Compiled Annual Performance Outcome Reports of CCDDB & CCMHB I/DD Funded Programs for Contract Year 2019

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Compiled Annual Performance Outcome Reports of CCDDB & CCMHB I/DD Funded Programs for Contract Year 2019

Champaign County Regional Planning Commission Community Services
- **Decision Support Person for CCDDB -** $119,629

CU Able, NFP Inc.
- **CU Able Community Outreach -** $15,285

Champaign County Down Syndrome Network
- **Champaign County Down Syndrome Network -** $15,000

Champaign County Regional Planning Commission Head Start
- **Social-Emotional Development Services -** $73,605 (CCMHB funded)

Community Choices
- **Community Living -** $72,500
- **Customized Employment -** $87,000
- **Self-Determination Support -** $116,000

Developmental Services Center
- **Apartment Services -** $429,861
- **Clinical Services -** $174,000
- **Community Employment -** $361,370
- **Community First -** $799,000
- **Connections -** $85,000
- **Employment First** - $80,000
- **Family Development Center -** $562,280 (CCMHB funded)
- **Individual and Family Support -** $404,428
- **Service Coordination -** $410,838

PACE
- **Consumer Control in Personal Support -** $21,000
- **Opportunities for Independence -** $49,000

Rosecrance Central Illinois
- **Coordination of Services - DD/MI -** $35,150

United Cerebral Palsy
- **Vocational Services -** $34,590

Champaign County Regional Planning Commission Decision Support Person Centered Planning Performance Outcome Report – FY19

In your CCMHB program plan (application), you identified performance outcomes in three domains: consumer access, consumer outcomes, and utilization data. Now, you must report on the actual outcomes your program activities achieved in those three domains.

Agency name: Champaign County Regional Planning Commission
Program name: Decision Support Person Centered Planning (FY19)
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)

The following are eligibility criteria for services: 1) all individuals in Champaign County with a suspected ID/DD diagnosis will be eligible for a PUNS meeting. Those who are determined to have an ID/DD diagnosis and registering on PUNS are eligible to participate in a preference assessment; 2) adults with an ID/DD who are in the emergency and critical categories on PUNS, with preference given first to emergency followed by those who have been in critical for the longest period of time, are eligible for conflict free person centered planning; and 3) individuals with an ID/DD diagnosis who are nearing graduation from both public and private high schools in Champaign County and requesting assistance with transition to adult ID/DD services are eligible for Transition Consultant 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 criteria was determined in the following ways:

- As indicated in the DHS PUNS Manual, "The PAS/ISC agency is to use the guidelines put forward in the Level I screening process to ensure there is a reasonable basis to believe the person has a developmental disability. A reasonable basis would include that the person has an intellectual disability (with onset before age 18), cerebral palsy (before 22), epilepsy (before 22), one of the Pervasive Developmental Disorders (PDD) (before 22), or other conditions, such as Autism Spectrum Disorders, that fall within the Related Condition category" (PUNS Form Completion Manual, page 2).

- For individuals completing a preference assessment and registering on PUNS, staff gathered any relevant IEP documentation, psychological evaluations, and/or medical records to indicate an intellectual or developmental disability. If those materials were not made available, staff relied on self-report or guardian report of an intellectual or developmental disability.
- Individuals who participated in person centered planning were required to be registered on PUNS and staff gathered the aforementioned documentation. As directed by CCDDB staff, individuals in DSC's Community First program were served with person centered planning services.
- Eligibility for transition consultant services was determined by referrals from high school professionals, participation in special education classes, and/or IEP documentation.
- In addition, all individuals served were assisted with registering on PUNS if they had not already do so.

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

Target populations learned about the program through referrals from other CCDDB funded programs, outreach events, flyer distribution to local community committees and agencies, referrals from high school professionals, CCRPC's website and social media accounts, direct contact from individuals with ID/DD and their families, and inter-organizational referrals through CCRPC's community services programs.

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 seek assistance or are referred to the Decision Support Person Centered Planning program will receive assistance if they meet program eligibility if staffing capacity allows.

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

100% of clients seeking Decision Support Person Centered Planning services who met eligibility criteria were provided services.

Due to the capacity of 40-45 clients at any given time for the Person Centered Planning Services, at times throughout the fiscal year clients served through DSC's Community First Program had to wait until a client was closed from services before being served.

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 requests for services will be addressed in 48 business hours with completion of assessment of eligibility within 10 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):

95 percent of referred clients will be assessed for eligibility within the designated timeframe described above.

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

95 percent of referred clients were assessed for eligibility within the designated timeframe described above for Person Centered Planning and Transition Consultant clients.

85 percent of referred clients were assessed for eligibility within the designated timeframe described above for Preference Assessment clients.

NTPC clients registering on PUNS for the first time were not always seen within the 10 business day timeframe due to the high volume of clients registered for PUNS in Champaign County. Crisis situations were prioritized and seen within the 10 time day 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 estimated length of time from assessment of eligibility/need to engagement in services is five 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):

95 percent of referred clients will be assessed for eligibility within the designated timeframe described above.

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

95 percent of referred clients were assessed for eligibility within the designated timeframe described above.

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 is one to three months. Participants participating in person centered planning will be provided case management services and the estimated average length of participant engagement in services is 6 months to one year.

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

Depending on the services provided, participant engagement ranged from one month to one year. Clients served with person centered planning services were engaged as a long as they were still receiving services through DSC's Community First 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)

The Decision Support Person Centered Planning Program will collect the required demographic data of zip code, race, ethnicity, age, and gender. Additional data to be collected is household income of Treatment Plan Clients (TPC), insurance information, and Medicaid RIN number.

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

We collected the following extra demographic information:

- Type of insurance (Medicaid, Medicare, private insurance, etc.).
- If applicable, Medicaid RIN number.
- Household income (TPC clients only)

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. Outcome # 1: Individuals with ID/DD will have greater choice of services and supports in Champaign County.
2. Outcome #2: Individuals with ID/DD transitioning out of secondary education will have a transition plan in place to adult ID/DD services.
3. Outcome #3: Individuals selected from PUNS who were provided service through the Decision Support Person Centered Planning Program will be supported in service connection based on their personal preferences; they will also meet eligibility criteria and have quicker access to Medicaid Waiver Services upon being selected from PUNS.

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:
Individuals with ID/DD will have greater choice of services and supports in Champaign County.	Preference Assessment, Discovery Tool, and Person-Centered Plan.	Client/guardian, provider agency staff

Individuals with ID/DD transitioning out of secondary education will have a transition plan in place to adult ID/DD services.	Transition Plan, Individualized Education Plan (IEP).	Client/guardian, school staff
Individuals selected from PUNS who were provided service through the Decision Support Person Centered Planning Program will be supported in service connection based on their personal preferences; they will also meet eligibility criteria and have quicker access to Medicaid Waiver Services upon being selected from PUNS.	DHS required Pre-Admission Screening (PAS) paperwork and Medicaid Waiver Service award letters.	CCRPC staff, DHS Division of Developmental Disabilities

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

Outcome information, as applicable, was gathered for each participant served. Outcome information collected was based on the service received.

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?

- NTPC = 301
- TPC = 184

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

NTPC (preference assessment) – 154/301 = 52%. 100% of individuals were given the opportunity to complete a preference assessment, however, for individuals who have been on PUNS for several years, they are reporting no changes to their preferences and thus not wanting to complete a preference assessment again.

TPC – 184/184 = 100%

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

Outcome information was collected at the time of the PUNS registration or annual update meeting. Clients served with person centered planning services completed a Personal Plan annually. Personal plan dates coincided with the former Individual Service Plan (ISP) date set forth by the provider.

Results

8. 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:
    1. Means (and Standard Deviations if possible)
    2. Change Over Time (if assessments occurred at multiple points)
    3. 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)

Proposed Outcome: 100% of individuals will be given the opportunity to complete a preference assessment. With the development of a person centered plan, 100 percent of individuals will be supported in identifying services, community resources, and natural supports based on their preferences.
Results: 100% of persons eligible for DD services were given the opportunity to report their service preferences. This is standard practice during annual PUNS registration or PUNS update meetings. However, only 52% choose to participate in a preference assessment. 100% of individuals were supported in identifying services, community resources, and natural supports based on their preferences through the development of a person centered plan.

Proposed Outcome: 100% of eligible individuals working with a Transition Consultant will be registered on PUNS, will be advised of community resources, and will be provided support in developing a transition plan prior to graduation.

Results: 100% of eligible individuals working with a Transition Consultant were registered on PUNS, advised of community resources, and provided support in developing a transition plan prior to graduation.

Proposed Outcome: 95% of individuals selected from PUNS who were provided service through the Decision Support Person Centered Planning will be found eligible for Medicaid Waiver Services through the PAS process. 90% of individuals selected from PUNS who were provided service through the Decision Support Person Centered Planning Program will begin receiving services within three months.
Results: N/A - PUNS selection for 2019 occurred in August, following FY19.

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

No.

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

N/A

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

N/A

(Optional) Narrative Example(s):

12. 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)

<u>TPC – Preference Assessment Case Study</u>
DDB funded ISC staff met with client and his mother at their home to update client's PUNS. Per client, no changes in the past year. ISC checked with client and mom on the TPC goals from last year. Per mom, they have not contacted the RPC Transition Consultants for assistance for transition to adult agencies or to enroll in Medicaid. ISC informed them those TPC goals will continue.

ISC and client created two new TPC goals for client to complete along with applying for Medicaid and contacting a Transition Consultant. Client will send a copy of his ID card and copies of his Social Security benefits letter and step-dad's pay stub to put into his file.

TPC – Person Centered Planning Case Study

During the Discovery process client P. reported that although she enjoys her current job, she does not receive many hours there. She often finishes her tasks early and they send her home even before her shift is up. She identified that she would really like to find a job that could offer her more hours each week and that would be closer to her home as she relies on the MTD system to get her to & from her job.

CCDDB funded ISC wrote this outcome into P.'s plan and presented the plan to the provider. P. is already linked to a formal employment program through the provider. The PCP helped to express her wishes of working closer to home and obtaining more hours to the provider. ISC also spoke with P. about using natural supports to assist her in achieving this outcome as well. P. reported later that her friend was helping her review help wanted ads. She also has been picking up applications on her own and has taken the initiative to speak with a restaurant manager about a job. ISC was able to monitor progress toward desired outcome at quarterly face to face meetings.

TPC – Transition Consultant Case Study

The student's mother contact this Transition Consultant per the recommendation of Jim Mayer, Transition Specialist/STEP Coordinator. The student's mother called the afternoon before her daughter's IEP meeting. She expressed concern that her daughter's school had not provided the necessary life skills classes that she needed and was now trying to push her out to adult services. The mother felt she was not being heard and wanted an advocate present at the review meeting. Mother and this Transition Consultant discussed her vision for her daughter's future. We outlined the tasks required to achieve her daughter's goals for adulthood and what she felt was needed to achieve those goals.

At the IEP meeting the school personnel explained to Mother that her daughter was higher functioning than the students who were going to be attending classes in the fall and that they couldn't afford to provide specialized classes for one student. They recommended she get involved in adult services but if the student wanted to attend classes this fall she certainly could. The student's mother stated she need time to make a decision. They agreed to give her a week to explore adult services and then let them know if the student would be attending fall classes.

The student's mother stated she was not sure if continuing high school after graduation was in the best interest of her daughter or if she should move into adult services. This Transition Consultant agreed to provide her with information about the adult services that may be helpful for her daughter's future. The student's mother contact this Consultant to inform me she and her daughter decided to continue with the classes at her local High School. They also requested follow up appointment mid school year to discuss adult services.

TPC – Transition Consultant Case Study

The Transition Consultant (TC) met with the mother of a student in the Urbana transition program. Since her English is limited, a district interpreter joined us. The mom is interested in planning for her son's exit from secondary education. We discussed the programs eligible to her son at that time. In the meantime, she was told about Champaign Urbana Special Recreation's afterschool program, summer camp, and their scholarships, the DRS Home Services Program, and DSC's Individual and Family Support Program. When her son receives his citizenship, the TC will help mom apply for SSI for her son. Many of the needs expressed by the mom are needs of the entire family. The TC referred the family to the Wesley Evening Food Pantry, which is in the same building as the student's school, to the Refugee Center, to the Child Care Assistance Program with the Child Care Resource Service, and to the Regional Planning Commission for case management services. She was also accepted into the RPC No Limits program.

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

Based on the client identified outcomes and information learned from the Discovery and Person Centered Planning process, if desired, some clients were assisted with identifying additional services/supports and/or requesting assistance with new outcomes.

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 registering on PUNS who need linkage/referral to community resources and brief conflict free case management including gathering of PAS documentation prior to being selected from PUNS; adults receiving conflict free person centered planning who are in the emergency and critical categories on PUNS; and individuals/families receiving Transition Consultant services

Proposed: 100
Actual: 184
Explanation: the average caseload for person centered planning services ranged from 45-50 versus the 40 clients we proposed to serve in our application.

Non-treatment Plan Clients (NTPC):
Individuals registering on PUNS and completing preference assessment and persons PUNS registered updating their preferences.

Proposed: 150
Actual: 301
Explanation: Due to increased outreach events and transition consultant services, more clients are registering on PUNS thus increasing the number of preference assessments (NTPC clients).

Community Service Events (CSE):
Staff presentations and tabling at outreach events, meeting with Champaign County high schools and other professionals.

Proposed: 40
Actual: 59
Explanation: Transition Consultants continue to promote the program and attended a number of outreach events in the community beyond what was anticipated.

Service Contacts (SC):
Individuals attending outreach events.

Proposed: 200
Actual: 462
Explanation: Because we attended more community service events, our screening contact numbers were higher than anticipated. Staff also attended a few events with large audience participation: Future Planning Workshop, disABILITY Resource Expo.

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).

Performance Outcome Report Template

In your CCMHB program plan (application), you identified performance outcomes in three domains: consumer access, consumer outcomes, and utilization data. Now, you must report on the actual outcomes your program activities achieved in those three domains.

Agency name:	**CU Able**
Program name: **CU Able Community Outreach**	
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)

- Consumers will access the website from any location with an internet connection.
- CU Able's scheduled meetings are free and open to anyone who has an interest in the disability community. We require registration for events so that we may collect numbers and demographic figures for event planning and grant writing.

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.)?

- Self-report
- Attendance records

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

- Facebook
- Word of mouth
- Disability Expo
- Monthly parent network 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):

- Most of those who request membership into the Facebook group are approved. Approval is dependent upon the screening question we ask, which is “Please tell us about your connection to special needs in the Champaign-Urbana area.”

- All are welcome at monthly meetings and other events.

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

- 87% of requests for membership were approved.
- 100% of attendees at monthly meetings and other events

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):

- Parent network meetings are held once a month.
- Families can get help with questions or advice from other parents about their child on Facebook at any time. Response times vary, depending on other members in the group.

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):

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. beyond race/ethnicity, age, gender, zip code)? (Demographic Information, question #1 in the Program Plan application)

On the moms retreat registration form, we include an optional question asking for the disability of the child/children they care for.

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

The following disabilities were reported by the caregivers at the moms retreat: Reactive Attachment Disorder, Disinhibited social engagement disorder, fetal alcohol syndrome, ADHD, autism, Oppositional Defiant Disorder, Conduct Disorder, genetic abnormality, global developmental delays, Angelman Syndrome, chiari malformation, Down Syndrome, Tourette’s Syndrome, Apraxia, Epilepsy, Disruptive Mood Dysregulation Disorder, and Sensory Processing Disorder.

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.

FY 2019 Measurable goals are as follows:
1. CU Able will hold 12 regular meetings.
2. CU Able will hold 4 educational opportunities annually.
3. CU Able will reach 10 new TPC and 15 new NTPC.
4. CU Able will plan 2 family events annually.
5. CU Able will organize and host 1 moms retreat annually with at least 35 participants and 50% of them being located in Champaign County.
6. CU Able will record and post 10 events with closed captioning on the Facebook page and website.

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:**
Hold 12 regular meetings	attendance sheets, demographic surveys	participants
Hold 4 educational opportunities	attendance sheets, demographic surveys	participants
Reach 10 new TPC and 15 new NTPC	attendance sheets, demographic surveys, Facebook Insights	parent participants
Plan 2 family events	online sign-ups, Facebook event comments	participants
Organize and host a Moms Retreat with at least 35 participants and 50% of them being located in Champaign County.	demographic information collected at registration	participants
Record and post 10 events with closed captioning on the Facebook page and website.		Facebook videos

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

Attendance sheets were filled out by all participants. Satisfaction surveys were passed out at the end of the moms retreat and filled out by most, but not all, participants.

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

We attempted to collect information from all participants at the monthly meetings, educational events, and moms retreat. We did not attempt to collect information from the family dinners since they were more social and we didn't want to interfere with the dynamics of the families.

5. How many total participants did your program have?

The following are the numbers of family members **(NTPC)** that attended events in FY 2019.

17 participants at the monthly meetings
15 participants at educational events
18 participants in the moms retreat
17 participants at the family dinner

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

We attempted to collect information from all participants at monthly meetings, educational events, the moms retreat, and the family dinner.

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

We collected the following information from family members **(NTPC)** that attended events in FY 2019.

17 participants at the monthly meetings
15 participants at educational events
18 participants in the moms retreat
17 participants at the family dinner

Informal information was also collected in comments in the Facebook group.

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

We collected information at the end of each event or meeting.

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)

From the surveys collected at the moms retreat, we learned that while the moms enjoyed the speaker and the topic, there also was a need for something fun or funny. In previous years we've had activities that involved a lot of laughter, so we held a laughter yoga session at the retreat in July 2019. As in previous years, participants commented on how much they enjoyed their time discussing resources and relaxing with other moms who are on a similar journey.

Attendance at in-person events varied. Many times the same parents came to the monthly meetings, but attendance at those meetings was consistently low. However, our Facebook membership increased by more than double what we expected. This confirmed for us the importance of having an online support network that families can access 24/7/365, such as the CU Able Facebook group.

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.

TPC = person with disability
NTPC = family member of the person with a disability
CSE = all events (whether support, networking/social, or educational) that CU Able hosts
SC = Facebook members

Treatment Plan Clients (TPC):
Target: 52
Actual: 25

Non-treatment Plan Clients (NTPC):
Target: 56
Actual: 29

Community Service Events (CSE):
Target: 16
Actual: 17

Service Contacts (SC):
Target: 100
Actual: 243

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).

Performance Outcome Report Template

In your CCMHB program plan (application), you identified performance outcomes in three domains: consumer access, consumer outcomes, and utilization data. Now, you must report on the actual outcomes your program activities achieved in those three domains.

Agency name: Champaign County Down Syndrome Network
Program name: Family Support Network
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) The DSN offers support to families with members with Down syndrome, the community and professionals by being a source of the most current information as it pertains to the various aspects of Down syndrome. The DSN provides support to new parents, foster, or adoptive parents who are guardians to children and adults with Down syndrome by providing home and/or hospital visits to talk about the experience of having a child with Down syndrome

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.)? Members self-report on their Down Syndrome diagnosis

3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.) The annual Buddy Walk & associated advertising is the largest community outreach event, but many other events including special educational workshops, holiday dinner & various social events bring member families & related professionals via word of mouth, Facebook, our web-site & direct email lists.

4.

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): ongoing

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): Ongoing

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): Ongoing

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

Demographic Information

3. *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 attendance counts & zip codes. Race, ethnicity, age, gender is approximated.

4. 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

8. *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.

This year, DSN has provided targeted activities to particular age ranges as requested by the families we serve. DSN has held a "teen and tween" dance party to encourage both Down syndrome children and their peers to interact in a positive social setting. Second only to the Buddy Walk in attendance, is our holiday party in December which brings nearly all of our families together for a brunch as well as introductions of our new families. Of course, our largest event is the annual Buddy Walk which is usually attended by at least 1000 people each year. DSN hosted many other smaller events throughout the year as well.

The DSN brochures and informational brochures are printed in both English and Spanish. Both area hospitals in Champaign-Urbana receive brochures. The DSN has referred families to appropriate community services such as early intervention, respite, pre-school, early childhood, daycare, vocational and recreation programs. Advocate family members have also assisted families who have children with Down syndrome with support at IEP meetings, vocational and recreational meetings, as well as guardianship assistance. The DSN provides the opportunity for both the community and people with Down syndrome to raise awareness through the Buddy Walk. In September, several board members and their children appeared on WCIA's "Ci Living" to promote the Down Syndrome Network and the Buddy Walk.

