Compiled Annual Performance Outcome Reports of CCDDB & CCMHB I/DD Funded Programs for Contract Year 2022

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Champaign County Regional Planning Commission Community Services
Decision Support Person for CCDDB - $311,489

CU Autism Network
Community Outreach Programs - $38,000

Champaign County Regional Planning Commission Head Start
Early Childhood Mental Health Svs - $121,999 (CCMHB funded)

Community Choices
Community Living - $164,069
Customized Employment - $201,000
Self-Determination Support - $160,251

Developmental Services Center
Clinical Services - $174,000
Community Employment - $361,370
Community First - $847,659
Community Living - $456,040
Connections - $85,000
Employment First - $80,000
Family Development - $596,522 (CCMHB funded)
Individual and Family Support - $429,055
Service Coordination - $435,858

PACE
Consumer Control in Personal Support - $24,267

Champaign County Regional Planning Commission
Decision Support Person Centered Planning
Performance Outcome Report – FY22

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 (CCRPC)
Program name: Decision Support Person Centered Planning FY22
Submission date: 8/24/22

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 I/DD diagnosis will be eligible for a PUNS meeting. Those who are determined to have an I/DD diagnosis and registering on PUNS are eligible to participate in a preference assessment; 2) adults with I/DD who are in the seeking services category on PUNS are eligible for conflict free person-centered planning (as long as capacity allows); and 3) individuals with an I/DD diagnosis who are nearing graduation from secondary education in Champaign County are eligible for Transition Consultant services. All individuals served must be registered on PUNS to be eligible for services.

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

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 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" (Independent Service Coordination Manual, Section 4: PUNS for Persons with Developmental Disabilities). All persons served need to be registered on PUNS to demonstrate eligibility.

- 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 not currently receiving Home and Community Based Services, Medicaid waiver funding. Staff worked closely with DSC and Community Choices to coordinate person centered planning services for individuals receiving services through their CCDDB funded programs.
- 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 done so.

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

Target populations will learn about the program through:

- Direct referrals from other service providers
- 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 I/DD and their families
- Inter-organizational referrals through CCRPC's community services programs
- Targeting mailings regarding Transition Consultant Services are also sent out to individuals on PUNS who are in secondary education.

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):

95% of individuals who seek assistance or were referred to the Decision Support Person Centered Planning program will receive assistance if they meet program eligibility.

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

100% of individuals who sought assistance or were referred through the Decision Support Person Centered Planning program received services.

We did not have a wait list during FY22, so 100% of those referred to this program were linked to a county funded ISC upon referral.

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 the timeframe from request for services to assessment of eligibility will occur within five 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% of referred clients will be assessed for eligibility within the estimated timeframe described above.

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

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

85% of referred clients were assessed for eligibility within the designated timeframe described above for Preference Assessment services. Many contributing factors caused wait times longer than 5 days to occur. One such factor is the time it takes families/ISC to gather necessary documents for eligibility determination such as IEP's, medical history, psychological evaluation, etc. There has been an increased number of new intakes coming in as well over the last several months. In addition, ISC continues to complete screening COVID screening prior to all in-person visits. Any potential Covid symptoms in the home require a meeting to be rescheduled

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% of referred clients will be engaged in services within five business days.

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

85% of referred clients were engaged in services within 5 business days. There were various reasons for services beginning outside of the 5 days including difficulty contacting families, ISC staff changes, Covid/illness, etc.

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

The estimated length of participant engagement is one to three months. For person centered planning participants, it is one to three years.

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

The average length of engagement for preference assessment clients was one month.

The average length of engagement for transition consultant services was one month.

The average length of engagement for person centered planning services was one to five years. The average wait time for PUNS is currently estimated to be at five years. Individuals are remaining engaged with us until selections from PUNS.

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 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.

Consumer Outcomes – *complete at end of year only*

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

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

Outcome #1: Transition Consultants will strengthen connections in the community to increase referrals for students transitioning out of secondary education.
Outcome #2: 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.
Outcome #3: ISC's with Decision Support Person Centered Planning will identify potential crisis situations quickly and coordinate with supervisor for smooth transition to a state funded ISC for completion of crisis funding packet for Medicaid-Waiver funding as appropriate.

Please note that some of our consumer outcomes are different from those in our FY22 application. Through our partnership with the Evaluation Capacity Building (ECB) team over the past year, we have honed our evaluation processes for the Decision Support Person Centered Planning program, and this has included ensuring our evaluation outcomes accurately reflect our program's performance. At the recommendation of the ECB team, we revised some of our consumer outcomes for our FY22 PMO to align with our program activities more closely.

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:
Transition Consultants will strengthen connections in community to increase referrals for students transitioning out of secondary education.	Preference Assessment, Individualized Education Plan (IEP), Satisfaction Surveys	Client/guardian, school staff, provider agency staff. Information collected by Transition Consultant and Program Manager.
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. Information collected by Case Managers and Program Manager.
ISC's with Decision Support Person Centered Planning will identify potential crisis situations quickly and coordinate with supervisor for smooth transition to a state funded ISC for completion of crisis funding packet for Medicaid-Waiver funding as appropriate.	Satisfaction Surveys, DHS Pre-Admission Screening (PAS) paperwork, Medicaid Waiver Service Award Letter	CCRPC staff, provider agency, DHS Division of Developmental Disabilities Information collected by Case Managers and Program Manager.

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 provided.

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 = 169
TPC = 292

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

100%

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

NTPC (preference assessment) – 57/169= 34%. 100% of individuals were given the opportunity to complete a preference assessment, however, for individuals who have been on PUNS for several years, they reported no changes to their preferences and thus did not choose to complete a preference assessment again. The program also experienced staff turnover and staff on Family Medical Leave during FY22 which resulted in below normal return rates on preference assessments. FY21 yielded a 64% response rate, FY20, a 69% response rate, and FY19 yielded a 52% response rate.

TPC (Satisfaction Survey) -61/292= 21%. 100% of individuals were given the opportunity to complete a satisfaction survey. Satisfaction surveys can be completed in Survey Monkey. Low response rate could be contributed to difficulty navigating this system. ISC's should make sure to have paper copy with self-addressed stamped envelope available to clients who are not able to use computer to complete. Other contributing factors to low returns in Champaign County include staff family medical leave and staff turnover.

8. 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 PUNS registration or annual update meeting. Clients served with transition consultant services completed a goal plan with their Case Manager and IEP information was provided to Case Manager at intake. Clients served with person centered planning services completed a satisfaction survey annually.

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)

Proposed Outcome: 100% of individuals will be given the opportunity to complete a preference assessment. 100% of individuals will be supported in identifying services based on their preferences through their person-centered plan.
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 34% chose to participate in a preference assessment.

Proposed Outcome: 100% of eligible individuals working with a Transition Consultant will be registered on PUNS and provided support in developing a goal plan prior to graduation.
Results: 100% of eligible individuals working with a Transition Consultant were registered on PUNS 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 Program will be found eligible for Medicaid Waiver Services and 90% will begin receiving services within three months.
Results: 36 individuals who received Decision Support Person Centered Planning services were selected from PUNS in FY22 (July 12, 2021). 97.2% of individuals selected from PUNS who were provided service through the Decision Support Person Centered Planning program were found eligible for Medicaid Waiver Services.
A breakdown of when award letters were issued by DHS/DD is as follows:

Client	Award Letter Issue Date	Service	Explanation
Client 1	08/04/21	AHBS	No Delay
Client 2	08/18/21	AHBS	No Delay
Client 3	08/18/21	AHBS	No Delay
Client 4	08/18/21	AHBS	No Delay
Client 5	08/26/21	AHBS	No Delay
Client 6	08/31/21	AHBS	No Delay
Client 7	09/15/21	AHBS	No Delay
Client 8	9/17/21	AHBS	No Delay
Client 9	10/26/21	AHBS	No Delay
Client 10	10/27/21	AHBS	No Delay
Client 11	10/28/21	AHBS	No Delay
Client 12	10/29/21	AHBS	No Delay
Client 13	12/13/21	AHBS	No Delay
Client 14	12/17/21	AHBS	No Delay

Client 15	01/06/22	AHBS	Delay in receiving all necessary documentation for the funding request.
Client 16	01/12/22	AHBS	Delay in receiving all necessary documentation for the funding request.
Client 17	01/13/22	AHBS	Change in ISC staff.
Client 18	01/14/22	AHBS	Delay in receiving all necessary documentation for the funding request.
Client 19	01/20/22	AHBS	Delay in receiving all necessary documentation for the funding request.
Client 20	01/31/22	AHBS	Delay in receiving all necessary documentation for the funding request.
Client 21	03/15/22	AHBS	Difficulty in reaching guardian; delay in Discovery/PCP process
Client 22	03/25/22	AHBS	Delay in receiving all necessary documentation for the funding request.
Client 23	05/12/22	AHBS	Difficulty getting in contact with individual
Client 24	05/24/22	AHBS	Delays in receiving all necessary documentation for funding request
Client 25	07/12/22	AHBS	Delays with Medicaid approval
Client 26	07/20/22	AHBS	Delay in receiving all necessary documentation for the funding request.
Client 27	N/A	N/A	Delay in receiving all necessary documentation for the funding request.
Client 28	N/A	N/A	Delay in receiving all necessary documentation for the funding request.
Client 29	N/A	N/A	Over assets for Medicaid, family is working to spend down money on items individual's needs
Client 30	N/A	N/A	Delay in receiving all necessary documentation for the funding request.
Client 31	N/A	N/A	Undecided on services/funding
Client 32	N/A	N/A	Declined funding
Client 33	N/A	N/A	Closed due to no response
Client 34	N/A	N/A	Closed due to no response
Client 35	N/A	N/A	Closed due to no response
Client 36	N/A	N/A	Not Clinically eligible

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

Yes, for person centered planning services.

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

The Department of Human Services, Division of Developmental Disabilities has an outcome performance measure for all Independent Service Coordination (ISC) agencies that 100% of person centered plans will be updated within 365 days of the previous year's plan.

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

Of the clients served in FY22 who had a Personal Plan developed in FY21, 85% had their Personal Plans completed within 365 days of their previous plan. This was due to: difficulty in getting in touch with client and/or guardian, cancelled appointments, person centered plan being completed yet waiting on signature from individual and/or guardian and barriers with COVID-19.

(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)

TPC – Preference Assessment Case Study

Client moved to Illinois with her family in the mid 2000's and was enrolled on the PUNS List in 2015. She became involved with Community Choices in 2017 and with the assistance of their vocational program she obtained a volunteer position at Salt & Light. In addition to this, she enjoys participating in community activities with Community Choices and with Champaign-Urbana Special Recreation.

This Client had been on the PUNS List for seven years but was selected in July of 2021 to received Medicaid Waiver Funding. Client and family worked with ISC to complete AHBS funding packet and have been awarded funding. Client chose Self-Direction Assistance through Community Choices and has hired Personal Support Workers.

TPC – Transition Consultant Case Study

Our Transition Consultant met with mom in the fall of 2021 via Zoom and was introduced to her 17-year-old adopted daughter at the end. The rural school was extending her daughter's graduation date a year to 2023 because of Covid. Current goals for mom are for daughter to get a job in the community and to have more community involvement since sister went away to college. Mom also wants to learn about tasks that need to be done at 18 for her daughter and how the disability service works. Mom is concerned about daughter's safety in the community.

The Transition Consultant encouraged mom to invite the county Transition Specialist to next school meeting to explain how STEP works and advocate along with her to find an internship or volunteer work. Transition Consultant explained how mom could look for a volunteer or someone paid by the state-funded respite program to assist her daughter in the youth church program. The youth leader has said that her daughter needs an assistant to be in program. Transition

Consultant provided respite information, information on the police database for those with disabilities (METCAD), how to get a regular or disability state ID, a Power of Attorney form, and information on other tasks needed to be done at age 18. The Transition Consultant also discussed community services, including Community Choices which can provide parent support and Champaign-Urbana Special Recreation. Transition Consultant explained the disability service system and gave information on IPADD Unite and CU ABLE, two online supports groups.

TPC – Person Centered Planning Case Study

Client was recently opened at DSC through Community First program. During the Discovery process, ISC learned that client would like to engage in work in the community. As he is young, he doesn't have that many job experiences. ISC included client's desire to increase job skills to one day obtain a job in the community. Client attends Career Readiness and MTD group to practice job and communication skills, job applications and building his resume. He is also learning routes to local establishments to ensure that he would be able to get to and from a job in the community in the future. In addition to this, DSC Supported Employment Services have begun working with client in working on job skills in an environment that client prefers. The goal will be for client to be referred to Competitive Employment once he successfully completes Career Readiness and Supported Employment. ISC continues to monitor client's progress towards his future goal of Competitive Employment.

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)

Now that DHS/DD sends out early notification letters for all upcoming PUNS selections, the Decision Support Person Centered Planning program will ensure, at the time the early notification letters are sent out, all clients who will be selected from PUNS:

1. Ensure client would like to move forward with services
2. Have applied and received Medicaid approval
3. Have a physical exam completed within the last year on file
4. Have a psychological evaluation completed within the last 5 years on file
5. Have an Inventory for Client and Agency Planning (ICAP) completed within the last year on file.
6. Have social security card on file

Another finding from our evaluation is that there can be a longer period of time than we would like to see between when we send a referral to the Licensed Clinical Psychologist we contract with (to complete the required psychological evaluation for each client selected from PUNS who does not have one within the last five years) and when we get the completed report back. With this in mind, we continue to explore options for contracting with additional LCPC's in the Champaign County area.

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.

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

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 seeking services category on PUNS; and individuals/families receiving Transition Consultant services.

Proposed: 220
Actual: 292
Explanation: Consistent PUNS selections have continued led to our Champaign County PUN Coordinator assisting more families with the gathering of PAS documents. We also have had a higher number of intakes leading to more linkage/referrals to other community resources.

<u>Non-treatment Plan Clients (NTPC):</u>

Individuals registering on PUNS and completing preference assessment and persons PUNS registered updating their preferences.

Proposed: 220 Actual: 169 Explanation: In addition to difficulties in getting in touch with clients/guardians. Program experienced staff out on FMLA over the past fiscal year which appears to have impacted numbers significantly.
Community Service Events (CSE): Staff presentations and tabling at outreach events, meeting with Champaign County high schools and other professionals. Proposed: 40 Actual: 46
Service Contacts (SC): Individuals attending outreach events. Proposed: 300 Actual: 744
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 Autism Network
Program name: Community Outreach Education Programs
Submission date: 8/24/2022

Consumer Access – *complete at end of year only*
Eligibility for service/program
1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application) **Any public agency, business, organization or resident of Champaign County that needs supports or wants to learn more about ASD**
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.)? **Our members and/or attendees of events, meetings and community outreach presentations filled out a sign in sheet (when applicable).**
3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.) **They learned about our services through outreach events, media, website, referrals, and email list.**
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): **20 days**
	b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application): 100%
	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): 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): 100%
	c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame: 100%
7.	**a)** *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application): Annually
	b) *Actual* average length of participant engagement in services: annually

Demographic Information

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

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

Consumer Outcomes – *complete at end of year only*

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

1. *From your application,* what impact on consumers did you expect your program activities to have? That is, what outcome(s) did you want your program to have on the people it is serving? (Consumer Outcomes, question #1 in the Program Plan application). Please number each outcome.
   The Community Outreach Education Program which includes the Autism Aware Program will promote inclusion and education. It will improve access to the community and provide materials for management and staff of local businesses, schools and peers to provide the ASD community with more Autism Sensory friendly, non discriminatory environments to utilize as well as sensory kits to be implemented.

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
Demographic Information	Sign in sheet	Members/attendees
Increase member attendance by inquiring needs and wants in the ASD community	survey	Members/attendees

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

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?

Various numbers depending on event, topic and attendance

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

All attendees to events and over 1400 via survey collection through FB members and 300+ from our email list.

7. How many people did you *actually* collect outcome information from? **100+**

8. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc) **The information was collected at each event and with on going posted survey.**

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)

CUAN learned that each participate had their own specific needs and the members of rural and diverse community were in low attendance.

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

n/a

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

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

(Optional) Narrative Example(s):

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

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

Utilization Data Narrative –

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

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

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

1. Please copy and paste the definitions of service categories your program specified in your program plan application in the sections below**. You will report the actual numbers of clients/contacts/community events for each reported service category in the Part II Utilization/Production data form (located on the online system).** If your

estimated number of clients/contacts/community events for reported service categories significantly differfrom your actual numbers, you may give a narrative explanation for that discrepancy here.
Treatment Plan Clients (TPC): n/a
Non-treatment Plan Clients (NTPC): n/a
Community Service Events (CSE): 32
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: Champaign County Regional Planning Commission Head Start
Program name: Early Childhood Mental Health Services
Submission date:8/26/2022

Consumer Access – *complete at end of year only*

Eligibility for service/program

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

Children are eligible for services funded by this grant if they score above the cut-off on the ASQ-SE screening and/or the Social-Emotional Development Specialist (SEDS) child observation indicates the child needs additional support.

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

Teachers, SSPC, and Site Managers determine the need for Social-Emotional Goal setting after screening yields an ASQ-SE score indicating eligibility for services OR challenging and disruptive or age inappropriate behavior have been documented in the classroom. This family support team in collaboration with the SEDS will determine eligibility and will work closely with the SSPC's who are assigned to the child's site.

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

CCHS shares information with families about the social-emotional services provided by the Social-Emotional Development Specialist (SEDS) at parent meetings, and through brochures and the parent handbook. Further, the SEDS provides parent education trainings that pertain to trauma informed care, social-emotional development, and strategies to reduce challenging behaviors and increase social-emotional skills.

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

90

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

98

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):
14

b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application): **98**

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

100

5. a) *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application): 1 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): 95%

c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame: 100%

6. 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 Social Skills and Prevention Coach is 9 months.

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

8 months

Demographic Information

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

CCHS collects data for the Office of Head Start. Beyond race, ethnicity, age, gender, and zip codes, Head Start staff obtains information about a family's structure, income, language, education, employment, military status, marital status, and housing status such as homeowner, renter, or homeless.

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

- Total # of Children in HS and in EHS: 585
- Total # of Expectant Mothers in EHS/Expansion: 19
- Total # of Families: 532
- Total # of children with a IFSP or IEP: 52
- Total # of children referred for DD or Special Ed: 32
- Total # of Homeless children/families: 45 (42 families)
- Total # of family served with income below 100% FPG: 343
- # of families at 100-130% FPG : 115
- # of children/families in foster care system: 24
- # of children/families on public assistance: TANF=13; SNAP=305
- # of children/families over income: 61
- # of families who speak:
    - English – 502
    - Spanish – 31
    - Middle Eastern – 27
    - African – 2
    - East Asian – 3
    - European and Slavic – 36
    - Native Central American – 3
- Education level
    - Advanced degree or baccalaureate degree – 57
    - Associate degree, vocational school, or some college – 185
    - High school graduate or GED – 237
    - Less than high school graduate - 53
- Employment
    - At least one parent/guardian is employed, in job training, or in school – 457
    - No parent/guardian is employed, in job training, or in school – 75
- Marital Status: We track family type

- Two parent families – 119
- Single parent families – 413
- Breakdown:
  - Parent(s) (biological, adoptive, stepparents) – 502
  - Grandparents – 8
  - Relative(s) other than grandparents – 1
  - Foster parent(s) not including relatives – 18
  - Other – 0

- Military status: 1
- Housing status: Of the 42 families who experienced homelessness, 15 acquired housing.
- Rural families: 10 families

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. Children will demonstrate improvement in social skills related to resilience such as:
a. Self-Regulation
b. Initiative
c. Relationship building/Friendship skills
d. Emotional Literacy
e. Problem-Solving

2. Head Start staff will demonstrate improvement interpersonal, stress management, and caregiving skills. And a reduction in Burnout/compassion fatigue.

