Compiled Annual Performance Outcome Reports of CCDDB & CCMHB I/DD Funded Programs for Contract Year 2021

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Champaign County Regional Planning Commission Community Services
Decision Support Person for CCDDB - $311,488

CU Able, NFP Inc.
CU Able Community Outreach - $17,200 **–** report missing

CU Autism Network
Community Outreach Programs - $15,000

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

Champaign County Regional Planning Commission Head Start
Social-Emotional Development Services - $21,466 (CCDDB funded)
$99,615 (CCMHB funded)

Community Choices
Community Living - $89,000
Customized Employment - $182,000
Self-Determination Support - $146,000

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 - $429,058
Service Coordination - $435,858

PACE
Consumer Control in Personal Support - $24,26

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

Champaign County Regional Planning CommissionDecision Support Person Centered Planning Performance Outcome Report – FY21

In your CCMHB program plan (application), you identified performance outcomes in three domains: consumer access, consumer outcomes, and utilization data. Now, you must report onthe 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 FY21
Submission date: 8/23/21

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 iseligible 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 an I/DD who are in the seeking services category on PUNS are eligible for conflict free person centered planning; and 3) individuals with an I/DD diagnosis who are nearing graduation from high schools 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 onan 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, Section4: PUNS for Persons with Developmental Disabilities).
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 werenot 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, Community Choices, Rosecrance, and PACE to coordinate person centered planning services for individualsreceiving services through their CCDDB funded programs.
Eligibility for transition consultant services was determined by referrals from highschool professionals, participation in special education classes, and/or IEP documentation.
In addition, all individuals served were assisted with registering on PUNS if they hadnot already done so.

3. How did your target population learn about your services? (e.g., from outreachevents, 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

4. a) *From your application,* estimated percentage of persons who sought assistance orwere 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 whoreceived services:

98% of individuals who sought assistance or were referred through the Decision Support Person Centered Planning program received services.

This was related to capacity of caseload size for the person centered planning Case Managers. Each Case Manager maintained a caseload of 45 clients. At times, new clients were referred to CCRPC for person centered planning services and due to Case Managers being at capacity, new clients would have to wait 1-2 months for services.

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

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 theProgram 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.

90% of referred clients were assessed for eligibility within the designated timeframe described above for Preference Assessment services. Due to COVID-19 and only conducting remote visits with clients, requests for PUNS appointments were not always able to be accommodated within 5 business days.

6. a) *From your application,* estimated length of time from assessment of eligibility/needto 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 theProgram 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 serviceswithin that time frame:

90% of referred clients were engaged in services within 5 business days. Some clients referred to us for person centered planning services by provider agencies were difficult to getin contact with. However, provider agencies were very helpful in assisting us with gaining contact and explaining person centered planning services.

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

The estimated length of participant engagement is one to three months. For personcentered 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 year.

Demographic Information

1. *In your application* what, if any, demographic information did you indicate you wouldcollect 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 programcollected.

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 onthe people it is serving? (Consumer Outcomes, question #1 in the Program Plan application). Please number each outcome.

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

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

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

Outcome:	Assessment Tool Used:	Information Source:
Individuals with I/DD will have greater choice of services and supports in Champaign County.	Preference Assessment, Discovery Tool, and Person-Centered Plan.	Client/guardian, provider agency staff. Information collected by Case Managers and Program Manager.

Individuals with I/DD transitioning out of secondary education will have a goal plan in place developed collaboratively with their Transition Consultant.	Individualized Education Plan (IEP) and Goal Plan.	Client/guardian, school staff. Information collected by Transition Consultants and Program Manager.
Individuals selected from PUNS who were provided service through the Decision Support Person Centered Planning Programwill 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 Managers.

3. Was outcome information gathered from every participant who received service, oronly 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 informationfrom?

N/A

5. How many total participants did your program have?

NTPC = 228
TPC = 423

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) – 147/228 = 64%. 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. FY20 yielded a 69% response rate and FY19 yielded a 52% response rate.

TPC – 423/423 = 100%. Even during COVID-19, Case Managers were able to complete all Person Centered Plans with clients on their caseload despite the process being difficult due to all visits being conducted virtually (via email, phone, FaceTime, Zoom, and Microsoft Teams).

8. How often and when was this information collected? (e.g. 1x a year in the spring; atclient 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 theirCase Manager and IEP information was provided to Case Manager at intake. Clients served with person centered planning services completed a Personal Plan annually and had (at minimum) quarterly visits with their Case Manager.