9. 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.)
N/A

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

10. Was outcome information gathered from every participant who received service, or only some? N/A

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

12. How many total participants did your program have? **All programs & public interactions including the Buddy Walk, TPCs & NTPCs would be about 1200, see the utilization narrative below for more explanation. Generally, Buddy Walk numbers are excluded from the quarterly reporting.**

13. How many people did you *attempt* to collect outcome information from? N/A

14. How many people did you *actually* collect outcome information from? N/A

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

Results

16. 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:
    1. Means (and Standard Deviations if possible)
    2. Change Over Time (if assessments occurred at multiple points)
    3. 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

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

NO

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

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

(Optional) Narrative Example(s):

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 young couple looking forward to the birth of their first child receives an in-utero diagnosis of Down syndrome for their child. In the 7th month, the mother contacts DSN via our website or Facebook page inquiring about how to connect with other DS families in the area for support. Our new parent liaison calls the mother to encourage her & answer any questions she might have, making her aware of services we provide, upcoming events & if interested, contact information for other mothers of young DS children to connect with.
At that time or shortly after the birth of the child, depending on the family's comfort level with direct interaction, a home visit is scheduled. During the home visit, a new parent packet with many books, brochures & DVDs are presented in a re-usable DSN book bag. If the family is Spanish speaking, a Spanish-speaking member may make the initial connection & present appropriate materials as well.

A friendship is established & the visitor's DS child may come along to meet the family. If interested & available, the father may also be connected with other member fathers too. A friendship connection is made; the new family is added to the email lists & Facebook group. As social events, educational workshops & other opportunities are presented, the family is always encouraged to participate & member families provide ongoing support follow-ups. Depending on any difficulties that we are made aware of regarding chronic medical or developmental issues, DSN may also try to help with an array of community resource connections or reach out regarding specific assistance needs. As the child grows, we provide topical support resources such as discussion panels, workshops (for families and/or professionals), IEP advice/consultations, parent/sibling support events or a variety of social/community parties/events. The 2 largest events of the year that seem to have the broadest appeal is the annual Buddy Walk, which usually attracts well over 1000 participants & the holiday brunch with around 350 DS family related attendees.

The above of course describes an ideal case scenario across a broad spectrum of experiences. Sometimes new families are not receptive to their DS diagnosis & require thoughtful support interactions & careful follow-up. We are sensitive to this & have found it may take months or years of contact for a family to fully embrace DSN participation. Some member families may attend all events, while others may only attend one or two per year. Lastly, we do see good engagement on Facebook & view that as additional critical means for online support for our member families, which often also leads to ad-hoc in-real-life member connections too.

20. 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.

2. 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. **TPCs are people within Champaign County with Down syndrome and/or their immediate family members who attended events (excluding the Buddy Walk)** **NTPCs are people outside of Champaign County or professional within the county involved in programs.** **CSEs are all of our sponsored events, excluding the Buddy Walk. It brings in people from all over east-central Illinois & there were about 1100 people & over 50 teams at the October 2018 Buddy Walk. CSEs also do not include DSN's major sponsorship of the local Penguin Project production of High School Musical Jr. which included about 16 DS children. This production was run by the Champaign Special Rec Dept.**
Treatment Plan Clients (TPC): 243
Non-treatment Plan Clients (NTPC): 118
Community Service Events (CSE): 20
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).

Performance Outcome Report Template

In your CCMHB program plan (application), you identified performance outcomes in three domains: consumer access, consumer outcomes, and utilization data. Now, you must report on the actual outcomes your program activities achieved in those three domains.

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

8. *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.

9. 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.

10. 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.

11. 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.

12. 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.

13. 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).

14. 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

5. *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

6. 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

15. *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.

16. 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

17. 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.

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

19. How many total participants did your program have?

60 Students were referred for social emotional evaluations.

20. 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.

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

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

22. 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

23. 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 turnover rate for teachers was 11%.
This year between January 2019 and June 2019 the turnover 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

24. 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.

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

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

(Optional) Narrative Example(s):

27. 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)

28. 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.

3. 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).

Performance Outcome Report Template

In your CCMHB program plan (application), you identified performance outcomes in three domains: consumer access, consumer outcomes, and utilization data. Now, you must report on the actual outcomes your program activities achieved in those three domains.

Agency name: Community Choices
Program name: Community Living FY19
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)

To be eligible for the Community Living Programs, individuals must be at least 18 years of age and have a documented developmental disability. For the Community Transitional Support services, participants must have the ability and willingness to ultimately live on their own, or with minimal support within one year. Anyone meeting general eligibility requirements and interested in gaining skills can participate in the Personal Development classes.

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.)?

Determination of Developmental Disability/need for services is made through the PUNS screening assessment completed by the PAS agent at the Regional Planning Commission. We ask that all persons seeking services verify that they have completed this screening tool or assist them in completing it. We also ask that they provide documentation of an I/DD diagnosis from a doctor or psychologist.

Determination of ability and willingness to live on their own and participate in the Community Transitional Support program is based on conversations with the person and their family. If they express a desire to move out, we will work with them to make that a possibility.

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

Many of the participants using our Community Transitional Support (CTS) program have been involved for longer than we have kept data on how they heard about our services. We have had 2 new participants in this program this year. One person had been using HBS Self Direction Assistance supports through Community Choices and expressed an interest to move out. They were informed of the CTS program and chose to take part. The other person was a long time member of the Community Choices Co-op and thus aware of the supports we offer. They and their family member were ready to begin a move-out process and contacted us looking for support through this program.

During intakes for membership serval individuals have expressed an interest in using CTS services in the future. Some of these people found out about our services through the school system, word of mouth, and one person was referred by a service provider in Charleston where they are from about supporting their adult child to move to the Champaign area. None of these individuals were ready to start working with us at this time, however.

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):

Formal data on referrals has not, to date, been collected. Informally, in the past year, no individuals who've requested services through the Community Transitional Support program have been turned away.

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

100% of individuals (n=2) who sought support through our Community Transitional Support Program began receiving services. Because both of these individuals were already associated with our organizations, they had already completed intakes and provided necessary documentation.

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):

Engagement in all Community Choices services begins with referral (formal or informal) and an intake meeting with the Membership Coordinator, typically scheduled within two weeks of the initial contact. The length of time between intake and assessment for services is dependent upon how quickly individuals can provide the required documentation.

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):

Formal assessment and documentation of need is based on outside sources (PUNS screening, medical or psychological reports of diagnosis).

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

NA – Based on outside sources

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 Community Transitional Support Program has the capacity to support approximately 15 individuals. Once paperwork is complete individuals seeking support will either begin services right away or be placed on a waiting list and served on a first-come, first served basis if the program is currently at capacity. Since it’s inception, the program has not had more than one or two people on it’s waiting list. They are generally able to be served within 1-3 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):

Because this program has historically had no or a very short waiting list, there is limited data on the length of time between intake and engagement in services.

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

100% of individuals (n=2) seeking support in the Community Transitional Support program began receiving services within the 1-3 month timeframe expected.

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

This program is designed in three phases, plus consultation services that last a total of approximately 2 years from start to fade-out. This timeline may be adjusted due to changes in the individual’s circumstances, increased or decreased support needs, or the participant’s choice to leave the program.

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

A total of 20 people were served in some capacity in the Community Transitional Support Program during FY19.

8 people have been part of the program for 6-7 years. They began in the program prior to the phase model being implemented and have continued to receive minimal “consultation” level supports.

Of these 8 people:

- 1 has restarted the program using the phase based model following a change in his life circumstances
- 2 Continued to receive minimal services because they live with people who are also receiving more extensive support in the program.
- 2 are continuing to receive very minimal consultation/check-in services (and may be closed by the end of FY20)
- 3 were closed by the end of FY19

9 people were part of the program this year and began their support using the phase-based model.

- The overall average length of time in the program for these 9 people is 2.4 years.
- Of the people (n=5) in the final formal stage (Reaching Out), their average length of time in the program is 3.4 years.
- One person restarted the program after several years of support and a change in life circumstances. His time in the program was not factored into the above averages, but instead into the pre-phase reporting on length of time in the program.

3 People received services but discontinued progress either due to change in life circumstances or a personal choice not to work with us.

[These numbers are separate from the individuals who participated in Personal Development Classes. These are an opt-in support. There is not a formal assessment or plan developed for people wishing to participate in this activity besides our general intake process. During FY19 19 total people participated in at least 1 class. (2 people participated from DSC’s Community Day Program, but service contacts/NTPC status was not counted on CC reports. Classes typically last 8 weeks/sessions]

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)

Beyond the basic demographic information required for all CCMHB/CCDDB programs, Community Choices will also gather the individual’s RIN number, their PUNs eligibility, and what type of medical insurance they have access to (Private Insurance, Medicare, Medicaid, etc) in order to provide all needed information for the with the Developmental Disability Specific program reporting and eligibility requirements. Information about involvement with other service providers will also be collected to ensure supports are not duplicated.

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

There were several individuals in the Community Transitional Support Program that were found to not be on the PUNS waiting list. Some of them had originally reported to us that they had signed up in the past, so there was some confusion which continues to be sorted out. At this time there are 3 people who are in the process of registering or appealing their status on the PUNS list.

RIN numbers have also been challenging for some people to report to us, as they self-manage their benefits and have been unsure of where to find this number or have lost the documents that contain it. We continue to update these as the information becomes available to us.

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.

Program Outcome: With planning and support individuals with I/DD can live in community based locations and build social connection.

Outcome Goals: Previous annual survey data was used as a source to develop the following benchmarks:

- 75% of participants will report that participation supported their efforts to live independently. 70% will indicate that participation helped them to connect with others and community.

Consumer Outcome 1 - **PLANNING:** ***Individuals with I/DD plan and develop community-based living options.***

Outcome Goals:

- 4 individuals develop person-centered goals focusing on a move-out plan and skills they would like to work on.

- 4 individuals successfully complete the planning phase by moving into a community-based living situation of their choice.

Consumer Outcome 2 - **MOVE-OUT:** ***Individuals with I/DD develop the skills needed to live independently.***

Outcome Goals:

- 5 individuals successfully complete the Move-Out phase by:
    1. meeting their self-determined goals
    2. improving their POM score in at least one area
    3. showing the ability to complete critical areas for independence on the Independent Living Skills Checklist.
- Individuals will update their plans and goals annually

Consumer Outcome 3 - **REACH-OUT:** ***Individuals with I/DD develop connections to people and community.***

Outcome Goals:

- 6 individuals successfully complete the Reach-out phase by:
    - meeting their self-determined goals
    - improving their initial POM score in at least 2 areas
    - regularly engaging in 1 new activity in the community

Consumer Outcome 4 – **PERSONAL DEVELOPMENT CLASSES:** ***Individuals with disabilities will develop their independent living skills***

Outcome Goals:

- 15 individuals with I/DD will participate. 5 courses will be offered. Individuals can participate in multiple courses.

- 100% of participants will indicate growth or identify a new skill based off the course assessment.

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.)

Program Outcome: With planning and support individuals with I/DD can live in community based locations and build social connection.

Assessment Tool: The Annual Member Survey, designed with the support of the UIUC psychology department and their research-based recommendations to be accessible to those with I/DD, will be used to measure success/satisfaction and personal growth as a result of participation in the CL program.

Consumer Outcome 1 - **PLANNING:** ***Individuals with I/DD plan and develop community-based living options.***

Assessment Tool: Individuals complete Personal Outcome Measures (evidence-based assessment developed by CQL), and an Independent Living Skills Checklist to determine areas where skills development is needed and to refine personal goals for the move-out process. These are initial, baseline assessments of the CTS program.

Consumer Outcome 2 - **MOVE-OUT:** ***Individuals with I/DD develop the skills needed to live independently.***

Assessment Tool: Regular meetings with participants will serve as a formative assessment on progress toward their self-determined goals (these are generally skill-based in the Move-Out phase). Annually, participants renew their POMs and Independent Living Skills Checklist and review their personal goals. This is a mid-program assessment of progress toward outcomes.

Consumer Outcome 3 - **REACH-OUT:** ***Individuals with I/DD develop connections to people and community.***

Assessment Tool: Regular meetings with participants will serve as formative assessment on progress toward self-determined goals (these are generally connection/socially oriented in the Reach-out phase). Annually, participants renew their POMs, independent living skills checklist, and review their personal goals.

Consumer Outcome 4 – **PERSONAL DEVELOPMENT CLASSES:** ***Individuals with disabilities will develop their independent living skills***

Assessment Tool: The number of courses and attendance rate will be recorded. A pre-post course assessment designed to be accessible for and completed by individuals with I/DD will be used to measure the skill growth by participants.

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
Program Outcome: With planning and support individuals with I/DD can live in community based locations and build social connection. **Expected Outcome:** *- 75% of participants will report that participation supported their efforts to live independently. 70% will indicate that participation*	Assessment Tool: The Annual Member Survey, designed with the support of the UIUC psychology department and their research-based recommendations to be accessible to those with I/DD, will be used to measure success/satisfaction and personal growth as a result of participation in the CL program.	The survey is completed by participants in the Community Living Program as well as any involved family members. Completion of the survey is voluntary.

helped them to connect with others and community. **Actual Outcome:** - Unfortunately, the response rate for people involved in the Community Transitional Support program was very low. One 2 people using these supports responded. - Though distributed, no family members of people engage in this program responded. - 100% (n=2) indicated that their involvement helped them to mature and grow “a little”. - 50% indicated that participation supported their independence and connection to the community “a little” while the other person indicated it supported them “somewhat”. -		
Consumer Outcome 1 - **PLANNING:** ***Individuals with I/DD plan and develop community-based living options.*** Expected Outcomes: - 4 individuals develop person-centered goals focusing on a move-out plan and skills they would like to work on. - 4 individuals successfully complete the planning phase by moving into a community-based living situation of their choice.	Assessment Tool: Individuals complete Personal Outcome Measures (evidence-based assessment developed by CQL), and an Independent Living Skills Checklist to determine areas where skills development is needed and to refine personal goals for the move-out process. These are initial, baseline assessments of the CTS program.	Participant interview, discussion, and observation

Actual Outcomes: - 3 people completed the planning phase by developing a plan and moving out. - These individuals developed goals related to budgeting, meal planning, bill paying, organization, getting and using a smart phone, and taking the MTD. - 1 person began the planning process but did not complete it by the end of the year. - 1 additional person was supported to move into a more ideal living situation, but did not re-do the initial planning process. His plan and goals continued to relate more to community engagement and connection.		
Consumer Outcome 2 - **MOVE-OUT:** ***Individuals with I/DD develop the skills needed to live independently.*** Expected Outcomes: 5 individuals successfully complete the Move-Out phase by: - meeting their self-determined goals - improving their POM score in at least one area - showing the ability to complete critical areas for independence on the Independent Living Skills Checklist. - Individuals will update their plans and goals annually Actual Outcomes: 5 People were served in the move out phase - 2 people completed a plan within the move-out phase. (This meant that 1 year had	Assessment Tool: Regular meetings with participants will serve as a formative assessment on progress toward their self-determined goals (these are generally skill-based in the Move-Out phase). Annually, participants renew their POMs and Independent Living Skills Checklist and review their personal goals. This is a mid-program assessment of progress toward outcomes.	Participant interview, discussion, and observation

elapsed since they entered the move-out phase.) 3 other completed a plan during the year but it was their initial plan from when they shifted into the move-out from the planning phase. - All 5 people served in this phase completed a POM interview. This was the initial POM for 1 person (thus there is no score to compare it to). The average score increase for the other 4 individuals was +1 compared to their 1st score. - 4 out of 5 individuals learned independent living skills such as paying bills online, following a weekly schedule, meal prep/cooking, and how to manage a bank account. - 4 out of 5 individuals met the goals outlined in their plans. 1 made personal achievements and progress toward a different living situation, but they did not link explicitly to her written goals. -		
Consumer Outcome 3 - **REACH-OUT:** ***Individuals with I/DD develop connections to people and community.*** Expected Outcomes: 6 individuals successfully complete the Reach-out phase by: - meeting their self-determined goals - improving their initial POM score in at least 2 areas - regularly engaging in 1 new activity in the community	Assessment Tool: Regular meetings with participants will serve as formative assessment on progress toward self-determined goals (these are generally connection/socially oriented in the Reach-out phase). Annually, participants renew their POMs, independent living skills checklist, and review their personal goals.	Participant interview, discussion, and observation

Actual Outcomes: - 6 people were served in the Reaching Out phase. - 5/6 (83%) of people met their self-determined goals. The one person who did not, broke his leg mid-way through the year and moved home while he recuperated. - Participants increased their POM scores by an average of 1.15. - 5/6 people (83%) began engaging in a community/social activity during the year. The one person who did not experienced the broken leg. * An additional 6 people were supported in "Consultation". These individuals had either already completed the 3 phases or been part of the program since before this approach was adopted. Most received minimal and as-needed services such as support with: advocating for repairs and updates at their residences, updating DHS paperwork, bus passes, and linking to social groups such as a video game club at Enchantment alley and an independent brunch club with some other CC members.		
Consumer Outcome 4 – **PERSONAL DEVELOPMENT CLASSES:** ***Individuals with disabilities will develop their independent living skills*** Expected Outcomes: 15 individuals with I/DD will participate. - 5 courses will be offered. Individuals can participate in multiple courses. - 100% of participants will indicate growth or identify a new skill based off the course assessment.	Assessment Tool: The number of courses and attendance rate will be recorded. A pre-post course assessment designed to be accessible for and completed by individuals with I/DD will be used to measure the skill growth by participants.	Participant feedback, and staff observation

Actual Outcomes: 6 Classes were held - Women's Group & Men's Group (social and coping skills) - Health Sexuality - Health Relationships - Home Safety - Community Safety Outcomes: - Women's Group ○ 4/4 (100%) Reported they learned something from the class ○ Examples: Different emotions, how feeling sad was connected to being lonely and scared - Men's Group ○ Unfortunately the last class was cancelled unexpectedly so evaluations were not completed - Home Safety ○ (7/7) 100% participants reported they gained confidence ○ 50% of parents reported a lot more confidence in having their adult children home alone, 50% reported a little more confidence. - Community Safety ○ 6/6 (100%) reported they learned new		

skills related to community safety ○ 50% participants gained confidence ○ 50% participants did not gain confidence - Healthy Relationships ○ 2/6 (40%) learned a lot, 40% learned some, and 20% learned a little ○ 4/5 (80%) reported learning more about all of the 5 target areas. 20% learned more about 3/5 target areas - Healthy Sexuality ○ 4/4 (100%) learned a lot ○ 3/4 (75%) reported learning more about all of the 5 target areas. 25% learned more about 3/5 target areas		

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

Overall program outcome information was gathered using our participant survey. It was requested from all our participants and all of our participants family members for whom we had contact information. This is done with 1 survey that relates to all CC programs and services. It was sent to a total of 206 people. Because only 1 email list of participants is kept, we are not able to report the exact number of people from this list that were specific to the Community Living Program. Participation was optional, though strongly encouraged.

- A total of 33 surveys were returned (response rate of 16%)
- Of these 2 surveys from Community Living Program participants were returned.

- 0 surveys from the family members of Community Transitional Support participants were returned. Many of the individuals that are part of this program do not have strong connections with their family making a low response rate somewhat expected.

Consumer Outcome information related to our Community Transitional Support program was gathered from all participants actively working in the planning, move-out, or reaching out phase. Prior to actively joining the program and developing their first plan, data on goals, etc. is not collected. After an individual has moved into the consultation (as-needed, informal support), they no longer have a formal plan and goals for which data is collected. For these individuals, service contact reports are kept to document support.

Consumer Outcome information related to Personal Development Classes is requested from all people who participate in classes. It is optional but strongly encouraged.

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

Data was attempted to be collected from all participants. The type of data that was gathered was dependent on which part of the program they participated in.

5. How many total participants did your program have?

A total of 19 unique people were served in some capacity in the Community Transitional Support Program during FY19.

A total of 19 unique people participated in our Personal Development classes during FY19 (plus an additional 2 individual which were not counted in formal records as they were DSC clients with supports being reported under their grants)

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

Overall Program Outcome Data – this was sent to a total of 206 people, including all Community Transitional Support participants with email addresses and any family members for whom we had contact information. Because this is kept as one overall contact list, the precise number of Community Living specific individuals the survey was shared with is not easily calculated. We will work on clarifying this process in future years.

Community Transitional Support – We attempted to collect Consumer Outcome Data from the 11 individuals who were working actively through the phases of the program. We did not attempt to collect consumer outcome data for those individuals who were served exclusively with consultation services.

Personal Development Classes
Women’s Group & Men’s Group (social and coping skills) – 5
Health Sexuality - 5
Health Relationships - 5

Home Safety - 7
Community Safety - 6

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

Overall Program Outcome Data – This was gathered with our survey. We received a total of 2 surveys back from people who had participated in some sort of Community Living service.

Community Transitional Support – We collected Consumer Outcome Data from 9 of the 11 individuals we attempted to reach. 1 person had yet to complete their plan and assessments at the end of the fiscal year. The other had a broken leg mid-year and put his services on hold.