3. Parents will demonstrate improvement in stress management and caregiving skills.

4. Classroom management will demonstrate social-emotional sensitive interactions in fidelity with the Pyramid Model.

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

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

Outcome:	Assessment Tool Used:	Information Source:
1. Improvement in social skills and resilience	Teaching Strategies GOLD	Classroom Teacher
2. Low to normal levels of burn out and compassion fatigue	PROQOL	Teacher and Coach
3. Parents demonstrate improvement in stress management	**Parenting Stress Index; and Adult DECA**	parent
4. Classroom management strategies are used with fidelity	**TPOT/TPITOS - classroom management**	Teacher and coach

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

Only some.

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

Not all services and supports that are provided are formal and intensive. We only collect outcome information on the formal/intensive services with TPC's.

5. How many total participants did your program have?

421 NTPC's and 155 TPC's

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

400

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

369

8. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc) 4 times a year.

Results

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

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

We learned that the children in our Head Start program had significant social emotional skills improvement from the Fall checkpoint in October, where 49% of the Head Start children met the expected benchmark for social emotional development. By July, 80% of our preschool aged students met the bench mark for social-emotional development. This was an improvement from our outcomes from last year.

This year we experienced significant burnout levels in our teachers because of staff shortages and absences. The program has made plans to improve these outcomes next year by closing down a site in order to increase the number of teachers in each of our open classrooms. We hope to see an improvement from these changes.

This year we didn't track outcomes with parents because of our staff shortage issues.

We found that through our ongoing coaching model we saw improvements in classroom behaviors and fidelity of services over time. Significantly we saw improvement in teacher stress and relationships with children when we provided them weekly reflective consultation to process and brainstorm new strategies.

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

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

Through the GOLD Outcomes Assessment, CCHS sets a program goal that at least 90% of the Head Start children who age out of the program are developmentally, socially, emotionally and health ready for Kindergarten. CCHS anticipates that at least 85% of all enrolled children will make age-appropriate progress in social-emotional development. For children remaining in the program, CCHS sets a goal of 50% of children who receive services for the full period of engagement (9 or 12 months depending on the child's enrollment option) will not require a continuation of services.

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

(Optional) Narrative Example(s):

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

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

Utilization Data Narrative –

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

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

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

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

Treatment Plan Clients (TPC): Estimated 80 Actual 155
Non-treatment Plan Clients (NTPC): Estimated: 400 Actual: 421
Community Service Events (CSE): Estimated: 5 Actual: 8
Service Contacts (SC): Estimated: 3000 Actual: 2,962
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 (Inclusive Community Support)
Submission date: 8/26/22

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 as defined by the PUNS screening. To use Inclusive Community Support, participants must have the desire to ultimately live on their own and be able to be by themselves for the majority of the day. 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.)?

Enrollment on the PUNS Database, which requires a screening assessment through the CCRPC, is used as an eligibility determination tool. The Membership Coordinator met with the individuals requesting services to explain the programs and supports that are available and to determine if they would like to become members. It is this internal intake process for which the timeframe estimates are based.

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. Referrals to the Connect program come from area schools, and through word of mouth. In addition, we can refer to and from Developmental Services Center, Champaign County Regional Planning Commission, Rosecrance, The Autism Program, and PACE. We informally reach out to

the community through participation in outreach events – such as the Disability Expo, Transition Conference, Jettie Rhodes Neighborhood Day, and more.

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):

90%

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

83%

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):

14 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%

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

Formal assessment is done outside of Community Choices. The time frame 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 a 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):

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:

83%

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

Support is designed to last at least 2-3 years, but may be longer depending on circumstances. Classes are 8 weeks.

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

2.6 years (range: 0-7 years)

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.

Gathering and verifying PUNS enrollment data and medical insurance has become a part of all current and regular intake meetings. We ensure that all individuals coming to Community Choices for services are actively enrolled in 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.

During FY22 we worked in great depth with Emily Blevins from the UIUC Evaluation Capacity team to improve and redesign our data and evaluation methods. In this process, we updated and refined the outcomes, assessment tools, and data collection systems linked to this program. We wrote those updated outcomes into our FY23 grants from this same program. For consistency, and in order to use the systems we've spent considerable time on, for the purpose of this report, we will be using the updated outcomes as laid out in the FY23 grants. Below those, in italics, are the original outcomes include in our FY22 applications. While they are distinctly different, the reader should be able to see the continuity between them.

UPDATE OUTCOMES (based on FY23 Applications):

1. FAMILY SUPPORT AND PLANNING: Whole Families have access to the supports that are important for them to fulfill their Community Living Plan.
    a. Families feel that they have an achievable long-term plan for sustainable community living.
    b. Families indicate a decrease in time spent providing daily living support.
    c. Families indicate an increase in their quality of life.
    d. Family members indicate that ICS has supported their person to achieve desired housing, and build natural supports, skills, and connections.

2. HOUSING, LEARNING, CONNECTING: Participants build lives in the community.
    a. HOUSING
        i. Participants maintain stable housing over time
        ii. Participants indicate they are satisfied with their housing
        iii. Participants indicate ICS has been helpful in finding or sustaining preferred housing.
    b. LEARNING
        i. Participants develop the skills they identified as in critical for community living
        ii. Participants indicate that Inclusive Community Supports have been helpful in skill building.
    c. CONNECTING
        i. Participants identifying a desire to build connections, find belonging with people, places, or groups in their community.
        ii. Participants indicate ISC has been helpful to their building community connections.
        iii. Participants have people and places where they are comfortable

3. PERSONAL OUTCOME MEASURES

a. Participants increase their POM scores in targeted outcomes over time
b. Participants increase their POM Supports present for targeted outcomes over time

4. PERSONAL DEVELOPMENT CLASSES: Individuals with I/DD build distinct independent living skills

    a. 100% of participants [15] will indicate growth or skill development based on the course assessments.

ORIGINAL FY22 OUTCOMES:

1. *PROGRAM OUTCOME:* ***With support and planning, people with I/DD can live in housing of their choice and be part of the community.***

    GOAL:

    - *100% of participants indicate they are satisfied with their housing.*
    - *100% of participants indicate they have help other than parents.*
    - *100% of participants feel they have learned how to do new things.*
    - *100% of participants indicate they have people and/or places they feel comfortable around.*

2. *Consumer Outcome A -****PLAN: Participants build a Community Living Plan based on what is important to them and for them.***

    GOALS for Sustained Community Support
    - *15 participants will build a plan for Community Living*
    - *15 participants choose the supports they want and need to carry out that plan.*

    GOALS for Transitional Community Support
    - *15 Participants develop an annual transitional supports plan for Community Living*
    - *15 Participants ID goals based on their priorities*

3. *Consumer Outcome B -* ***LIVE, LEARN, CONNECT****:* ***Participants build lives in the community.***

    GOALS for Both Transitional and Sustained Community Support
    - *8 Participants move into preferred housing*
    - *22 Participants sustain their housing*
    - *30 Participants meet their self-determined goals for skill building*
    - *30 Participants meet their self-determined goals for connections*
    - *Over time, all participants increase their POM scores for targeted outcomes [15 participants this year, 30 in future years]*

4. *Consumer Outcome C -* ***USE SUPPORT - Participants have access to the supports that are important for them to fulfill their Community Living Plan.***

    GOAL for Sustained Community Support
    - *Over time, all participants increase the POM Supports Present for targeted outcomes.*
    - *People use supports to maintain their preferred housing*

5. *Consumer Outcome D* - ***PERSONAL DEVELOPMENT CLASSES: Individuals with I/DD build distinct independent living skills***

   GOAL:
   - *15 unique people will participate in at least one of 5 courses*
   - *100% of participants will indicate growth or skill development based off the course*

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).

INFO ON ASSESSMENT TOOLS:

- INITIAL FAMILY EVALUATION FORM - Self-Report measure given to all families after the intake planning meeting
- ANNUAL FAMILY EVALUATION FORM - Self-report measure given to all families 12 months following their intake and annually thereafter
- QUARTERLY CHECK-INS /QUARTERLY NARRATIVE REPORTS - Reports drafted by case workers summarizing case notes and participants' progress with their goals as reported on the Narrative Report (see below)
- INDEPENDENT LIVING SKILLS CHECKLIST (ILSC) - An inventory of critical community-living skills, self-efficacy measures, and participant experience questions reviewed with each participant at intake and annually thereafter
- ACTION PLAN - A document summarizing the person's self-determined goals, and supports provided. Used to guide the quarterly progress records kept in the Quarterly Narrative Reports.
- PERSONAL OUTCOME MEASURES (POM) - A highly regarded assessment tool developed by CQL to determine the presence of key life outcomes and support toward those outcomes. This is an interview style assessment that is scored to create a quantitative measurement. This is completed with participants annually.
- CLASS PRE/POST EVALUATIONS - Evaluations are developed to assess course objectives for each class. Effort is taken to collect pre and post class data for all participants.

Outcome:	Assessment Tool Used:	Information Source:
1a: Families feel that they have an achievable long-term plan for sustainable community living.	Initial Family Eval Form	Families of Participants

1b: Families indicate a decrease in time spent providing daily living support.	Annual Family Eval Form	Families of Participants
1c: Families indicate an increase in their quality of life.	Annual Family Eval Form	Families of Participants
1d: Family members indicate that ICS has supported their person to achieve desired housing, and build natural supports, skills, and connections.	Annual Family Eval Form	Families of Participants
2ai: Participants maintain stable housing over time	Quarterly Check-In/Narrative Reports	Staff Records (based on case notes, meetings, and client self-reports)
2aii: Participants indicate they are satisfied with their housing	Independent Living Skills Checklist	Participant & Staff
2aiii: Participants indicate ICS has been helpful in finding or sustaining preferred housing.	Independent Living Skills Checklist	Participant & Staff
2bi: Participants develop the skills they identified as in critical for community living	Action Plan & Quarterly Check-in/Narrative Report	Staff Records (based on case notes, meetings, and participant self-reports)
2bii: Participants indicate that Inclusive Community Supports have been helpful in skill building.	Independent Living Skills Checklist	Participant & Staff
2ci: Participants identifying a desire to build connections, find belonging with people, places, or groups in their community.	Action Plan & Quarterly Check-in/Narrative Report	Staff Records (based on case notes, meetings, and participant self-reports)
2cii: Participants indicate ISC has been helpful to their building community connections.	Independent Living Skills Checklist	Participant & Staff
2ciii: Participants have people and places where they are comfortable	Independent Living Skills Checklist	Participant & Staff

3a: Participants increase their POM scores in targeted outcomes over time	POM	Participant Report, Staff Scoring
3b: Participants increase their POM Supports present for targeted outcomes over time	POM	Participant Report, Staff Scoring
4a: 100% of participants [15] will indicate growth or skill development based on the course assessments.	Class Pre/Post Evaluation	Participant

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

Data for each outcome was not collected from every participant. Some outcomes only applied in certain circumstances. For example, we are only able to gather data about people's achievement of goals after they have had time to work on those goals. Likewise, we are only able to gather data on people's assessment of their support from us *after* we've had the opportunity to provide that support.

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

We do collect data for each outcome from every person for whom it applies. This could mean that for some people we collect very little data. For example, participants have the option of completing a Planning Session with us, getting our feedback and ideas, and then choose to work toward that plan without Community Choices' support, in a more self-directed model. For these people we do not collect Independent Living Skill Checklist data, POM scores, or progress on goals, as it would not make sense to do so.

Family members are also an exception, as the Family Evaluations are sent as a survey which families have the option to complete. While we very much encourage their responses, it is not mandatory and we do not expect to ever achieve a 100% response rate.

5. How many total participants did your program have?

26 TPCs - those who are part of the Inclusive Community Support Program
19 NTPCs - those who participated in one or more of our Personal Development Classes

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

As applicable, we attempted to collect data from all 26 participant TPCs and 19 NTPCs.

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

For Inclusive Community Support, we collected applicable data from all 26 participants, though at least 3 of those have very little applicable data that could be reported, as they did not move forward in the program. There were some instances also, where participants opted out of completing one or more of our assessment tools.

For Family Evaluation Data, we had 6 responses from the 16 families we reached out to.

For Personal Development Classes there were a total of 23 pre-evals (some people took more than one class) and received 15 post-evals.

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

Outcome data was collected at various times depending on the type of information or assessment used. See below:

- INITIAL FAMILY EVALUATION FORM - 1x per year following the planning interview
- ANNUAL FAMILY EVALUATION FORM - 1x per year, 12 months after the planning interview or plan update
- QUARTERLY CHECK-INS /QUARTERLY NARRATIVE REPORTS - Quarterly
- INDEPENDENT LIVING SKILLS CHECKLIST (ILSC) - Annually as part of the person's plan update or initial planning period
- ACTION PLAN - Annually as part of the person's plan update or initial planning period
- PERSONAL OUTCOME MEASURES (POM) - Annually as part of the person's plan update or initial planning period
- CLASS PRE/POST EVALUATIONS - Prior to or during the first class session and during the last class session (generally 6-8 weeks later) or just after

Results

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

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

1a: Families feel that they have an achievable long-term plan for sustainable community living.

*Families reported an average of **3.3 out of 5** to the question: "I have a clear idea of what I would like a community-based living situation to look like for my family member with I/DD" This is equivalent to an answer between "Somewhat" and "A fair amount".*

*Families reported an average of **3 out of 5** to the question: "I know the immediate next steps necessary to make community-based living possible for my family member with I/DD". This is equivalent to the answer "Somewhat".*

*Families reported an average of **2.7 out of 5** to the question: "I feel confident that my family member can continue to live in the community without me." This is equivalent to an answer between "Very Little" and "Somewhat".*

*Families reported an average of **3.7 out of 5** to the question: "I was provided with resources or ideas I am eager to use in my next steps". This is equivalent to an answer between "Somewhat" and "A fair amount".*

All of these questions were based on their participation in our Planning Interview Process.

1b: Families indicate a decrease in time spent providing daily living support.

Because this was the first year of this iteration of our Inclusive Community Support program, we do not have follow-up or "after" data to compare families' initial responses to. In future years we will be able to make these comparisons.

*Families reported spending an average of **43.4 hours per week** providing support, instruction, and prompting to their adult family members with I/DD.*

*When asked how manageable this felt, families responded, on average, that **it as "Somewhat Manageable", or 3 out of 5** on our scale.*

1c: Families indicate an increase in their quality of life.
With this outcome as well, we do not have comparison data to provide an evaluation of if change occurred as a result of the program. All respondents were giving their "Initial" evaluation. In future years we will be able to report the change between "before support" and "after support" data.

1d: Family members indicate that ICS has supported their person to achieve desired housing, and build natural supports, skills, and connections.
As above, we do not have comparison data to provide an evaluation of if change occurred as a result of the program. All respondents were giving their "Initial" evaluation. In future years we will be able to report the change between "before support" and "after support" data.

2ai: Participants maintain stable housing over time
95% of participants maintained stable housing over time.

2aii: Participants indicate they are satisfied with their housing
85% of participants indicated that they are satisfied with their housing.

2aiii: Participants indicate ICS has been helpful in finding or sustaining preferred housing.
29% of participants indicated that the ICS program was helpful in their finding or sustaining their housing. This low percentage is likely due to the number of participants that were stable in their homes. Our support may not have been concretely linked to housing stability, so while helpful, might not have been noted to our participants as having a direct impact.

2bi: Participants develop the skills they identified as in critical for community living
92% of participants made progress on at least 1 goal during the fiscal year. Of the participants who had more than 1 goal, 57% made progress on multiple goals during the fiscal year.

2bii: Participants indicate that Inclusive Community Supports have been helpful in skill building.
85% of participants indicated that ICS was helpful in their gaining new skills.

2ci: Participants identifying a desire to build connections, find belonging with people, places, or groups in their community.
Of the 5 participants with goals related to connections, 100% made progress.

2cii: Participants indicate ISC has been helpful to their building community connections.

67% of all participants indicated that they felt that ICS was helpful to their building community connections. Of the participants with specific connection goals, 100% indicated that they felt ICS was helpful in supporting them to build connections.

2ciii: Participants have people and places where they are comfortable
100% of participants indicated that they had people and places they were comfortable around. In retrospect, we probably should have phrased this question better. Asking if someone has people and places besides their family and home may have elicited more varied and accurate results.

3a: Participants increase their POM scores in targeted outcomes over time
We targeted 11 specific outcomes of the 21 total POM outcomes that we felt this program had the capacity to impact for our participants.

Between this year and last year, average POM scores increased by 5%. The average increase from now and participants' initial POM was -1%. Because of changing reporting structures and outcomes in this program over time, we do not feel that this data is fully complete and no valid conclusions can likely be drawn from it.

3b: Participants increase their POM Supports present for targeted outcomes over time
Like the outcomes, we targeted 11 specific supports from the POM.

Between this year and last year, the average POM Support Score changed by -19%. The average changed from this year and participants' initial year was -6%. These scores are also affected by the changing reporting structures in this department over time. Additionally we found that for some individuals a decrease in supports can be indicative of progress in their lives, as they may simply need fewer support or could be moving on to a living situation where fewer supports are imposed on them.

4a: 100% of participants [15] will indicate growth or skill development based on the course assessments.
6 classes were held out of a goal of 5. There were a total of 19 participants.

Class 1: Transportation around Town - (100% of Participants Responded to pre and post eval) 100% indicated skill growth in key areas
80% indicated they were not Very Confident using the MTD Website to make travel plans and in riding the bus independently.
60% indicated they were Confident using ride-sharing services.

Class 2: Floral 411 - (100% of Participants Responded to pre and post eval)
100% indicated skill growth in the areas of floral care practices, basic design, floral/plant knowledge

100% indicated they now had an new interest they planned to pursue

Class 3: Cooking - (83% of Participants Responded to pre and post eval)
80% of respondents indicated a growth of confidence and skill related to cooking as well as an interest to try the recipes at home

Class 4: Stress Management - (25% of participants responded to pre and post eval)
100% of respondents indicated a greater comfort with multiple self-care skills and practices

Class 5: Let's Move - (0% of participants responded to pre and post eval)

Class 6: A Practical Guide to Friendships (50% of participants responded to the pre and post eval)
100% of respondents indicated a strong understanding of the key topics of the class: characteristics of friendship, boundaries, conversation and listening skills, conflict resolution, and meeting logistics

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

No - There is no comparative benchmark for our program services.

First, while some of our assessment tools are evidenced based and highly regarded within the I/DD field (the POM), it does not come with benchmarks that users are supposed to be aiming toward. The assessment is used to describe a person's life situation. CQL, the tools creator, is very clear that it would be unlikely for anyone, with or without a disability, to have all of 21 outcomes present at any one time in their life. Similarly, not everyone may *need* supports in all 21 of the areas. The creator's intent with this assessment is instead to look at change - Are people having more outcomes present over time? Are people who need a support getting access to that support? Within our program, this is also how we are using the tool - Are our participants increasing the positive things in their lives? Are they accessing new supports as needed?