Results

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, youcould report the following:

Means (and Standard Deviations if possible)
Change Over Time (if assessments occurred at multiple points)
Comparison of strategies (e.g., comparing different strategies relatedto 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 basedon 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 64% 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 Program will be found eligible for Medicaid Waiver Services and 90% will begin receiving services within three months.
Results: 21 individuals who received Decision Support Person Centered Planning services were selected from PUNS in FY21 (July 12, 2021). 100% 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	8/31/2020	HBS	No delay.
Client 2	9/2/2020	CILA	No delay.
Client 3	9/3/2020	HBS	No delay.
Client 4	9/14/2020	HBS	No delay.
Client 5	9/16/2020	HBS	No delay.
Client 6	10/7/2020	HBS	No delay.
Client 7	10/20/2020	HBS	No delay.
Client 8	11/6/2020	HBS	No delay.
Client 9	12/17/2020	HBS	No delay.
Client 10	1/25/2021	HBS	Delay in receiving required documentation for Pre-Admission Screening (PAS) process.
Client 11	1/27/2021	HBS	Difficulty connecting with family/individual to gather required documents to complete PAS process. Closed from PUNS in June 2021 as family decided to stay with Department of Rehabilitation (DRS) services.
Client 12	3/19/2021	HBS	Change in ISC staff.
Client 13	5/5/2021	HBS	Delay in receiving all necessary documentation for fundi request packet; difficulty maintaining contact with individual.
Client 14	5/18/2021	HBS	Delay in receiving all required documents necessary for funding request.
Client 15	5/21/2021	HBS	Change in ISC staff.

Client 16	N/A	TBD	Difficulty maintaining contact with individual & family; difficulty obtaining all required documents for PAS process.	
Client 17	N/A	N/A	Moved out of state. Closed from PUNS.	
Client 18	N/A	N/A	Decided not to move forward with funding in June 2021 Closed from PUNS.	.
Client 19	N/A	N/A	Family decided not to move forward with a funding request. Closed from PUNS.	
Client 20	N/A	N/A	Closed from the PUNS on 4/2021 due to inability to contact family/individual.	
Client 21	N/A	HBS	Delay in receiving necessary documents for funding request.	

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 FY21 who had a Personal Plan developed in FY20, 90% had their Personal Plans completed within 365 days of their previous plan. This was due to: difficultyin 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 barrierswith 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

ISC notified client and his parents in December 2020 at the client's PUNS meeting that the client is on the PUNS pre-selection list. ISC informed the family to apply for Medicaid at this time to avoid a delay in receiving Medicaid waiver funding. ISC checked with client and his

father after a few months to see if they had had applied for Medicaid. Client's father informed ISC they had not completed the application because they had problems with filling out the application. ISC went through the Medicaid application with dad and answered any questions that he had. In July, client's father informed ISC they had received a Medicaid card for the client and they received a letter from DHS informing client that he was selected to apply for the Medicaid Waiver program. Client is now completing the Pre-Admission Screening (PAS) paperwork to be submitted to DHS.

TPC – Transition Consultant Case Study

Measuring success amidst a global pandemic has been a challenge; many of our usual practices no longer applied. One of the Transition Consultant's (TC) clients recently graduated and was not interested in engaging in any community activities. Her mother recognized that was not a positive lifestyle for her daughter. The TC met with the client and her mother prior to the pandemic to develop a sense of her interests and hopes for her future. Over the last year the TC and client exchanged many emails and phone calls. They discussed available services and how to access those services. The TC also passed along information regarding guardianship provided by a CCRPC Independent Service Coordination (ISC). The client was also selected from the Prioritization for Urgency of Need for Services (PUNS) list in order to apply for Home and Community Based Medicaid Waiver Services.

The client's mother recently emailed the TC with an update on her daughter's community engagement. She is now involved with job coaching, employment, and has Home Based Support. The client's mother is knowledgeable and often just needs some direction and support.

TPC – Transition Consultant Case Study

The client's mom contacted the TC wanting guidance on where her son could receive testing so that he'd qualify for Home and Community based Medicaid Waiver Services when his name was selected from the PUNS database. She was told by a special needs attorney that her son needed to have the Wechsler Adult Intelligence Scale (WAIS) test done prior to age 18, and she wanted to know where she could have this done. While some testing might be necessary, especially closer to the time of selection, it is not limited to this one test. The attorney also recommended she contact a special needs benefits planning firm to assist.