Personal Development Classes
Women's Group & Men's Group (social and coping skills) – 5
Health Sexuality – 4 (one person chose not to complete their evaluation)
Health Relationships - 5
Home Safety - 7
Community Safety - 6

Evaluations are completed on the last day of class. If a person was not present for the last day of class, they would not have completed the evaluation.

In the case of Men's group, the final class session was cancelled, so evaluations were not completed.

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

Overall Program Outcome Data – This is collected annually in the spring.

Community Transitional Support – Plans and assessments are completed annually. Data related to individual self-determined goals is collected continually in a formative way and synthesized and reported on quarterly.

Personal Development Class Evaluations – These are gathered at the end of each class throughout the 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)

Community Transitional Support

FY 19 marked a distinct refinement in the Community Transitional Support program and the criteria with which we use to evaluate it. Though the program has continued to work toward the same long term and overall outcomes since it's inception, it was not until FY16 that we outlined the specific 3-phase process. The intent was that this process would take 2-3 years from start to finish. For individuals starting the process from it's start, they are now reaching the end of the expected timeframe. This has also given us reason to examine the process, what is working, what needs more clarity, and where there are areas for improvement.

Our first observation was that movement through the phases tends not to be as linear as we have defined – this was particularly evident for the people who began the program prior to us defining the phase-process. Many of these individuals have continued to receive minimal services even though they are, in most cases, living very independent lives. Though our intent has been to provide supports for a time-limited period and enable people to move forward on their own, we've found that people value their continued connection with us and benefit from an occasional touchstone for troubleshooting that their other natural supports may not be able to offer.

For people who did begin the program using the phase-based approach, we have found that their movement through the phases was also less-linear than the process as defined on paper. This is due to two main reasons. The first is that life is complex, and many circumstances affect a person's trajectory towards large independent living goals. We often find that rather than a linear process, more accurate would be cyclical process. A person plans, learns skills, makes connections, then because of their new abilities and connections makes new plans. For some, they may experience a health crisis which forces them to make a different plan, to re-focus on learning new adaptive skills and takes the emphasis off of building new connections for a period. We have found this to be the case for many of the people that we support. People's needs and goals are fluid and change for many reasons. We try to accommodate this while still focusing on the larger goal of moving out and building an independent life in the community. In learning with our participants, we have also come to better understand the goals and life trajectories of people with I/DD to not be fixed. People don't achieve independence and stay there, static, for the rest of their lives. They make new goals for themselves and continue to grow – and benefit from having supports that can grow with them.

The second reason we have found that has made clear and distinct movement through the phases challenging, is because we had not clearly defined the criteria that indicated a person had shifted into the next phase of their support. As we refined the program for the FY19 grant cycle, we worked to identify clear indicators for the successful completion of each phase. We provide the framework for what is necessary and indicative of increased independence and self-sufficiency and the person defines what goals within that framework are important to them. Each phase is defined both by these self-determined goals as well as the more systematic POM assessment.

This clearer system for defining success for participants has helped us to better track where people still need additional support and when they are approaching a period in their lives where they able to be primarily self-sufficient. We found that the individuals we supported had met many for the self-determined goals they'd set for themselves. These were generally very practical goals relating to cooking, money management, and navigating the rental system. Farther along in the process, goals relating to community connections were often harder to support people in achieving. Unlike their practical counter-parts, connection goals were could be very dependent on others, logistics, and the person's overall comfort with new people and groups. Unsurprisingly, for the people we support in the CTS program, like for all people, finding genuine and meaningful connections was challenging. We did find great success in a weekly brunch club, and a bi-weekly video game group. Both of these started organically between a pair of people who over time and with the support of CC staff invited others into the group. They have become a great starting point for people to build their comfort level with making and maintaining friendships and a great jumping off point for many other untracked but positive and meaningful social experiences.

In the upcoming year, we will continue to refine how we collect data and track people's progress toward full community living. With a clearer picture of the skills and areas where people need support we will be able to better determine where in our process participants are needing more or less support and what are reasonable timeframes for them to achieve their goals. By doing this we will also be able to better track when and how new people can continue to join the program.

Personal Development Classes

During FY19, CC chose to focus on the theme of *Safety* in the selection of classes that were offered. This was chosen based on the observations from staff in their work directly with participants and members, and through suggestions by parents at our Family Support Group regarding the fears and concerns which they felt held them and their adult children back from fuller independence. Classes included all areas of safety – Home Safety (kitchen and cooking safety, security, and emergencies) and Community Safety (transportation, navigation, and safely asking for help when needed). We also did a series on Healthy Relationships (safety and communication in interpersonal relationships) and Sexuality (safety in physical relationships and personally), which was informed by a series of Women's and Men's group classes focusing on social and coping skills.

For all the classes we elicited input from individuals and families about what issues they felt were safety concerns for them and worked to incorporate that information into the class content. We also included a follow up with each class that reviewed the information covered so that the person and/or their family could work to incorporate the learning into normal routines.

Evaluations of classes were positive overall. Participants in most cases indicated that they learned from their time in the classes. We found that the self-reports given by the participants in the class tended not to match the formative assessments gathered throughout the sessions by facilitators. While we greatly value the feedback given directly by self-advocates and people with I/DD generally, this dissonance is something that we realize that we need to address in our evaluation techniques. For example, when asked about one new things that people learned in women's group, answers focused on "emotions" while much of the conversation and formative assessment by facilitators indicated that there were big take-aways relating to communication and how to reach out to friends. We worked this year to have a more consistent and streamlined evaluation tool with the hope that participants would be comfortable with the format. Because the data we got did not seem to be all that reflective of the learning that occurred, we will be working on new techniques in the upcoming year to address these concerns. The current direction is to make the assessment more specific to the content and to ask involved family members to also report on if skills are being generalized into normal routines. We did this in small ways on some of the classes and it seemed to be helpful.

Also noteworthy of our classes this year were our efforts to collaborate with outside community organizations and other service providers. We were able to develop enthusiastic partnerships with RACES to teach our Healthy Relationships Class and Public Health to teach our Sexuality Class. Not only were we able to provide our participants with information from educators who are experts in the content, but in doing so we supported these organizations to be better informed and equipped to support people with I/DD who access their services directly. We were also able to open this class up to participants from DSC's Community Day Services program and hope that it can be pilot for future collaboration.

Achievements Beyond our Deliverables:

For many years individuals and families have come to us looking for alternative housing options. One of the ways that we have sought to support people with this is with Supportive Roommates – a person that lives with a person with I/DD and provides some minimal supports in exchange for free or reduced cost rent. For years it has been very difficult to find people that are interested in taking on this type of role. Families, and us to some extent, have looked to the university to fill this need, but not found success. After several people came to us actively looking for this type of support this year, we decided to take a step back and reexamine or strategy. Instead of looking for students and within known networks, we shifted our focus to the target people who were likely to attracted to the benefits of this type of role. We decided to focus on people who were housing insecure, people who were potentially isolated but open to taking on supportive roles, and those who might be interested in alternative or progressive housing approaches. We created a list of groups and individuals who we felt would be most likely to be connected to people fitting these profiles and educated them on the need and Community Choices' role in supporting this type of work. Late in FY19 we began connecting with a case worker at the Phoenix Center. She was working with a client who was homeless who she felt would be a great fit for this type of role. In early FY20 interviews began with a family and are going well. We are hopeful that this approach could be a mutually supportive strategy to address housing and support needs within the broader community.

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)

The Community Transitional Support (CTS) program was designed to last at a minimum of 2 years, for those participating from start to completion. Below, I will share two examples, one of how service might look when all goes fully as planned, and another for when challenges and other life factors affect outcomes:

Example 1: All goes as Planned

Person A is an individual who experiences a development disability. He is 26, has Autism and lives at home with family. He has a few core interests, in this case sports. He likes helping other people, but doesn't have any friends or strong connections outside of his parents and a few other family members. His family is enthusiastic for him to move out into his own place, but also very worried about how it will work. He is motivated to move out, but is worried that he will disappoint people if it doesn't go well. During the planning phase, Person A and the CTS staff person spend time getting to know each other. They develop a rapport and are able to discuss the person's fears as well as their hopes for what living in their own place will look like. On the team side of things, the CTS staff person is able to facilitate conversations with the entire family about how to make the move successful and comfortable for everyone. He is able to serve as an advocate for Person A when there are disagreements or misaligned expectations. Through this communication and partnership, the entire team feels there is a clear plan and system ready to start up when Person A finds an apartment.

When the person moves into their new place, they focus on getting settled, learning how to get around, where to get groceries – all the essentials. The family is a strong part of this process and are enthusiastic to get the person settled. Once that initial phase has passed the CTS staff and Person A meet regularly. They work on the goals developed during the planning phase. When questions and concerns come up the team communicates with each other, and all parties play a role in offering support when needed.

As the person builds confidence in their skills, the focus of meeting begins to shift toward reaching out and developing stronger ties and connections with friends and community groups. The CTS staff person's role begins to involve more investigating social options and support in encouraging and coaching the person to make those relationships sustainable. As this happens the reliance on the CTS staff begins to fade and the person reaches directly to their landlord for issues with the apartment, to call their friends for rides, and to ask those personal connections for advice when needed. Once these connections are well established, the CTS staff person backs away more formally, but remains a support and resource available when needed.

Example 2: All does not go as planned

Person B is kind, thoughtful, and loves to joke. He recently moved into a new apartment but through a church connection was referred to the CTS program when it was clear that he was struggling to care of his dwelling. He didn't have any family or many other supports in the area. He was working at a local restaurant as a dishwasher.

Though the person was already living in the community, it was not sustainable. The CTS staff person began the planning phase with them, but focused instead on goals that would help build sustainability, rather than on skills necessary for someone to move out for the first time. Meetings begin regularly. Though the initial focus emphasizes skills development, a secondary effort is put toward building the person's connections from the beginning and helping them to grow the network of people they could look to when they need advice or support. Though this effort is going well, while the Person is walking to work, they slip on the ice and experience a back injury. They aren't able to work and though their boss is understanding after a few weeks of him taking time off, he loses his job.

The focus of the CTS staff person then shifts to ensuring that Person B can keep their apartment, utilities, etc. They apply for assistance and research additional community resource to help the situation. With support the CTS staff is able to get the person on a waiting list of Employment support, but also helps out by meeting the person at the library to submit applications. After two months the person runs out of savings and is evicted.

The process at this point goes toward crisis management – keep the person from being homeless, negotiating with the landlord, and accessing additional community resources.
Once the crisis has been weathered, the process goes back to the start – with the planning phase.

Example 3: Cyclical Services
Person C and D have been living together with two other people in a house for several years. They were both part of the CTS program and had worked with CC staff to learn many practical skills for living on their own and built connections with others and with activities happening in the community. On paper, they had both completed or nearly completed the three phases of the CTS program.

During this their time living together, though, they eventually concluded that they'd like to leave the larger shared space and get a smaller apartment for just the two of them. Because of this their work with the CC's Community Support Specialist shifted back from Consultation and Reaching Out back to Planning. Together they begin discussing finances, neighborhoods, and what housing characteristics they'd like. Once they move they have discussed a need to work on some new skills for the new space and how to work together and how to maintain the groups and outside friendships that hope to continue.

This example shows the cyclical nature that this program can take on. Like all people, the participants in this program do not tend to find one living situation and stick with it forever. The experiences, skills, and connections they develop can and do lead to new opportunities, which may need support.

These examples are based on actual participants in the CTS program. The affect that life events, current networks, and financial resources can have on the process can be significant.

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)

During FY19, we began working on new and more effective ways to evaluate this program. It supported us in getting a better sense of where all the people we are working with are in terms of support needs and process towards fuller independence. It has helped us to see where we may have the capacity to support new people and how to better ensure that we are working directly on the goals that will allow them to be self-sufficient. The shift in how we record participant progress is helping us to better tell the story of the people we are supporting and know where they need more support and where they are ready move forward on their own.

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):
Definition: These are the individuals being serviced in our Community Transitional Support Program.

Target: 15

Actual: 19

Explanation: The additional participants in the program can be accounted for in two ways:
1. There were a few people who remained part of the program but received only very minimal services. Several of these people were closed at the end of Q4.
2. There were 1-2 people who had expressed interest in being part of the program and were listed on the official participant list, but chose not to continue and have since been closed.

Non-treatment Plan Clients (NTPC):
These are the individuals that participate in our Personal Development/Life Skills classes.

Definition: These are the individuals that participate in our Personal Development/Life Skills classes.

Target: 15

Actual: 19

Explanation: More people signed up for classes than expected. 1 additional class was held beyond the target, providing another opportunity for new people to participate.

Community Service Events (CSE):
Definition: These are the events where we share with the broader community about the services we offer related to our programs, our goals, and the people who would be eligible or benefit from participation.

Target: 2

Actual: 4

Explanation: Though our goal was 2, there were additional opportunities to share information about this program with other organizations and the broader community.

Service Contacts (SC):
Definition: These are meetings with participants, time spent working on supports/connections/tools on behalf of the individual, and time spent working and communicating with the person's team.

Notable: during FY18 service contacts for TPCs shifted into a "Claim" system where activities were tracked using the CCDDB's online system.

Target: 1420 – (1170 Community Transitional Support) 250 (Personal Development Classes)

Actual: 1828 Claims – (Community Transitional Support), 246 Service Contacts (Personal Development Classes

Explanation: With the change to the Online Claim reporting system, service contacts that previously would have been tracked as a single service are now sometimes broken down into multiple. For example, if the Community Transitional Support staff meets with someone in the planning phase for 1.5 hours and as part of that meeting they make a .5 hour phone call to the person's family member, this would be counted as 2 claims (a 1 hour for Planning and .5 hour claim for Family Correspondence). This could account for the additional claims.

OTHER:
Definition: This accounts for direct hours working directly with a person using services or their family, or directly on their behalf. These are now recorded as part each "Claim" in the online system. Direct hours for personal development classes are recorded on time sheets from the staff facilitating the class.

Target: 1602 – (1482: Community Transitional Support, 120: Personal Development Classes)

Actual: 1137: Community Transitional Support, 269.5: Personal Development Classes

Explanation: The online claim reporting system has been a significant adjustment for staff, particularly those in the Community Transitional Support Program. For this program in particular, there is one staff person who generally spends a great deal of his day in the community meeting with participants, talking to others on the phone, and answering emails/texts with others and families in between meetings and on the go. This format of service delivery does not lend itself well to precise data tracking. And honestly, this individual does struggle with organization and documentation despite his great skill at working with people. In the past he would report his direct time by the day, which I believe was easier for him to manage. If he was out seeing people all day, then the calculation of 6-7 hours of direct time was easy to manage. The new system has been challenge for him to translate into more distinct chunks of time. We are honing in on better ways to track and report this information and are looking forward to connecting with the UIUC Evaluation Team for suggestions on better ways to track this data in accurate, manageable, and meaningful ways.

Though there have been bumps alone the road in managing this data, it proving to be useful in areas of program administration and as a way to identify where we can improve our service delivery as well as our internal record keeping.

The additional hours relating to Personal Development Classes can be accounted for due to the following:

1. One additional class was held.
2. Considerable work was put into preparing for and personalizing the classes this year, working with parents to ID content to cover, and collaborating with outside groups to support instruction. This extra attention resulted in additional time invested.

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).

Performance Outcome Report Template

In your CCMHB program plan (application), you identified performance outcomes in three domains: consumer access, consumer outcomes, and utilization data. Now, you must report on the actual outcomes your program activities achieved in those three domains.

Agency name: Community Choices
Program name: Customized Employment FY19
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)

Adults with disabilities in Champaign County who are currently unemployed or underemployed and who are interested in community-based customized employment are the primary targeted population. Based on census data, we estimate there to be roughly 2,000 adults (ages 21-64) with developmental disabilities in Champaign County. Based on their Blueprint for Employment First in Illinois, Equip for Equality estimates that only 20% of people with developmental disabilities are employed and only 6% in integrated community settings.

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.)?

Determination of Developmental Disability/need for services is made through the PUNS screening assessment completed by the PAS agent at the Regional Planning Commission. We ask that all persons seeking services verify that they have completed this screening tool or assist them in completing it. We also ask that they provide documentation of an I/DD diagnosis from a doctor or psychologist.

Individuals with I/DD are invited to contact us or be referred for employment support if they are interested in finding a job. We use self-report by the person rather than a vocational assessment to determine if a person would like a job.

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

We had a total of 6 new participants during FY19. All found out about our Employment program by being members of the organization, by being served previously, or through a DRS referral (this individual was served via the grant only for the discovery process – job development was funded through DRS).

We recruit members through word of mouth, through the school system, at local resources fairs such as the Disability Expo and Northern Champaign County Resource Fair.

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):

Of individuals who indicate a desire to use our services after an informal meeting to explain the program and eligibility, it is estimated that over 90% of individuals will eventually receive services

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

6 of 14 (43%) participants who entered the waiting list during FY19 were served in FY19. The remaining 57% are still on the waiting list and will be served in FY20 or when they indicate they are ready to start a job search. 2 individuals of this 14 got to the top of the waiting list but were either not interested any more or not ready (per their request) to begin 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):

Engagement in all Community Choices services begins with referral (formal or informal) and an intake meeting with the Membership Coordinator, typically scheduled within two weeks of the initial contact. The length of time between intake and assessment for services is dependent upon how quickly individuals can provide the required documentation.

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):

Formal assessment and documentation of need is based on outside sources (PUNS screening, medical or psychological reports of diagnosis).

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

N/A – Assessment is based on outside sources. Data is 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):

Once paperwork is complete, individuals are placed on the waiting list and served on a first-come, first-served basis. Due to the individualized nature of the services, Employment Specialists can only support a limited number of people at a time. Individuals are typically on the waiting list for 3-12 months before actively working toward employment. Information about a person’s position on the waitlist is available to them at any point.

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):

While specific baseline data for this is not available, it is estimated that over 90% of individuals who are added to the waiting list will initiate active services within 12 months.

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

Community Choices began tracking this information during FY19, so comprehensive data is not available given the number of people we were working with from prior to the exact dates being tracked. We have developed a new system for keeping track of this information so better data will be available in the future.

For individuals we worked with this year, who’s start date on the waiting list was tracked, **the average length of time from entry to engagement was 7.25 months (n=4) or 100% of individuals tracked were served in the expected timeframe.** (One individual was on the waiting list 10 months because she was still in school. She was served when she graduated. Engagement would have been faster otherwise.) In upcoming years better data on this wait time will be available.

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

Discovery and job development typically last 2-6 months. On the job support can extend up to 18 months from the individual’s hire date.

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

We began tracking this information during FY19, so comprehensive data is not available given the number of people we work with who started prior to these exact dates being tracked. The new system that we have been using will tell us this information for future participation, but we were not able to recreate it for individuals who had already begun services prior to the new system being put in place.

We are able to report the length of time that it took people to find a job from the time they completed discovery and held a team meeting.

Data for 10 individuals served this year is available. **The average length of time to find a job is 4.2 months. It ranged from 1 month to 9 months for the 10 people whose progress we tracked**.

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)

Beyond the basic demographic information required for all CCMHB/CCDDB programs, Community Choices will also gather the individual's RIN number, their PUNs eligibility, and what type of medical insurance they have access to (Private Insurance, Medicare, Medicaid, etc) in order to provide all needed information for the Developmental Disability Specific program reporting and eligibility requirements. Information about involvement with other service providers will also be collected to ensure supports are not duplicated.

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

When individuals reach out to Community Choices to engage in any sort of services or renew their membership, we ask them to report their PUNS enrollment status. For new participants we have been successful in gathering accurate information. For people who have been engaged in services with us for some time, though they report to us that they are on the PUNS list, there have been cases where we have been notified later that they were not actually enrolled. When this occurs we work with that person to make an appointment to be screened and added to the list. There was one individual served in FY19 that we found was not on PUNS.

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.

OVERALL PROGRAM OUTCOME: With opportunities for strength-based vocational assessment and person-centered support, individuals with I/DD can find, obtain, and keep community-based competitive employment.

Outcome Goal: *Previous annual survey data was used a source to develop the following benchmarks*

- 100% of participants with I/DD will report that they are getting the support they need to meet employment goals.
- 85% will report that their strengths and interests are important to the employment process.

SPECIFIC CONSUMER OUTCOME 1 – DISCOVERY: Individuals develop a personalized employment plan based off interests and strengths.

Specific Outcome Goal:

- 11 individuals will complete the process and agree on a personal employment profile based on their strengths and interests.

SPECIFIC CONSUMER OUTCOME 2 – JOB MATCHING: Individuals will acquire community based employment based upon their strengths and interests.

Outcome Goal:

- 7 Individuals will obtain paid employment,
- 4 individuals will obtain volunteer jobs or internships.
- [NOTE: An additional 8 individuals will achieve this outcome with the support of DRS funding]

SPECIFIC CONSUMER OUTCOME 3 – SHORT-TERM SUPPORT: Individual with I/DD, negotiate and learn their roles and duties to be successful at their jobs.