We hope that as we gather data for more participants over more years, we may be able to create realistic benchmarks specific to our program. Currently we do not have enough of this data to make those estimations. And even over time, there are some limitations to the inferences that we'll be able to make as each person's progress should be specific to their own situation. Some participants will likely start out with fewer resources in their lives and thus have greater room to experience improvement. Others will have many facets of their lives set before engaging with us. Their progress may always be more slight, though often no less significant for their own experience.

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

In the last year we have been working closely with the UIUC Eval Capacity Team to build systems that will allow us to capture data that reflects the actual experience of our participants. Their progress, and our success, is shown most effectively through the achievement of personal goals. Finding a system that can effectively capture that for a wide range of goals, skills, and supports has been challenging. We believe that we have built a much stronger system to do this. Because we haven't always had this system, we don't have much data to use to create a good estimate of what type of success we should be seeing.

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

This was a year of considerable transition and growth for this department and program. We expanded the number of supports available, increased our staff, and redesigned our process to meet the needs of our participants, their families, and our staff. As we rolled out these new offerings we first realized that our plan to keep a version of our original Transitional Support Program along with the Sustained Supports Program did not make a lot of sense. It was a distinction without a difference. Because of this we decided merge both "tracks' and simply refer to it all as Inclusive Community Support. Because our goal had always been to create a program with a great deal of flexibility, we did not feel that we'd be losing anything with this change.

In launching these expanded services, we also knew that we wanted better ways to track data and make conclusions about our program's effectiveness. We worked with UIUC's Eval team to do this. This year's data is our first effort at using the evaluations, systems, and methods that we designed with their support. We knew in that design that our data for this year would not be fully complete. Much of our evaluation is based on a person's experience over time. This was the first year that we had made efforts to support and guide people toward more sustainable community living. We are hopeful that our systems will allow us better access to track and report on this data over time.

What can we conclude after the first year of this program?
Our greatest success so far has been supporting people to achieve progress on their individual goals. This is not surprising as specific progress on a specific goal that you choose for yourself is likely the most motivating for the person, for the staff working with them, and to see clear and distinct progress from the data perspective. If someone wishes to learn to cook and they have succeeded in regularly making four new recipes on their own, this is clear. It is not impacted by how they are feeling the day that you interview them, as can happen with the POM. It is also the aspect of this program that is probably the most important. Our intent is to help people learn and do the things that are important to them so they can live a full life in the community. If progress is happening here, then things are working.

It is difficult for families to know and articulate what services and supports they need and what those services look like. Families want to see their adult children move out, but when confronted with the actuality of that, they find it difficult to figure out first steps. Family patterns and dynamics built over many years are difficult to break down to allow new patterns to emerge. We had initially expected that families would immediately be looking for our support with very in depth elements of support for their adult children and siblings. What we found was that, initially at least, more plans included goals related to discrete goals and routines that focus on the concrete skills needed for community living. Our support in these areas seemed to give families additional energy to continue tackling the more complicated areas of support for their people (benefit management, budgeting, health and wellness). It will be interesting to see how this changes over time - if our current participants/families continue to give duties to us as they move through life, or if new participants begin coming to us asking for more in depth support from the start.

Finally, we are still seeing the ways that the Pandemic is impacting people with I/DD. Many of our participants are communicating that they are finding it challenging to change their more isolated routines. Being active in the community, taking the bus, reaching out to others, attending events, are all areas where, despite some positive data, from our evaluations, we are still hearing that people are struggling. As we work with people, formally and informally, on building their connections, we are finding that we have to start with much smaller steps and more comfortable venues as we encourage them to experience the world.

We are also seeing our participants feel the economic, housing, and benefit impact of the pandemic. For our participants with limited resources, less stable housing, and fewer social networks, their situations have in many cases become much worse. Housing is less affordable, pushing people into less safe neighborhoods and less well cared for dwellings. People have had their healthcare postponed leading to worse or more completed outcomes. And even our participants with more resources and good family support are often affected by the complications at social security and DHS offices.

This program, like many I/DD support programs, is trying to address a person's whole life, with all its complexity and nuance. More than anything, this year, and our data, has been a reminder of how many forces in our communities and culture impact the people that we are working with. In past years, we have discussed in these reports our desire to find a way to capture data that can reflect the up and down nature of people's lives. We believe that we have built a program that can better move and flex to support those ups and downs, but it may be some time before we are able to determine if the data that we are targeting and tracking can capture the true experience that our participants are having in the world.

(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)

With the redesign of this program, we wanted to build a clearer and more functional process for our participants, their families, and our staff. Our goal has been to create a program that can fill in the gaps and provide the support that a person may need in order to live in the community. We have found that it is often one or two areas that participants and families feel are holding them back from taking bigger steps for community-based living.

We also wanted to create a system where it would be very clear for everyone what the supports were that we would be offering, how much of that support we were able to offer, and how it would be funded. We often have described our services as ala carte, and that was definitely a quality we wanted to build into the redesign of how this program would run. Additionally, because some of the services available within this program can be funded with SDA (55A) Funding through people's Home Based Support Waivers and others can't, we wanted to be sure we were being very explicit about which services would affect someone's HBS budget and which would not.

Besides these logistical elements, we also wanted to engage families in the process. The catalyst for this expansion came from the parents of members. Some of their adult children were still living at home and others were living in the community. What these groups had in common was a growing concern that as they aged, passed away, or were not able to support in such a robust way, that there would be no other options for support for their family members except for a CILA. So we knew that to make this program successful, some of our efforts would need to be working with parents/family members to begin to take over some of the intensive support duties they were currently carrying.

Below is a description of what our new process looks like as a new participant and their parent engages with it:
Person/Participant = Jane
Parent/Family member = Bob

Bob and Jane are new to services with Community Choices. They reach out through our website contact page and are connected with our Membership Coordinator. She speaks with them on the phone, gets a sense of what they are looking for in services and sets up an intake meeting. Before the meeting she goes through the list of documents that are needed to verify eligibility. They find a good time about 2 weeks after that initial call.

At the meeting, our Membership Coordinator goes over the various services that CC offers and hears about what Jane is interested in, what they might want support with, and a bit about their family. She gives them the option of membership based on Jane's interest in meeting new people and doing more stuff around town. Bob expresses that he is getting older and having a

harder time helping Jane organize her day and staying on top of things. He explains that they have talked about Jane starting to work toward getting her own place so that she can be more settled as he gets older. With this the Membership Coordinator goes over the details of the Inclusive Community Support program in more detail and sees if the Lead Community Support Specialist (LCSS) might be around to join them for a few minutes. He is not, so they wrap up the meeting and agree to set up a call with someone from the department in the next couple of days.

Bob and the LCSS speak on the phone the next day. The LCSS learns that the family does have the HBS waiver but hasn't done much with it and that they really don't know what the first step is to putting their funding to work or to starting the process to Jane moving out. The LCSS speaks with Jane too and explains who he is and what he does with people in his job. Jane seems excited and talks about how she'd really like to get a cat once she moves out but that she is also really nervous about being away from her family. The LCSS explains that it would be a good idea to sit down and go over the various pieces of community living and decide on some first steps together.

About a week later The LCSS and another staff from the program sit down with Jane and Bob for a Planning Interview. In this meeting outline there are conversation guides about eight main areas where someone might need support in order to live on their own (Self-Determination/Advocacy, Housing, Household Management. Finances, Budget, and Gov't Benefits, Health & Safety, Transportation, and Connections/Community Engagement). Within each of these areas the staff lead the family through a conversation about how things currently work, what they would like to see change, and what are the critical supports or steps needed to make that change possible. Because Bob is starting to think about long-term plans and estate issues, the group also goes over some resources and checklists that can help him decide how to move forward. We wrap up the meeting by summarizing the basic areas where it sounds like the family might need support. For Jane and Bob, this looks like they may need our supports in the areas of Housing, Health and Wellness, Skill Building, and HBS Coordination. We agree to send a written summary of our discussion within the week and explain the next steps.

A week after the meeting we send a summary of the supports that CC might be able to offer as well as the other resources that came up as options at the Planning Interview. The family is interested in moving forward with our services, so the Community Support Specialist reaches out to set up a time to do initial planning assessments with Jane, including the POM interview and the Independent Living skills checklists. It takes 2-3 meetings over two weeks for the pair to complete these. At the end, the CSS compares the information he's learned getting to know Jane on her own to furter refine the suggested supports the team discussed at the Planning Interview. In the meantime, Bob is sent an initial Family Evaluation Survey through a google form to get a baseline assessment of how he is feeling about the planning process, supports, and state of their current family living situation.

Using the information from the Planning Interview, POM, and Independent Living Skills checklist, the CSS writes up a draft Action Plan. This includes the goals (things were we'll help Jane gain independence on) and the supports (areas where Jane may need some ongoing assistance for the long term) that Community Choices is able to offer to facilitate Jane moving toward independent community living. Because some of the goals and supports outlined are billable under the waiver (health and wellness, housing) and some are not (skill building, and community connections), we also include a draft budget of what our services will cost from their HBS budget as well as what services we are able to offer through our CCDDB grant. We send this to Jane and Bob and set up a meeting for the following week to discuss.

At this meeting the group goes over the goals and makes a few tweaks. They also talk about scheduling and which staff will be able to provide support in the various areas. Finally they discuss the budget and agree on a set number of max hours that CC will be under SDA for the allowable supports and which areas will be covered through the grant. They finalize a schedule for their first meetings and complete some updated HBS paperwork.

Jane's Action Plan involves her working with two different CC staff. One is working with her on skill building and community connections and the other is working on housing and HBS management. In total they are seeing her for about 4 hours per week. They continue on this routine for the next year. Jane learns many new skills related to household management and learns about several places around town that she is interested in. She is also getting close to ready to actually move into her own place.

About 11 months later, the CSS starts working on updating her plan. They do a new POM and Independent Living Skills Checklist and through that discuss what new skills are supports she might need as her move-out gets closer. The CSS reaches out to Bob and they discuss how things are going and if a new planning interview is needed. He thinks that they don't and he completes an Annual Family Eval form. The CSS takes this info and writes up a revised Action Plan and budget for the next year and sends it to Jane and Bob to review. They all agree that it looks good.

This process continues on updating each year or more frequently as Jane's transition to community based living progresses. As Jane gets more comfortable in her own apartment and Bob gets a bit older, the group decides to meet again for another Planning Interview. At this meeting Bob is interested in transitioning some of his management of Jane's benefits over to her with support from CC. These new services are worked into a new Action Plan and budget and supports are updated and continue.

Another Version:

A Self-Directed Version - In this example the participant and their family are interested in getting support with planning for community-based living, but aren't sure if they're ready to start or if they need outside support to make it happen.
Participant = Robert
Parent = Susan

In this example, Robert and Susan's experience follows the same pattern as Jane and Bob's up through the Planning Interview. At the end of their meeting, however, they explain that they got a lot of good ideas and are excited to think about plans for the future, but that for now, everything we discussed seems like actions they can take on their own. We follow up a few days later with a summary of the meeting including the steps we discussed that could help move Robert toward Community Living. We let the family know that if anything changes they should reach out to us.

Two years later Robert and Susan do reach back out and are ready to start putting more concentrated effort into Robert's move. We do another planning interview and move forward with an Action Plan.

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)

With the redesign of this program, we wanted to build a clearer and more functional process for our participants, their families, and our staff. Our goal has been to create a program that can fill in the gaps and provide the support that a person may need in order to live in the community. We have found that it is often one or two areas that participants and families feel are holding them back from taking bigger steps for community-based living.

Data, records and observations from previous years support this. Over the years we found that while participants may no longer need support in some areas, they were not able to make progress in other areas, despite working on goals for more than 1 year with varying types and levels of interventions. A small amount, or sometimes the same amount, of support from staff or a parent continued to be needed. Ultimately changing our mindset and approach has allowed us to develop a program where our participants can live more independent community-based lives, while continuing to get the support they need to complete some of those vital tasks.

Data and reports also support the shift from thinking that everyone needs to be able to transition out of using services and supports. In its first iteration, these services and supports were designed to be a transitional program of 1-2 years. We learned that a transitional model wasn't practical or successful by tracking participants' goal progress and documenting the contexts of what was happening in their lives. In short, life happens. For example, a person

may be progressing quickly on their skill building goals and developing more confidence. But when the person has a serious injury that causes them to need to move back in with their family for a period of time, the progress stops, and maybe that person's confidence regresses. Now that person may be re-learning those same skills, and/or needs to regain confidence by experiencing success with smaller goals before they feel capable and ready to move back to their more independent living setting and continue with new program goals.

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.

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

This includes adults with I/DD who are participants in the Inclusive Community Support Program.

GOAL: 30 TPCs will be served

- 15 will be individuals continuing in the Transitional Community Support Program
- 15 will be new individuals joining the Sustained Community Support Program option.

Actual Outcomes: 26 TPCs were served

- Early on in FY22, we merged the two programs together under the renamed Inclusive Community Support Program. We saw little reason to keep the 2 different distinctions when services were operating similarly.

Non-treatment Plan Clients (NTPC):

This includes adults with I/DD who participate in Personal Development Classes.

GOAL: 15 NTCPs will be served

Actual Outcomes: 19 NTCPs were served.

Community Service Events (CSE):

This includes outreach events to organizations, community groups, area service providers and other events meant to support the community's knowledge of these programs as well as the importance of people with I/DD having the opportunity to meaningfully connect with and engage in their communities.

Goals: 4 CSEs held

Actual Outcome: 8

Community Services Events included a UIUC Job Fair, Jettie Rhodes Neighborhood Day, The CU Autism Walk, a Transition Conference Round Table, ICS Informational Meeting, YAP Open House, a Case Managers Round Table, and meeting with Cunningham Township.

Service Contacts (SC):

Service contacts for TPCs are now recorded as Claims through the online service reporting system. Service Contacts/Claims include activities directly working with individuals in the program as well as activities on behalf of the person. Service contacts for NTCPs will be reported in the traditional format (total count of contacts).

GOAL: Transitional Community Support – 975 Service Contacts/Claims

Sustained Community Support - 2304 Service Contacts/Claims

Personal Development Classes – 250 Service Contacts

Actual Outcomes: Inclusive Community Support - 1171 Service Contacts/Claims

Personal Development Classes - 116 Service Contacts

Other:

This includes direct hours by staff supporting people with I/DD. For TPCs these hours will be recorded via the Claims online reporting system. For NTCPs, these will be recorded and reported in the traditional format.

GOAL: Transitional Community Support – 1300 Direct Hours

Sustained Community Support - 3288 Direct Hours

Personal Development Classes – 180 Direct Hours

Actual Outcomes: Inclusive Community Support Program - 1602 Direct Hours

Personal Development Classes - 461.5 Direct Hours

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: Community Choices
Program name: Customized Employment
Submission date: 8/26/22

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 Customized Employment services, individuals must be at least 18 years of age and have a documented developmental disability. Most importantly, individuals must be motivated to work. If individuals meet DRS criteria, their short-term services can be funded through DRS, and they transfer to the grant for longer-term support. Those that do not meet DRS criteria start with the grant from the beginning.

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.)?

Enrollment on the PUNS Database, which requires a screening assessment through the CCRPC, will be used as an eligibility screen. Motivation will be determined by an individual requesting services and reporting a desire to work.

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. Referrals to the Customized Employment program come from the Division of Rehabilitation Services, area schools, and through word of mouth. In addition, we can refer 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 the Northern Champaign County Community Resource Fair.

The Customized Employment department serviced 14 new people with funding from it's CCDDB grant. Of those 14 people:

- 9 were already engaged, or had been in engaged, in CC Connect or Inclusive Community Support programs
- 1 was referred by her Special Ed Case Manager when she transitioned out of Unit 4 Schools
- 1 was referred by the PAS Agent at CCRPC
- 1 reached out to us from our website
- 1 was referred by their DRS Counselor who thought they'd be a good fit for our Workforce Empowerment Program.
- 1 was referred by a self-advocate friend who used our services.

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

90%

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

14/16 people referred during FY22 began services. Of the two who did not begin, one only wanted services if her social security appeal did not go through (still no decision on this as of 8/2022), and the other was not yet on PUNS and we are still waiting for them to follow up with Mary Rascher before we can begin.

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):

14 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: Because eligibility is screened by an outside agency and requires the person/family to follow through with the outside agency, we do not have a way to report this information specifically.

Most referrals report being on PUNS when we first meet with them. If this is the case we follow up to confirm with CCRPC within 2 weeks for 100% of people.

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

30 Days

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

75%

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

10% began services within 30 days. There was an average wait of 64 days, though this average was affected by people choosing to wait to begin services in order to take part in Workforce empowerment, slow response to CC reach-out, and others.

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 Matching typically last 2-6 months, followed by up to 18 months of long-term support.

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

We track our services as episodes. One Episode contains the search for one job and the support that goes into sustaining that job. If a job is not a good fit, the person is let go for a reason outside their control, etc., we begin a new episode.

The average length of employment support episodes for those completing an episode this fiscal year is 362 days. Within this average there is a range of 69 to 1031 days.

Some people who have short episodes of employment begin a new episode very quickly. Longer episodes can generally be accounted for due to lengthy job searches or a long period of successful employment.

Discovery averages 70 days. Job searches averaged 101 days (with a range of 11 to 395 days).

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.

All additional demographic data for Customized Employment participants is reported quarterly in our client and claim uploads.

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. Program Outcome **- With strength-based vocational assessment and person-centered support, individuals with I/DD can find, obtain, and keep community-based competitive employment.**

GOAL:

a. 100% of participants with I/DD will report engagement and support in the employment process.
b. 85% will report that their strengths and interests are important to the employment process.

2. Consumer Outcome A - **DISCOVERY: Individuals develop a personalized employment plan based on interests and strengths.**

GOAL:

a. 20 individuals will complete Discovery and agree on a personal employment profile based on their strengths and interests.
b. All individuals will begin the Discovery process within 30 days of engaging with the department.

3. Consumer Outcome B - **JOB MATCHING: Individuals will acquire community based employment based upon their strengths and interests.**
   GOAL:
   a. 13 Individuals will work to obtain paid employment,
   b. 7 individuals will work to obtain volunteer jobs or internships.
   c. [NOTE: An additional 5 individuals will achieve this outcome with DRS funding]

4. Consumer Outcome C - **SHORT-TERM SUPPORT: Individuals with I/DD, negotiate and learn their duties to be successful at their jobs.**
   GOAL:
   a. 20 individuals will receive job negotiation and coaching leading toward greater independence when at their jobs.
   b. [NOTE: An additional 5 individuals will achieve this outcome with DRS funding]

5. Consumer Outcome D - **LONG TERM SUPPORT: Individuals with I/DD maintain their jobs through ongoing support and job expansion.**
   GOAL:
   a. 30 individuals receive on-going support according to their needs.
   b. 70% of individuals keep their jobs for at least 1 year.