The young man, who is turning 18 this summer, will continue in the school district's transition program until age 22. His father is deceased, and the son has been receiving child survivor benefits. The TC explained the process of qualifying as a DAC (Disabled Adult Child) so that he can continue receiving Social Security benefits as an adult. While talking with a Social Security counselor about another issue, the TC was able to learn more about the process.
The TC talked to the mom about the extension he could receive while still in school and that this would buy him time until his DAC status was confirmed. In addition, we also discussed the reasons for applying for Medicaid and the TC provided guardianship information.

TPC – Person Centered Planning Case Study

The client found himself on the verge of homelessness as the pandemic began, and his provider, Community Choices, assisted him in finding a temporary place to live. The client had no job and no income when he moved to the area but desired to obtain employment as well as a permanent home. The client had applied for Social Security benefits and received notice in September 2020 of disapproved claims. The ISC offered to assist the client in appealing this decision. The ISC completed required documentation and submitted client's appeal packet to the Social Security office and in November 2020, the client was approved for SSI and SSDI benefits. The client now has consistent, monthly income that will allow him to obtain affordable housing. The ISC also assisted the client in obtaining a copy of his birth certificate and social security card which he did not have.

The client began working in spring 2020 with support through the Department of Rehabilitation Services (DRS). The client achieved his personal outcome of obtaining employment and continues to work towards his goal of obtaining permanent housing and living independently.

TPC – Person Centered Planning Case Study

During the Discovery process, the client reported that he had returned to work two times a month but would like to go back to work weekly again (as he did prior to the pandemic). The ISC reached out to his provider to let them know about his interest in increased hours at work and his Employment Specialist was able to advocate for him to have increased hours.

The client also reported there were daily life skills that he would like to learn. The ISC and family discussed the possibility of hiring someone through respite services. The ISC provided client and his mother with information regarding respite services through the Illinois Respite Coalition and Envision Unlimited. The ISC also mailed brochures for both providers to the client and his mother for further consideration.

TPC – Person Centered Planning Case Study

During clients annual Discovery/Person Centered Planning process, client indicated to ISC that she was unhappy where she was currently living at that she desired to move. At the timethe client was living in a supported living facility and she was not too fond of some of the practices and rules of the facility. She explained to the ISC that she relocated to the area and initially her and her mother thought that a supported living facility would be a good fit for theclient because it allowed her more independence. After living there for a while, the client decided she preferred not to live in a facility but to have her own apartment where she couldlive totally independently as she had in the past. The ISC informed the client about the Champaign County Housing Authority and a new living community for the elderly and disabled that they recently announced they were currently accepting applications for. The

client expressed her interest in applying for housing there; she and the ISC worked together to get the application submitted.

Because the living community was a new development and still under construction the process and waiting list were long and the client soon became anxious and doubtful that she would be approved. To help decrease these feelings of doubts, the ISC communicated with the Housing Authority regularly on the client's behalf and provided the client with updates. Afew months after the client submitted her application she was devastated after receiving a letter of denial from the Housing Authority indicating that she was not approved due to age qualifications. The ISC reached out to the Housing Authority to find out more information about the denial and learned that the application had been denied because the client had applied under the age qualifications instead of the disability qualifications. ISC was informed that the client could submit the proper documentation to qualify for the disability inclusion. ISC then assisted client with retrieving and submitting this documentation. As a result, the client was later approved for the living community and moved in.

Months later the ISC went to visit the client in her new apartment. The client was ecstatic about her new apartment and independent lifestyle.

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:
Ensure client would like to move forward with services
Have applied and received Medicaid approval
Have a physical exam completed within the last year on file
Have a psychological evaluation completed within the last 5 years on file
Have an Inventory for Client and Agency Planning (ICAP) completed within the lastyear on file
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 completedreport back. With this in mind, the Assistant Director of Community Services has been exploring opportunities to contract with an additional Licensed Clinical Psychologist. An initial introductory meeting was held with the University of Illinois' NeuroBehavioral Assessment Laboratory (INBAL) to discuss what we are looking for.

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 yourestimated number of clients/contacts/community events for reported service categories significantly differ from your actual numbers, you may give a narrative explanation for that discrepancy here.

Treatment Plan Clients (TPC):

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

Proposed: 200
Actual: 423
Explanation: The caseload size of the person centered planning case managers extended beyond 45 people at times which resulted in serving more TPC clients.