Outcome Goal:

- 11 individuals will receive job negotiation and coaching leading toward greater independence (less reliance on job coach presence) when at their jobs.
- [NOTE: An additional 8 individuals will achieve this outcome with the support of DRS funding]

SPECIFIC CONSUMER OUTCOME 4 – LONG TERM SUPPORT: Individuals with I/DD maintain their jobs through ongoing support and job expansion.

Outcome Goal:

- 25 individuals receive on-going support according to their needs.
- 70% of individuals keep their jobs for at least 1 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.)

OVERALL PROGRAM OUTCOME: With opportunities for strength-based vocational assessment and person-centered support, individuals with I/DD can find, obtain, and keep community-based competitive employment.

Data Collection: The overall outcome will be measured using the Annual Member Survey, designed with the support of the UIUC psychology department and their research-based recommendations to be accessible to those with I/DD and to measure satisfaction with the support and results of the Customized Employment Program.

SPECIFIC CONSUMER OUTCOME 1 – DISCOVERY: Individuals develop a personalized employment plan based off interests and strengths.

Assessment Tool: A discovery process based off the Griffin and Hammis's Customized Employment Model, using asset-based assessment, multiple data sources including community based observation, individual and team interviews will be used to develop job seeker profiles.

SPECIFIC CONSUMER OUTCOME 2 – JOB MATCHING: Individuals will acquire community based employment based upon their strengths and interests.

Assessment Tool: Regular meetings with employment program participants including observation and discussion with stakeholders will be used as formative assessment data to inform the level and type of support offered.

SPECIFIC CONSUMER OUTCOME 3 – SHORT-TERM SUPPORT: Individual with I/DD, negotiate and learn their roles and duties to be successful at their jobs.

Assessment Tool: Regular meetings with employment program participants including observation and discussion with stakeholders will be used as formative assessment data to inform the level and type of support offered.

SPECIFIC CONSUMER OUTCOME 4 – LONG TERM SUPPORT: Individuals with I/DD maintain their jobs through ongoing support and job expansion.

Assessment Tool: Meetings and contacts with employment participants and their teams will be recorded in the individual's file. These will be used to assess ongoing support needs.

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
OVERALL PROGRAM OUTCOME: With opportunities for strength-based vocational assessment and person-centered support, individuals with I/DD can find, obtain, and keep community-based competitive employment. Expected Outcomes: - 100% of participants with I/DD will report that they are getting the support they need to meet employment goals. - 85% will report that their strengths and interests are important to the employment process. Actual Outcomes: * 5 participants responded * 9 Family Members responded - 4/5 (80%) of Participants with I/DD reported they were getting at least some of the support they needed to work toward their employment goals. 3/5 (60%) felt they were getting all the support they needed. No participants felt they were not getting the support they needed. - 8/9 (89%) Family respondents reported their family member was getting at least some of the support needed to work towards employment goals. 6/9 (67%) felt they were getting all the support they needed. 1/9 (11%) reported they were not getting the support they needed. - 5/5 (100%) of respondents with I/DD felt their strengths and interests were important to the employment process. - 9/9 (100%) of the family respondents felt that their family members’	Data Collection: The overall outcome will be measured using the Annual Member Survey, designed with the support of the UIUC psychology department and their research-based recommendations to be accessible to those with I/DD and to measure satisfaction with the support and results of the Customized Employment Program.	The survey is completed by participants in the Customized Employment Program as well as any involved family members. Completion of the survey is voluntary but encouraged.

strengths and interests were important to the employment process.		
SPECIFIC CONSUMER OUTCOME 1 – DISCOVERY: Individuals develop a personalized employment plan based off interests and strengths. Expected Outcome: - 11 individuals will complete the process and agree on a personal employment profile based on their strengths and interests. Actual Outcomes: - 8 People completed the discovery process and employment plan. - 2 individuals completed this process during FY18 but found jobs during FY19	Assessment Tool: A discovery process based off the Griffin and Hammis's Customized Employment Model, using asset-based assessment, multiple data sources including community based observation, individual and team interviews will be used to develop job seeker profiles.	Information is gathered primarily from the participant through interviews and observation. Supplementary information is gathered from family and other team members.
SPECIFIC CONSUMER OUTCOME 2 – JOB MATCHING: Individuals will acquire community based employment based upon their strengths and interests. Expected Outcomes: - 7 Individuals will obtain paid employment, - 4 individuals will obtain volunteer jobs or internships. - [NOTE: An additional 8 individuals will achieve this outcome with the support of DRS funding] Actual Outcomes: - 6 people found Paid Employment - 4 people found Volunteer Jobs - 5 People found jobs with DRS funding (our contract was amended mid-year making this the max number of placements we could be paid for).	Assessment Tool: Regular meetings with employment program participants including observation and discussion with stakeholders will be used as formative assessment data to inform the level and type of support offered.	Staff records will document progress and achievement of employment goals and jobs acquired.
SPECIFIC CONSUMER OUTCOME 3 – SHORT-TERM SUPPORT: Individual with I/DD, negotiate and learn their roles and duties to be successful at their jobs.	Assessment Tool: Regular meetings with employment program participants including observation and	Staff records will document progress and support needed

Expected Outcomes: - 11 individuals will receive job negotiation and coaching leading toward greater independence (less reliance on job coach presence) when at their jobs. - [NOTE: An additional 8 individuals will achieve this outcome with the support of DRS funding] Actual Outcomes: - 11 People received short term job coaching	discussion with stakeholders will be used as formative assessment data to inform the level and type of support offered.	by participants and employers.
SPECIFIC CONSUMER OUTCOME 4 – LONG TERM SUPPORT: Individuals with I/DD maintain their jobs through ongoing support and job expansion. Expected Outcomes: - 25 individuals receive on-going support according to their needs. - 70% of individuals keep their jobs for at least 1 year. Actual Outcomes: - 21 people received ongoing/long term support related to their jobs. - Of the 6 people we supported to find jobs in FY18, 5 (83%) were still employed at the same place 1 year later (some are approaching 2 years at their jobs).	Assessment Tool: Meetings and contacts with employment participants and their teams will be recorded in the individual's file. These will be used to assess ongoing support needs.	Staff records will document progress and support needed by participants and employers.

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

Outcome information was collected from all participants, especially as it related to individualized support and outcomes. For data related to job retention, and access, engagement, and duration of services, we began using different data collection systems during FY19. Because of this we do not have a consistent data set for longer term or historical reporting, which did affect the answers to some of the questions on this report.

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

We attempted to collect data from all participants.

5. How many total participants did your program have?

33 people received support through the Customized Employment Program in FY19. 27 people were continuing clients from FY18. There were 2 new participants in Q1, 0 in Q2, 1 in Q3, and 3 in Q4 – a total of 6.

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

We attempted to collect outcome information from all participants. Some reporting (such as feedback from our survey) was optional.

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

Outcomes for this program were generally related to participants being hired and receiving support for employment. Formal assessments were not a significant part of the outcome evaluation process. Information related the support offered to participants was collected for all those accessing services. This was generally done through service contact notes, meeting notes, etc.

Our overall program outcome data was collected via our participant survey, which was returned by 14 people.

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

Information related to participant outcomes was collected throughout their engagement in services with us. As support fades, collection of service contact and meeting notes decreases along with the person's need for our involvement.

Survey data was collected annually in the spring.

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)

<u>Overall Outcomes</u>

Based on the data, this program was relatively successful this year. Our overall goal was to find 11 jobs for people with I/DD in our community. Though we were only able to find 10 positions for people, there are several of those job matches that we are particularly proud. In our reports from FY18, we recorded a trend of people seeking employment who had higher support needs and more particular environmental considerations to accommodate in a good job match. This trend continued during FY19, but our program was more prepared to meet the needs of the people seeking services. Though we do not take or put much stock in highly quantitative measures of people's abilities (IQ, ICAP scores, etc.), many of the people we worked with again this year receive a high percentage of support throughout their day. We are happy to report that they were able to find jobs that welcomed them and aligned with their skill sets.

For example, one individual that we worked with this year lives in a group home, uses an electric wheelchair, and an AAC device for communication. He loves sports and is a huge Illini fan. We were able to carve a position for him working at Memorial Stadium in the Premium Seating area for home football games. He uses his device as a tool to both greet people and direct them toward their seats. He loves his job, is welcomed by the other staff there, and is looking forward to the upcoming season.

We knew when we started working with this person, and with many other individuals this year, that we would need to work more closely with the person's family and other support systems to both get to know what type of job would work for them practically, but also how we would ensure that the wrap-around follow up was present to create stability at the job – beyond our job development and coaching supports. This intention early on proved to be critical in our long-term success.

The past two years were learning and building years for our Employment department as the needs of the people we have served where changing. Emphasis on job development has often been about building relationships with employers and helping them understand the benefits of hiring people with I/DD. What we realized and began emphasizing this year, is the importance of creating buy-in and support from the person and their natural support team as well. Families, friends, and community connections can all be integral parts of a successful employment venture, especially for people who do need more support – if only so that the person has someone who they can vent to about their job when they come home and had a hard day. When looking for more specifically carved positions, we also have to be more explicit about developing trusting connections with the person, the family, PSWs, and other supports, so that concerns or doubts can be tackled and resiliency within each family system can be built.

Learning from these experiences, we began re-designing our discovery process during FY19. We wanted to find more consistent ways to capture these team approaches throughout our work with people – from start to finish – and make sure that all parties understood the expectation for their input and involvement whenever possible. When we have had people come to us thinking that we would find them or their family member a job without any personal involvement, we have all been at a disadvantage. In contrast, when people come to us with their families and everyone is actively engaged and working toward that goal, our cooperative efforts have been very effective. For people with higher support needs this additional engagement has been critical. Our new design will be more explicit about the roles that each person has and how their buy-in and support will lead to positive outcomes. We are hoping to have it completed mid-FY20.

Reflecting on this year's experience in comparison to the overall program outcome feedback from our survey is interesting. It would be difficult to argue a direct and validated link between the input quick survey responses, but there are some connections that do make sense. We had expected that everyone we worked with would feel they were getting the support they needed. It is certainly our hope that this is the case. In our actual outcome data, while the responses were not negative, they were not as positive as we anticipated. We feel that this is likely because the survey went to all people receiving support, regardless of where they were at in the process. So, for example, if someone had been searching for a job for some time, but was not getting hired, it very reasonable that they would feel like they weren't getting the support needed, since their goal was not being realized. With an updated process where timelines, expectations, and greater collaborative buy-in from the team was developed and maintained throughout the process (as we are working to institute), our hope would be that even if people are not finding work quickly, that they will feel because of their informed and engaged involvement that support is present and that movement toward their goals is occurring.

Also interesting is the extent to which people felt that their or their family members' skills and interests were valued by the person supporting them. This seems to indicate that we are doing a good job currently of ensuring a trusting and person-centered relationship between the support person/staff and the person looking for work. It also seems to show that our current process, focusing on employment themes and ideal conditions, is a valid one – if not one that can be bolstered with additional supportive circles working to put them into action.

Though an obviously small sample size, we will keep these observations and reports in mind as we continue to hone our approach and processes.

<u>A General Note on Quantitative Data:</u>
With shifts in the grant and reporting structures in the past two years, we have had to redesign our internal data collection systems. Though it has taken us some time land on a process that is user friendly while also providing helpful and needed data, mid-way through FY19 we found a system that has been working well. Because it took a while to get there, and because historical data was not always able to be translated into the new approach, we were not able to provide as full a quantitative picture of our program engagement as would have been preferred.

The data that we have has proved to be very helpful and interesting. The average wait times for services, as well as the average length of time on the job search, for example, are both pieces of information that will be very helpful for program administration as well as to share with people interested in support.

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)

Below are 2 versions of service delivery, similar to how they were reported last year. These continue to be accurate versions of each end of the spectrum of what support can look like. Following that there is description of how the less productive process will work using the tools we are including in the updated discovery process:

<u>Things go as planned:</u>
Person A is a new member of Community Choices. They graduated from a local high school about 4 years ago and had several vocational experiences as part of their time there. Some of these were positive, others were not to the person's liking. After spending a few years mostly sitting at home during the day and doing some recreational activities and some volunteering with a church group, they decide they'd like to find a job. They still live at home with their parents, who have been enthusiastic about them finding a job, but knew that employment support was difficult to access, so hadn't pushed it until recently. After a membership intake meeting with Community Choices, they learned that support was available, so the Membership Coordinator helped set up a meeting with the Lead Employment Specialist to talk about moving forward. At this meeting the Lead ES explained the process and waiting list. She double checked eligibility documentation and briefly got to know Person A. Following this Person A was placed on the waiting list.

After about 3 months they were next on the list and a CC employment staff person gave the family a call to say they'd be ready to start in the next couple of weeks. They have a brief meeting to start things out and go over the process. From their the next few meetings are part of the Discovery process. The CC staff person meets with Person A in different settings to get to know them, build trust, and see what types of environments the person is the most comfortable in. The staff person also sets up some interviews (with Person A's permission) to talk with their parents about their ideas and insights on employment for their loved one. When this is all complete, the CC staff person sets up a team meeting where the direction for job development is decided on as a group.

During this next phase, the CC staff person spends time working on needed skills that might have come up during the discovery process and applying for jobs that are linked to the themes, environments etc. that are part of the person's plan. They visit some places that the CC staff thinks the person might like to see if they might be interested in applying. The person gets a couple of interviews in the first few weeks, but isn't offered a job. After another month or two they get an offer. The CC staff coordinates with the team to get all the needed supports in place for the person to start including logistics with the family, accommodations and scheduling with the employer, as well as working with the individual to answer any additional questions or concerns they might have.

For the first 2 weeks, the CC staff attends each shift with Person A. They support the person to learn their role, identify people they can look to for help as needed, and build good routines related to arrival, clocking in, asking for time off, etc. During week 3 the Person A is doing well and the CC staff begins to fade back. By week 5 the CC staff is providing check ins a couple of times per week. They are also checking in the Person A's family to make sure that there aren't other issues that need to be addressed. As Person A builds their confidence, the CC staff fades out more. Check ins move back to weekly and after a couple of months, they become less frequent. After 3 months, though the employer gets a new manager. The CC staff learns this when they call in to check with the supervisor about how things are going. At this point they come back in more frequently to make sure that routines and accommodations haven't changed and help to reaffirm the relationships that have been built between all parties. Check ins continue and the CC staff is available as needed if Person A or the employer have questions or concerns.

<u>Things do not go as planned:</u>
Person B is 35 and has just started the process of finding a job for the first time. They are excited to be making money and want to start right away. Their parents are totally on board and are also ready for them to start working right away. Person B is interested in computers and enjoys comic books. They were referred to Community Choices through someone at their church. After about 4 months on the waiting list with period check-ins, Person B is next on the list to receive services. The CC staff person calls them to let them know and doesn't hear back. After a couple of days they try again, this time also calling Person B's parents. They again don't hear back and try emailing. After an additional week, Person B's mom responds and says that they are ready start too. They arrange the first meeting with the whole team to talk about the process and moving forward. Everyone comes, but Person B is not excited go through the discovery process and just wants to apply for jobs right away. The CC staff person explains why its important and encourages the person to give it a try. They arrange a first meeting and it goes well. At the end they set a date for the second meeting, but when the day comes, Person B doesn't show up. The CC staff follows up and talks with Person B's parents. They said they forgot and reschedule. This continues for the next few weeks with Person B missing several meetings, sometimes because they were sick, because they planned something else during that time, or simply because they forgot.

When they have finished up the discovery process, the team meets again and decides how to move forward. The themes that came out of the discovery phase don't get that deep into the person's interests and strengths, likely due to the rocky path through the process. The CC staff person continues to discuss with Person B and their family the importance of keeping meetings, as employers will expect a person to be punctual and reliable to keep a job. During the job development process the CC staff person and the team try several strategies to address the issues of punctuality and organize supports that will be necessary to make this consistent. Person B and the family are both frustrated at this point and express their concern that Person B has not yet found a job. They indicated that they thought that's why they came to an agency looking to find a job.

Eventually after working on applying for jobs Person B gets an interview. Unfortunately they doesn't show up. Their parents are very upset. Person B says they still want a job and a new appointment communication routine is put in place. Things go pretty well for a few weeks and they get another interview in the book department of a store that sells graphic novels. The interview goes well and Person B gets the job. The first two weeks go well and the CC staff person supports and helps to get logistics and routines set up so that success can continue. This includes a plan to go over the schedule each week and plot out shifts on a white board calendar in Person B's apartment. After a few weeks Person B no call no shows for work and is fired.

<u>Adjustments Moving Forward:</u>
In the previous "Things don't go as Planned" example there are a few changes that we believe have the potential to create a more collaborative and team-based understanding that will result in more buy-in and better luck at finding a sustainable job match for person B.

1. We will hold an initial meeting before discovery including the person's family (if they are involved.) We'll outline everyone's roles and clarify how each person can support the process.
2. We will also begin outlining the personal networks for the person looking for a job and their natural supports – essentially, who do they know. This will help everyone feel that they have something to contribute and emphasize the importance of building on existing social networks during the job search process. Over time understanding and building these connections could also help others find successful job matches.
3. We will also provide a clear and visual timeline of how and when services will occur.
4. During and just following the discovery process we will continue to connect with involved family members to get their ideas, input, and feedback. Before convening the meeting, we will give everyone tools and a template to bring to the meeting so that the conversation can be most productive.
5. At the meeting we will still focus on themes, but be more explicit about ideas, connections, and what role everyone can actively play in supporting the job development process.
6. Finally when the person is hired, we will develop an additional plan that will cover the practical and logistical elements that need to be in place so the person can be successful. This is likely to include transportation, but could also cover financial considerations, information sharing, and any other job specific health/safety/communication issues that are likely to come up.

Many of these steps were part of our previous process but in a less formal way. We also understand that some people we work with do not have an involved family to be contribute to the process. The tools and clarity that we're building in should be helpful to the team, whatever the size. The emphasis will be on clearly and explicitly building buy-in from all involved.

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)

As described above, there are many changes that we are building into our program that are based either on the formal evaluations made for this grant as well as the more formative assessments that we made in the course of providing service. The formal data in conjunction with the trends and individual reports and observations that we have made lead to significant shifts in the way we will be organizing and communicating with participants about our support.

Some of the techniques that we are now using to record progress through our support process will also become more useful the longer they are tracked. Already we are seeing some trends in how long people are waiting for services and how long it is taking to find jobs. This is valuable information for our own organizational planning and very useful to give to interested participants for a transparent and clear idea of when they can expect services.

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):
Definition: Individuals with I/DD who receive employment-focused support from the CC Customized Employment team.

Target: 36

Actual: 33

Explanation: The support needs of people receiving long-term support are always variable leading to variability in our overall participant list. Additionally, because we were not as successful during FY18 in finding jobs for participants, there was a slightly smaller pool of people to support in this follow-along capacity.

Non-treatment Plan Clients (NTPC):

N/A

Community Service Events (CSE):

Definition: These are the events where we share with the broader community about the services we offer related to our programs, our goals, and the people who would be eligible or benefit from participation.

Target: 4

Actual: 5

Explanation: Additional opportunities to share information about this program with the community were available and seemed worthwhile.

Service Contacts (SC):

Definition: These are meetings with participants, time spent working on supports/connections/tools on behalf of the individual, and time spent working and communicating with the person's team.

Notable: during FY18 service contacts for TPCs shifted into a "Claim" system where activities were tracked using the CCDDB's online system.

Target: 965

Actual: 1389

Explanation: Explanation: With the change to the Online Claim reporting system, service contacts that previously would have been tracked as a single service are now sometimes broken down into multiple. For example, if the Employment Specialist meets with someone in for discovery for 1.5 hours and then immediately follows this up with a .5 hour phone call to the person's family member with would be counted as two claims (1 for discovery and 1 for family correspondence), where previously it would likely have been recorded as one service contact. This could account for the additional claims.

OTHER:

Definition: This accounts for direct hours working directly with a person using services or their family, or directly on their behalf. These are now recorded as part each "Claim" in the online system.

Target: 1325

Actual: 1188

Explanation: With the shift to the online claim reporting system staff have to be significantly more precise than with their previous direct hour record keeping. In the past if they were working on paperwork for several participants, making calls to family members, and meeting with several participants over the course of an afternoon, they would easily be able to identify this as direct time, as the entire period was devoted to the specific support needs and goals of people they were working with. They now need to be able to break that down into distinct chunks of time that are tracked and entered. This information and method does give good insight into the efforts and work output of the

program. It does also tax the administrative and record keeping demands of the staff providing direct support, who report anecdotally that these more fleeting supports, connections, and communications are not being tracked and entered as consistently. Because of this it is difficult to know if the direct time worked is less than our target, or if we simply have not tracked and reported it as accurately as intended. We are continuing to look for ways to more manageably and meaningfully record these 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).