6. Consumer Outcome E - **FIRST TIME JOB SEEKER PROGRAM: First-time job seekers with I/DD will build skills, experience, and employment self-determination through structured supports.**
   GOAL**:**
   a. CC offers 2, 12-week FTJS Exploration Programs
   b. 10 total people with I/DD Participate
   c. Each person completes 12 week curriculum, 2 6-week supported intensive job-shadowing experiences with a summary What Works reflection

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).

*List each outcome as it is on the application and on the Outcomes Mapping Document that we used with Emily.

Outcome:	Assessment Tool Used:	Information Source:

1a: 100% of participants with I/DD will report engagement and support in the employment process.	Assessment: The overall outcome will be measured using the Annual Participant 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 will be presented to all participants and their families (if they are involved). Full participation will be encouraged.	
1b: 85% will report that their strengths and interests are important to the employment process.	Assessment: The overall outcome will be measured using the Annual Participant 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 will be presented to all participants and their families (if they are involved). Full participation will be encouraged.	
2a: 20 individuals will complete Discovery and agree on a personal employment profile based on their strengths and interests.	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.	All individuals initiating employment support and completing the discovery process will develop a plan.	
2b: All individuals will begin the Discovery process within	A discovery process based off the Griffin and Hammis's	All individuals initiating employment support and	

30 days of engaging with the department.	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. *(Job Placement Tracking SpreadSheet will be used to track progress through program)*	completing the discovery process will develop a plan. *Job Placement Tracking will be entered by employment staff as their participants work through the program.*	
3a: 13 Individuals will work to obtain paid employment,	All job offers for people using employment supports will be tracked and communicated through regular meetings.	Staff will collect job offer information from all participants.	
3b: 7 individuals will work to obtain volunteer jobs or internships.	All job offers for people using employment supports will be tracked and communicated through regular meetings.	Staff will collect job offer information from all participants.	
4a: 20 individuals will receive job negotiation and coaching leading toward greater independence when at their jobs.	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 on the job.	Employment staff will use contact notes to track support need and participant progress.	
5a: 30 individuals receive on-going support according to their needs.	Meetings and contacts with employment participants and their teams will be recorded in the individual's file. These will be used to determine status and assess ongoing support needs.	Employment staff will use contact notes to track support need and participant progress.	
5b: 70% of individuals keep their jobs for at least 1 year.	Meetings and contacts with employment participants and their teams will be recorded in	Employment staff will use contact notes to track support need and participant progress.	

	the individual's file. These will be used to determine status and assess ongoing support needs.	
6a: CC offers 2, 12-week FTJS Exploration Programs	Classroom assessment will use a pre and post survey design. Intensive Job-Shadowing experiences will use the development of a What Works reflection upon session completion. *(Tracked in Quarterly Narrative Reports)*	Employment staff will give a pre and post survey to assess learning and work with each participant to build individualized reflections to aid self-determination throughout the 12-week program. *(Data Tracked by staff in Quarterly Narrative Reports)*
6b: 10 total people with I/DD Participate	Classroom assessment will use a pre and post survey design. Intensive Job-Shadowing experiences will use the development of a What Works reflection upon session completion. *(Tracked in Quarterly Narrative Reports)*	Employment staff will give a pre and post survey to assess learning and work with each participant to build individualized reflections to aid self-determination throughout the 12-week program. *(Data Tracked by staff in Quarterly Narrative Reports)*
6c: Each person completes 12 week curriculum, 2 6-week supported intensive job-shadowing experiences with a summary What Works reflection	Classroom assessment will use a pre and post survey design. Intensive Job-Shadowing experiences will use the development of a What Works reflection upon session completion. *(Tracked in Quarterly Narrative Reports)*	Employment staff will give a pre and post survey to assess learning and work with each participant to build individualized reflections to aid self-determination throughout the 12-week program. *(Data Tracked by staff in Quarterly Narrative Reports)*

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

Our program outcome data was gathered using our Member and Participant Surveys. This is a google-form based survey that allows respondents to automatically skip through questions that

do not apply to them. It is distributed to all Community Choices Members, their families, all participants who are not members, and their families should we have their contact information.

The survey is optional, though highly encouraged. In an attempt to increase our rate of response, this year we include the survey for Members as a section of our Membership Renewal documents. Members were automatically prompted to complete the survey or to follow a link that would take them to an anonymous version of the document. Program participants and their families who are not members, received several email blasts and prompts encouraging them to share their feedback.

- A total of 17 surveys were completed. Of these, 8 (5 family perspectives, 3 participant perspectives) belonged to people who had participated in our Customized Employment Department.
- Surveys were sent to approximately 200 member contacts and 50 non-member contacts.

Data related to other Consumer Outcomes was collected for all participants.

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?

41

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

41

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

41 individuals for outcomes 2, 3, 4, and 5. 8 individuals for outcome 1, and 8 individuals for outcome 6 (Workforce Empowerment Program/First time Job Seekers - this was the total number of participants in this specific service).

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

Data for outcome 1 was collected 1x per year during the spring (with multiple reminders). All other outcome data was collected on an ongoing basis.

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)

** This is where you report ACTUAL outcomes achieved. "Here's what we found . . . "

1a: 100% of participants with I/DD will report engagement and support in the employment process.
Of the 8 responses we got to this question, 6/8 or 75% indicated they were engaged "Very Much" or "A Little".

1b: 85% will report that their strengths and interests are important to the employment process.
Of the 8 responses we got to this question, 8/8 or 100% indicated their strengths and interests were important to the employment process.

Using our Job Placement Tracking tools, we also found that of the 16 people we supported to find employment through our CCDDB grant, 100% found a job related to the Employment Theme developed through their Discovery Process.

For those individuals who found work funded through DRS, 8/9 found employment connected to their employment themes.

2a: 20 individuals will complete Discovery and agree on a personal employment profile based on their strengths and interests.
13 individuals completed our Discovery Process.

2b: All individuals will begin the Discovery process within 30 days of engaging with the department.
10% of participants started Discovery within 30 days. The average was 63 days, though this average was affected by people choosing to wait to begin services in order to take part in Workforce empowerment, slow response to CC reach-out, and others.

3a: 13 Individuals will work to obtain paid employment,
15 individuals found paid employment with our support during FY22.

An additional 9 individuals found paid employment with our DRS-funded support.

3b: 7 individuals will work to obtain volunteer jobs or internships.
1 individual found volunteer employment with our support during FY22. Additional individuals participated in volunteer activities within our Connect Department opportunities and during our Workforce Empowerment Program (First Time Job Seekers Program).

4a: 20 individuals will receive job negotiation and coaching leading toward greater independence when at their jobs.
20 individuals received job negotiation and coaching on their jobs.

5a: 30 individuals receive on-going support according to their needs.
18 individuals received on-going or long-term support related to their needs. This generally involved collaborating with employers, providing updated job coaching on new tasks, and check-ins to ensure job sustainability.

5b: 70% of individuals keep their jobs for at least 1 year.
13/20 (65%) participants who were employed at the start of FY22 were still employed at the close of the fiscal year.

Of the 7 participants who had left their positions, 1 was due to an injury and 1 due to the summer job ending. Two were let go for "cause" (not being a good fit or being too slow based on their internal metrics). The other two chose to leave.

The average length of time that this group has maintained their employment is 17 months.

6a: CC offers 2, 12-week FTJS Exploration Programs
CC offered 2 rounds of a 12-week First Time Job Seekers Program, dubbed our Workforce Empowerment Program.

The first round partnered with Urbana Park District and the Red Herring.
The second round partnered with Urbana Park District and iHotel.

6b: 10 total people with I/DD Participate
8 total people with I/DD participated in the program.

While there was additional interest in the program from others, reported barriers included transportation and willingness to commit to all 12 weeks of the program.

6c: Each person completes 12 week curriculum, 2 6-week supported intensive job-shadowing experiences with a summary What Works reflection
4/8 or 50% of participants completed a reflection. Barriers to completing this step included missing sessions during the reflection period or dropping out prior to this portion of the program.

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

No - there is no set benchmark that outlines if a person is able to find employment, how long that might take, or what sort of employment (related to the person's interests) a person may find. The only benchmarks that we may be able to use are data from our previous work in these areas. However, this data is somewhat limited due to changing documentation and outcome tracking that has occurred over the years, though our ability to compare between years is increasing.

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

*Explain why it might be arbitrary - ie we're doing our best to determine what improvement looks like for our participants.

We have been refining our evaluation tools in this and other programs for the past few years. Data older than a year or two is more difficult to use for comparison as it was not recorded as thoroughly or in the same location. However, we do have relatively complete data for the past 2-3 years that we can use to put this year's outcome data in context.

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

Outcome 1:
Data for this outcome is collected through a participant and member survey that we distribute each spring. We have consistently had low response rates, though this year was particularly low. With only 8 responses it is difficult to come to any broad-ranging conclusions, however, there are some inferences that can be made.

We always strive to create an engaging and motivating process for our participants while looking for work. It can be a long, frustrating, and confidence-testing process for many. Our efforts in this area focus primarily on the individual job-seeker, and less on their family member. This is because of the inherent need to assert some independence, self-sufficiency, and communication skills outside those that relate to the person and their family relationships. The job search is about building the relationship between the person and their employer/potential employer, not about engaging the family. Data that came directly from our job-seeking participants was very positive. Of the 3 that responded, 100% indicated that they were "Very Much" engaged in the employment process. So while overall, we did not meet our target, for the people for whom this target was most important, their assessment of our work was very positive.

Our employment process is also designed to emphasis the interests, skills, and desires of the job seeker in order to create strong, sustainable, and mutually beneficial employment relationships. It was encouraging to see that our participants felt the impact of our work in this area.

Outcomes 2, 3, and 4:

We had great success in finding good employment matches with our participants this year. We were able to find 16 job matches during the fiscal year and an additional 9 matches funded through DRS. Even accounting for the size/staffing of the department over the past few years, this is by far the most successful year we have had. In FY20, even before the start of the Pandemic our efforts at supporting people to find jobs was very challenging and we had far fewer job matches than we had aimed for. In FY21, during a full fiscal year of managing the pandemic, we already began to see improvements in the speed and ease with which we were making job matches.

I believe that there are a number of reasons for this. While we did redesign our discovery process during the past few years and make some slight adjustments in other areas, the overall structure and emphasis of our program has remained the same. The variables that have changed, I believe, are more external.

The Pandemic vastly affected businesses. They had to become agile and creative in order to survive. They have also experienced significant impacts on their own workforce and labor markets. This has the unintended effect of creating a more hospitable and welcoming environment for job seekers with disabilities. Our participants benefit from employers who are willing to be creative with their scheduling, job descriptions, tasks, and hiring overall. And while it is not the main reason I would hope that employers would choose to hire people with I/DD, a lack of other candidates surely had a positive impact on our job seekers being offered positions.

It is our hope that this unexpected window of opportunity offered by the Pandemic will create a snowballing positive effect into the future. We know that people with I/DD can be effective, loyal, and hardworking employees. Much of our challenge in this field is to get others to see that. This means that the more people we are able to support to get hired, the more we are pushing back that mindset of hesitance. We are also shifting the attitudes of anyone who may interact with someone with I/DD who's on the job. The more unexpectional we can make it be for someone with a disability to be visibly contributing to the economy, the easier it will be for future job seekers to find work.

The other impact of the Pandemic was that many people with I/DD lost their employment in the initial months. This created a wider pool of job-seekers with prior experience who were looking for work this year. Prior to COVID, the profile of many of our new job-seekers was trending younger and with more support needs. This was overall a great thing, as it meant that within education and family systems, people with I/DD entering the workforce was becoming the norm. It also made the job development process for us more challenging. We chose to add a First Time Job Seekers program to our services to address some of these challenges, for example. This year however, the influx of participants looking to get back into the workforce after a pandemic-related hiatus did give them and us an additional leg-up that some of our younger, less experienced participants did not have. In comparison, we had less new participants this year who were just coming out of school or who had few employment

experiences. Those that did, we encouraged them to participate in our Workforce Empowerment Program.

Outcome 6:
This was our first year offering our First Time Job Seekers Program. We decided to call it our Workforce Empowerment Program (WEP), as it is not exclusively for people without job experiences.

We had 8 participants start the program. Of those 2 dropped out early on in their session. From the first session, in fall of 2021, 2 out of the 3 participants are now employed. The third person is currently looking for work. From session two all three individuals are seeking employment (this session ended in late March of 2022). All participants increased or maintained their knowledge of job-related skills based on the pre/post tests.

The qualitative assessment of the most actively engaged participants also has positive results. One individual has made remarkable progress in many areas of her life since engaging in this program. Prior to her involvement, she would frequently talk about continuing to live at home, not being sure she would be able to keep a job, and down-playing her many admirable qualities. Since the program she has found a job she loves at a local restaurant, has decided to move out, and just found an apartment which she will move into in early FY23. While we cannot say that WEP was the cause of these positive changes in this person's life, the facilitator has followed along with this individual and noted her discussing how she's applied the things she learned in the program to multiple areas of her life.

For other participants the impact has been positive, though less pronounced. The other individual, who has since found work after completing the program, credits WEP in reinforcing her desire to go into childcare. Prior to involvement she was interested in this field but hadn't had experiences in other environments. Getting to actually try different jobs helped her to feel confident going on to seek a job in the childcare field, which she now has. Other participants have shown a greater openness to different job ideas and acknowledgement of their skills in more areas according to reports from our Employment Specialists who worked with them both before and after the program.

We are hopeful that as we move into year two of this program we will see additional positive results and be able to make some changes that will limit the barriers that people have had to involvement. The long time-commitment and transportation were the most common concerns that people had with signing up. In FY23 we plan to wrap our weekly Friday session into our Monday Workshop. This will limit it to 2 days per week, rather than 3. While we do not have a strong plan to address transportation, we are working to attract new participants earlier so that we can work with them to find acceptable transportation options.

(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)

Things go as planned:

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 there 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 with 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, 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.

Things do not go as planned:

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 periodic 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 to the initial meeting, but Person B is not excited to go through the discovery process and just wants to apply for jobs right away. The CC staff person explains why it's 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 don'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.

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 a result of cases similar to Person B's above, we have developed some additional tools to support job seekers in these circumstances. The most noteworthy is our Workforce Empowerment Program.

Now, when we work with someone who we see similar patterns emerging to those of Person B, we would likely pause and meet with the person to present the option of pausing our standard Employment Process and enroll them in the next session of WEP. This would give them a chance to learn the critical soft skills necessary to find and keep a job, to practice the routines and responsibilities required to find a job, give them some real-life experience to base their preferences on, and give our Employment Specialists the opportunity to observe them on the job in a low-stakes environment.

Over the past few years, we have also improved our methods at tracking outcome data. We have a better more complete picture of how long it is taking people to find work, what type of work they are doing, and why they may be leaving their positions. These timelines have helped us to see trends over time and will continue to inform future changes. Within our Inclusive Community Support program, we have spent considerable time redesigning our evaluation methods with the UIUC team. In the upcoming year, we hope to apply some of what we learned to our data collection methods within this department as well.

We have also made some internal changes to the running of the department that also seems to be contributing to increased success. We have been meeting weekly as a department where staff share ideas, leads, and challenges related to those they're working with. As an administrator, I have noticed a much greater degree of collaboration, networking, and moral since instituting these meetings.

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):

This includes adults with I/DD who are participants in the Customized Employment program.

GOAL: 40 TPCs will be served

ACTUAL: 41 TPCs were served

Non-treatment Plan Clients (NTPC): N/A

Community Service Events (CSE):

This includes outreach events to organizations, community groups, area service providers and other events meant to support the community's knowledge of these programs as well as the importance of people with I/DD having the opportunity to work in the community.

GOAL: 4

ACTUAL: 5

Service Contacts (SC):

Service contacts are now recorded as Claims through the online service reporting system. Service Contacts/Claims include activities directly working with individuals in the program as well as activities working on behalf of the person (including connecting to employers, collaborating with families and natural supports, and documenting the support provided).

GOAL: 1840 Service Contacts

ACTUAL: 1795

Other:

This reports direct hours by staff with and on behalf of people with I/DD and their employment goals. For TPCs these hours will be recorded via the Claims online reporting system.

GOAL: 2772 Direct Hours

ACTUAL: 2410

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: Community Choices
Program name: Self-Determination
Submission date: 8.26.22

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 programs in the Connect Department and part of the Self-Determination Grant, individuals must be at least 18 years of age and have a documented developmental disability and become a member of Community Choices. Membership includes completing the intake process and appropriate paperwork. 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.)?

Enrollment on the PUNS Database, which requires a screening assessment through the CCRPC, is used as an eligibility determination tool. The Membership Coordinator met with the individuals requesting services to explain the programs and supports that are available and to determine if they would like to become members. It is this internal intake process for which the timeframe estimates are based.

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. Referrals to the Connect program come from area schools, and through word of mouth. In addition, we can refer to and from Developmental Services Center, Champaign County Regional Planning Commission, Rosecrance, The Autism Program, and PACE. We informally reach out to the community through participation in outreach events – such as the Disability Expo, Transition Conference, Jettie Rhodes Neighborhood Day, and more.

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. No individuals who do not meet eligibility requirements and who have requested services will be turned away.

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

All our services and supports are opt-in. Not all members chose to participate in offered services. 85% of members with disabilities participated in services during FY22. If we include family members, 81% of members participated in services and supports throughout the year. Additional family members also participated in events 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. This meeting is planned around the individual's schedule and typically held 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. Many individuals initiate services with the required assessment/eligibility information available.

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

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:

Formal assessment is done outside of Community Choices. The time frame 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 a 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 membership paperwork is complete, there is no wait to access Self-Determination support services.

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

Members are continually given the choice and opportunity to engage with self-determination programs through a monthly social calendar and targeted communication about additional opportunities for participation. Members are encouraged to be active participants of 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:

Once a person completes their intake and eligibility documentation, they can participate in program activities immediately. Services/supports in this program are opt-in, so new members can participate in what is happening right away.

Due to the structure of the program, limited data is available related to this question. Members are continually given the choices 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.

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 can choose to renew which includes updating paperwork and eligibility.

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

Between FY21 and FY22, 96% of members renewed their membership.

The renewal period occurs in 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. It is not uncommon for people to leave and then return to 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 will also gather the 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 has become a part of all current and regular intake meetings. We ensure that all individuals coming to Community Choices for services are actively enrolled in 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.

1 - **Program Outcome: Participation with CC leads to greater supportive networks and connections.**

GOAL:

- Members with I/DD: 70% indicate they made a friend and 60% of those friendships will be defined as at least somewhat close. 75% indicate that CC provides them with a supportive community.
- Family Members: 55% indicate they connected with another family member and 45% of those connections were meaningful. 75% indicate CC provides them with a supportive community.

