need for service based on an assessment; (c) have limited financial resources to meet the cost of their care. UNCC's targeted population includes children and youth in grades K-12 who are enrolled in Urbana School District who benefit from community based academic, social emotional and recreational enrichment activities. More specific; UNCC continues to serve as a link in meeting the need of providing additional community-based efforts that address the issues of emotional and/or mental wellness as it relates to positive self-worth and self-esteem for youth that are "unserved, under served, or inappropriately served."
2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)? 1. Verified via local school districts data base 2. Verified via birth certificate, mail, medical card, etc…
3. How did your target population learn about yourservices? (e.g., from outreach events, from referral from court, etc.) 1. Word of mouth 2. School referral 3. Outreach/awareness events

4. a) *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application): **100%**

b) *Actual* percentage of individuals who sought assistance or were referred who received services: **100%**

5. a) *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application):

The estimated length of time from assessment of eligibility to engagement in services is between 24 to 48 hours; which normally includes review of application/registration documents, communication with parents and school personnel, verification of income (where applicable) and coordination of transportation services.

b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application**): 100%**

c) *Actual* percentage of referred clients assessed for eligibility within that time frame: **100%**

6. a) *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application): **2 days**

b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application): **100%**

c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame: **100%**

7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application):
1 year / 8 years (K – 8th grade)

b) *Actual* average length of participant engagement in services:
1 year or up to 8 years (K-8th grade)

Demographic Information

1. *In your application* what, if any, demographic information did you indicate you would collect beyond those required (i.e. beyond race/ethnicity, age, gender, zip code)? (Demographic Information, question #1 in the Program Plan application)

No additional demographics collected.

2. Please report here on all of the extra demographic information your program collected.

Consumer Outcomes – *complete at end of year only*

During the application process, you identified participant outcomes that your program activities would impact. Here, report the actual participant outcomes achieved as a result of your program activities

1. Was outcome information gathered from every participant who received service, or only some? **Yes**

2. If only some participants, how did you choose who to collect outcome information from?

3. How many total participants did your program have? 220

4. How many people did you *attempt* to collect outcome information from? 220

5. How many people did you *actually* collect outcome information from? 220

6. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc)

1. **Weekly for middle and high school youth and then at final report card distribution**
2. **1 X per year for elementary youth (at end of school year)**

Results

7. What did you learn about your participants and/or program from this outcome information? Please be specific when discussing any change or outcome, and give appropriate quantitative or descriptive information when possible. For example, you could report the following:

i. Means (and Standard Deviations if possible)
ii. Change Over Time (if assessments occurred at multiple points)
iii. Comparison of strategies (e.g., comparing different strategies related to recruitment; comparing rates of retention for clients of different ethnoracial groups; comparing characteristics of all clients engaged versus clients retained)

The following is a summary of key discoveries that have evolved from outcomes related to data collected and/or practices used with service delivery to participants in UNCC's Community Study Center are:

Consistency in routines, direct correlations between classroom academics and afterschool assistance, along with parent/family support continue to be the best combinations that produces positive outcomes related to personal and educational development of school age youth. Examples of strategies used to accomplish productive outcomes are:

1. Begin academics upon arrival and allow for additional time even when other activities are scheduled;
2. Daily backpack checks for all elementary students;
3. Email, text, and/or phone call between classroom teachers and center staff regarding homework and supplemental academics that support class work;
4. Partnering with classroom teachers and administrators to obtain digital resources and websites that compliments the classroom instructions;
5. Hiring retired and current educators to provide supplemental academics;

Partnering with school personnel in an effort to provide social-emotional development activities that are in-line with school district and state level curriculum.

8. Is there some comparative target or benchmark level for program services? Y/ **N**

9. If yes, what is that benchmark/target and where does it come from?

10. If yes, how did your outcome data compare to the comparative target or benchmark?

(Optional) Narrative Example(s):

11. Describe a typical service delivery case to illustrate the work (this may be a "composite case" that combines information from multiple actual cases) (Your response is optional)

12. In what ways was the evaluation used to support changes in practice? What changes were made based on evaluation findings? (Your response is optional)

Utilization Data Narrative –

The utilization data chart is to be completed at the end of each quarter (including quarter 4) using the online reporting system.

Comparative yearly totals (i.e. reporting estimates and actual numbers) and the narrative section described below are to be completed at end of year only.

Here, you will report on the different types of service categories specified in your program plan application. Please remember that programs **do not** need to collect and report on every category- instead, you are to report only the ones that are most useful for understanding program impact.

1. Please copy and paste the definitions of service categories your program specified in your program plan application in the sections below**. You will report the actual numbers of clients/contacts/community events for each reported service category in the Part II Utilization/Production data form (located on the online system).** If your estimated number of clients/contacts/community events for reported service categories significantly differ from your actual numbers, you may give a narrative explanation for that discrepancy here.

Treatment Plan Clients (TPC):

Non-treatment Plan Clients (NTPC):

Non-treatment Plan Clients are defined as service recipients with case records but no treatment (or service) plans, to which substantial services are provided.

UNCC Community Study Center provided community based academic support, tutoring, Reading/literacy/Math instruction, social/emotional development, prevention, intervention, and career opportunities for 220 (124 continued from previous year) Non-Treatment Plan Clients (NTPC).

Community Service Events (CSE):

Service Contacts (SC):

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