Self-Determination FY19 Program Outcome Report

In your CCMHB program plan (application), you identified performance outcomes in three domains: consumer access, consumer outcomes, and utilization data. Now, you must report on the actual outcomes your program activities achieved in those three domains.

Agency name: Community Choices
Program name: Self-Determination FY19
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)

To be eligible for Self-Determination/Connect Program services, individuals must be at least 18 years of age and become a member of Community Choices. Membership includes completing the intake process and appropriate paperwork, including verification of PUNS enrollment and documentation related to a developmental disability. Individuals must also be motivated and share the responsibility of working towards the outcomes and life they want.

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.)?

Determination of eligibility for the PUNS database requires a screening assessment through Champaign County Regional Planning commission. We ask the person to verify that they have completed the screening and have confirmed eligibility using the PAS screening tool. We also ask that all participants in the program provide documentation of a developmental disability from a doctor or psychologist.

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

Community Choices conducts formal and informal outreach within the Champaign-Urbana community and Champaign County. We can provide formal referrals to and from Developmental Services Center, Champaign County Regional Planning Commission, Rosecrance, UPC, The Autism Program, and PACE. We informally reach out to the community through participation in outreach events – such as the Disability Expo, and through word of mouth information sharing in 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):

Formal data on referrals has not, to date, been collected. However, no one who is eligible is turned away within this program. Most services provided in this program function in an opt-in format, so once a person becomes a member, it is their choice to receive services or participate in program opportunities.

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

82% of members with disabilities participated in services during FY19. If we include family members, 89% of members participated in services and supports throughout the year. Additional family members also participated in events and opportunities that were open to the public.

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):

Engagement in all Community Choices services begins with referral (formal or informal) and an intake meeting with the Membership Coordinator, typically scheduled within two weeks of the initial contact. The length of time between intake and assessment for services is dependent upon how quickly individuals can provide the required documentation.

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):

Formal assessment of eligibility is based on PUNS screening, which is completed on outside sources. To date, no data has been collected on this. Meetings are typically within 2 weeks or based on the interested party's schedule/preference.

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

Formal assessment is done outside of Community Choices. The time fram is based on the individual/family's schedule and their interaction with the PAS screener at CCRPC. If needed, Community Choices staff will assist individuals to get set up for PUNS screening.

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 person completes their intake and eligibility documentation, they are able to participate in program activities immediately. Services/supports in this program are opt-in, so new members have the opportunity to participate in what is happening right away.

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):

Due to the structure of the program, limited data is available related to this question. Members are continually given the choice and opportunity to engage with self-determination programs through a monthly social calendar and targeted communication about additional programs to the greatest extent that they choose.

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

No data is available on this.

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

Membership lasts for one year, at which point individuals are offered the opportunity to renew, which includes updating their paperwork and eligibility. The renewal period occurs during the spring. Members returning after a membership lapse may also be asked to come in for a renewal meeting with the Membership Coordinator depending on changes to their circumstances.

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

Between FY18 and FY19, 89% of members renewed their membership.

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)

Beyond the basic demographic information required for all CCMHB/CCDDB programs, Community Choices also gathers individual’s RIN number, their PUNs eligibility, what type of medical insurance they have access to (Private Insurance, Medicare, Medicaid, etc), as well as information about involvement with other service providers to ensure supports are not duplicated.

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

Gathering and verifying PUNS enrollment data and medical insurance information has become a part of all current and regular intake meetings. We ensure that all individuals coming to us for services are actively enrolled on PUNS. There are some individuals who have received services in some capacity for many years who have either lost their PUNS registration or have been denied. We are working with these individuals when we are made aware to either register or to appeal their status.

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.

OVERALL PROGRAM OUTCOME: Participation within Community Choices will lead to greater supportive networks and connections.

Outcome Goal: *Previous annual survey data was used as a source to develop the following benchmarks*

- 70% of respondents with I/DD will indicate that they made a friend and 60% of those friendships will be defined as at least somewhat close. 75% will indicate that being a member of CC provides them with a supportive community.
- 50% of respondents who are family members of someone with I/DD will indicate that they connected with another family member and 45% of those connections were found to be meaningful. 75% will indicate that being a member of CC provides them with a supportive community.

SPECIFIC CONSUMER OUTCOME1 – FAMILY SUPPORT AND EDUCATION**: *Individuals with I/DD and their Families support each other and gain knowledge of the DD service system***

Specific Outcome Goal:

- 4 public Co-op meetings will be offered. 1 Members-only meeting will be held.
- 4 family parties will be held. An average of 20 members will attend each.
- 6 Family Support Group Sessions will be held. 16 family members will participate.

- 100% of participants in the Family Support Group will indicate a strategy or resource they learned or an increased connection with other participants

SPECIFIC CONSUMER OUTCOME 2 – BUILDING COMMNITY: ***Individuals with disabilities engage with each other and community-based groups and opportunities***

Specific Outcome Goal:

- 48 opportunities will be offered with an average of 8 participants attending each.
- 4 co-op clubs will be supported. 17 participants will be part of a co-op club.
- 1 collaboratively run event will occur. 6 individuals with disabilities will connect with a community group, organization, or project
- all individuals organizing co-op clubs or working on facilitated connections to the community will self-indicate a minimum of one additional connection to people and/or places on the Circles of Support tool.

SPECIFIC CONSUMER OUTCOME 3 – LEADERSHIP AND SELF ADVOCACY: ***Individuals with disabilities build leadership and self-advocacy skills, better direct their services and shift mindsets in the broader community and service system.***

Specific Outcome Goal:

- 1 course will be offered, serving 10 self-advocates
- 80% of course participants will indicate an increase or example of a leadership skill or mindset that they gain.
- Individuals with I/DD will have opportunities to demonstrate their leadership growth by participating in IN Project Activities such as Mentoring, Community Conversations, and Media Engagement.

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
OVERALL PROGRAM OUTCOME: Participation within Community Choices will lead to greater supportive networks and connections. **EXPECTED OUTCOMES**: 70% of respondents with I/DD will indicate that they made a friend and 60% of those friendships will be defined as at least somewhat close. 75% will indicate that being a part of CC provides them with a supportive community 55% of respondents who are family members of someone with I/DD will indicate that they connected with another family member and 45% of those connections were found to be meaningful. 75% will indicate that being a member of CC provides them with a supportive community **ACTUAL OUTCOMES**: 89% of respondents with I/DD indicated that they made a friend and 78% of those friendships were defined as at least somewhat close. 100% indicated that being a part of CC provides them with a supportive community 86% of respondents who are family members of someone with I/DD indicated that they connected with another family member and 68% of those connections were found to be meaningful. 90% indicated that being a member of CC provides them with a supportive community	Annual Member Survey	Members

SPECIFIC CONSUMER OUTCOME 1 – FAMILY SUPPORT AND EDUCATION: *Individuals with I/DD and their families support each other and gain knowledge of the DD service system* **EXPECTED OUTCOMES:** 4 public Co-op meetings will be offered. 1 Members-only meeting will be held. 4 family parties will be held. An average of 20 members will attend each. 6 Family Support Group Sessions will be held. 16 family members will participate. 100% of participants in the Family Support Group will indicate a strategy or resource they learned or an increased connection with other participants. **ACTUAL OUTCOMES:** 4 public Co-op meetings were held. 1 Members-only meeting was held. 4 family parties were held. An average of 28 members attended each. 7 Family Support Group Sessions were held. 9 family members participated. 56% of participants in the Family Support Group indicated a strategy or resource they learned or an increased connection with other participants.	The number and attendance rate of quarterly co-op meetings, Family Parties, and support groups will be recorded. The family support group will use a pre/post course evaluation to determine the outcomes of participation. Formative assessments via informal feedback from members will be used to direct the content of groups and resources offered by Community Choices.	Staff Records, Staff Observations, Members
Specific Consumer Outcome 2 – BUILDING COMMUNITY: *Individuals with Disabilities engage with each other and community-based groups and opportunities.* **Expected Outcomes:**	The number and attendance rate of social opportunities, co-op clubs, and Open	Staff Records and Observations, Members

48 opportunities will be offered with an average of 8 participants attending each. 4 co-op clubs will be supported. 17 participants will be part of a co-op club. 1 collaboratively run event will occur. 6 individuals with disabilities will connect with a community group, organization, or project All individuals organizing co-op clubs or working on facilitated connections to the community will self-indicate a minimum of one additional connection to people and/or places on the Circles of Support tool. **Actual Outcomes:** 49 opportunities were offered with an average of 6 participants attending each. 5 co-op clubs were supported. 16 participants were part of 1 or more co-op clubs. 2 collaboratively run events occurred. 8 individuals with disabilities connected with a community group, organization, or project 4/5 individuals organizing co-op clubs or working on facilitated connections to the community self-indicated a minimum of one additional connection to people and/or places on the Circles of Support tool.	Champaign activities will be recorded. A pre-post model assessment using a modified Circles of Support worksheet (an established measure based off the Circles Curriculum) will be completed by participants with I/DD to assess facilitated connections.	
Specific Outcome 3 – LEADERSHIP AND SELF ADVOCACY: *Individuals with Disabilities build leadership and self-advocacy skills, better direct services and shift mindsets in the broader community and service system.* **Expected Outcomes:**	The number and attendance of the Step Up to Leadership Course will be recorded. A pre-post course assessment tool designed to be accessible to	Staff records and observations, Members

1 course will be offered, serving 10 self-advocates 100% of course participants will indicate an increase or example of a leadership skill or mindset that they gain. Individuals with I/DD will have opportunities to demonstrate their leadership growth by participating in IN Project Activities such as Mentoring, Community Conversations, and Media Engagement. **Actual Outcomes:** 1 course was offered, serving 9 self-advocates 56% of course participants will indicate an increase or example of a leadership skill or mindset that they gain. 13 individuals with I/DD had opportunities to demonstrate their leadership growth by participating in IN Project Activities such as Mentoring, Community Conversations, and Media Engagement.	individuals with I/DD will be used to measure leadership skills in those participating in the Step Up to Leadership Course.	

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

Much of this data was gathered through staff record keeping, so all pertinent events were included in the data collection.

Evaluations for the Step Up to Leadership Course and Family Support Group were distributed during the final session date. Not all participants were present on those dates.

One of the 5 co-op clubs started later in the year and will not be completing the follow up (comparison) evaluation tool until FY20.

Some of the information in the above table reflected data gathered from our member survey. The purpose of the questions was to gather information related to the short and long term outcomes of involvement, rather than as service/activity specific outcomes. The survey had different formats for members with disabilities and family members of people with disabilities. It was sent to approximately 150 members. We received 33 responses.

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

Evaluations for the Step Up to Leadership Course and Family Support Group were distributed during the final session date. Not all participants were present on those dates.

One of the 5 co-op clubs started later in the year and will not be completing the evaluation tool until FY20.

Participants self-selected if they wanted to respond to the annual member survey. It was not mandatory, though encouraged.

5. How many total participants did your program have?

167 – This includes members with disabilities, their self-selected family members, and family /community members who attend our public education and community events. Of this: 68 were members who have a disability, the rest were family members.

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

Family Support Group: 9 total family members participated in at least 1 support group session. 5 were in attendance on the last session date and received evaluations and a request to complete.

Step Up to Leadership: 9 members with disabilities participated in the course. 6 were in attendance on the last session date and received evaluations and a request/support to complete.

Co-op Clubs: 4 club organizers were asked to complete a Circles of Support worksheet.

Member Survey: The member survey was sent to 150 people. This included members with disabilities and family members of those individual members with disabilities.

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

Family Support Group: 5 evaluations were returned.

Step Up to Leadership: 6 evaluations were returned.

Co-op Clubs: 4 Circle of Support Worksheets were completed.

Member Survey: 33 responses were collected. .

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

Family Support Group: The support group met once a month, September – March, during the year. Evaluations are given on the last session date of the year in March.

Step Up to Leadership: The course met once a week for 8 consecutive weeks. Evaluations were given on the last scheduled meeting.

Co-op Clubs: Co-op clubs are each unique and meet at various frequencies. Club organizers were asked to complete a Circles of Support Worksheet after their club meets 6 times.

Member Survey: This is competed once per year in the spring. A paper copy is given at the Annual Membership Meeting in March. An online (Google forms) version is also available and emailed to all members. Paper copies are also offered to participants by staff during regular meetings.

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)

The focus of this program is to help people be connected. We believe that the more people with disabilities and their families have opportunities to learn about their options, see themselves as contributors and leaders in their communities, and have experiences of being contributor and leader, the more connected and more relationships they will have. Because being connected is subjective, and because this program is designed with an opt-in structure with varying levels of engagement, it has been challenging to find evaluation techniques that will accurately tell the story of the impact our involvement has had on our members with disabilities and their families.

The Logic Model we created in FY2017 addresses how our services and supports in the Self-Determination program can be a continuum of options that allow people to access relationship and leadership building opportunities in ways that work best for them. There are multiple entry points into this program, and while it is not a specific linear trajectory of options, individuals have the option of increasing and their depth of work with us over time. As individuals develop skills, experience success, and develop natural supports, it is also our goal to fade out our level of support with individuals over time.

Using our annual membership survey to respond to our overall outcome of being connected has been challenging. In the past, we have tried using longer, detailed surveys, but struggled with getting responses. We have been attempting to streamline our evaluation process, but this approach hasn't given us useful data. We've learned that our membership survey questions are general enough to apply to all of our program participants, but we are not asking the questions that allow us to capture data that is reflective of the highly individualized work we do. We've been asking some simple questions about very complex ideas – which results in data that has not been as helpful in evaluating our services and supports.

In response to this realization, we are beginning to work on a new logic model that will help us define our long-term goals, link short-term outcomes with current activities, and identify changes or additions we need to make within our program activities. We are exploring how we can implement evaluation tools throughout the year and also continue to increase the frequency and quality of recording staff observations. This will help us collect meaningful data and create snapshots of the impact our services and supports have helped program participants be leaders, become connected, and develop relationships.

Family Support and Education

Helping families support each other, learn about the services systems, and advocate for what they are looking for is an important element of this program. We offered 5 Co-op meetings this year focusing on different topics relating to disability services and supports. The best attended meeting focused on finding personal support workers (PSWs) and how to use PSWs to support people with I/DD in creating the life they want at home and in their community. PSW support continues to a topic that families and individuals need information on. Based on this, we are in the first stages of planning workshops for PSWs our members with disabilities and their families' employ, as well as workshops on supervising PSWs for the members and families.

Our Family Support Group provides more opportunities for families to look to each other for support, and for us to learn about how we can support families and members with disabilities in different ways. Family Support Group is an open, but facilitated group where families share their experiences, trouble shoot potential strategies for change with support from CC staff, and explore their role as a parent of adult with a disability. The group met once a month for seven months and explored topics such as: supporting adults with I/DD in navigating friendships, navigating family conflicts, and questions or concerns about adults with I/DD having sexual relationships. While the attendance was smaller in the group, the regular attendees were able to suggest solutions for each other, and encourage each other's progress and action. The Family Support Group also provided valuable feedback about what types of supports they and their adult children need, and where CC can better meet their needs. Particularly informing was the session discussing families' concerns with adults with I/DD having sexual relationships. The insights gained prompted CC staff to create a parental component to the Healthy Sexuality and Healthy Relationships classes offered to members with disabilities.

Quantitative data from our Membership Survey supports these more informal or qualitative reports and records. 86% of family respondents felt that Community Choices staff supported their personal goals, while 90% felt that Community Choices provided them with a supportive community. 86% of family members reported that being involved in the cooperative helped them build connections with other families, and 68% felt that the connections they made were meaningful. While we had a relatively small sample of the entire membership respond, it does provide some meaningful insight on value and responsiveness of our supports to families of people I/DD.

Building Community

During FY19 we continued to offer regular social opportunities to our members with disabilities. These were in both group opt-in settings and in smaller, personalized, and person driven settings. For our group social opportunities we continued to emphasize community events that would be welcoming and fun, but also ones that pushed people to explore options slightly outside what their normal activities might be, or ones that we could see people being able to become “regulars” at. During FY18 we established ourselves as a regular trivia team at Jupiters with a core group of members. During FY19, we continued to offer Trivia Night and it was our most popular group social opportunity. In addition, members with disabilities have opportunities to participate in planning our monthly social opportunities and take on leadership and hosting responsibilities at those group opportunities.

With our Co-op Clubs and Open Champaign opportunities, members with disabilities had the opportunity to develop more personalized connections with people and to more directly learn and put into practice the skills they need to keep those relationships going without our support. One of the clubs we worked with needed support on how to manage conflicts between individuals within the group. Club members who were in conflict learned and practiced how to work through conflict and be able to rejoin and enjoy the activity. Other club members learned how to support the people in conflict by providing space and offering encouragement to rejoin the group when ready.

With our Open Champaign opportunities we were able to help members deepen their relationships with community groups, both on an individual basis and through partnering with other organizations to create community-building events. The best example of an individual Open Champaign connection was with Champaign Ladies Amateur Wrestling, or CLAW. One of our members with a disability joined the group as a supporting character early in the year. Over FY19 she participated in 2 wrestling shows and a holiday special as friend of one of CLAW’s most popular wrestling characters, Punky Bruiser. Our member connected with the person who portrays Punky and the two of them lead a dance workshop together at CC’s first UNconference in June. The UNconference was a collaboration between Community Choices, The Urbana Park District, Imbibe Urbana, The Independent Media Center and 25 O’clock Brewing. It was a crowd-sourced event where community members led sessions about their hobbies, interests, and skills that were open for the public to attend. Creating this event was a new, unique way for us to offer opportunities for our members with disabilities and their families to connect with folks in the community who have similar interests. The UNconference is also an avenue for spreading the message of inclusion and building a receptive community.

For our members with disabilities, one of the questions we asked in our Membership Survey was if our supports and opportunities within this program helped tem build friendships and if those friendships were close. Results indicated that 89% of respondents did feel that involvement helped them make friends. Only one person felt that the connection they made was very close, but 78% of the respondents felt that the connection they built was at least a little close. It is difficult to conclude much from the small sample size of data and varying levels of involvement people have in the services and supports we provide. We continue to have work to do in supporting people to build sustainable relationships and finding evaluation tools that provide helpful data, given the structure of the services and supports.

Leadership and Self-Advocacy

Building off what we learned in FY18, we offered our Step Up to Leadership course once in FY19, during the spring. 56% of the class participants indicated that they increased their leadership skills.

Members with disabilities also had other opportunities to demonstrate their leadership growth through events and opportunities to take on new roles in their lives, within the organization, and the community. Two members planned and led sessions about their hobbies at the UNconference. Others took on the leadership role of becoming a mentor to a student with I/DD through the CU One-to-One Mentoring program. We provided opportunities for members with disabilities to influence the community by being involved with our Community Conversations Advisory Board and also through creating media features for local media outlets. The Community Conversations Advisory Board is a group of CC self-advocates are attempting to influence their local community by addressing topics that are important to them and others with I/DD. During FY19, the board created a Healthcare Professional's Guide to Working With Patients with Developmental Disabilities. The guide focuses on how healthcare professionals, patients, and their support people can all work together to improve healthcare appointments for patients with I/DD and increase the role people with I/DD have in their own healthcare.

In looking at the quantitative data from our membership survey, 67% of members with disabilities felt that opportunities CC offered helped them be a leader in their own life. 73% of family member respondents felt that the member with a disability had gained leadership skills. It is difficult to draw conclusions from this data. We asked a very simple question about the very complex idea of leadership. The data also represents a relatively small sample of the full membership, and each member has a unique level of participation.

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)

Members of Community Choices have full freedom to participate or not in the supports and opportunities that we provide. As explained above, our goal is to help people be more connected and to build their relationships, self-determination, and social capital. Anecdotally, we have seen that member participants who choose to be involved can build strong, meaningful connections and social roles. Below you will read about what the services and supports, as well as some of the potential outcomes, might be for individuals who are both highly involved and those with more limited involvement:

Highly Engaged Participant

Person A recently moved to Champaign from another part of the sate. They are in their late 20s and have a diagnosis of autism. Being new to town, they don't know many people. They have a strong relationship with their mother, but she did not move to the area. The hope was that this area would provide additional opportunities in terms of supports. Person A became a member of the organization. Initially their mother was the main point of contact. She received our monthly social calendar and took care of arranging RSVPs, rides, etc. Person A attended a few different social opportunities that we offered – a dinner, a lunch, some local music downtown on a Friday evening. Over time, they became more comfortable with the staff and the routine of doing things in the community. After a couple months, Person A heard about an opportunity to be part of one of our Open Champaign events. This event was part of the partnership with a local poetry group and photography group. Poetry was something Person A had some interest in, so he decided to drop in. During the event he shared with a CC staff person that he liked to take photos, also. After the event, the CC staff person followed up with Person A about their interest in photography. They discussed what some possible next steps would be. Person A had really enjoyed the event and was comfortable with the people CC had partnered with, so he and the CC staff decided that potentially joining this photography group made sense. The CC staff person worked with Person A to find out more details about the club and how one might join. They went together for the first few times. The CC staff person helped facilitate relationships directly between the photo group members and Person A. Over a few months of meetings, Person A had started getting emails and texts about meetings directly from the group and was comfortable going on his own. CC staff would meet with Person A periodically to make sure things were going well. Person A was able to maintain their involvement with the photo group. His confidence in his own art increased and he would frequently show it to others and talk about the experience. As other opportunities to be involved in self-advocacy and community building came up, Person A was also more eager to participate, having had such a positive and welcoming experience the first time. With increased independent communication between Person A and the photo group, and continued support throughout the process from CC staff, Person A began taking over the communication, logistics, and follow up necessary for his participation in other CC supports.