2 - FAMILY SUPPORT AND EDUCATION: ***Members support each other and gain knowledge of the DD service system***

GOAL:

- 5 Co-op meetings – 50 individuals reached.
- 4 Family Parties – 25 members attend each.
- 6 Family Support Group Sessions ~ 16 family members participate.
- 100% of Support Group participates indicate a strategy/resource learned or increased connection with others

3 - BUILDING COMMUNITY: ***Members with I/DD engage with each other and community-based groups and opportunities***

GOAL:

- Community Social Opportunities
  - 48 Routine Social Opportunities
  - 2 Opportunities for Scaffolded Community Engagement (Park District Classes, Cooking classes, community-based ½ day social groups)
  - 48 Connection zoom sessions
- Personalized Community Connections
  - 15 CC members complete Connection Exploration process
  - 3 new Co-Op clubs, 2 continuing clubs ~ 17 members participate
  - 3 Open Champaign Individual Connections ~ 3 members participate
  - 2 Open Champaign Events ~ 12 members participate

4 - LEADERSHIP AND SELF ADVOCACY: ***Individuals with Disabilities build leadership skills to better direct their services, and shift mindsets in the broader community and service systems.***

GOAL:

- 1 Leadership course offered - 80% of participants indicate an example of a leadership skill or mindset that they gain or increase confidence in.
- 10 members will have opportunities to demonstrate leadership growth by participating in Mentoring, Human Rights & Advocacy Group, or other leadership activities.

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

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

Outcome:	Assessment Tool Used:	Information Source:
1: Program Outcome: ***Participation with CC leads to greater supportive networks and connections.*** EXPECTED OUTCOMES 1a: Members with I/DD: 70% indicate they made a friend and 60% of those friendships will be defined as at least somewhat close. 75% indicate that CC provides them with a supportive community. 1b: Family Members: 55% indicate they connected with another family member and 45% of those connections were meaningful. 75% indicate CC provides them with a supportive community.	Annual Member Survey	Members with I/DD and their family members
2: FAMILY SUPPORT AND EDUCATION: ***Members support each other and gain knowledge of the DD service system*** EXPECTED OUTCOMES 2a: 5 Co-op meetings – 50 individuals reached. 2b: Family Parties – 25 members attend each.	The number and attendance rate of quarterly co-op meetings, family parties, and support groups will be recorded. The family support group will use an end of year evaluation to determine the outcomes of participating. Formative assessments via informal feedback from members will be used to direct the content of groups	Attendance data and program evaluations.

2c: 6 Family Support Group Sessions ~ 16 family members participate. 2d: 100% of Support Group participates indicate a strategy/resource learned or increased connection with others	and resources offered by Community Choices.	
3: BUILDING COMMUNITY: ***Members with I/DD engage with each other and community-based groups and opportunities*** EXPECTED OUTCOMES <u>Community Social Opportunities</u> 3a: 48 Routine Social Opportunities 3b: 2 Opportunities for Scaffolded Community Engagement (Park District Classes, Cooking classes, community-based ½ day social groups) 3c: 48 Connection zoom sessions <u>Personalized Community Connections</u> 3d: 15 CC members complete Connection Exploration process 3e: 3 new Co-Op clubs, 2 continuing clubs ~ 17 members participate	Number and attendance rate of routine and scaffolded social opportunities Recorded number and scoring of POMs during the exploration process Annual Member Survey	Attendance data; Members who participate in the exploration process

3f: 3 Open Champaign Individual Connections ~ 3 members participate 3g: 2 Open Champaign Events ~ 12 members participate		
4: LEADERSHIP AND SELF ADVOCACY: ***Individuals with Disabilities build leadership skills to better direct their services, and shift mindsets in the broader community and service systems.*** EXPECTED OUTCOMES 4a: 1 Leadership course offered - 80% of participants indicate an example of a leadership skill or mindset that they gain or increase confidence in. 4b: 10 members will have opportunities to demonstrate leadership growth by participating in Mentoring, Human Rights & Advocacy Group, or other leadership activities.	Number of leadership/self-advocacy events and their attendance; assessment questionnaire for those participating in the leadership course Annual Member Survey	Class participants, Human Rights and Advocacy Group members, and others engaged in advocacy projects

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

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

Evaluations for the Step Up to Leadership Class were emailed to class participants after the final session date. Not all participants chose to complete the evaluation.

Evaluations for the Family Support Group were emailed to everyone who had participated in at least one session during FY22. Not all participants chose to complete the evaluation.

Some of the information was gathered from our annual member survey. The survey is structured to skip questions about programs or supports that the person or their family member does not use. The survey was sent to 202 members. We received 17 responses. This is a significant decrease from FY21 when we received 47 responses.

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

We attempted to collect outcome information from all members with I/DD, and their self-selected family members. People choose if they want to complete service evaluations and/or respond to the annual member survey. It is not mandatory.

5. How many total participants did your program have?

202 – This includes members with disabilities, their self-selected family members, and family/community members who attend our public education and community events. Of this, 69 were members with disabilities. The remaining 133 were family members.

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

We attempted to collect outcome information from 202 people.

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

Annual Member Survey: 17 of 202 responses were returned

Family Support Group Survey: 3 of 21 responses were returned

Step Up to Leadership Class: 3 of 5 participants completed the survey

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

Membership Survey: This is completed once per year in the spring.

Family Support Group Evaluation: This is completed once per year in the summer.

Step Up to Leadership Class: This is completed at the end of the 8 week class.

Results

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

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

OUTCOMES

1: Program Outcome: *Participation with CC leads to greater supportive networks and connections.*

1a: Members with I/DD: 80% indicated they made a friend and 75% of those friendships were defined as at least somewhat close. 90% indicated that CC provides them with a supportive community.

1b: Family Members: 67% indicated they connected with another family member and 75% of those connections were meaningful. 67% indicated CC provides them with a supportive community.

2: FAMILY SUPPORT AND EDUCATION: *Members support each other and gain knowledge of the DD service system*

2a: 5 Co-op meetings – 36 individuals reached.

2b: Family Parties – avg. or 23 members attend each.

2c: 7 Family Support Group Sessions ~ 21 family members participate.

2d: 67% of Support Group participants indicate a strategy/resource learned or increased connection with others

3: BUILDING COMMUNITY: ***Members with I/DD engage with each other and community-based groups and opportunities***

3a: 37 Routine Social Opportunities

3b: 2 Opportunities for Scaffolded Community Engagement: Art, Community Volunteering

3c: 329 Connection zoom sessions

3d: 6 CC members complete Connection Exploration process

3e: 6 new Co-Op clubs, 1 continuing clubs ~ 21 members participate

3f: 4 Open Champaign Individual Connections ~ 5 members participate

3g: 0 Open Champaign Events ~ 0 members participate

4: LEADERSHIP AND SELF ADVOCACY: ***Individuals with Disabilities build leadership skills to better direct their services, and shift mindsets in the broader community and service systems***

4a: 1 Leadership course offered - 67% of participants indicate an example of a leadership skill or mindset that they gain or increase confidence in.

4b: 15 members will have opportunities to demonstrate leadership growth by participating in Mentoring, Human Rights & Advocacy Group, or other leadership activities.

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

No. This is a unique program and there is a lack of evidence-based best practices and assessment tools for this type of work within the field.

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

We do our best to establish benchmarks and targets for ourselves, based on outcomes over time. However, it is difficult to create these within our own data due to the opt in nature of this program and inconsistent response rates. We have also seen a trend of post-covid lack of

involvement, which we suspect is due to various reasons, including people developing a more isolated routine, and changes within family structure during covid.

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

The Self-Determination/Connect program is an opt-in program with focus on helping people connect. 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 positive experiences doing so, the more connected they will feel and the more meaningful relationships they will have. 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.

We have learned that members with I/DD and family members who are involved in more individualized Self-Determination supports and programming, are more likely to respond that they have developed a meaningful friendship or connection in the last year, and that Community Choices provides them with a supportive community. However, it is challenging to compare data each year when we struggle with low response rates with our surveys. Of the 17 returned evaluation surveys, we found that 80% of members with I/DD reported they made a friend and 75% of those friendships were defined as at least somewhat close. 90% of members with I/DD indicated that CC provides them with a supportive community.

<u>Family Support and Education</u>

Helping families support each other, learn about the service systems, and advocate for what they are looking for is an important element of this program. We offered 4 co-op meetings this year focusing on different topics relating to disability services and supports. We also held a members-only meeting that focused on the expansion of services in the newly-titled Inclusive Community Support department (formerly Community Living). All co-op meetings were held through zoom in FY22. We hope that attendance improves and attracts people from outside the cooperative in FY23 when we plan to hold these meetings in-person.

Our Family Support Group met 7 times during FY22. Some months had up to 15 people attend, some months had 1-2 people attend. With only having 3 Family Support Group evaluations returned at the end of FY22, it is difficult to know what changes and improvements to make to ensure that the group is meeting the needs of our family members. Discussions at the group meetings included social security issues, family dynamics, home-based support questions, and general services that are available to everyone in the community. 67% of family support group participants indicated a strategy/resource learned or increased connection with others. And informal feedback through comments at group meetings indicated that attendees “like meeting in social settings” and “catching up with each other.”

The small amount of quantitative data from our membership survey supports these more informal and qualitative reports and records. 67% of family members indicated they connected with another family member and 75% of those connections were meaningful. 67% of family members indicated CC provides them with a supportive community.

Building Community

During FY22 we returned to offering in-person social opportunities, except for a short period during the winter when covid numbers increased, and outdoor activities were not an option. Large community events did not return for most of FY22, and as a result we offered small, regularly scheduled social opportunities at events and locations where we could see people becoming "regulars" at. We also built in opportunities for members to build their confidence using public transportation. Members had the option of riding the MTD with CC staff to lunch clubs at the various restaurants each month, or meeting there.

Community Choices also offered 329 opportunities for connection through zoom. For members who live in more rural areas, or don't have as easy access to transportation, zoom sessions allow them to be more connected with co-op members on a regular basis. We continued to "host" zoom 3 zoom sessions per week for members in FY22, on regular days and times. Sessions were member-led, allowing people to discuss a variety of topics together. CC staff checked in during at least 2 of the 3 sessions each week to help problem-solve any technical issues and give announcements about upcoming CC activities.

During FY22, lingering COVID concerns and restrictions limited the number of community spaces and events that were available. We were not able to plan partnered Open Champaign events simply because it was difficult to plan for the future - especially large, in-person, public events. COVID concerns also affected the number of community groups and clubs meeting in-person. Members were also hesitant to participate in our exploration process, not knowing if it would be possible to connect with their preferred groups and activities. But this also allowed us to really concentrate on providing new ways for members to connect with each other. The Connect staff hosted two "co-op club mixers" where members with I/DD who wanted to organize a club around an interest could share their ideas with members with I/DD who were interested in joining a club. This approach was successful and more co-op clubs were formed during FY22 than in past years.

Leadership and Self-Advocacy

Members with disabilities had opportunities to grow and practice their leadership skills. Our Human Rights and Advocacy Group (HRA) continued to strengthen their efforts in our community. The HRA presented to two U of I Special Education classes, and also CCMHDDB agency case managers. They worked with Shandra Summerville to become an option for agencies to satisfy one of their CLC learning requirements.

The HRA also approved two additional projects that partner with Visit Champaign County. One HRA member joined the Chambana Welcome Crew as an ambassador. Ambassadors are available to meet with people new to the C-U community and clue them in to fun events, community services, and local organizations that meet their needs.

The second project, Accessible Champaign County, is a long-term partnership focused on sharing the accessibility information of entertainment locations and encouraging restaurants, theaters, etc with the community. A second goal of the project is to encourage entities to improve their physical, cognitive, and sensory accessibility. During FY22, a committee of CC members with I/DD, family members, and community members created an assessment tool that can be used to gather information at various locations. In FY23, the tool will be piloted and necessary changes will be made. Partnerships with U of I SPED classes have been created to have students visit locations and complete the assessments.

(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. 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 during this past year.

<u>Highly Engaged Participant</u>
Member A and their family members have been members at Community Choices for over 3 years. Over the past year Member A participated in weekly social opportunities, and was also participating in another member's monthly co-op club where 4 friends would get together for coffee at a local coffee shop. Member A may also participate in member-led zoom meetings to develop additional connections to other CC members.

While participating in weekly social opportunities, Member A connected with a new Community Choices member, Member B Member A and Member B began texting each other on a regular basis. When Community Choices shared information about a special event happening at a local coffee house, Member A and Member B coordinated going together. Then they continued to make plans to hang out on their own outside of Community Choices programming.

Limited Engagement Person

Member C is new to Community Choices. Member B attends 1-2 member-led zoom sessions each week as a step to building connections outside of their own family. Member C initiates a few interactions, but looks happy to answer questions when other members initiate conversations with them.

Member C and his family participated in a POM with a member of the Connect staff. The Connect staff recommended attending social opportunities to discover places, activities, and people Member C may be interested in. At this time, Member C attends 1 social opportunity per month, and the quarterly family parties with their parents. Member C isn't interested in joining any co-op clubs or groups right now, but seems to be satisfied with the amount of contact and connections they have within CC right now.

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. Continuing to have a low survey response rate has been particularly challenging. We have learned that members with I/DD and family members who are involved in more individualized Self-Determination supports and programming, are more likely to respond that they have developed a meaningful friendship or connection in the last year, and that Community Choices provides them with a supportive community.

The Self-Determination/Connection program is an opt-in program. In FY22 we made changes and attempted new ways to help members with I/DD and their family members become more involved or connected with co-op activities.

1) The Connect staff hosted two "co-op club mixers" where members with I/DD who wanted to organize a club around an interest could share their ideas with members with I/DD who were interested in joining a club. This approach was successful and more co-op clubs were formed during FY22 than in past years.
2) During FY21, members reported that they liked being able to connect with each other through zoom. For members who live in more rural areas, or don't have as easy access to transportation, zoom sessions allow them to be more connected with co-op members on a regular basis. We continued to "host" zoom 3 zoom sessions per week for members in FY22, on regular days and times. Sessions were member-led, allowing people to discuss a variety of topics together. CC staff checked in during at least 2 of the 3 sessions each week to help problem-solve any technical issues and give announcements about upcoming CC activities.
3) We've changed and adapted our Family Support Group since it began. It began with a once a month meeting with a specific structure that included sharing, lessons, and take-home assignments. Based on feedback we changed it a few years later to a more open format where family members could come to socialize and/or ask questions and

share with others. We stopped meeting during COVID as most family members who had regularly attended reported that meeting through zoom just didn't fit in their schedules. When the weather was agreeable, we held the support group outdoors at one of the local bars with patio seating or a beer garden. People reported that it was good to be able to see each other in person and socialize with each other. We continued that format in FY22 with mixed success. Some months having up to 15 people attend, some months having 1-2 people attend. With only having 3 Family Support Group evaluations returned at the end of FY22, it is difficult to know what changes and improvements to make to ensure that the group is meeting the needs of our family members. But we will continue to ask for and collect informal and formal feedback during FY23.

4) During FY21, we received a lot of informal feedback from members with I/DD and family members that they "missed seeing everyone" and that they "missed the family parties." During FY22 we were able to hold 3 family parties in-person with some adaptations for COVID, but we continued to hold our quarterly co-op meetings through zoom because it was difficult to find a large enough meeting space due to some COVID restrictions still in place with individual venues. In FY23 we will be able to hold our quarterly co-op meetings in-person. To encourage people to attend, and meet the need to connect again, we are starting each co-op meeting with a 30 minute "social hour." During this time we will have light snacks and people can chat and catch up with each other before the meeting begins.

Utilization Data Narrative –

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

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

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

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

categories significantly differ from your actual numbers, you may give a narrative explanation for that discrepancy here.

Treatment Plan Clients (TPC):

N/A

Non-treatment Plan Clients (NTPC):

Individual co-op members with I/DD will be counted. Their involved family members will be counted as well, and family members/individuals within the broader community who attend our public events will be counted.

Goals:

80 NTPCs with I/DD

90 NTPCs without I/DD (Family/Community Members)

Actual Outcomes:

69 NTPCs with I/DD
133 NTPCs without I/DD (Family/Community Members)

The discrepancy between our goal of 80 NTPCs with I/DD and actual outcome of 69 NTPCs with I/DD, could be due to the post-covid lack of involvement we've seen. During the pandemic, people were encouraged to develop more isolated routines. It may take a few years before people are willing to change those routines.

Community Service Events (CSE):

This includes outreach events to organizations, community groups, area service providers and other events meant to support the community's knowledge of these programs as well as the importance of people with I/DD having the opportunity to meaningfully connect with and engage in their communities.

Goals: 4 CSEs held

Actual Outcomes: 10 CSEs held

Through being involved in work groups, like the Champaign County Sex Educators, and connecting with the University of Illinois SPED department, staff and members have received more opportunities to speak to various classes and organizations.

Service Contacts (SC):
Service Contacts are direct interactions with participants or activity directly related to their support.

Goal: 2380 Service Contacts

Actual Outcome: 3245 Service Contacts

Other

Accounts for Hours worked directly with participants or activity directly related to their support

Goals: 1788 Direct Hours

Actual Outcomes: 1748 Direct Hours

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).

DSC Clinical Services
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 22**

Consumer Access – *complete at end of year only*

Eligibility for service/program

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

People with a formal diagnosis of ID/DD seeking clinical support are eligible for services.

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

Eligibility is determined by psychological assessments that include IQ test scores, resulting in a full-scale IQ score below 70 or a documented developmental disability with deficits in three life skill areas. The person must be eligible for the PUNS list. The determination of the need for clinical services is assessed by DSC's clinical consultants or upon referral from an individual's physician/provider with whom he/she has an established relationship.

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

The Disability Expo/Third Thursday Resource Round-ups, the Champaign County Transition Planning Committee's Round Table presentation, support group referrals, physician and interagency referrals, DSC website, Facebook, outreach events, brochures, and other informational materials are some of the ways the target population learn about this program.

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): **70%**

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

8/11 (73%) received services funded by this grant. The other individuals were referred to other providers such as Promise Healthcare, Carle Psychiatry/Psychology Services, and Elliott Group through insurance.

5. **a)** *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application): **30 days**

b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application): **90%**

c) *Actual* percentage of referred clients assessed for eligibility within that time frame:
11/11 or 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): **30 days**

b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application): **90%**

c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame:
3/8 or 38%. Three people engaged in services within 30 days. One individual has not scheduled their first appointment despite Clinical and DSC staff reaching out to the guardian to encourage they schedule the first appointment. Four individuals were referred to psychological assessments only. The psychologist had several scheduling delays and did not complete the evaluations within 30 days.

7. **a)** *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application):
Services remain available as long as needed. Quarterly reviews are conducted to confirm continued need.

b) *Actual* average length of participant engagement in services:
Average length of participation in services range from 3 months to long-term support.

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)

Disability, referral source and guardianship status are also collected.

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

Referral Sources have included physician, DSC team members, families, and individual requests about services. This year of the 11 screening contacts: three were referrals from families, seven were referred from DSC Staff, and one was a self-referral from a person already receiving psychiatry services through the Clinical practice.

Consumer Outcomes – *complete at end of year only*

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

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

Outcome 1: Clinical Manager will conduct quarterly reviews regarding the assessment, progress, and frequency of appointments for all people receiving counseling support.
Outcome 2: DSC Psychiatric Practice will review patient progress on a regular basis and attempt to reduce the number and dosage of psychotropic medications when deemed clinically appropriate and document such attempts in the psychiatric notes.
Outcome 3: Clinical Manager will conduct annual individual self-assessments regarding effectiveness of clinical services on the person's overall sense of wellbeing.