Non-treatment Plan Clients (NTPC):

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

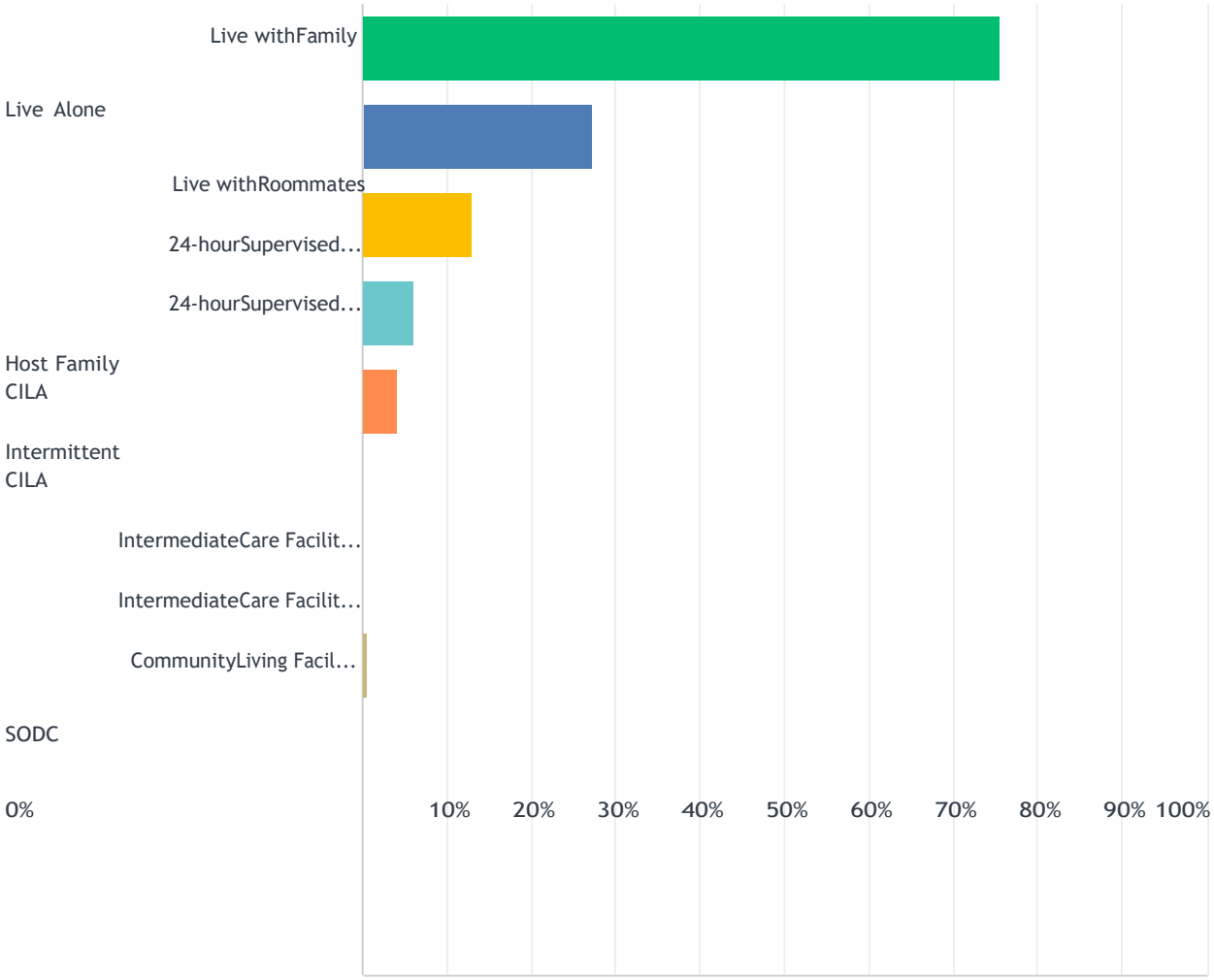
Proposed: 250 Actual: 228 Explanation: Some clients/families were more difficult to reach during the pandemic.
Community Service Events (CSE): Staff presentations and tabling at outreach events, meeting with Champaign County high schools and other professionals. Proposed: 40 Actual: 48
Service Contacts (SC): Individuals attending outreach events. Proposed: 300 Actual: 340
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).

Q1 Personal Background and Social Summary (Provide a one-paragraph overview of the individual including a brief summary of the person's background, skills, and abilities, personal likes and dislikes current and future vision/hopes, relationships with family members and support staff) -Answers documented and on file.

Answered: 147 Skipped: 0

Q2 What is your preferred living arrangement?