Limited Engagement Person

Person B is in his 50s and lives in a small town in rural Champaign county. He doesn't have any family in the area, but has a brother a couple hours away who is involved. He gets some support from a couple neighbors that he's known for most of his life. Person B enjoys gardening and watching TV.

Trying new activities and getting to know new people is generally something that he is uninterested in doing. He has been a member of Community Choices from the early days, but did not participate in much for the first few years. He and his neighbor would always come to one or two of the CC family parties each year, often bringing a dish he made with vegetables from his garden. At these events, he and his neighbor got to know a few of the staff and a few of the other members. With the support and encouragement of his neighbor, Person B agreed to try out a trivia night. Because this was a relatively stable group of attendees, he was able to get to know the other people he'd see there. He also got to know the routine of the event and agreed to come back most every month. It became a highlight for him. He is still unsure about trying additional classes and opportunities, but has consistently been a part of this group and reports enjoying and valuing his time there. His brother stays engaged in the coop, but at a distance. Though he's not able to participate in in-person events, he will email periodically with questions about system changes or announcements he reads in the newsletter or through emails from the CC Staff.

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)

Using our annual membership survey to respond to our overall outcome of being connected has been challenging. In the past, we have tried using longer, detailed surveys, but struggled with getting responses. We have been attempting to streamline our evaluation process, but this approach hasn't given us useful data. We've learned that our membership survey questions are general enough to apply to all of our program participants, but we are not asking the questions that allow us to capture data that is reflective of the highly individualized work we do. We've been asking some simple questions about the very complex ideas of connectedness, leadership, and belonging – which results in data that has not been as helpful in evaluating our services and supports.

In response to this realization, we are beginning to work on a new logic model that will help us define our long-term goals, link short-term outcomes with current activities, and identify changes or additions we need to make within our program activities. We are exploring how we can implement evaluation tools throughout the year and also continue to increase the frequency and quality of recording staff observations. This will help us collect meaningful data and create snapshots of the impact our services and supports have helped program participants be leaders, become connected, and develop relationships.

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 - This program does not have TPCs

Non-treatment Plan Clients (NTPC):

Definition: This is the total count of persons participating in some opportunities offered by this program during the fiscal year. It includes individuals who are members of the Community Choices Co-op, their family members and non-member family members, community members who attend events for support and/or education.

Target: 145

Actual: 162

Explanation:

Community Service Events (CSE):

Definition: These are events where we share with the broader community about the services we offer related to our programs, our goals and the people who would be eligible or benefit from participation.

Target: 4

Actual: 8

Explanation: There were additional opportunities to share information about this program with other organizations and the broader community. Several of these related to our work planning and executing the UNconference, which was designed to inform and engage the community.

Service Contacts (SC):

Definition: These are meetings with participants, time spent working on supports/connections/tools on behalf of the individual, and time spent working and communicating with the person's team.

Target: 1846

Actual: 2210

Explanation: Following our CQL visit during the summer of 2018 (end of FY18) and our strategic visioning session in August of 2018, we developed lots of ideas for how we could engage our members and the community. We tried many of these out over FY19. We held Co-Op happy hours open to members and the community, we planned the UNconference, and worked to develop stronger partnerships with external groups and link those resources to the specific needs of our members and their families. Many of these activities required the involvement of our who staff, beyond just the dedicated Connect Dept. staff, which resulted in some additional service contact that were not anticipated when the grant was written.

Additionally, prior to the Claim reporting system, service contacts that related to either Employment or Community Living that more general (for example, people contacting us to learn more about services, to ask for 1-time support, advise, or information) would have been counted as a service contact within that department. Because we no longer have a way to report that support without officially opening those people in the online system, a few additional service contacts have been counted as Self-Determination (similar to how we would count an outreach or an intake contact.)

<u>Other:</u>

Definition: This accounts for hours working directly with a person using services, a family member, or on their behalf.

Target: 1256

Actual: 1659

Explanation: Similar to the explanation above, considerable work was put into reaching out to members, finding new ways for them to engage. Some of these efforts required considerable staff time, which accounts for the increase in direct hours. Likewise, some additional hours that may have been reported under the CL or CE program previously were likely reported here.

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).

Performance Outcome Report

In your CCMHB program plan (application), you identified performance outcomes in three domains: consumer access, consumer outcomes, and utilization data. Now, you must report on the actual outcomes your program activities achieved in those three domains.

Agency name: **DSC**
Program name: **Apartment Services**
Submission date: **FY 19**

Consumer Access – *complete at end of year only*

Eligibility for service/program

15. *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 is determined based on psychological assessments that include IQ test scores, with a person with a full scale score below 70 or a documented developmental disability with deficiencies in three life areas as being considered eligible. Documentation of IQ/developmental disability is required at the time or presentation to Admissions. The person must also be eligible for the PUNS list.

16. 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.)?

Documentation of IQ/developmental disability is required at the time of presentation of Admissions. Copy of PUNS verification form is maintained in file.

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

Some of the major outreach efforts include the Champaign County Transition Planning Committee Roundtable and Disability Expo. Many referrals come from the Champaign County Regional Planning Commission.

18. 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 75% will receive the service within the fiscal year.

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

Nineteen people were presented to Admissions requesting services through this program. Eleven of those nineteen were opened and eight were not. (11/19 = 58%)
Two do not want services until several years from now and two people are waiting for an opening at CU Independence. These four were placed on the waiting list. Admissions did not agree the program could support the other four for various reasons.

19. 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 from intake to assessment of eligibility by Admissions Committee

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):

90%

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

100% of those requesting services were presented to Admissions within 30 days.

20. 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):

three to six 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):

90%

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

100% of those deemed eligible for services were opened for services within an average of 13 days.

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

Six months to 25+ years.

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

Average length of participant engagement for the 56 people provided support during the FY is nine years ranging from 15 days to 37 years.

1-9 years = 36 people
10-15 years = 8 people
15-25 years = 10 people
Over 25 years = 2 people

Demographic Information

7. *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

8. 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

29. *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: Individuals participating in the Apartment Services Program will maintain/make progress toward their defined goals.

Outcome 2: Individual will be given opportunities to explore and/or participate in new activities or hobbies.

30. 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: maintain/make progress toward defined goals.	**Monthly program reviews and contact notes**	**Data collected by staff**
Outcome 2: New activities or hobbies are explored or participated in.	**Information collected from participants on quarterly basis by program staff.**	**Individual receiving services reported to program staff.**

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

Outcome 1: Sixteen random goals are reviewed per quarter.
Outcome 2: All participants are asked. Information reported on those who respond or staff may report on something they know occurred.

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

Randomly chosen

33. How many total participants did your program have?

56 people were provided support during the FY.

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

Outcome 1: Reviewed 64 different goals.
Outcome 2: All participants.

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

56 people

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

Quarterly

Results

37. 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)

Outcome 1: Target of 80% was met at 80%. Those that have been in the program the longest, were more likely to meet their defined goals.
Outcome 2: Target of 35 new opportunities was met with 54 new opportunities reported. People are wanting to be more involved in their communities and to try new things.

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

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

Benchmarks/targets come from annual Program Evaluation process.

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

Outcome 1: Target of 80% was met at 80%.
Outcome 2: Target of 35 new opportunities was met with 54 new opportunities reported.

(Optional) Narrative Example(s):

41. 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)

42. 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.

4. 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 receiving support through the Apartment Services Program funded by the Champaign County Developmental Disabilities Board. Target is 60 people.

Non-treatment Plan Clients (NTPC): **n/a**

Community Service Events (CSE): **n/a**

Service Contacts (SC):
Individuals screened for Apartment Services support. Target is five.

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).

Performance Outcome Report

In your CCDDB program plan (application), you identified performance outcomes in three domains: consumer access, consumer outcomes, and utilization data. Now, you must report on the actual outcomes your program activities achieved in those three domains.

Agency name: **DSC**
Program name: **Community First**
Submission date: **FY 19**

Consumer Access – *complete at end of year only*

Eligibility for service/program

22. *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 with ID/DD who are interested in participating in their community with staff support through our Community First Program are eligible for services. A documented diagnosis of a developmental disability and enrollment in the PUNS database is required.

23. 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 based on psychological assessments that include IQ test scores, with a person with a full scale score below 70 or a documented developmental disability with deficiencies in three life areas as being considered eligible. The person must also be eligible for the PUNS list.

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

People learn about services through a variety of sources. A DSC representative attends transition IEPs, provides tours for families, and meets with them to discuss possible services and their availability. Information is also distributed at community service events such as the disAbility Resource Expo.

Referrals are received directly from individuals and their families, high school vocational coordinators who have been unsuccessful in obtaining employment for a student nearing the end of their educational eligibility, and other advocates of the person. DSC also receives referrals from the local DRS office when individuals with ID/DD are in search of day program support. People who are employed in the community but are seeking additional connections also request services.

25. 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):

90% of people who are referred will receive services

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

Seventeen requests for services were presented to the Admissions Committee and 12 were opened within the fiscal year for 71%. The 5 who were not opened were added to the wait list with two being offered services but eventually declining. Two are slated to be opened in September 2019 when the new groups start. One person will remain on the wait list as requires more support than is available at this time.

26. 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):

Within 30 days of receipt of requisite eligibility documentation, an individual's request for supports and services will be presented to the Admissions Committee for consideration.

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):

90% of those referred will be assessed for eligibility within the 30-day timeframe.

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

100% of those referred were presented to the Admissions Committee for consideration within 30 days.

27. 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):

Ability to engage in services is determined by the number of people already served in the program. Additionally, most groups are three months in duration and entry into some groups mid-course may not be possible. Therefore, the estimated length of time from assessment of eligibility of need to engagement in services is six to nine 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):

When services are available, people are contacted about current and upcoming groups or activities. People choose what they want to participate in and when they want to start. The estimated percentage of eligible clients who will be engaged in services within the above estimated time frame is 75%.

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

83% of the twelve people opened in the program this fiscal year, were engaged in services within 6-9 months of being deemed eligible. The average time between Admissions and engagement in services for the 12 people who were opened was 4 months. One person had been on the wait list for 18 months and one for 12 months. Most were engaged in services within one month.

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

Participation in services is not time limited, although people who gain employment decrease or discontinue their participation in this service.

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

The overall average length of participation in services for the 56 people during the fiscal year was 6 years.

Demographic Information

9. *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

10. 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

43. *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: Participants in the program will be formally opened in the Community Employment Program for active job exploration.

Outcome 2: People will complete interest inventories to determine new areas of interest. Inventories to be kept and data to be evaluated by program manager.

Outcome 3: New groups will be offered based on interests of program participants. Documentation will be maintained to show correlation between interest inventories and new groups offered.

44. 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. Participants in the program will be formally opened in the Community Employment Program.	**Record of openings into Community Employment Program maintained.**	**Program staff.**
2. People will complete interest inventories to determine new areas of interests.	**Inventory offered to all program participants. Inventories to be kept and data to be evaluated by program manager.**	**All program participants.**
3.New groups will be offered based on interests of program participants.	**Interest inventories are maintained to show correlation between interest inventories and new groups offered.**	**Program participants.**

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

46. If only some participants, how did you choose who to collect outcome information from? **Those who were opened in Community Employment and those who completed interest inventories.**

47. How many total participants did your program have?

56 people during the fiscal year received services from this program.

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

All

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

23 people completed interest inventories

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

Throughout the fiscal year

Results

51. 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)

People are becoming more comfortable with trying new activities. It has been interesting to see the process of how each person discovers their likes and dislikes and how this can relate to them exploring employment. Or for some, deciding not to explore employment, but to expand their newfound interests in their communities.

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

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

Based upon prior program evaluation process and estimates of targets by the Director of the program.

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

Outcome 1: Target of four was met with four people from the Community First program being formally opened in Community Employment.

Outcome 2: Target of 28 to complete interest inventories was not met with only 23 completed.

Outcome 3: At Clark Road, nine new groups were offered based upon the interests of the program participants. At Bradley and Philo, 33 activities were offered based upon the interests of the participants. The target was eight.

(Optional) Narrative Example(s):

55. 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)

Jasmine is 35 and lives with her mother. Jasmine's father died and her mother has been her sole caregiver since then. Her mother was worried about her safety and didn't want her to work so Jasmine started attending Clark Road upon graduation 10 years ago. Jasmine started participating in groups that were offered. She liked working at Clark Road so she was reluctant to participate initially but after participating in a basic cooking group, she was eager to try more. She tried the water aerobics class but didn't like it so she switched to Random Acts of Kindness. She enjoyed the feedback she got from people when the group helped a community member or organization in need. She came up with ideas for acts of kindness as did other group members. She liked helping others so much that she was open to thinking about working at a job helping others. When the next group sign-up period came around, she signed up for job club. Her Employment Counselor also talked with her about taking the MTD class so she could learn how to ride the MTD to basic stops in town. The next step in the process will be working with the Job Club instructor and an Employment Specialist to develop an employment plan. Given her support needs and a desire (both Jasmine and her mother) to work no more than 10 hours per week, she will continue to participate in Community First while she searches for a job that can make necessary accommodations. She will continue to participate in groups through Community First when she is not working.

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

Although interest inventories were completed by program participants, other factors influence group choice including an interest in attending groups based on participation of friends and also who leads the 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.

5. 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): **Champaign County residents with ID/DD participating in the program who do not receive state funding for these services. Target number to be served during FY 19 is 53.**
Non-treatment Plan Clients (NTPC): **Peers who accompany the TPCs for activities and events. Target is 40 people.**
Community Service Events (CSE): **Informational meetings or tours requested by parents, teachers, and other professionals as well as formal presentations to organizations, civic groups, and other community entities. Target for FY 19 is four.**
Service Contacts (SC): **Meetings with prospective participants, transition meetings, and tours of the program by those interested in services. Target is five.**
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).

Performance Outcome Report

In your CCDDB program plan (application), you identified performance outcomes in three domains: consumer access, consumer outcomes, and utilization data. Now, you must report on the actual outcomes your program activities achieved in those three domains.

Agency name: **DSC**
Program name: **Community Employment**
Submission date: **FY 19**

Consumer Access – *complete at end of year only*

Eligibility for service/program

29. *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 with a formal diagnosis of ID/DD, 18 years or older who want help finding a job are eligible for services.

30. 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 based on psychological assessments that include IQ test scores, with a person with a full scale score below 70 or a documented developmental disability with deficiencies in three life areas. The person must also be eligible for the PUNS list.

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

People learn about the program through participation in IEPs, Department of Rehabilitation Services, school programs, community events such as the Disability Resource Expo, and family meetings through the Employment First Program, and current employers.

32. 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):

Seventy percent of those who seek services will be served within the fiscal year based upon the support needs of the person seeking support and those in the program.

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

This fiscal year 24 requests for Community Employment services were presented to Admissions with 19 of those being opened within the fiscal year. Target met at 79%.

33. 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):

Within 30 days of receipt of requisite eligibility documentation, an individual's request for Community Employment support and services will be presented to the Admissions Committee for consideration.

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):

90% of people referred will be assessed for eligibility within 30 days.

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

100% of people referred were presented to Admissions Committee within 30 days.

34. 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 to engagement of services is six to nine months or sooner as resources allow.

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 percentage of eligible clients who will be engaged in services within the above estimated time frame is 75%.

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

100% of the people were assessed for eligibility and engaged in services within the six to nine month target. All were engaged within 30 days.

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

The length of engagement in services ranges from one year to ongoing long term support contingent upon the needs of the employee and employer.

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

Average length of engagement for the 19 new employees hired within the fiscal year is 5.7 months. For overall program, people have been engaged from one month to 21 years.

Demographic Information

11. *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

12. 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

57. *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. **People will maintain their job for at least one year.**
2. **New employers/businesses will hire individuals with ID/DD.**

58. 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.)

1. **A database is maintained to track when individuals are opened for job development, when and where they obtain employment, and their on-going employment status. This information is reviewed quarterly and evaluated year to year as well. This database has been in place for ten years.**
2. **Same as above.**

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. **People will maintain their job.**	1. **Recorded in database.**	1. **DSC staff.**
2. **New employers/businesses will hire.**	2. **Recorded in database.**	**2.DSC staff.**

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

60. If only some participants, how did you choose who to collect outcome information from? **n/a**

61. How many total participants did your program have?
71 total participants received support in FY 19

62. How many people did you *attempt* to collect outcome information from?
Outcome information was gathered from all 28 people who gained employment a year ago.

63. How many people did you *actually* collect outcome information from?
Outcome information was gathered from all 28 people who gained employment a year ago.

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

Results

65. 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)

1-Target of 75% of people will maintain employment for one year.
17/22 for 77.3% maintained their competitive jobs for one year.
6/6 maintained their supported employment positions for one year.
Overall – 23/28 for 82.1%.
This goal continues to be a good measure of the effectiveness of job matches. This fiscal year two people were successfully closed from the program as deemed no longer needing job coach support. One person retired from a company he had worked at for many years.

2-Target of eight new businesses to hire people with developmental disabilities enrolled in the program.
Nineteen new businesses from many different employment sectors hired people in the program this fiscal year. Over the last three fiscal years, a total of 48 new businesses hired people enrolled in this program. This speaks to the impact of the LEAP program and the continuing change in the employment culture in the area.

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

67. If yes, what is that benchmark/target and where does it come from?
The comparative targets were established from past results.

68. If yes, how did your outcome data compare to the comparative target or benchmark?
1-Target of 75% of people will maintain employment for one year.
17/22 for 77.3% maintained their competitive jobs for one year.
6/6 maintained their supported employment positions for one year.
Overall – 23/28 for 82.1%.

2-Target of eight new businesses to hire people with developmental disabilities enrolled in the program.
Nineteen new businesses hired people in the program.

(Optional) Narrative Example(s):

69. 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)

John graduated from high school three years ago. Although he tried to find a job, he wasn't ever called for an interview, and after a few months he stopped looking. For the past 2 ½ years he has spent a lot of time in his room playing video games and hanging out with friends. Lately he has spent more time in his room and less with his friends. John's parents are worried about him staying in his room and are also frustrated that he hasn't gotten a job. They want him to start paying for his phone and other bills. They reached out for help looking for a job. After meeting with John and his parents, an Employment Specialist (ES) is assigned to work with John. The initial meetings between the ES and John include establishing a relationship. The ES gathers information about past experience, interests, hobbies, etc. They meet with teachers from high school and speak with a supervisor from a business where he volunteered while in school. The meetings also help John get back in the habit of keeping scheduled appointments and taking an active role in seeking employment. His readiness is evaluated in part through his participation in the appointments, his active involvement in identifying potential businesses to visit, and his engagement with employers. This process takes some time as John will often call to cancel or just not show up for appointments. They also work on soft skills such as making self-introductions, attire, and physical presentation.

During this time an employment plan is developed that sets the direction for the types of jobs to pursue. Following this plan, they continue to visit businesses, submit applications, and practice those skills that enhance John's chances for employment. When John is called for an interview he has already had many opportunities to practice speaking confidently about his strengths. They review questions typically asked during initial interviews. John chooses to attend the interview independently although he knows the ES is able to attend for support. John is offered a job and the ES and John iron out the logistics of his schedule, including start times, lengths of shifts, number of days, etc. based on transportation needs, stamina, and other factors. Although the ES provides transportation to and from work for the first week of employment to limit the number of new experiences he has to deal with, teaching John the bus routes to and from work will begin the second week if all goes well. The ES assists John with all new employee orientation which includes learning how to clock in and out, new employee training modules completed on the computer, setting up passwords for payroll, and how to find his schedule on the computer. They work together to learn the responsibilities of his job, identify aids that may be of benefit, and any accommodations he may need in addition to his work schedule based on MTD bus route times. The ES also helps John make connections with co-workers and identifies any who may be strong advocates for John and someone he can go to with questions as the support fades. Over the next few weeks the ES is with John whenever he works. As John is able to initiate job responsibilities independently the ES begins to fade support. Communication is maintained with the supervisor to ensure all is going well and to establish a relationship. Throughout these first few weeks John is also establishing habits that affect his work indirectly such as getting enough sleep and packing a lunch so he's not hungry during his

shift. When John feels comfortable with his job and his supervisor is also confident, the ES will reduce visits based on the needs of John and the employer. As John establishes himself as a valued employee, the ES evaluates the job to identify potential for advancement or additional hours.