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

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

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

1. Quarterly reviews for those receiving counseling.	**1. Quarterly reviews are maintained.**	**1. Clinical Coordinator**
2. Review of patient progress to reduce medications.	**2. Psychiatric notes are maintained.**	**2. Clinical Coordinator**
3. Annual individual self-assessments regarding effectiveness of clinical services on the person's overall sense of wellbeing.	**3. Assessment created using resources from Evaluation Capacity Building Team online measure bank.**	**3. Service participants**

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

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? **60**

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

Sixty people from counseling and psychiatry for outcomes one and two. Fifty-one (100% of those in the practice at the end of fourth quarter) for Overall Wellbeing Clinical Services Evaluation, outcome number three.

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

Sixty people from counseling and psychiatry for outcomes one and two. Thirty-five for Overall Wellbeing Clinical Services Evaluation, outcome number three.

8. 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 consults with individuals at least every three months. Clinical Services Evaluation is completed one time per year.

Results

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

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

The Clinical Manager has consistent contact with an individual's team and the consultants to be aware of status and to continually evaluate the need. Quarterly reports are completed but often there is contact in between the quarterly reports.
Outcome 1 results: A total of 47 people received counseling this fiscal year and quarterly reviews were completed on all 47 for 100%.
Outcome 2 results: A total of 23 people received psychiatry services this fiscal year and patient progress was reviewed at least quarterly on 100%.
Outcome 3 results: 51 surveys were sent out over the course of the fiscal year. 35 were returned (69%). Of the 35 returned scores broke down as follows: 1=0, 2=1, 3=5, 4=7, 5=22. 83% scored their overall sense of wellbeing at a 4 or higher. All individuals who returned the survey stated they wanted to continue seeing their provider.

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

11. If yes, what is that benchmark/target and where does it come from?
The target for all three outcomes is 100%. The target was established based on past program evaluation of outcomes.

12. If yes, how did your outcome data compare to the comparative target or benchmark?
All three outcomes met their benchmarks.

(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)

An individual who is part of the psychiatry and counseling aspects of Clinical Services had been stable for many years. He was seeing the psychiatrist once every three months and received counseling support when major changes happened in his life. Recently, this person's team noticed significant changes in the person's mood, work consistency, and overall independence level. The person displayed a quieter affect and was missing steps of his job or not showing up at work at all. He was terminated from one place of employment after five years because the employer could not work with the person's inconsistency anymore. The person stopped eating regularly and stopped caring for his personal

appearance. As these changes were noticed by team members, each one of them reached out to the team as a whole and included the Clinical Manager. The Clinical Manager immediately relayed the information to the person's psychiatrist and counselor. Within a few days, the psychiatrist coordinated with the person's medical doctor to look over and change medication dosages and the counselor started daily visits and phone calls. The DSC team members were able to also increase supports. The person started seeing the psychiatrist every four weeks with check-ins by the Clinical Coordinator every two weeks, reporting back to the psychiatrist and counselor. The counselor would report back to the Clinical Manager with his observations and opinions of changes in mood and safety issues. DSC staff would add or decrease support based on these reports.

Within one month, the individual has started to stabilize. He has been eating regularly again, resumed his personal hygiene and self-care routines, and started back at work. He went out of his apartment to visit with family and friends on the weekend. He reports that he has more energy and although still has anxiety and several concerns he feels that he can work through them rather than avoid them by just lying on the couch in his apartment. His counselor has backed off to one face to face session and one phone call per week as they work on dealing with changes and other stressors in the person's life. The psychiatrist is still adjusting medication slowly to deal with some of the displayed depressive symptoms.

This is an example of what happens for each individual involved in the Clinical Services program. The team approach facilitated a quick response to keep this person safe and get him back on his feet. Such a rapid, collaborative response decreased the risk of further job loss, isolation, and physical and emotional harm.

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

The Clinical Manager evaluates services by reviewing quarterly summaries, speaking with individuals and their families, and communicating with the counselors/psychiatrist. As a result of the Clinical Services Evaluation assessment the Clinical Manager reached out to participants and their families to discuss concerns brought forth through the assessment. One consistent issue that was brought up was the fact that individuals wanted to see their doctor and counselor in person rather than through telehealth. As a result, and abiding by directives from CDC, DHS, and IDPH most appointments are back to face-to-face or a hybrid model with some team members joining through telehealth, but with the individual meeting face to face with the practitioner. Telehealth is still an option if needed for both the individual and team members.

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 with an Individual Service Plans (ISP) funded by CCDDB. Target was 61 and 59 received services.

Non-treatment Plan Clients (NTPC):

Individuals with service and support records but no formal Individual Service Plans who are funded by CCDDB. Target was four and four received services.

Community Service Events (CSE):

Contacts/meetings to promote the program, including public presentations, consultations with community groups, or caregiver. Also includes representation at community outreach events. Target of two was not met with one completed in third quarter.

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 of 10 was exceeded as 11 were completed.

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).

DSC Community Employment
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 22**

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)

Champaign County residents 18 years of age and older who have a documented intellectual/developmental disability and want help finding or maintaining a job; people who are in open plan through the Department of Rehabilitation Services are not eligible.

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

Eligibility is determined by psychological assessments that include a full-scale IQ score of 70 or below or a documented developmental disability with deficits in three life skill areas. The person must be eligible and enrolled through PUNS.

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

People learn about this program through a variety of resources such as, the Illinois Department of Rehabilitation Services, school programs, Champaign County Transition Planning Committee, Champaign County Transition Services Directory, community events such as the Disability Resource Expo, current employers, other individuals/families, and social media.

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): **75%**

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

In FY 22, 15 people requested services and 13 received those services for 87%. Of the two that did not receive services, one no longer wanted services and DSC was not able to meet the needs of the other individual.

5. **a)** *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application): **30 days**
b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application): **90%**
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): **45 days**
b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application): **75%**
c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame: **Of the 13 people opened for services during the fiscal year, 11 were opened within 45 days for 85%.**
7. **a)** *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application): **Job coaching support is provided as long as needed for the person to maintain employment.**
b) *Actual* average length of participant engagement in services: **Average length of participation is five and a half years.**
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) **Disability, referral source and guardianship status are also collected.**
2. Please report here on all of the extra demographic information your program collected. **Referrals for those new to the program this fiscal year came from individuals, families, and their support teams. The primary disability of those in the program is an intellectual**

disability. Nineteen percent have a diagnosis of autism and 20% have a documented mental illness. Forty-five percent have guardians.

Consumer Outcomes – *complete at end of year only*

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

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

Outcome 1: People will actively participate in job development activities including job club and employment discovery.
Outcome 2: People will participate in supported employment.
Outcome 3: People will maintain employment over the fiscal year.
Outcome 4: People will be satisfied with their Community Employment services.

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

Outcome 1: A referral is completed for each person referred for job development. When the person is opened in the program, a movement form is completed and kept in the main clinical file. An Employment Specialist is assigned to start job development. Monthly progress is documented by the Employment Specialist. Direct service hours are documented in the CCDDB direct service hour data base.
Outcome 2: Names of people engaged in supported employment are maintained in a database.
Outcome 3: Database is maintained.
Outcome 4: Satisfaction Surveys will be distributed to participants annually.

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

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

1-People will actively participate in job development activities including job club and employment discovery.	**Referral is made and Employment Specialist is assigned to start services.**	**Monthly progress is documented in Therap system by program staff. Direct service hours documented in DDB database.**
2- People will participate in supported employment.	**Names of people engage in supported employment are maintained in a database.**	**Program staff**
3- People will maintain employment over the fiscal year.	**Database is maintained.**	**Program staff**
4- People will be satisfied with their Community Employment Services.	**Surveys are distributed in May.**	**Surveys reviewed by Quality Assurance Committee.**

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

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

5. How many total participants did your program have?

Sixty-nine people funded with DDB monies were provided services in Community Employment in FY 22.

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

For outcomes 1-3 all were included. For outcome 4, satisfaction surveys were offered to 36 people.

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

The sixty-nine people supported with DDB funding. For outcome four, 12 of the 36 surveys were returned.

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

Results

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

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

Outcome 1: Twenty-four people participated in job development activities.
Outcome 2: Twenty-five people participated in supported employment.
Outcome 3: 93% maintained employment.
Outcome 4: 100% satisfied with services.

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

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

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

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

Outcome 1: Target of 20 was exceeded with 24 people participating in job development activities.
Outcome 2: Target of 26 was not met but 25 people participated in supported employment.
Outcome 3: Target of 80% was met with 93% maintaining employment.
Outcome 4: Target of 90% was exceeded with 100% reported being satisfied with services.

(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)

DJ is a hard worker who wants to work 40 hours per week but not at one job. He has stated he doesn't like working in the same place that many hours and his work history confirms this preference. DJ enjoyed his current two jobs but wanted to pick up a few extra hours somewhere else. DJ was quickly hired at a local fast food establishment. The Employment Specialist working with DJ worked with all three employers to coordinate schedules so they didn't conflict with each other. Initially his duties were limited to keeping the dining room clean and running carry out orders to customers' cars. DJ became interested in learning how to make desserts, something this restaurant is famous for. With support of the Employment Specialist, DJ quickly learned how to use the ice cream machines. He was really blossoming in this new position when he shared that he wanted to add learning to

take orders which includes using the cash register. Due to his limited reading skills, the Employment Specialist made flash cards that mimic the keys on the cash register in order to ease the memorization process. His bosses provided opportunities during slow times to practice using the cash register. He now is versatile in three different jobs within the restaurant which decreases his boredom and likelihood of leaving the job.

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)

Each person's ideal job conditions are unique to that person. Through the discovery process, whether the person is looking for their first job or their tenth job, job developers identify the best job fit for each person. We continue to use this tried and true method to support people in finding fulfillment in their work life.

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):

Champaign County residents with a documented diagnosis of ID/DD formally opened in this program who do not receive state funding for these services. Target of 70 was not met this year with 69 receiving services.

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

Community Service Events (CSE):

Community service events include formal presentations or tours to organizations, civic groups, school personnel, or other community entities. Target of two was exceeded with participation in four community events.

Service Contacts (SC): **Service contacts includes contacts with people or anyone in their support network seeking information about the Community Employment Program. Target of fifteen was not met with 11 service contacts being completed.**
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).

DSC Community First
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 22**

Consumer Access – *complete at end of year only*

Eligibility for service/program

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

People must have a documented diagnosis of a developmental disability and an interest in participating in their community with staff support. Enrollment in the PUNS database is required.

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

Eligibility is determined 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 deficits in three life areas as being considered eligible. The person must also be eligible for the PUNS list.

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

Ongoing outreach efforts occur via the Champaign County Transition Planning Committee, Disability Expo/Third Thursday Resource Round-ups and information included on our website, and circulation of our brochures at community events. People learn about services through tours for families that include discussion of possible services and their availability. Referrals are received from individuals and their families; the Champaign County Regional Planning Commission; the local DRS office when individuals with I/DD are in search of day program support; and employed people who are seeking additional connections. We are responsive to requests and are enhancing outreach efforts in rural Champaign County.

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): **90%**

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

Eight people requested services in FY 22. Of those, six were opened for 75%. Of the two not opened, one is targeted to be opened in FY 23 but are still deciding if the program meets their needs and the other one changed their mind about services voicing concerns about being in the community preferring a more site-based program.

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

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): **180 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): **75%**

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

Of the six people opened in the program in FY 22, five were opened within the target of 180 days. One person delayed the start of services due to their fear of Covid.

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

People participate until they are no longer interested in services.

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

Average length of participation is seven and a half years.

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)

Disability, referral source and guardianship status are also collected.

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

The majority of individuals receiving services in this program have a primary diagnosis of an intellectual disability. Eighteen percent have a diagnosis of autism and 18% have a mental health diagnosis. Referrals from the fiscal year came from families, individuals, and schools. Thirty-one percent of those served during the fiscal year have a guardian.

Consumer Outcomes – *complete at end of year only*

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

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

Outcome 1: People will try new things.
Outcome 2: People assume a leadership role in what they do.
Outcome 3: People explore employment as they make community connections.

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

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

Outcome:	Assessment Tool Used:	Information Source:
E.g. 1. Increased empowerment in advocacy clients	Measure of Victim Empowerment Related to Safety (MOVERS) survey	Client
1. People will participate in at least one new group.	**1. Group rosters are established at the beginning of each trimester noting the group,**	**1. Direct Support Professionals**

	the leader, and the group participants.	
2. People will become a co-leader.	**2. Documentation noted in group rosters.**	**2. Direct Support Professionals**
3. People will explore employment as they make community connections.	**3. Entry of opening in Community Employment Program.**	**3. Assigned DSC Case Coordinator**

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

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?
Services were provided to 45 individuals during the fiscal year.

6. How many people did you *attempt* to collect outcome information from? **45**

7. How many people did you *actually* collect outcome information from? **45**

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

Results

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

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

Outcome 1: All 45 individuals participated in at least one new group or activity over the fiscal year.
Outcome 2: Four people became co-leaders of a group.
Outcome 3: Six people were formally opened in the Community Employment program over the fiscal year to actively participate in job exploration or employment in the community.

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

11. If yes, what is that benchmark/target and where does it come from?
Based on prior program evaluation process and estimate of targets.

12. If yes, how did your outcome data compare to the comparative target or benchmark?
Outcome 1: Target of 35 was exceeded with 45 people participating in at least one new group.
Outcome 2: Target of five was not met with four people acting as co-leaders.
Outcome 3: Target of five was exceeded with six people exploring employment.

(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)

Austin is 25 years old and lives with his mother. His mother reached out to DSC in an effort to get him out of the house and connected with other people his age, especially while she was at work. Austin was reluctant at first but one of the groups offered was on paranormal activity, one of his self-professed favorite topics. He is an engaging and energetic person and quickly developed friendships with others in the group, especially given his wealth of knowledge on the subject. When the next three-month session of groups was offered, he was interested in participating four days a week. His group selections included a group based on the game, Dungeons and Dragons, as well as groups that focused on exercise and physical activity including Leonard Center to work out/Health Matters, a curriculum that encompasses healthy living and the YMCA swim group. Through his connections with others in the groups, he has expanded his interest to include the possibility of employment. When new groups start in July, Austin will continue to participate in groups two days of the

week but will now be participating in supported employment opportunities through the Community Employment program on three days of the week.

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

Initial interest in community engagement through Community First often begins with participation in a group in an area of interest a person feels knowledgeable about or having a connection with group members prior to engagement. Over time, many participants become more engaged in the decision-making process regarding groups in general. Group sessions were reduced from four months to three months at the request of group participants.

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):

Champaign County residents with I/DD participating in the program who do not receive state funding for these services. Target of 55 was not met with 45 people receiving services over the fiscal year. Covid, staff shortage, and lack of interest affected the ability to meet the target.

Non-treatment Plan Clients (NTPC):

Peers who accompany the TPCs for activities and events. Target of 50 was exceeded with 63 NTPCs.

Community Service Events (CSE):

CSEs will include formal presentations to organizations, civic groups, and other community entities. This will also include representation at community outreach events such as the Disability Expo/Third Thursday Resource Round-ups and TPC. Target of three was met with attendance at four Community Service Events.
Service Contacts (SC): **Meetings with prospective participants and tours of the program by those interested in services. Target of five was exceeded with eight service contacts being completed.**
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).

DSC Community Living
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 Living**
Submission date: **FY 22**

Consumer Access – *complete at end of year only*
Eligibility for service/program
1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application) **A person must have a diagnosis of a developmental disability as defined by the State of Illinois and be on the PUNS list.**
2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)? **Eligibility is determined 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 deficits in three life areas as being considered eligible. The person must be eligible and enrolled through PUNS.**
3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.) **Some of the ongoing outreach efforts occur via the Champaign County Transition Planning Committee Roundtable, Disability Expo/Third Thursday Resource Round-ups, information included on our website, and circulation of our brochures at community events. We are responsive to requests and are enhancing outreach efforts in rural Champaign County.**
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): **75%**
b) *Actual* percentage of individuals who sought assistance or were referred who received services:

66.7% Six people requested services with four individuals with DDB funding receiving services in FY 22. More information is needed before opening the other two for services but plans to do so in early FY 23.

5. **a)** *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application): **30 days**

b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application): **90%**

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): **45 days**

b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application): **90%**

c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame:
Of the four people opened for services during the fiscal year, three were engaged in services within 45 days for 75%.

7. **a)** *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application):
Services are provided as long as a person has a need and chooses to actively participate.

b) *Actual* average length of participant engagement in services:
Average length of program participation for FY 22 was ten years.

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)

Disability, referral source and guardianship status are also collected.

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

85% of those receiving services have an intellectual disability and over 16% have a diagnosed mental illness. Referrals came from other community providers as well as families and individuals themselves. Six of the people have a legal guardian.

Consumer Outcomes – *complete at end of year only*

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

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

Outcome 1: Community Living Program participants will pass monthly housekeeping and safety reviews using the recently developed electronic form in collaboration with the Building Evaluation Capacity Team.

Outcome 2: Community Living Program participants will have an opportunity each month to connect to the community they reside. Opportunities may include: attending local events, making a new friendship, identifying values and interests, and researching prospects within their community.

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

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

Outcome:	Assessment Tool Used:	Information Source:
E.g. 1. Increased empowerment in advocacy clients	Measure of Victim Empowerment Related to Safety (MOVERS) survey	Client
1. Community Living Program participants will pass monthly	**1. Electronic form developed with the Building Evaluation**	**1. Participants and staff**

housekeeping and safety reviews.	**Capacity Team and maintained spreadsheet.**	
2. Community Living Program participants will have an opportunity each month to connect to the community they reside.	**2. A list of new community participation opportunities.**	**2. Participants and staff**

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

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?
49 people with DDB funding received services this fiscal year.

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

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

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

Results

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

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

Outcome 1: 68% passed at 80% or greater
Outcome 2: 62% of participants were reported to have made connections to the community. Concern that not all community opportunities were reported during the fiscal year. Discussions on how to more accurately report outcomes will occur.

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

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

Outcome 1 Target: 75% will pass reviews at 80% or greater

Outcome 2 Target: 75% will have opportunity to connect with their community

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

Outcome 1: Target of 75% not met with 68% passing safety reviews at 80% or greater.

Outcome 2: Target of 75% was not met with 62% of the participants reporting community connections. Concerns of data collections will be discussed and addressed.

(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)

CLP services vary depending on the needs of the individuals. There were several challenging situations this year. One challenge required support from program staff to rectify a lease termination initiated by the individual prior to securing another place to live. With many hours spent on the telephone and in-person visits with Champaign Housing Authority, the individual was able to extend their lease agreement, along with treating their residence for bed bugs, while searching for a new place to live. At this time, there are two potential residences available to the individual.

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

In reviewing the evaluation tool created in collaboration with U of I Evaluation Capacity Building Team, it was recognized that the tool was not allocating success for satisfactory performance. Scoring mechanisms were revised and fourth quarter numbers reflect this.

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 receiving support through the Community Living Program funded by the Champaign County Developmental Disabilities Board. Target is 56 people.

Target was not met with 49 people receiving services in the fiscal year. The lack of staff as well as the increased needs of certain people already receiving services affected the ability to meet this target.

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

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

Service Contacts (SC):
Individuals screened for Community Living Program Services support. Target is eight. Seven individuals were screened during the fiscal year.

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).

DSC Connections
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 22**

Consumer Access – *complete at end of year only*

Eligibility for service/program

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

People with ID/DD who are interested in pursuing their creative talents are eligible for services. A documented diagnosis of a developmental disability and enrollment in the PUNS database is required.