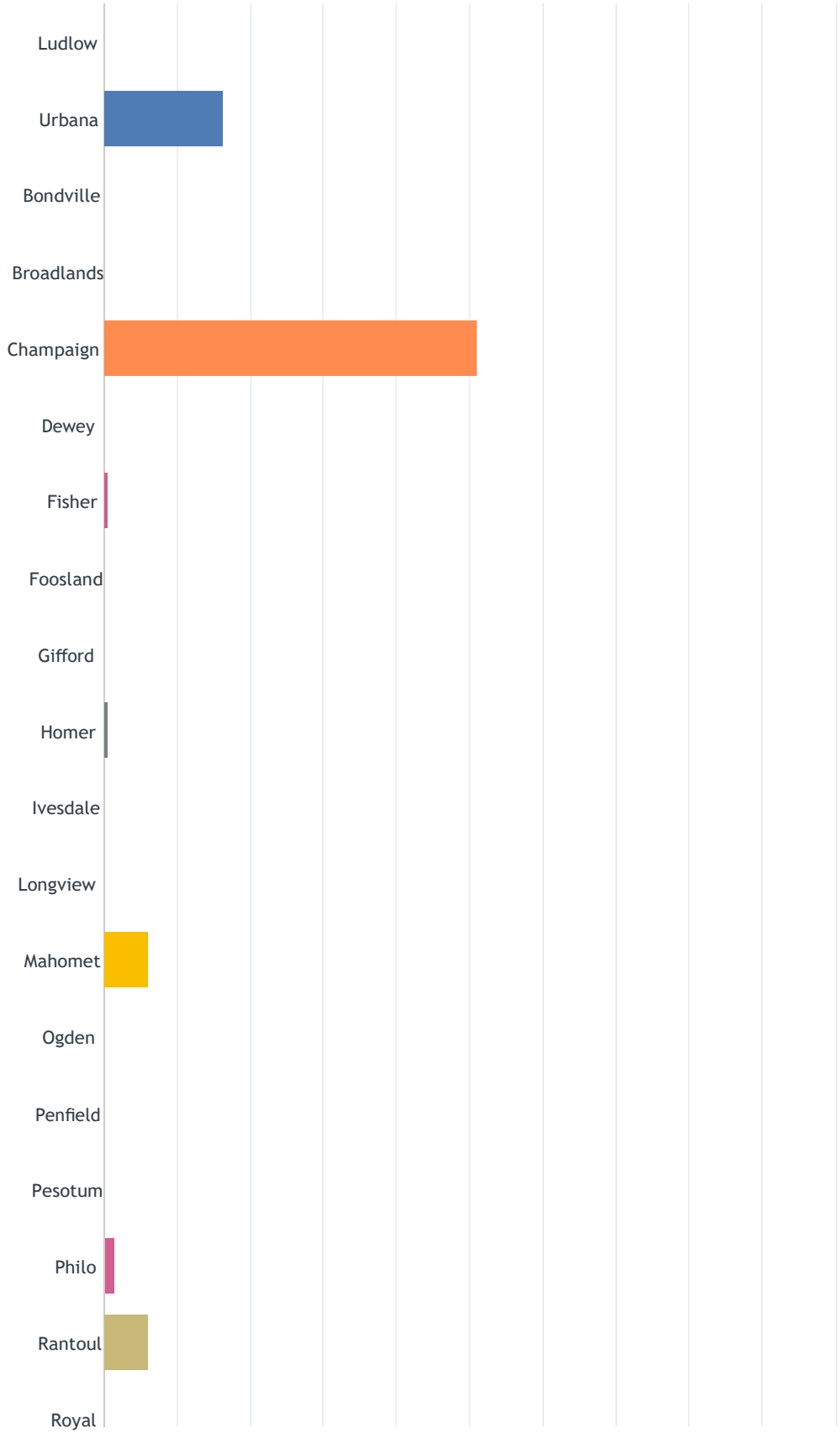
Answered: 147 Skipped: 0

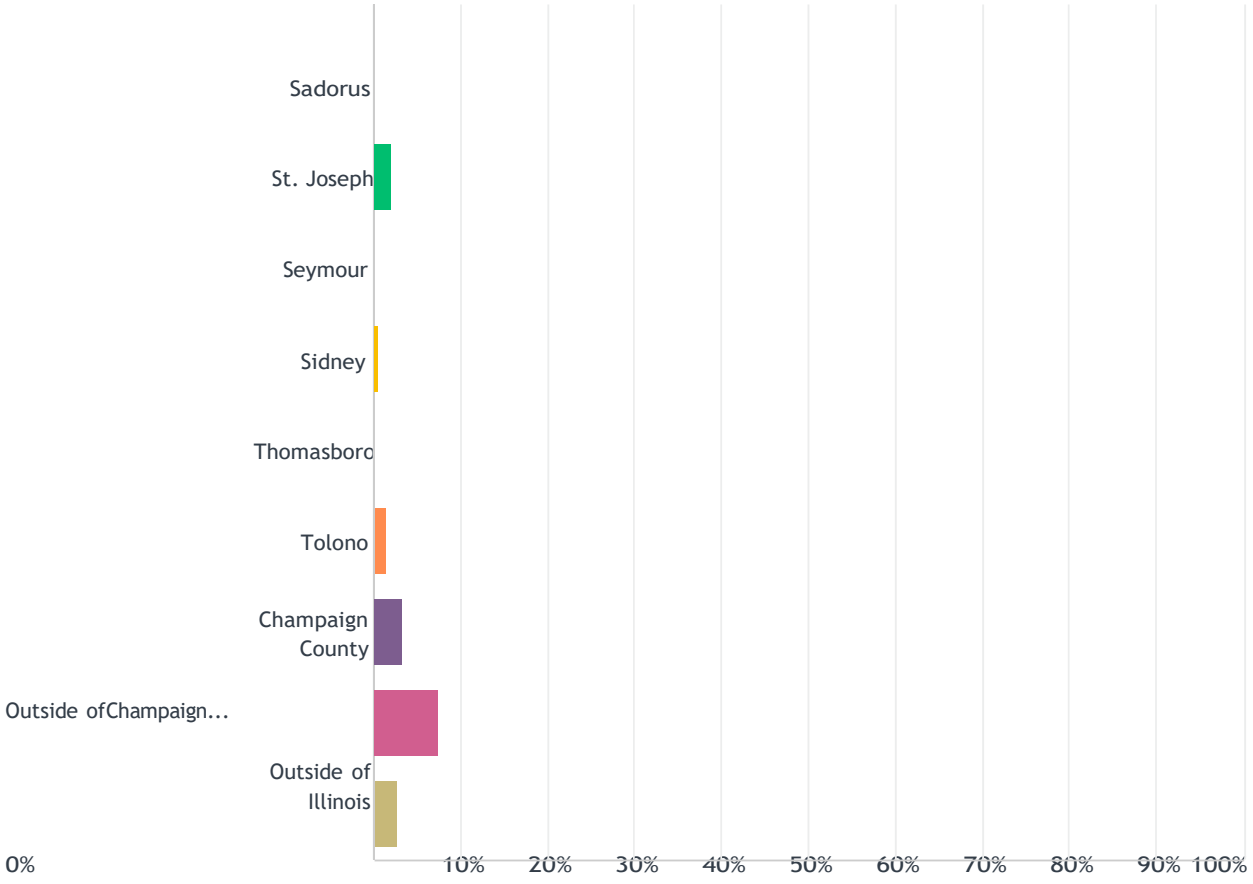


ANSWER CHOICES	RESPONSES	
Live with Family	75.51%	111
Live Alone	27.21%	40
Live with Roommates	12.93%	19
24-hour Supervised Group Home (CILA) - Single Bedroom	6.12%	9
24-hour Supervised Group Home (CILA) - Shared Bedroom	4.08%	6
Host Family CILA	0.00%	0
Intermittent CILA	0.00%	0
Intermediate Care Facility (ICF/DD)	0.68%	1
Intermediate Care Facility (ICF/DD)	0.00%	0
Community Living Facility (CLF)	0.00%	0
SODC	0.00%	0
Total Respondents: 147		

Q3 Where do you want to live? (City, county, or geographic region)