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

As we've continued to identify people from our in-house programs who are interested in employment we recognized most required a significant level of support and reduced work hours. Support may be needed to navigate transportation and they might be unable to commit to regular work hours. Therefore, we added supported employment work opportunities. We continue to seek to develop relationships with more businesses interested in hiring small work crews who complete work tasks that are carved out for them. This requires an on-going commitment of staff resources to provide these opportunities.

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.

6. 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.

<u>Treatment Plan Clients (TPC):</u>

Champaign County residents with a documented diagnosis of ID/DD receiving supports from the program. TPCs included under this application are those individuals and services not funded by the state. Target is 55 people.

Non-treatment Plan Clients (NTPC): **n/a**
Community Service Events (CSE): **Formal presentations or tours to organizations, civic groups, school personnel, or other community entities. Target is two.**
Service Contacts (SC): **Includes contacts with people interested in the Community Employment Program. Target is eight.**
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).

Performance Outcome Report

In your CCDDB program plan (application), you identified performance outcomes in three domains: consumer access, consumer outcomes, and utilization data. Now, you must report on the actual outcomes your program activities achieved in those three domains.

Agency name: **DSC**
Program name: **Clinical Services**
Submission date: **FY 19**

Consumer Access – *complete at end of year only*

Eligibility for service/program

36. *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 and adults with intellectual and developmental disabilities who reside in Champaign County, regardless of affiliation with DSC.

37. 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 Verification – medical and psychological documentation presented during the intake process, as well as residency documentation.

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

Disability Expo, transition meetings, support group referrals, physician and interagency referrals, DSC website, Facebook, outreach events, brochures, and other information materials.

39. 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):

90% of those seeking services will receive those services contingent on available resources.

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

100% received services. 7/18 = 39% (those who sought and received services from DSC). The other 11 people were referred to community services from other agencies.

40. 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):

Referral to eligibility determination timeline is 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):

90% of people referred for services will be assessed for eligibility within 30 days.

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

All seven who received services from DSC were deemed eligible within 30 days.

41. 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):

Assessment/eligibility to service provision timeline is 30 to 60 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):

90%

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

5/7 were engaged in services within 60 days = 71% (the two that were not seen within the target time frame were referred to a more specialized DSC consultant for counseling initially who was not able to see them right away)

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

Average length of participation in services ranges from 6 months to long term support.

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

For those receiving a new service this fiscal year, one individual consulted with the psychiatrist for one visit, three had psychological evaluations which is one visit, the other three were counseling services with one receiving five sessions and the other two have been seen for six months.

Demographic Information

13. *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

14. 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

71. *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: Other clinical/financial options will be explored before offering DSC Clinical Services to new referrals.

Outcome 2: DSC's Clinical Coordinator will conduct quarterly reviews regarding the assessment, progress, and frequency of appointments for all people receiving DSC/CCDDB funded Counseling Support.

Outcome 3: DSC Psychiatric Practice will review patient progress on a regular bases and attempt to reduce the number and dosage of psychotropic medications when deemed clinically appropriate and document such attempts in the psychiatric notes.

72. 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: options explored.	**Pursuit of community options is documented.**	**Clinical Coordinator**
Outcome 2: quarterly reviews for those receiving counseling	**Quarterly reviews are maintained.**	**Clinical Coordinator**
Outcome 3: review of patient progress to reduce medications	**Psychiatric notes are maintained.**	**Clinical Coordinator**

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

Yes

74. If only some participants, how did you choose who to collect outcome information from? **n/a**

75. How many total participants did your program have?

65 TPC and six NTPC totaling 71.

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

All of them.

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

All of them.

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

Quarterly reports are completed by all counselors and the psychiatrist should consult with individuals at least every three months.

Results

79. 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)

The Clinical Coordinator tends to have consistent contact with an individual's team and the consultants to be aware of status and to continually evaluate the need. Quarterly reports are done but often there is contact in between the quarterly reports.

Outcome 1: 13/18 = 72% - - three people requested a specific counselor and two were returning patients of particular providers.
Outcome 2: 241/241 = 100%
Outcome 3: 84/87 = 97%

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

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

The target for outcomes 1-3 is 100%. Targets were established based on past program evaluation of these outcomes.

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

Outcome 1: 13/18 = 72%
Outcome 2: 241/241 = 100%
Outcome 3: 84/87 = 97%

(Optional) Narrative Example(s):

83. 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)

84. 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.

7. 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 with case records and Individual Service Plans (ISP) funded by CCDDB. Target: 65

Non-treatment Plan Clients (NTPC):

Residents of Champaign County with service and support records but no formal Individual Services Plans who are funded by CCDDB. Target: Five

Community Service Events (CSE):

Contact/meetings to promote the program, including public presentations, consultations with community groups, or caregivers, and small group workshops. Target: Two

Service Contacts (SC):

Phone and face-to-face contacts with people who may or may not have open cases in a given program – including information and referral contacts, initial screenings/assessments, and crisis services. Target: 10

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).

Performance Outcome Report

In your CCDDB program plan (application), you identified performance outcomes in three domains: consumer access, consumer outcomes, and utilization data. Now, you must report on the actual outcomes your program activities achieved in those three domains.

Agency name: **DSC**
Program name: **Connections**
Submission date: **FY 19**

Consumer Access – *complete at end of year only*

Eligibility for service/program

43. *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)

Potential participants are opened in DSC's Community First Program.

44. 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 requirement is being enrolled in the Community First Program. Interest in participating in the activities is determined by self-report from potential participants.

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

People in the Community First Program learn about the activities offered at The Crow at 110 from the DSP organizing the activities at the site.

46. 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):

90% of those who voice interest will be able to access the services provided within the fiscal year.

b) *Actual* percentage of individuals who sought assistance or were referred who received services: **100%**

47. 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):

60 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):

90% of those who voice interest will be given estimated date of participation within 60 days.

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

100%

48. 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):

Three to six 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):

90%

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

Given the availability of multiple groups offered at The Crow each week, 100% of people who requested groups at The Crow were able to participate in at least one group of their choice within three to six months.

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

Participant engagement is not time limited.

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

It is rare for participants to disengage group participation prior to the end of the 4-month group length. Participants choose new groups approximately every 16 weeks.

Demographic Information

15. *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

16. 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

85. *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: New creative exploration classes will be developed as program participants continue to define areas of interest.

86. 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: New creative exploration classes will be developed as participants continue to define areas of interest.	**Record of classes and who attends will be documented.**	**Manager of program.**

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

Only those people who voiced an interest and chose to participate.

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

Involved all of those people in the Community First Program who voiced interest.

89. How many total participants did your program have?

27 TPCs and 19 NTPCs

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

All people open in the Community First program (56 over the fiscal year) were offered the opportunity to participate in groups held at The Crow.

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

All people open in Community First were included - - total = 56.

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

New groups are offered approximately every 16 weeks. Group choices is the first step in the process.

Results

93. 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)

Outcome: Fifteen classes were created based upon areas of interest. Some of these classes included: Small critters, science, and writing.

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

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

The targets chosen were estimates from the Director of the program as to what could be accomplished during the fiscal year.

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

Outcome was met.

(Optional) Narrative Example(s):

97. 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)

Jane has participated in multiple art groups offered at The Crow at 110. Her art has been displayed at The Crow during the Boneyard Arts Festival and she has also sold homemade soap at a booth at Ebertfest and as part of the Market In the Square event. She continues to do art on her own and also co-instructed an introduction to art group for some of her peers. She signed up for Poetry Writing group when new group sessions were offered. One of her first poems was a description of the color purple, her favorite color. The group is planning a poetry reading in the near future.

98. 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 definition of artistic interests has expanded to include not only traditional art, but also creative expression through poetry reading and writing, storytelling, short story development, and music. Multiple groups have been added to support this shift in emphasis.

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.

8. 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):

People participating in DSC's Community First Program interested in pursuing their creative interests and talents at The Crow at 110. Target is 25 people.

Non-treatment Plan Clients (NTPC): **People not receiving county funding for day program services participating in activities. Target is ten people.**
Community Service Events (CSE): **The number of events either hosted or attended by program participants. Target is four.**
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).

Performance Outcome Report

In your CCDDB program plan (application), you identified performance outcomes in three domains: consumer access, consumer outcomes, and utilization data. Now, you must report on the actual outcomes your program activities achieved in those three domains.

Agency name: **DSC**
Program name: **Employment First**
Submission date: **FY 19**

Consumer Access – *complete at end of year only*

Eligibility for service/program

50. *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 business that shows an interest can access the LEAP certification process.

51. 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.)?

Businesses outside of Champaign-Urbana will be the target population for this access goal in FY 19 but all businesses will be offered the training as approached or requested.

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

Businesses generally learn about these trainings through word of mouth and outreach conducted by the two positions supported by this grant. Business outreach has included LEAP trainings for an array of community employers from small businesses with an audience of two to HR departments and hiring managers of large employers or community wide events with 50 participants per event. Recognition of employers who are becoming more disability aware includes not only social media of both Community Choices and DSC, but community events such as the Disability Resource Expo.

53. 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 those businesses interested will be provided the service.

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

100%

54. 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 when the business voices interest and the actual training varies and depends upon the business' schedule for the most part.

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**

55. 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 when the business voices interest and the actual training varies and depends upon the business' schedule for the most part.

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):

Staff worked with all businesses to arrange the training to best fit their employees' schedules and what worked best for the business.

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

100%

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

The training generally takes under two hours. Engagement or follow-up occurs three months later unless the company reaches out first.

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

Average training took 1.75 hours.

Demographic Information

17. *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)

Zip codes of businesses participating in the LEAP training. Total equaling 37 businesses this fiscal year.

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

61820 – eleven businesses

61821 – six businesses
61822 – five businesses
61801 – four businesses
61802 – eight businesses
61866 – two businesses
61874 – one business

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

99. *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: A quarterly newsletter including information about the disability community and employment of people with ID/DD will be provided for employers.

Outcome 2: One lunch and learn meeting will be arranged providing an opportunity for employers to learn from service providers as well as each other. Collaboration on this project will be with the local Chambers of Commerce.

Outcome 3: Two informational meetings including panels will be provided for individuals currently participating in day program, on waiting list for services and those transitioning from high school. Families will be surveyed to determine what they know/need to know about services in Champaign County to assist in choosing meeting topics.

Outcome 4: A community-wide training on customized employment will be hosted.

100. 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: quarterly newsletter provided to employers.	**Four newsletters**	**Coordinator of program**
Outcome 2: Lunch and learn meeting for employers.	**Record of meeting, who attended, etc.**	**Coordinator of program**
Outcome 3: Informational meetings	**Record of meeting, who attended, etc.**	**Coordinator of program**
Outcome 4: Training	**Record of training**	**Director of program**

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

n/a

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

n/a

103. How many total participants did your program have?

Thirty-seven businesses completed the LEAP certification training this fiscal year.

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

Reached out to over 13 businesses outside of the Champaign-Urbana area but only two participated in the certification process.

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

All participating businesses.

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

Quarterly

Results

107. 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)

Although over 13 businesses outside of the Champaign-Urbana area were approached about LEAP certification participation, only two eventually completed the training. LEAP representatives have found that many of the businesses in the rural areas of the county are smaller and do not have the capacity for employees to take time away from work to attend trainings. Will continue to reach out to these area businesses and explore other avenues such as job fairs and Chambers of Commerce to possibly involve these areas.

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

Yes

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

Outcome 1: four newsletters
Outcome 2: one lunch and learn meeting
Outcome 3: two informational meetings
Outcome 4: one community-wide training

Benchmarks/targets were derived from what was thought could be achieved over the fiscal year.

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

Outcome 1: A newsletter was distributed to all LEAP certified businesses every quarter. The newsletters highlighted certified businesses, employer tips, LEAP success stories and information useful to employers.

Outcome 2: The lunch and learn meeting was held on October 29th on the topic of "Building an Inclusive Workplace from Managers to Frontline Staff". It was an open forum for employers to discuss how employees can be natural support to co-workers with disabilities. Guest speakers shared their experiences.
Outcome 3: On June 13th, "The Keys to a Successful Transition" informational meeting was held. One June 27th, the "Access to the Future" informational meeting was held.

Outcome 4: The community-wide training was unable to be held due to the non-availability of the preferred training company. However, Employment Specialists did attend the national APSE (Association of People Supporting Employment First) conference in June entitled "Gateway of Inclusive Employment".
(Optional) Narrative Example(s):
111. 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) **The E1st/LEAP Coordinator visits businesses based on leads from job developers or cold calls. An information sheet is shared with the business representative, typically someone from Human Resources or upper management. The conversation may include problems with maintaining personnel, job functions that fall through the cracks, and their familiarity with the benefits of employees with disabilities. LEAP training is offered to the business and is then arranged at a time convenient for employees of the business. Follow-up includes contact within one week of the presentation from the coordinator. If the business is interested in speaking about the possibility of hiring a job seeker following the training, an appointment will be scheduled to include a job developer for the purpose of speaking about business needs, to perform a job analysis, or to speak about the process of support for post-hire training, etc. If no opportunities are available at that time, a follow-up is done no later than 3 months-post training. At that time the coordinator follows up on any changes the company has made to increase opportunities for people with disabilities within their workforce.**

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

LEAP training – 37 businesses were LEAP certified during the fiscal year. LEAP trainings are scheduled based on the schedule of the employer and there were several trainings cancelled at the last minute by the employer due to staffing issues. Primarily a key mid-manager was unavailable. Multiple trainings were offered to these businesses so that all staff identified to attend by upper management would receive the training. Scheduling LEAP training for businesses outside Champaign-Urbana proved to be challenging. Most of these businesses are small independently owned businesses and owners reported an inability to free themselves or the few employees they had for training. Outreach to the Rantoul Chamber of Commerce did result in participation in a job fair with access to local employers. Although no trainings were scheduled from the event contacts/relationships were established. We also solicited input from school vocational staff on possible employers. We also began the process of developing a front-line training for businesses. While some businesses included front-line staff in addition to management, the training is more directed to those who influence or are directly involved in hiring of employees. This will be offered during FY20.

Informational meetings – Attendance at family informational meetings continues to be less than we hoped for. We worked with the Community Learning Lab to develop a family survey. Information on how to access the survey monkey was disseminated through social media channels by both Community Choices and DSC as well transition consultants through the CCDDB-funded Community Services Program, CCRPC, and schools. The 36 respondents represented those with family members still in school and about to age out of school services and those with jobs, both paid and volunteer. Employment and housing were the top areas of interest. The informational meetings included Successful Transition and Access to the Future. The first was well attended with 19 attendees while the second was attended by three people. We continue to evaluate outreach efforts and include others in our process.

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.

9. 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): **Number of people attending informational meetings. Target is 50 people.**

Community Service Events (CSE): **Represents the number of area professional business organizations who attend the LEAP training and are certified following the event. Target is 15 businesses.**

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).

Performance Outcome Report

In your CCMHB program plan (application), you identified performance outcomes in three domains: consumer access, consumer outcomes, and utilization data. Now, you must report on the actual outcomes your program activities achieved in those three domains.

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

Consumer Access – *complete at end of year only*

Eligibility for service/program

57. *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.

58. 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.

59. 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.

60. 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.

61. 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.

62. 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.

63. 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

19. *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

20. 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

113. *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.

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

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

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

By random selection of those receiving services each quarter.

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

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

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

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

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

120. 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

121. 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.**
122. Is there some comparative target or benchmark level for program services? **Yes**
123. If yes, what is that benchmark/target and where does it come from? **The comparative targets were established from averaging past results.**
124. 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):
125. 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.

126. 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.

10. 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).

Performance Outcome Report

In your CCDDB program plan (application), you identified performance outcomes in three domains: consumer access, consumer outcomes, and utilization data. Now, you must report on the actual outcomes your program activities achieved in those three domains.

Agency name: **DSC**
Program name: **Individual and Family Support**
Submission date: **FY 19**

Consumer Access – *complete at end of year only*

Eligibility for service/program

64. *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 and adults with intellectual and developmental disabilities (I/DD) who reside in Champaign County, regardless of affiliation with DSC.

65. 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 Verification – Medical and psychological documentation presented during the intake process, as well as residency documentation. Verification of PUNS enrollment is required.

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

Outreach: disAbility Expo, transition meetings, support group referrals, physician and interagency referrals, DSC website, Facebook, outreach events, brochures, and other informational materials.

67. 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% of those who seek assistance and are eligible will receive services within the fiscal year.

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

11 requests for services were presented to the Admissions Committee with four opened for services in the fiscal year for 36%.

68. 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):

Within 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):

90%

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

100% were assessed for eligibility within 30 days.

69. 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 of need to engagement in services is three to six 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):

90%

c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame: **36%**

Of the 11 requests, four were opened within an average of 2.5 months. The other seven were placed on the wait list and were not opened within the fiscal year.

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

Participation in services is not time limited.

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

Of the 54 provided services in FY 19, average length of engagement is four years. Two people have been in the program the longest for 11 years.

Demographic Information

21. *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

22. 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

127. *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: 80% of all individuals receiving day services and requesting community activities, will participate on a weekly basis.
Outcome 2: Individuals/guardians receiving IFS Respite (Intermittent Direct Support) will be satisfied with services.

128. 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: participation in community activities	**Documentation of activities will be maintained**	**Program manager**
Outcome 2: Satisfaction with respite (intermittent direct support) services	**Satisfaction Survey**	**Participants and families**

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

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

Outcome 1: Community activities were monitored for those in day program or receiving day support.
Outcome 2: Surveys were sent to the 30 people receiving intermittent direct support.

131. How many total participants did your program have?

A total of 54 participants for the FY: 17 TPC and 37 NTPC

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

35

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

All five receiving day support through the program.
Only six of the surveys of the 30 sent out were returned.

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

Outcome 1: Every quarter
Outcome 2: Fourth quarter

Results

135. 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)

Outcome 1: 74% of those supported in the day program, were able to access the community once a week.

Outcome 2: 100% of the surveys returned were positive.
There was a very small return on the satisfaction surveys with six out of the 30 being returned. Will consider contacting families by phone or email next year.

Families often struggle to find providers for Intermittent Direct Support hours. Will continue to advice families of available community resources such as the PACE Personal Support Worker Program, college education classes with students looking for part-time employment, and TAP.

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

137. If yes, what is that benchmark/target and where does it come from? **Previous program evaluation results.**

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

Outcome 1: 74% of those supported in the day program, were able to access the community once a week.

Outcome 2: 100% of the surveys returned were positive.

(Optional) Narrative Example(s):

139. 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)

There are generally four different types of requests for services within this program: monies for equipment, Intermittent Direct Support (respite), camp fees, and one-on-one day support. Decision on which request is honored depends upon the budget and available staff support. In the past, this program has usually provided support to those with intense needs.

140. 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.

11. 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): **Those individuals receiving funding from CCDDB with case records and Individual Service Plans. Target:17**
Non-treatment Plan Clients (NTPC): **Those individuals with service and support records but no formal Individual Service Plans who are funded by DDB. Target: 33**
Community Service Events (CSE): **Contacts/meetings to promote the program, including public presentations, consultations with community groups, or caregivers, and small group workshops. Target: Two**
Service Contacts (SC): **Phone and face-to-face contacts with those interested in services/supports provided by the Individual and Family Support Program. Target: Five**
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).

Performance Outcome Report

In your CCDDB program plan (application), you identified performance outcomes in three domains: consumer access, consumer outcomes, and utilization data. Now, you must report on the actual outcomes your program activities achieved in those three domains.

Agency name: **DSC**
Program name: **Service Coordination**
Submission date: **FY 19**

Consumer Access – *complete at end of year only*

Eligibility for service/program

71. *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 and adults with intellectual and developmental disabilities (I/DD) who reside in Champaign County and request support to enhance or maintain their highest level of independence in the community, at work, and in their home.

72. 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 based on psychological assessments that include IQ test scores, with a person with a full scale score below 70 or a documented developmental disability with deficiencies in three life areas. The person must also be eligible for the PUNS list.

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

Outreach – disAbility Expo; transition meetings, support group referrals, physician and interagency referrals, DSC website, Facebook, outreach events, brochures, and other informational materials.

74. 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):

90% of those who seek services will be served within the fiscal year based upon capacity to serve.

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

100%

75. 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):

Within 30 days of receipt of requisite eligibility documentation, an individual's request for services will be presented to the Admissions Committee for consideration.

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):

90% of those referred will be assessed for eligibility within the 30-day time frame.

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

100%

76. 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 to engagement in services is 30 to 60 days, contingent upon availability in desired program.

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):

90%

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

Twenty-three people were opened in Service Coordination this fiscal year. Because everyone opened for DSC support automatically receives services from this program as they are assigned a Case Coordinator, twenty were opened based upon availability into another program.