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

Eligibility is determined 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 be eligible and enrolled through PUNS.

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

People learn about services through tours that include discussion of possible services/availability, circulation of brochures at community service events like the Disability Resource Expo/Third Thursday Resource Round-ups and the Champaign County Transition Planning Committee's presentation. Referrals are received from individuals/families, Regional Planning Commission's ISC, the local DRS office when individuals with ID/DD are in search of day program support, and employed people who are seeking additional connections to the art community. DSC is responsive to requests and enhancing outreach efforts in rural Champaign County.

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): **90%**

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): **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%**
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): **120 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): **75%**
c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame: **100%**
7. **a)** *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application): **120 days – dependent on time of referral and the four-month rotation of community groups.**
b) *Actual* average length of participant engagement in services: **It is rare for participants to disengage group participation prior to the end of the four-month group length. Participants choose new groups approximately every 16 weeks.**
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) **Disability, referral source and guardianship status are also collected.**
2. Please report here on all of the extra demographic information your program collected. **Nineteen people or 73% have a diagnosis of an intellectual disability and 19% have an autism diagnosis. Twenty-seven percent have a legal guardian. All referrals were made by the participants.**

Consumer Outcomes – *complete at end of year only*

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

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

Outcome 1: People will participate in artistic activities and classes at The Crow at 110.
Outcome 2: Special events will be hosted to connect people with developmental disabilities to the greater community.
Outcome 3: New classes will be developed as people continue to define areas of interest. Record of classes and who attends will be documented.

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

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

Outcome:	Assessment Tool Used:	Information Source:
E.g. 1. Increased empowerment in advocacy clients	Measure of Victim Empowerment Related to Safety (MOVERS) survey	Client
1. At least 25 people will participate in artistic activities, classes, or events at The Crow at 110.	**1. List of those participating every quarter.**	**1. Program staff**
2. Three special events will be hosted at The Crow at 110.	**2. List of events hosted.**	**2. Program staff**
3. Four new classes/groups will be developed.	**3. List of new classes/groups.**	**3. Program staff**

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

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

5. How many total participants did your program have?

A total of 26 people participated in activities at the Crow as TPCs and 16 people as NTPCs.

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

All participants

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

All participants

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

Results

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

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

Outcome 1 results: Target exceeded with 26 people participating in activities at the Crow.
Outcome 2 results: Target exceeded with five events including several open houses at the Crow.
Outcome 3 results: Target not met with three new classes being developed based on interest of the participants.

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

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

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

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

Outcome 1: Target of 25 exceeded with 26 people participating in activities at the Crow.
Outcome 2: Target of three exceeded with five events occurring.

Outcome 3: Target of four new classes was not met with three new classes being developed. Classes are developed based on interest of participants and they chose to continue with the Music Expression group.

(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)

Kalib has worked at Clark Road for several years. He has had multiple jobs that last for a few months, but are then lost due to his cyclical mental health issues. He initially signed up for one art class which meant he worked at Clark Road four days per week and participated in an art group one day per week. He stuck with it for the entire four-month cycle and enjoyed the validation he got from other group members. He struggles with relationships with people but his relationships with other group members have grown over time. He wanted to try other groups but he lives in his own home so making money is important to him. Last quarter he signed up for the soap making group. This provides him with the opportunity to make money when he is able to engage meaningfully. He was enthusiastic about being involved in selecting new scents and has become a strong team member in the group. Recently he helped "man the table" at an open house and engaged easily with customers who were interested in purchasing soap, candles, and wax melts. He is now participating in groups including soap making three days per week and enjoying his newly discovered interest in self-expression through art and his ability to make money through a non-traditional job.

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)

Group content continues to change based on the direction of the participants. Initially Connections participants were interested almost exclusively in painting and drawing but over time have expanded their interests to include other mediums including clay, etc. Expansion of products to sell at open houses is based on the aspirations of the participants and has grown to include wax melts, candles, t-shirts, coffee mugs, and other items. Other artistic expression outlets include making music, poetry, and creative writing. Two people in particular expressed interest in the written word – one through his music and the other is writing several books.

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): **People participating in DSC's Community First Program interested in pursuing their creative interests and talents at The Crow at 110. Target of 25 people was exceeded with 26 people participating in activities at The Crow.**
Non-treatment Plan Clients (NTPC): **People participating in activities who are not receiving county funding. Target of 12 people was exceeded with 16 people participating.**
Community Service Events (CSE): **The number of events hosted at The Crow at 110. Target of three was exceeded with five events hosted.**
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).

DSC Employment First
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 22**

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) **Employers in Champaign County who want to ~~receive disability awareness certification~~learn about available employment services and the benefits of hiring people with disabilities ~~-~~through the LEAP training are eligible for the training at no charge. Additional complimentary disability awareness staff training is available for interested businesses within Champaign County.**
2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)? **Businesses must be located in Champaign County as evidenced by their zip code.**
3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.) **Businesses learn about LEAP through networking at Chamber of Commerce and Champaign Center Partnership events, presentations to Rotary clubs, presentations to area Exchange Clubs, Master Networks, local job fairs, referrals from other employers, social media, Champaign County of Disability-Inclusive Employers, cold calls from staff, and the "Take the LEAP Podcast."**
4. **a)** *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application): **100%**
b) *Actual* percentage of individuals who sought assistance or were referred who received services:

100% of businesses who requested LEAP or Frontline Staff training were able to participate.

5. **a)** *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application): **30 days**

b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application): **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): **30 days**

b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application): **100%**

c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame: **100%**

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

The training is generally one hour ~~one hour~~. Follow-up will occur within four months unless there is contact ~~company reaches out~~ prior to that milestone.

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

The average length of LEAP training is one hour including time for questions or comments. The average length of Frontline Staff Training is 45 minutes including time for questions or comments.

Demographic Information

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

In addition to the number of businesses that participate in the certification process, LEAP staff track business zip code, the number of employees who attend the sessions, the job titles of attendees, and the business sector for each company.

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

Farm & Garden:

- **Curtis Orchard** – 61822; The general manager attended a 4th Thursday virtual LEAP session.

Public:

- **Champaign County Recorder** – 61801; 4th Thursday virtual LEAP session; although this office has gone through LEAP training previously, the elected official in the position has changed.

Bookstore & Bakery:

- **The Literary** – 61820; 4th Thursday virtual LEAP session with the owner and one employee. This was done before the bookstore opened to the public.
- **G-Mart Champaign –** 61820; The staff attended the Frontline Staff Training on 06/07/22. The Manager was in attendance along with two Associates. The training took place in-person.

Parks & Recreation:

- **Urbana Park District** – 61801; This employer has already attended training and thus is not counted in this fiscal year's numbers. A manager who had not been through LEAP training attended a 4th Thursday virtual session.
- **Champaign Park District** - 61821 – Champaign-Urbana Special Recreation was LEAP re-trained on 04/12/22. Seven supervisors were in attendance for the in-person training. Those in attendance included employees from the following departments: HR, Horticulture Supervisor, Adult Program Coordinator, Receptionist, and Youth & Teen Coordinator.
- **Champaign Park District –** 61821; Frontline Staff Training on 05/23/22. The Champaign-Urbana Special Recreation "Summer Program Staff" and "Summer Camp Program Directors" were in attendance for the training. A total of nine staff members were present during the training.

Community Service & Non-Profit:

- **Salt & Light (Champaign store)** – 61821; In-person LEAP trainings were held over multiple days to ensure all staff could attend. Total staff trained between the two stores was roughly 15.
- **Salt & Light (Champaign store)** – 61821; In-person Frontline Staff trainings were held over multiple days to ensure all staff could attend. Total staff trained between the two stores was roughly 15.
- **Salt & Light (Urbana store)** – 61802; In-person LEAP trainings were held over multiple days to ensure all staff could attend. Total staff trained between the two stores was roughly 15.
- **Salt & Light (Urbana store)** – 61802; In-person Frontline Staff trainings were held over multiple days to ensure all staff could attend. Total staff trained between the two stores was roughly 15.
- **Habitat for Humanity of Champaign County** – 61820; In-person Frontline Staff training included eight staff (director and employees).

Massage Therapy:

- **BodyWork Associates** – 61820; Virtual Frontline Staff training for the owner and a front desk employee.
- **BodyWork Associates** – 61820; In-person training for the owner (LEAP training)

Technology:

- **Wolfram** – 61820; Virtual training for the HR Supervisor

Accounting:

- **CliftonLarsonAllen** – 61820; Hybrid in-person and virtual training of Champaign (16) and Danville (five) staff (LEAP training)
- **CliftonLarsonAllen** – 61820; Hybrid in-person and virtual training of Champaign (16) and Danville (five) staff (frontline staff training)

Church:

- **Anchor Church** - 61822; Lead Pastor attended a virtual 4th Thursday session

Real Estate:

- **The Mark Waldhoff Team at Keller-Williams Realty** - 61822; Four people attended a virtual session (LEAP training)
- **The Mark Waldhoff Team at Keller-Williams Realty** - 61822; Four people attended a virtual session (frontline staff training)

Art Supplies:

- **Art Coop –** 61801; Attended a virtual LEAP training on 04/21/22. The owner and co-owner were in attendance for the LEAP training session.

Recruitment:

- **Premier Employee Solutions-** 61821; LEAP trained on 04/13/22. The Brand Manager of Premier Employee Solutions was in attendance for the in-person training.

Hospital:

- **OSF Heart of Mary Medical Center-** 61801; LEAP trained on 04/19/22. Seven employees were in attendance for the hybrid training. Most employees were present for the in-person training, but two individuals watched the presentation via Zoom. Those in attendance included employees from the following departments: Hospital President, Director of Physician Services, Chief Nursing Officer, Director of Employee Relations, and VP Ancillary & Support Services

Pharmacy Store Chain:

- **Walgreens (Village at the Crossing) –** 61822; LEAP trained on 04/19/22. The Store Manager was in attendance for the in-person training.
- **CVS (Philo Rd**.) -61802; LEAP trained on 05/06/22. The Store Manager was in attendance for the in-person training.

Engineering:

- **Applied Pavement Technology Inc.-** 61801; LEAP Trained on 05/26/22. The Human Resources Manager was in attendance. The training took place virtually.

Marketing:

- **Roaming Fox Media-** 61801; LEAP trained on 05/26/22. The Director of Operations was in attendance for the training. The training took place virtually.

Media & Advertising:

- **The Illini Radio Group-**61821; was LEAP trained on 05/26/22. The General Manager attended the training. The training took place virtually.
- **Adams Outdoor Advertising –** 61821; FLS training on 06/23/22. The training was attended by one Account Executive with the company.

Cleaning Service:

- **Aligned Serenity –** 61801; LEAP Trained on 06/20/22. The training was attended in person by the Owner of the company.

Consumer Outcomes – *complete at end of year only*

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

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

Outcome 1: LEAP and front-line trainings will be scheduled with interested employers and offered at regular intervals for any interested parties to attend open sessions.

Outcome 2:
A quarterly newsletter including information about the disability community and employment of people with ID/DD will be provided for employers.

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

Outcome:	Assessment Tool Used:	Information Source:
E.g. 1. Increased empowerment in advocacy clients	Measure of Victim Empowerment Related to Safety (MOVERS) survey	Client
1. LEAP and front-line trainings will be scheduled with interested employers and offered at regular intervals for any interested parties to attend open sessions.	**1. List and dates of trainings maintained. Employer information including attendance, zip code, and business sector is maintained.**	**1. LEAP Coordinator**
2. A quarterly newsletter including information about the disability community and employment of people with ID/DD will be provided for employers.	**2. Information shared**	**2. LEAP Coordinator**

3. Was outcome information gathered from every participant who received service, or only some? **Information was gathered from every participating business.**

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?
Twenty-nine trainings occurred with Champaign County businesses.

6. How many people did you *attempt* to collect outcome information from?
Information was collected from all 29 businesses.

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

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

Results

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

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

Outcome 1: Twenty-nine trainings occurred with Champaign County businesses. (20 LEAP and nine Frontline)
Impact of the grant over FY 22 that DSC and Community Choices are aware of: At least 23 jobs were acquired from businesses who went through the trainings.

Outcome 2: Newsletters were distributed for each of the first two quarters. Following the second issue, readership statistics for the previous year were reviewed and found that there had been very little interaction with the content we had created. The decision was made to pause the newsletter for the remainder of the year. A feedback survey was sent to all newsletter subscribers asking for input regarding newsletter frequency, format, and content. Unfortunately, only one response was received. Twitter shares were started along with outreach through other information-sharing platforms. A podcast was created, so Champaign County can receive disability education through the "Take the LEAP Podcast."

The podcast will offer listeners information on the following subjects: job carving, benefits of hiring jobseekers with disabilities, and accommodations.

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

11. If yes, what is that benchmark/target and where does it come from?
Targets were derived from what was thought could be achieved over the fiscal year based on results of last year's when applicable.

12. If yes, how did your outcome data compare to the comparative target or benchmark?
Outcome 1: Target of 25 trainings was exceeded with 29 trainings being completed.

Outcome 2: Quarterly newsletters were not distributed but information to local businesses was shared every quarter through various platforms.

(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 LEAP Coordinator conducts outreach to the local business community to raise awareness of the LEAP program and to offer LEAP and Frontline Staff training to any Champaign County employer interested. Outreach primarily occurred at networking events through the Chamber of Commerce, Champaign County Partnership events, local Exchange Clubs, local Rotary Clubs, and through networking/job fairs in Champaign County. These events are often for establishing relationships rather than soliciting participation, and additional one-to-one interactions are usually necessary so that potential participants can learn more about the LEAP program before requesting a training for their businesses.

LEAP training sessions are held online every 4th Thursday and are open to anyone interested. Sometimes, an employer opts to attend one of these sessions instead of scheduling a private training at another time.
After the LEAP or Frontline Staff trainings occur, the slides and handouts are emailed to the business no more than 24 hours after the training as part of a thank you message. In addition, a thank you card is mailed to the business within a week of the event. Also, the LEAP Coordinator visits the business to deliver a framed certificate, asks if the employer has had any questions arise regarding the training, and a photo is taken of the recipient to share in a thank you post on DSC and Community Choices social media channels. Three to four months after the training, an additional follow-up is done with the business to see if they have made any changes to their practices or have any further questions. Intermittent contact is kept with the employer on an ongoing basis to maintain the relationship and to identify any additional requests for education.
If, at any time in the process, the employer expresses interest in hiring a jobseeker through our organizations, relevant contact and position information is gathered and passed along to the employment services team. However, it is made clear from the start that there is no obligation to have current vacancies or hire through our organizations in order to be eligible for the training.

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)

Due to the COVID-19 pandemic, the LEAP training was converted to a virtual offering. We found this increased efficiency by not having to drive to a business location, set up equipment, and drive back to the office. For many in-person trainings, these extra steps accounted for more time than the duration of the training did. However, audience participation tends to be greater with in-person trainings. In addition, offering a standing appointment in the form of a 4th Thursday LEAP session online expanded our reach by being able to advertise an open LEAP event on Chamber of Commerce and Champaign Center Partnership calendars. These sessions also allowed us to train multiple employers at the same time. For these reasons, we offered both virtual and in-person options for Champaign County businesses this fiscal year.

Due to lack of readership, the decision was made to discontinue the newsletter. The decision was made to move forward using a more modern media approach. Instead, a podcast was created, so Champaign County can receive disability education through the "Take the LEAP Podcast." The podcast will offer listeners information on the following subjects: job carving, benefits of hiring jobseekers with disabilities, and accommodations. The podcast can be accessed free of charge at dsc-illinois.org. A new episode of the podcast is released once per quarter.

In the fourth quarter, the Champaign County Directory of Disability-Inclusive Employers was launched online at dsc-illinios.org and communitychoices.inc. All employers in the county are eligible to register for the directory. By signing up, the employer expresses a

long-term desire to hire qualified people with disabilities. The directory offers guidance to employers on hiring practices from an accessibility perspective. Topics discussed could include recruitment approaches, applications, interview processes, and website accessibility. The directory is a public means of identifying inclusive employers. This will benefit those working with DSC and Community Choices as well as independent jobseekers. Also, members of the public who want to support those businesses will be able to view the list.

Utilization Data Narrative –

The utilization data chart is to be completed at the end of each quarter (including quarter 4) using the online reporting system.
Comparative yearly totals (i.e. reporting estimates and actual numbers) and the narrative section described below are to be completed at end of year only.

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

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

Treatment Plan Clients (TPC): **n/a**

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

Community Service Events (CSE):
Community Service Events are the number of LEAP and front-line staff trainings conducted. Target of 25 was exceeded with 29 being completed during the fiscal year.

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).

DSC Family Development
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 22**

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 individuals/families who meet the following criteria are eligible for this program:

- **are residents of Champaign County as shown by address**
- **have evidence of a need for service based on an assessment**
- **children, birth through age five, with or at-risk for developmental disabilities or developmental delay**

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.)?

To be eligible for state-funded services, children must be: 1) under three years of age; 2) have a 30% delay in one or more of the developmental areas; 3) and/or an identified qualifying disability. These same services and enhanced services for children up to age five are provided with CCMHB funds for children deemed "at-risk" but ineligible for state-funded services through the early intervention system.

Any child aged birth-5 years who resides in Champaign County is eligible for a developmental screening. Children identified as "of concern" based on screening results are assisted with connecting to state-funded services (either Early Intervention services if the child is under age three or services through the public school district if the child is over age three).

Children and families are determined eligible for PLAY Project services based on clinical judgement. PLAY Project curriculum is traditionally used for children with a diagnosis of autism, but can be used with any child who is an early communicator to help strengthen communicative bonds and support between the child and his/her caregiver.

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

Families learn about FD program services through collaborations with local hospitals and health clinics, child care centers, Crisis Nursery, local prevention initiative programs, and other agencies, as well as annual outreach events, such as, Read Across America, Disability Expo/Third Thursday Resource Round-ups, the Mommy Baby Expo, and the Homeschool Fair. Our developmental screener participates in quarterly screening events offered at Urbana Early Childhood in conjunction with the Champaign-Urbana Home-Visiting Consortium. Additionally, Child and Family Connections makes referrals to the FD therapists.
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): **Seven days**
b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application): **100%**
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): **Seven 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: **90%**

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

Participation may be for a one-time screening or until age five within the therapy program.

b) *Actual* average length of participant engagement in services: **18-24 months**

Demographic Information

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

Other demographic data collected includes primary disability and referral source.

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

Ninety percent of children served have developmental delay as primary disability. The remaining 10% of children have other health impairments.

Seventy percent of the children are referred from Child and Family Connections and 25% from daycare centers requesting developmental screenings for children. The remaining referrals are from families.

Consumer Outcomes – *complete at end of year only*

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

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

Outcome 1: Families will identify progress in child functioning in everyday life routines, play and interactions with others.

Outcome 2: Children will progress in goals identified on their Individualized Family Service Plan (IFSP).