Answered: 147 Skipped: 0

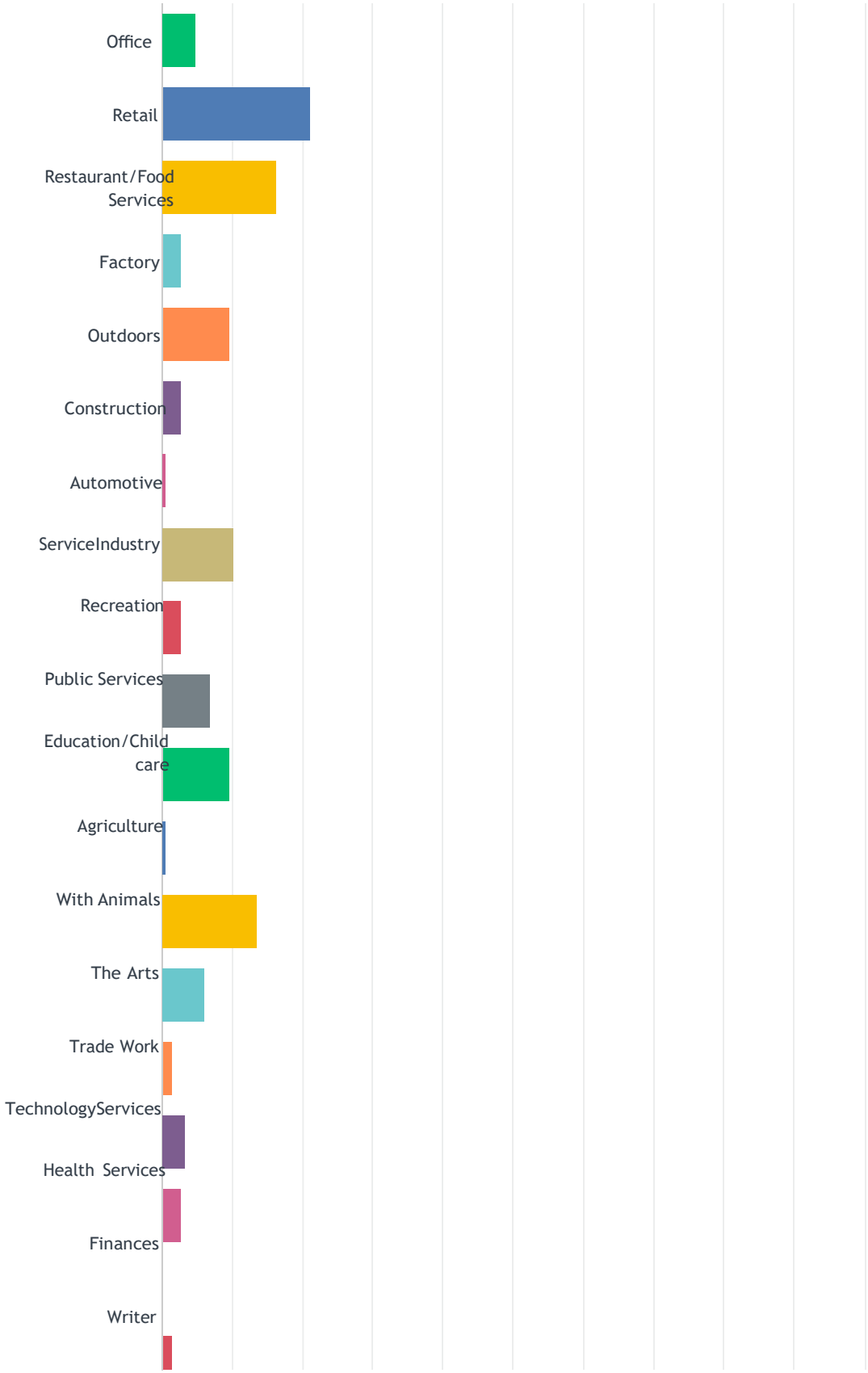


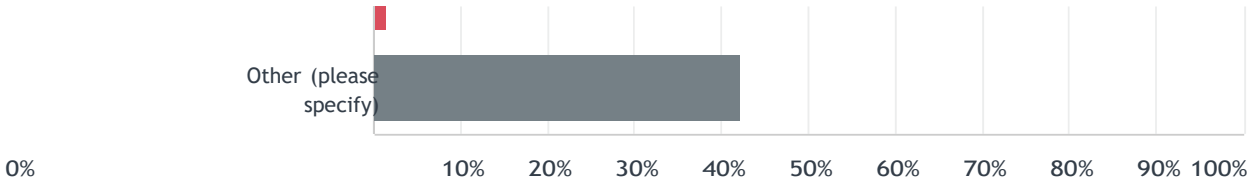

Sadorus
St. Joseph
Seymour
Sidney
Thomasboro
Tolono
Champaign County
Outside ofChampaign...
Outside of Illinois
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