Of the three requesting Service Coordination primarily, all three or 100% were engaged in services within 60 days of deemed eligibility.

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

Average length of participant engagement in services is one year to long term support.

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

Average length of participant engagement in services for the 273 people provided Service Coordination services this fiscal year is 15 years. Service Coordination is the constant in people's lives as they navigate the many choices of resources they might engage in throughout their lives.

Demographic Information

23. *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

24. 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

141. *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 actively participate in the development of their goals at their annual meeting.

Outcome 2: Individuals will maintain/make progress toward their defined goals.

142. 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: actively participate in the development of their goals.	**Self-report on specific survey questions from a random sample of participants.**	**Person receiving service.**
Outcome 2: maintain/make progress toward their defined goals.	**Review of notes and reviews.**	**Director of Program Assurance**

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

144. If only some participants, how did you choose who to collect outcome information from? **Fifteen people per month are chosen for goal review and surveys.**

145. How many total participants did your program have?

Total number of people served in FY 19 funded by DDB for Service Coordination under this grant is 273.

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

60 people

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

60 people

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

Results

149. 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)

Over the past several years, the personal plan process has been changing. Through the interviews conducted, it was found that people are still trying to understand all of the key players in their goal planning and maybe do not feel as involved as they have been in the past. Many voiced not really liking not having actual sit-down annual meetings with everyone. However, almost everyone did indicate they liked the activities they were involved with during the day and evening. Will revisit the questions asked and continue to monitor, adjusting the process as needed.

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

151. If yes, what is that benchmark/target and where does it come from?
Outcome 1 target = 98%
Outcome 2 target = 80%
Targets were estimated based on desired level of performance for both of these goals.

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

Outcome 1 target of 98% for self-report on goal development was not met. Outcome = 68%.

Outcome 2 target of 80% for goal review was met with 88%.

(Optional) Narrative Example(s):

153. 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)

154. 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.

12. 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):

Those individuals with case records and Individual Service Plans (ISP) funded by CCDDB. Target: 300.

Non-treatment Plan Clients (NTPC):

Residents of Champaign County with service and support records but no formal Individual Service Plans who are funded by CCDDB. Target: 36.

Community Service Events (CSE):

Informational meetings/requests, formal presentations to organizations, civic groups, school personnel, or other community entities. Target: two.

Service Contacts (SC):

Phone and face-to-face contacts with individuals who may or may not have open cases in a given program; including information and referral contacts, initial screenings/assessments, and crisis services. Target: 100

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).

Performance Outcome Report Template

In your CCMHB program plan (application), you identified performance outcomes in three domains: consumer access, consumer outcomes, and utilization data. Now, you must report on the actual outcomes your program activities achieved in those three domains.

Agency name: PACE, Inc.
Program name: Consumer Control in Personal Support
Submission date:9/20/19

Consumer Access – *complete at end of year only*

Eligibility for service/program

78. *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)
To be part of this program, people seeking work as a PSW must;

79. 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 ram their name through the health care registry, and conduct other basic background checks, and they had to complete the orientation prior to being eligible for the registry

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

PACE did extensive advertising about this program at CCDDB and TPC functions, as well as having a continuously running Facebook job ad

81. 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):

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

Data on this difference wasn't kept due to this being the first year of this report asking for it to be tracked

82. 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):

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:

Data on this difference wasn't kept due to this being the first year of this report asking for it to be tracked

83. 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):

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:
All people started their assessment, but may have waited due to the scheduling of the next PSW orientation. Even though at that point they are still NTPCs

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

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

Data on this difference wasn't kept due to this being the first year of this report asking for it to be tracked

Demographic Information

25. *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)

26. 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

155. *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 Potential/actual Personal Support Workers (PSWs) who went through orientation
2). Number of PSWs hired through our referral
3). Average number of hours of service per week PSWs from out list are providing services .
4). As a measure of impact, we will also show the number of people utilizing PACE's PSW referral service (although any time spent from this side will be paid for by other funding)

156. 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

All NTPCs in this program, therefore no official outcomes		

Was outcome information gathered from every participant who received service, or only some? All NTPCs in this program, therefore no official outcomes

An unofficial outcome of this program was the matching of 3 PSWs with individuals seeking to hire a PSW

If only some participants, how did you choose who to collect outcome information from? All NTPCs in this program, therefore no official outcomes

157. How many total participants did your program have?

All NTPCs in this program, therefore no official outcomes

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

0

How many people did you *actually* collect outcome information from? All NTPCs in this program, therefore no official outcomes

159.

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

All NTPCs in this program, therefore no official outcomes

Results

161. 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)

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

Y

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

The benchmarks are those listed below in this document

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

There was no comparative data since this is the program's inaugural year

(Optional) Narrative Example(s):

165. 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)

PACE advertises regularly on Facebook to attract people to attend the PSW orientation so they can be put on our registry. After a person comes across our posting, they send us a Facebook Message, and it starts a conversation about the position. The person then attends the PSW orientation, gets checked to make sure they are eligible for the registry, and if all goes well, they get matched with a consumer looking to hire a PSW

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

Each quarter, all PACE programs host a program advisory meeting to seek feedback from consumers on how our programs could provide more assistance. As this is the inaugural year of this program, the first advisory focused on fine-tuning our PSW orientation

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.

13. 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):
This program has no TPCs due to the participants be funded by CCDDB are people seeking employment as PSWs, and therefore are not typically people determined to be PUNS eligible.

Non-treatment Plan Clients (NTPC):
Target: 150 Actual:

Community Saervice Events (CSE):
Target: 12 Actual:

Service Contacts (SC):
Target: 200 Actual:

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).

Performance Outcome Report Template

In your CCMHB program plan (application), you identified performance outcomes in three domains: consumer access, consumer outcomes, and utilization data. Now, you must report on the actual outcomes your program activities achieved in those three domains.

Agency name: PACE, Inc.
Program name: Opportunities for Independence
Submission date: 9/19/19

Consumer Access – *complete at end of year only*

Eligibility for service/program

85. *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)

PACE consumers are served on a first-come, first-served basis. PACE procedures require a response contact within three-working days of the Initial consumer contact. Upon first contact, a consumer intake and Individual Services/Information and Referral (I&R) forms are filled out; these include demographic data such as consumer name, address, phone number, age, gender, race, disability status, ethnicity, referral source, veteran status, and voter registration status.
Along with the Individual Services/I&R form, a needs assessment is completed for each consumer. A verification of Intellectual/Developmental Disability, as defined by the CCDDB checklist, Is also used to verify eligibility. Upon initiation of services, each PACE consumer receives information on the appeals process which outlines the method to start the grievance process should issues develop in the provision of PACE services. Consumers will also be asked if they are and/or have been served under Medicaid and in what way. Screening for Medicaid eligibility will be part of the CCDDB checklist for eligibility.
If a consumer receives services through Medicaid as a Reintegration consumer at PACE, the consumer will be found ineligible for services for CCDDB/OIP, consistent with program funding rules. No other program at PACE presently has Medicaid-based funding.

86. 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.)? For consumers to be TPCs, they had to be approved by the ISC as being PUNS eligible. To be an NTPC, they had to be someone learning about the program that we believed would use the information

87. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.) We conducted CSEs throughout the area, and and conducted outreach to school throughout rural Champaign County to conduct our school based programs. Further, we work closely with the Special Ed co-op and the Transition Planning Committee

88. 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):

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

100% who sought services received them. If the person seeking services turned out not to be PUNS eligible, we served them using other funds, and they were simply counted as a NTPC under this program

89. 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):

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:

By PACE policy, all people seeking services are assessed through our process quickly. Many of the first interactions in this program would have happened at our school programs, and the participants would have completed initial PACE assessment on site, The next steps requiring ISC assessment took place on ISC's timetable

90. 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):

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:

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

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

Once participants began receiving services, they continue throughout the rest of the fiscal year.

Demographic Information

27. *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)

28. 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

167. *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.

PACE's Outcomes report has been developed and is based on the same life areas as the needs assessment and Independent Living Plan goals: Civil Rights and the Law, Health Care/Medical, Transportation, Communication, Housing, Youth/Family, Education and Training, Personal Assistance, Employment, Daily Living/Self Care, Equipment/Assistive Technology, Self. Help/Personal, Finance and Benefits, and Social/Recreation. Example: Self Care/Dally Living outcomes can be: Knows personal safety, Knows basic hygiene, Uses memory cue options, and Eats as Independently as possible. Equipment/Assistive Technology outcomes can be: Knows personal adaptive equipment needs, Acquires adaptive equipment, Uses adaptive equipment to maximize independence, Acquires mobility aid, Acquires visual aid, and Acquires repair/maintenance of adaptive equipment. Example: Civil Rights and the Law outcomes can be: Knows disability law (such as the ADA, IDEA, Fair Housing), Recognize and confront Infringement of rights, Acquired advocacy services, Change legal status, File appeal, or File suit.

168. 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
AT 101: Assistive Technology	PACE Needs Assessment	Independent Living Plans of individual TPCs
EM 211: Identify own barriers to employment	PACE Needs Assessment	Independent Living Plans of individual TPCs
HC 128: Understand Healthy Diet	PACE Needs Assessment	Independent Living Plans of individual TPCs

HC 129: Know Exercise Needs	PACE Needs Assessment	Independent Living Plans of individual TPCs
SH 501: Feel Better About Self	PACE Needs Assessment	Independent Living Plans of individual TPCs
SH 114: Learn About Own Disability	PACE Needs Assessment	Independent Living Plans of individual TPCs
TR 441: Use Specialized Transportation Without Assistance	PACE Needs Assessment	Independent Living Plans of individual TPCs

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

Outcomes information at PACE is only gathered for TPCs that achieve goals that they set as part of their Independent Living Plan (ILP) when they establish their Treatment Plan with PACE

170. If only some participants, how did you choose who to collect outcome information from? As stated above, outcomes are from all TPCs that completed their goals. Those not completing goals, as well as NTPCs don't have outcomes

171. How many total participants did your program have?

79

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

12

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

11

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

Outcomes are gathered once when the TPC agrees that they have achieved a goal that they set for themselves

Results

175. 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 shortfalls in this program (TPC target of 35, actual of 22, and CSE target of 25, and actual of 12) are not unexpected results with extended absence of the program's single staff member.

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

The only benchmark targets are those outlined in the CCDDB reporting system, and those listed below.

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

The benchmarks are those definitions set forth by CCDDB

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

PACE fell well short of data in previous years due to the medical leave of the staff member filling this position for the majority of the second half of the FY

(Optional) Narrative Example(s):

179. 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)

PACE staff member arranged with a school in rural Champaign County to do a monthly presentation during a specific part of the day. PACE staff goes to that class, and finds a person with a disability that has been consistently discounted and overlooked. Because the PACE staff member giving the presentation on self-advocacy has a visible disability, the student these themselves as potentially having a future in the adult-world. The student then is more engaged in the presentations that the PACE staff delivers than what they typically display in their daily classes

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

PACE conducts quarterly advisory meetings for all of our programs. In these advisory meetings, consumers tell staff what they want to see the program focus on. In this program, students got to pick topics of trainings. One such choice was finding out how to do advocacy.

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.

14. 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 different from your actual numbers, you may give a narrative explanation for that discrepancy here.

<u>Treatment Plan Clients (TPC):</u>

A consumer whom is already receiving services from CCDDB, or whom has been deemed eligible for services by the ISC following referral by PACE staff.

The shortfall in this area was due to extended absence of staff member managing thie program

Target: 35 Actual: 22

<u>Non-treatment Plan Clients (NTPC):</u>

In this contract, there are several groups that may either transition from an NTPC to a TPC, or whom are an NTPC due to their not being a direct program participant.

--A consumer starts out as an NTPC, and once we get confirmation from the ISC that they are PUNS eligible, they transition to a TPC. The other Group that gets classified as an NTPC are individuals whom receive information about the program, and whom we believe will benefit from the program (i.e. parents, professionals, etc.) Target: 30 Actual: 57 We had some larger outreach we completed in the first half of the FY
<u>Community Service Events (CSE):</u> Events which PACE conducts or participates in where; consumers believed to be eligible for CCDDB services, their families/friends, or service providers are provided with information about the Opportunities for Independence program. Target: 25 Actual: 12 We were short in this category due to the staff member in this program being having an extended leave for most of the second half of the FY
<u>Service Contacts (SC):</u> The number of distinct contacts which PACE Staff has with TPCs Target: 125 Actual: 140
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).

Performance Outcome Report Template

In your CCMHB program plan (application), you identified performance outcomes in three domains: consumer access, consumer outcomes, and utilization data. Now, you must report on the actual outcomes your program activities achieved in those three domains.

Agency name: Rosecrance Central Illinois
Program name: Coordination of Services DD MI
Submission date: 8-30-19

Consumer Access – *complete at end of year only*

Eligibility for service/program

92. *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 target population are individuals who are 18 years of age or older who reside in Champaign County and who are dually diagnosed with a developmental and mental health disability.

93. 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.)?

All consumers receiving services must have a Mental Health Assessment which indicates the need for coordinated services. While the services are available to any consumer or family meeting eligibility requirements, special emphasis will be placed on serving consumers that:

- Are presently residing in residential settings for persons with developmental disabilities.
- Are living in other settings (families, friends, or self) but are struggling in caring for self in these environments.
- Are at-risk of hospitalization or homelessness due to inadequate supports for their co-occurring conditions.

Some of the consumers screened may have limited financial resources or other 3rd party insurances that will not cover case management services. The grant will be used to support the costs of their services until which time Medicaid services can be obtained.

These cases will be prior approved by the Champaign County Mental Health & Developmental Disabilities Board.

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

Referrals come from developmental disabilities providers, mental health providers, pre-admission screening (PAS) agents, or through community members or families.

95. 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 estimated 80% of persons who sought assistance or were referred would receive services.

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

We anticipated to serve 15 new clients. 19 new clients were screened, therefore 100% were screened.

96. 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 clinician engages consumers within two weeks or sooner from the time of the referral. The clinician works with community partners and adjust~~s~~ his/her schedule to accommodate meetings and opportunities offsite to introduce the program, consult on potential referrals, and make service entry for new clients welcoming and with ease. This includes school systems which at times has older, special education students who meet criteria and need to transition into case management services. In these cases the families are often involved as well.

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 percentage of referred clients who will be assessed for eligibility within the 2 week time frame would be 75%.

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

19 clients were screened for services. Of these 47% or 9 clients were found eligible and engaged in services of the program within 20 days.

97. 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):

Per Medicaid Rule 132, the maximum length of time from assessment of eligibility (mental health assessment) to engagement (treatment plan development) is 45 days. Our goal is within 20 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 estimated percentage of eligible clients who will be engaged in services within this time frame would be 75%.

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

47% or 9 out of 19 that were screened were found eligible and engaged in services within 20 days.

98. 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 is 18 months.

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

The actual length of participant engagement in services was 3.1 years.

Demographic Information

29. *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 will only be collecting the demographic information that is required.

30. 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

181. *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.

By participating in this program we want clients to experience improved mental health and increased access to services and supports. We will demonstrate this by conducting the following surveys on admission of any new clients this FY and at discharge of any existing clients:

1. We will measure the overall improvement in mental health by administering the Global Assessment of Functioning (GAF) Scale. Clients are scored based on a 1-100 point range with 100 representing superior functioning. The clinician assigns a score based on the psychological, social and occupational functioning of the client. This assessment score is required by the State of Illinois for any client receiving Rule 132 Medicaid services.
2. We will measure improved Access to Services by administering the Self-Sufficiency Matrix, created by the Snohomish County Self-Sufficiency Taskforce. The Matrix includes a range of dimensions (i.e., In-Crisis, Vulnerable, Stable, Safe, and Thriving) to score the clients progression on this life domain.

While neither the GAF Scale nor the Matrix are validated tools, given the extensive purposes for which they have been utilized historically, we believe them to be a dependable tool with which to measure change in clients' functioning and provide program outcome data.

182. 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
10 point improvement on the GAF Scale for 75% of clients at initial screening and discharge.	Global Assessment Functioning (GAF) Scale	Client
1 Level Improvement on the Matrix for 75% of the clients who have participated in services for at least 6 months (at initial screening and discharge).	Self-Sufficiency Survey Matrix	Client

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

Outcome information was gathered only from clients who were discharged from the program during the FY.

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

Since these were new Outcome Instruments we were using this FY we decided to complete them only on new admissions or discharges from the program.

185. How many total participants did your program have?

31

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

6

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

6

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

At the time of the initial mental health assessment and discharge from the program.

Results

189. 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)

Six clients were discharged from services during this program year. 3 out of 6 or 50% required higher levels of care than what this program or their families could provide: 2 were transferred to residential group homes out of the area and 1 entered Hospice Care. The other 3 out of 6 or 50% were discharged for these reasons: 1 family decided to cease services due to change in Social Security benefits and it placing the client with a large spend-down to meet. The other 2 clients felt they had achieved their goals in the program and were ready for services to cease.

GAF Scoring: The scoring sheet we were using for the GAF scale administered to clients changed during FY19 that the agency was using. This skewed the numbers on 2 clients who originally scored higher on admission and lower on discharge, when in fact they had shown improvement. 1 client’s score remained the same for the short period in the service. 1 client’s scored showed improvement by 13 points. The last 2 scores of clients decreased which was indicative of the need for a higher level of care which was warranted and to whom they were linked.

The Self-Sufficiency Matrix: During FY19 we were to report the Self-Sufficiency Matrix scores at the initial mental health screening and at discharge of any new clients starting in this program. 6 clients were discharged from this program during the FY. All of these clients were admitted to the program prior to FY19, so we do not have admission data to report in this area for comparison in relation to an increase in level of improvement to occur.

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

No

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

N/A

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

N/A

(Optional) Narrative Example(s):

193. 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

194. 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.

15. 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.

    We exceeded projections in the following 3 areas:

    Treatment Plan Clients: 31 verses 30
    Community Service Events: 18 verses 12
    Service Contacts: 19 verses 15

    The reason these numbers were exceeded is felt due to the fact that the Service Coordinator position was filled the entire year. Christine Kline met with staff from local agencies about shared clients and services provided through this program. These contacts initiated more referrals from the providers. It also presented Christine with additional opportunities from these contacts for speaking engagements with other providers, organizations and groups they were able to link her to.

Treatment Plan Clients (TPC): are consumers with a completed Mental Health Assessment and a Treatment Plan. We project 20 Continuing TPCs, 10 New TPCs for a total of 30 TPCs.

Non-treatment Plan Clients (NTPC): N?a

Community Service Events (CSE): The number of contacts (meetings) to promote the program including speaking engagements, presentations at workshops, consultations with community groups and/or caregivers, meetings between agencies to plan community service events, interviews with media and attendance at open houses of other agencies to share information about services provided. We projected participating in 12 CSEs.

Service Contacts (SC): Engaging in a phone call or face-to-face contact with consumers who do not have a completed MHA, information and referral contacts, initial screenings/assessments, or crisis services. This may also include contacts for non–case specific consultations. We projected completing 15 SCs.

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).

Performance Outcome Report Template

In your CCMHB program plan (application), you identified performance outcomes in three domains: consumer access, consumer outcomes, and utilization data. Now, you must report on the actual outcomes your program activities achieved in those three domains.

Agency name: United Cerebral Palsy Land of Lincoln
Program name: Vocational Services DDB
Submission date: 8/28/2019

Consumer Access – *complete at end of year only*

Eligibility for service/program

99. *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)

UCP's Employment Program will target individuals with a developmental disability, ages 18-55, living in Champaign County who require extended support services or vocational training to maintain successful employment or become job ready. Referrals will come from the Division of Rehabilitation Services, CCRPC, schools and other developmental disability agencies.

100. 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 be PUNS tested and determined to have a developmental disability to be eligible for the program.

101. 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 developmental disabilities. UCP staff also attended community outreach events and networked with other community partners and employers to generate referrals.

102. **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. 100% of persons who sought assistance or were referred received services. 100% of people eligible for services received services.

103. **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.

104. **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.

105. **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 disability this process can take very little time or can be very long and require more intensive assistance.

Demographic Information

31. *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.

32. 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

195. *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 supports/job coaching to 20 individuals with disabilities.
2. UCP will provide vocational training to 10 individuals with disabilities.

196. 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 20 individuals with 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 to 10 individuals with 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

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

Outcome information was gathered from every participant.

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

199. How many total participants did your program have?

27

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

27

201. How many people did you *actually* collect outcome information from?
27

202. 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

203. 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 developmental disability 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.

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

205. If yes, what is that benchmark/target and where does it come from?
The benchmark for the year was to serve 20 individuals. We surpassed that benchmark by serving 27. 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.

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

Our individuals served exceeded the number anticipated in our grant application.

(Optional) Narrative Example(s):

207. 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)

208. 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.

16. 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 20 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 25 in-service 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 60 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).