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

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

Outcome:	Assessment Tool Used:	Information Source:
E.g. 1. Increased empowerment in advocacy clients	Measure of Victim Empowerment Related to Safety (MOVERS) survey	Client
1. Families will identify progress in child functioning in everyday life routines, play and interactions with others.	**1. Quarterly file review of parent report regarding child's functional skills, play skills, and interactions as recorded on the home visit contact note.** **Family surveys**	**1. Sources include: Families, quarterly file reviews, service notes, family surveys, and parent input and feedback.**
2. Children will progress in goals identified on their Individualized Family Service Plan. (IFSP)	**2. Review of assessments quarterly.**	**2. Sources include: program staff reviews of developmental assessments, IFSP notes, quarterly file reviews.**

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

4. If only some participants, how did you choose who to collect outcome information from? **A random sample of files were chosen for review.**

5. How many total participants did your program have? **815**

6. How many people did you *attempt* to collect outcome information from?
Sixty files were reviewed for each outcome.

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

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

Results

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

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

Parents reported progress in child functioning in everyday life routines, play, and interactions with others in 60/60 files reviewed for 100%. Children made progress in identified goals in 60/60 files reviewed.

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

11. If yes, what is that benchmark/target and where does it come from?
Comparative targets were established from averaging past results.

12. If yes, how did your outcome data compare to the comparative target or benchmark?
Outcome 1: Target of 90% was exceeded with result of 100%.

Outcome 2: Target of 90% was exceeded with result of 100%.

(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)

Family Development (FD) has been able to wrap around and support Jane and her two children, John (age 3) and Mary (age 2). In July 2020, FD's developmental screening specialist administered a screening assessment to John and referred him to Early Intervention (EI) for follow up evaluation. FD SLP evaluated John and recommended that he begin therapy services. When John turned 3 and aged out of EI, FD was able to continue to provide ongoing therapeutic supports. A developmental therapist with FD met with the family weekly to continue to support John and bridge the transition between home and preschool. Through working with John and his family, the developmental therapist was also able to administer a developmental screening to his younger sister, Mary. When concerns were noted on the screening, the developmental therapist assisted the family in a formal referral to EI. Mary

was evaluated by EI and qualified for therapy supports. Mary and John currently participate in FD's developmental play group, and since Mary is under age 3, the family is also able to be supported by FD's Parent Wonders ISBE-funded Prevention Initiative home visiting program.

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)

Given our multidisciplinary team approach, FD providers are able to consult and collaborate across disciplines (OT, PT, speech, social work). This aids in identification, screening, and evaluation process for children and families we serve as we are better able to meet global needs. Change in practice that continues to evolve includes teaming and co-evaluating to ensure that all of the child and family's needs are being identified and met through subsequent services and referrals.

Utilization Data Narrative –

The utilization data chart is to be completed at the end of each quarter (including quarter 4) using the online reporting system.
Comparative yearly totals (i.e. reporting estimates and actual numbers) and the narrative section described below are to be completed at end of year only.

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

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

Treatment Plan Clients (TPC):

All children receiving FD program services, living in Champaign County. Target of 655 was exceeded with 815 receiving services.

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 FD program regularly participates in the Mommy Baby Expo, the

Disability Expo/Third Thursday Resource Round-ups, Read Across America, Ready Set Grow, and the CUPHD fair. Target of fifteen was met.
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 of 200 was not met with 173 being completed. Some children are not being offered screenings if risk factors are identified by skilled providers with referrals for recommended services occurring quicker.**
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).

DSC Individual and Family Support
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 22**

Consumer Access – *complete at end of year only*

Eligibility for service/program

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

Eligibility is determined by psychological assessments that include IQ test scores, resulting in a full-scale IQ score below 70 or a documented developmental disability with deficits in three life skill areas. The person must be eligible and enrolled on the PUNS list. Children and adults with intellectual and developmental disabilities (I/DD) residing in Champaign County are eligible.
Requests for dual enrollment for IFS services and supports and those offered through the Community First program will be approved by the CCDDB board through the IFS Concurrent Case Review form.

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.)?

Evidence of I/DD diagnosis; medical, psychological, and school documentation presented during the intake process, as well as residency documentation is obtained. PUNS enrollment is verified.

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

The families of program participants inform the parents of individuals in the target population, the Disability Expo/Third Thursday Resource Round-ups; the Champaign County Transition Planning Committee's presentation, support group referrals, physician and interagency referrals, DSC website, Facebook, outreach events, brochures, and other informational materials.
Information is also shared via our website, and circulation of our brochures at community events. We are responsive to requests and are enhancing outreach efforts in rural Champaign County.

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): **75%**
b) *Actual* percentage of individuals who sought assistance or were referred who received services: **Four out of the six referrals received services in FY 22. The other two are scheduled to be opened for services in early FY 23. 67%**
5. **a)** *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application): **30 days**
b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application): **90%**
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): **90 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): **75%**
c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame: **Of the four opened in IFS in FY 22, 100% received services within 90 days.**
7. **a)** *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application): **Program engagement ranges from one specific event, to partial full or daily participation and can span the lifetime.**
b) *Actual* average length of participant engagement in services: **Average length of participant engagement in FY 22 is four years.**
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)

Disability, referral source, and guardianship status are collected.

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

All participants have a documented developmental disability. Referral sources for requests made in FY 22 came from families.

Consumer Outcomes – *complete at end of year only*

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

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

Outcome 1: All individuals receiving day services and requesting community activities, will participate on a weekly basis.
Outcome 2: All receiving Intermittent Direct Support will be satisfied with services.

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

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

Outcome:	Assessment Tool Used:	Information Source:
E.g. 1. Increased empowerment in advocacy clients	Measure of Victim Empowerment Related to Safety (MOVERS) survey	Client
1. Community activities	**1. Documentation of activities will be maintained.**	**1. Program Manager**

2. Satisfaction with services	**2. Satisfaction Survey**	**2. Participants and families**

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

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

Outcome 1: Community activities were monitored for those in day program or receiving day support.

Outcome 2: Surveys were sent to some of the families receiving Intermittent Direct Support.

5. How many total participants did your program have?

Forty-one people received services funded by DDB during the fiscal year.

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

Outcome 1: Those who received day program support – six people.

Outcome 2: Satisfaction surveys sent to 12 families receiving Intermittent Direct Support.

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

Outcome 1: All six receiving day program support.

Outcome 2: Only two of the 12 surveys were returned.

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

Outcome 1: Every quarter

Outcome 2: Fourth quarter

Results

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

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

Outcome 1: When requested, people attended community activities 85% of the time.

Outcome 2: Only two surveys were returned out of the 12 sent out. All were positive.

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

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

Previous program evaluation results.

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

Outcome 1: Goal met at 85%.

Outcome 2: Goal exceeded at 100%.

(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)

IFS/IDS funds were able to support a young gentleman in finding/participating in an outlet (TKD) as a therapeutic activity. He stated this opportunity has "helped him with exercise, leadership, and new skills, and makes for an ideal evening activity". His parents stated they have seen this activity be extremely beneficial for him in building his self-confidence, mental discipline, and self-control.

Services also supported someone in moving out on their own for the first time. It assisted them in gathering some items needed for his own apartment when his funds were quite limited.

Another young lady received an opportunity to participate in a camp. She had a rough year medically with three hospitalizations and a broken bone and loves to be active but her changing medical complexities were limiting. Having an opportunity to participate in a wheelchair racing camp really gave her a boost that she needed. It gave her the coaching and guidance on how to properly push a racing chair as well as interact with mentors and peers that have disabilities.

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)

Continue to evaluate community needs and how the program can support those needs.

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):

Those individuals with case records and formal Personal Plans funded by CCDDB. Target of 17 was not met with 11 people supported as a TPC. Shortage of staff affected this outcome.

Non-treatment Plan Clients (NTPC):

Those individuals with service and support records but no formal Personal Plans who are funded by CCDDB. Target of 32 was not met with 28 being supported. Inability for some to find providers as well as continued pandemic concerns affected this outcome.

Community Service Events (CSE):

Contacts/meetings to promote the program, including public presentations, consultations with community groups, or caregivers. Also includes representation at community outreach events such as Disability Expo/Third Thursday Resource Round-ups. Target of two was exceeded with attendance at four community service events.

Service Contacts (SC):

Phone and face-to-face contacts with people interested in services, including information and referral contacts, initial screenings/assessments, and crisis services. Target of eight was not met with five service contacts being completed.

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).

DSC Service Coordination
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 22**

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)

Person must have a diagnosis of a developmental disability as defined by the State of Illinois and be on the PUNS list.

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

Eligibility is determined by psychological assessments that include IQ test scores, resulting in a full-scale IQ score of 70 or below or a documented developmental disability with deficits in three life skill areas. The person must be eligible and enrolled on the PUNS list.

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

People learn of services through the Disability Expo/Third Thursday Resource Round-ups, the Champaign County Transition Planning Committee, support groups, physician and interagency referrals, DSC website, Facebook, outreach events, brochures, and other informational materials.

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): **90%**

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

Of the 20 people who sought assistance in FY 22, 15 received services for 75%. The other five will be opened in early FY 23.

5. **a)** *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application): **30 days**

b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application): **90%**
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): **30 days**
b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application): **75%**
c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame: **Five out of the 14 individuals opened in the program were engaged in services within 30 days for 36%. Five individuals were opened from the wait list. Covid and lack of staff affected opening dates for the remaining people.**
7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application): **Since the program offers support in all aspects of a person's life, in many cases, support continues for their lifetime.**
b) *Actual* average length of participant engagement in services: **Overall participant engagement averages 15 years.**
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) **Disability, referral source and guardianship status are also collected.**
2. Please report here on all of the extra demographic information your program collected. **Over 80% of those receiving services had an intellectual disability with 21% having autism. This year most of the referrals came from individuals and their families as well as schools.**

Consumer Outcomes – *complete at end of year only*

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

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

Outcome 1: People will actively participate in the development of their personal outcomes driving the content of the implementation strategies documented by assigned QIDP.
Outcome 2: People will participate in POM (personal outcome measures) interviews.
Outcome 3: People will maintain/make progress toward their chosen outcomes.

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

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

Outcome:	Assessment Tool Used:	Information Source:
E.g. 1. Increased empowerment in advocacy clients	Measure of Victim Empowerment Related to Safety (MOVERS) survey	Client
1. People will actively participate in the development of their personal outcomes driving the content of the implementation strategies documented by assigned QIDP.	**1. Personal Plan will be reviewed as well as monthly QIDP notes in each individual's record. Self-report will be documented.**	**1. Individual**
2. People will participate in POM (Personal Outcome Measure) interviews.	**2. POM interview booklets will be maintained. Participation in interview will be documented in the person's file.**	**2. Spreadsheet maintained.**
3. People will maintain/make progress	**3. Progress toward meeting personal**	**3. Documentation maintained.**

toward their chosen outcomes.	**outcomes is documented on a monthly basis and random files are reviewed each quarter to review progress.**	

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

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

5. How many total participants did your program have?
A total of 242 people received services this fiscal year.

6. How many people did you *attempt* to collect outcome information from?
60 for outcomes one and three.

7. How many people did you *actually* collect outcome information from?
60 for outcomes one and three.

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

Results

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

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

Outcome 1: 58/60 (97%) actively participated in the development of their personal outcomes.
Outcome 2: Six POM interviews were completed during the fiscal year.
Outcome 3: 48/60 (80%) of people maintained or made progress toward their chosen outcomes.

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

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

Targets were estimated based on desired level of performance for goals.

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

Outcome 1: Target of 98% was not met with 97% participating.
Outcome 2: Target of 20 was not met with six POM interviews being completed.
Outcome 3: Target of 80% was met.

(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 a couple of examples of supports provided:

- **A DSC Case Coordinator collaborated with other local providers to assist someone in a mental health crisis struggling to remain in their apartment. The outcome involved ending their lease on good terms and the individual moved to a new place keeping the resources they had.**
- **DSC Case Coordinator collaborated to assist and advocate for an individual who had a guardian to be in a relationship they desired even though their guardian disagreed. Education and support were provided for all to understand the parameters of guardianship.**

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

The ability to now have meetings in person as well as the ability to have additional people attend meetings virtually has helped to rebuild relationships and connections for many.

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 with case records and a formal Personal Plan and Implementation Strategies funded by CCDDB. Target is 280. Target not met as a total of 242 people received support during the fiscal year. Struggles with Covid and lack of staff continue.

Non-treatment Plan Clients (NTPC):

Individuals receiving services and supports without a formal Personal Plan and Implementation Strategies funded by CCDDB. Target is 36. A total of 34 NTPCs were supported. Most of the NTPCs are receiving Intermittent Direct Support through the Individual and Family Support Program and these families are having trouble finding and maintaining caregivers.

Community Service Events (CSE):

Contacts/meetings to promote the program, including public presentations, consultations with community groups, or caregivers. Also includes representation at community outreach events such as disability Expo/Third Thursday Resource Round-ups. Target is two. Target was exceeded with three Community Service Events throughout the fiscal year.

Service Contacts (SC):

Phone and face-to-face contacts with people who are interested in services – including information and referral contacts, initial screenings/assessments, and crisis services. Target is 75. Twenty service contacts were recorded. Need to examine how data is collected.

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: 8/26/2022

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)

To be part of this program, people seeking work as a PSW must; Go through an orientation to learn the role and rules of being a PSW, must pass the post-orientation quiz and must successfully pass the Illinois and National Sex Offender background check, Healthcare Registry check, and DCFS CANTS check.

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.)?

We ran each name through the health care registry, the Illinois and National Sex Offender background check and conducted DCFS CANTS checks. These checks came back clear. Each completed the orientation prior and passed the post-orientation quiz prior to being eligible to be added to the registry.

10. 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 and created a continuously running Facebook job advertisement, Ziprecruiter

advertisement as well as advertising on Indeed employment website. We created flyers that are posted at the front entrance of PACE, Inc. We continued outreach and collaboration with DSC, RPC, Illinois Respite, Community Choices, HACC and Illinois Worknet.

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):

This item does not apply. Our program works with NTPC.

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

100%- Everyone who initiated PSW services for FY22 received support and referrals through the PSW program.

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):
1-2 weeks after the orientation. Due to the pandemic, we have switched to online orientations. The materials for the orientations are available in the PACE foyer for perspective PSW's to pick up and also emailed to perspective PSWs with the zoom link. Conversations and invitations for upcoming orientations where done via email and phone calls. There were also limited in person contact for PSW drop ins who were inquiring about the orientations. Post orientation activities were also necessary such as, emails and phone calls for reminders to return completed orientation paperwork. Also, follow up calls were done to insure key topics were clearly understood by the PSW. A lot of program support was provided via Zoom, email, phone calls and limited in person appointments.

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):
Does not apply to our program.

c) *Actual* percentage of referred clients assessed for eligibility within that time frame: **100%-Anyone who reached out to initiate PSW services received PSW services.**
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): **Does not apply.**
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 does not apply. We recruit potential PSW's only.**
c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame: **This program is intended to recruit PSW's.**
14. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application): **This is a PSW registry program. PSW's may remain on the registry indefinitely. All PSW's are updated quarterly to remain active.**
b) *Actual* average length of participant engagement in services: **PSW's remain on the registry indefinitely depending on the information gather during quarterly evaluation.**
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)

PACE only collected the required demographic information from the PSWs

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

The collected demographics are used to insure potential PSW can be reached for possible matching with a TPC.

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.

1). Number of Potential/actual Personal Support Workers (PSWs) who went through orientation.
30
2). Number of PSWs hired through our referral.
7 PSW's were hired through this program in FY22.
3). Average number of hours of service per week PSWs from our list are providing services.
We do not track this data. This is based on the hours a consumer determines.
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)
In FY22 a total of 18 set of PSW referrals. Seven (7) successful matches for PSW and consumers. There were 10 PSW consumers who received referral names.

The following updated information were provided as outcome for the PSW program throughout the FY22:

During the third quarter, PACE received the following updates from consumers and their families who are seeking PSWs:
- A family found/hired a PSW for their son from the registry.
- A mother found two (2) PSW and is the hiring process.

- A consumer was able to find/hire two (2) back up PSWs.
- Collaborating with RPC, a consumer was able to find a PSW/Respite worker from the registry

Also, on the fourth quarter, an update was received that a PSW was hired by a consumer and the PSW paperwork was being processed

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 Tool Used:	Information Source:
E.g. 1. Increased empowerment in advocacy clients	Measure of Victim Empowerment Related to Safety (MOVERS) survey	Client
All consumers are NTPCs in this program, therefore no official outcomes		

17. 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 7 PSWs with individuals seeking to hire a PSW

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

All NTPCs in this program, therefore no official outcomes

19. How many total participants did your program have?

Funding for the consumer services is not provided by CCDDB and is provided by a different funding source. Unofficial outcome on the consumer side is that there were 10 PSW consumers who received PSW referral names.

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

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

22. 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

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)

This program is for recruiting and maintaining a PSW registry for potential referrals for TPC's.
This program met the following goals for FY22: We had a goal of 12 CSE's and exceeded our target goal for a total of 23. Our SC of 200 was exceeded by completing screening contacts for 359 potential PSW's. In FY22 PACE had a goal of 30 NTPC's. We met our goal with 30 NTPC's. Other was targeted as 3. We exceeded this goal with a total of 7.

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

11. If yes, what is that benchmark/target and where does it come from?
The comparative benchmark/target comparison from FY21 and FY22

Target goals for FY2021

- **Target CSE=12, actual number achieved 20**
- **Target SC=200, actual total achieved 409**
- **Target NTPC=30, actual total achieved 32**
- **Target TPC=0, actual total achieved 0**
- **Target Other=3, actual total achieved is 9**

The target goals for FY2022

- **Target CSE=12, actual number achieved 23**
- **Target SC=200, actual total achieved 359**
- **Target NTPC=30, actual total achieved 30**
- **Target TPC=0, actual total achieved 0**
- **Target Other=3, actual total achieved is 7**

NOTE: The results between FY21 and FY22 is impacted by the COVID19 pandemic in our community. Even with the pandemic the PSW program has exceeded the targeted expectations.

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

Even with the pandemic, **the PSW program met or exceeded all goals.**

(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)

PACE advertises regularly on Facebook, Ziprecruiter, and Indeed to attract people to attend the PSW orientation. PACE continues to recruit perspective PSWs so they can be added to PACE's PSW registry. After a perspective PSW comes across our posting, the PSW contacts us by phone, email or Facebook Messenger. We start a conversation about the referral program and how it works. The person is invited to the online orientation or the in person orientation. After the perspective PSW completes the orientation and paperwork, PACE, in turn, completes the necessary background checks. If the perspective PSW clears the background checks, the PSW is added to the registry and is referred to PSW consumers who are looking to hire a PSW based upon matching preferences. The PSW consumer will initiate the contact with the PSW and, hopefully, the PSW get matched with a consumer looking to hire a PSW.

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)

Each quarter, all PACE programs host a program advisory meetings to seek feedback from consumers on how our programs could provide more assistance. The quarterly advisory topics are based on consumers and PSW's stated needs and interests

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.
Treatment Plan Clients (TPC): N/A
Non-treatment Plan Clients (NTPC): **76** People completing PSW orientation
Community Service Events (CSE): **23** Events PACE provides to the community where information about the PSW program and CCDDB are shared
Service Contacts (SC): **359** The number of individual contacts we have with the NTPCs People attending CSEs or receiving information who are reasonably expected to utilize the information (potential PSWs, agencies, families involved in hiring PSWs)
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).