ANSWER CHOICES	RESPONSES	
Ludlow	0.00%	0
Urbana	16.33%	24
Bondville	0.00%	0
Broadlands	0.00%	0
Champaign	51.02%	75
Dewey	0.00%	0
Fisher	0.68%	1
Foosland	0.00%	0
Gifford	0.00%	0
Homer	0.68%	1
Ivesdale	0.00%	0
Longview	0.00%	0
Mahomet	6.12%	9
Ogden	0.00%	0
Penfield	0.00%	0
Pesotum	0.00%	0
Philo	1.36%	2
Rantoul	6.12%	9
Royal	0.00%	0
Sadorus	0.00%	0
St. Joseph	2.04%	3
Seymour	0.00%	0
Sidney	0.68%	1
Thomasboro	0.00%	0
Tolono	1.36%	2
Champaign County	3.40%	5
Outside of Champaign County	7.48%	11
Outside of Illinois	2.72%	4
TOTAL		147

Q4 Employment or Volunteer

Answered: 147 Skipped: 0

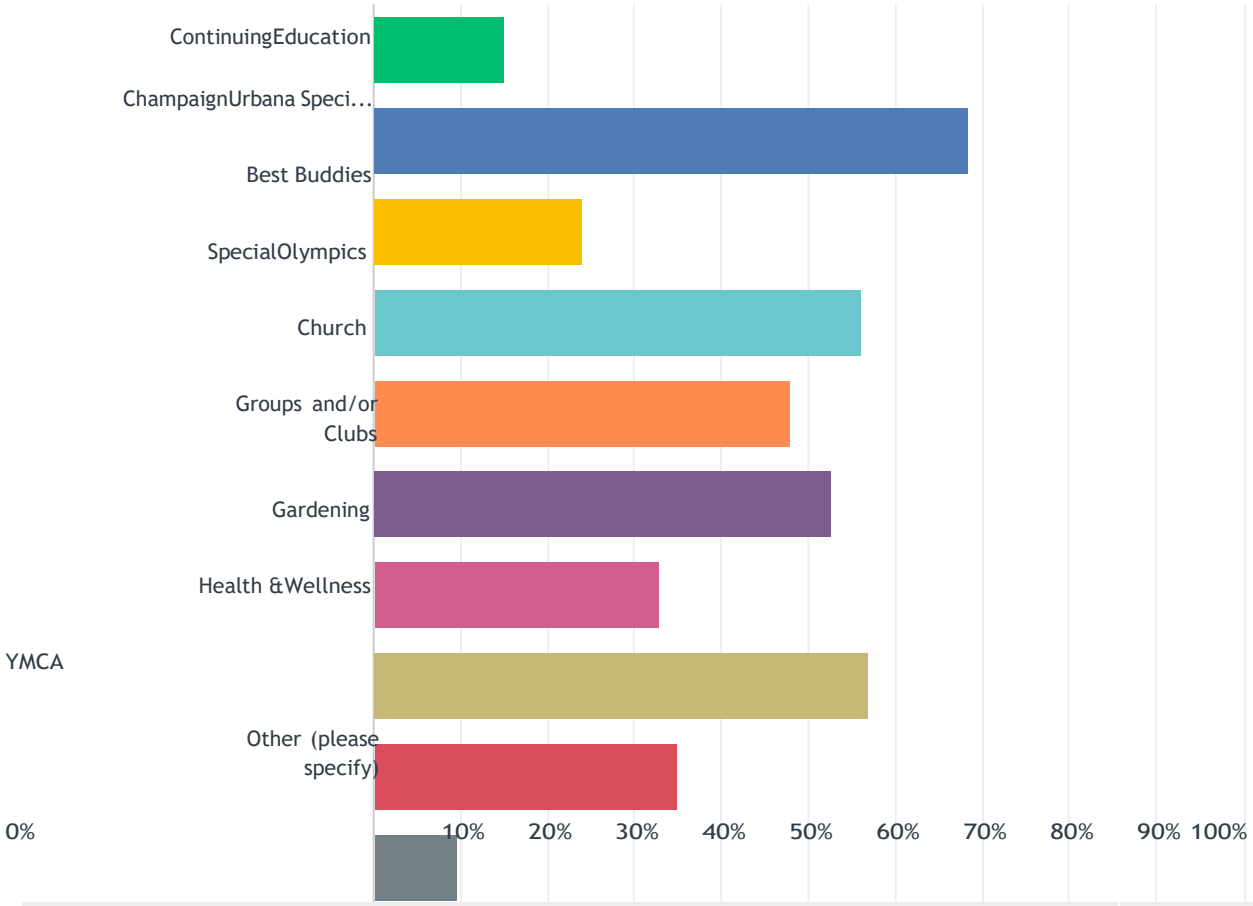




ANSWER CHOICES	RESPONSES	
Office	4.76%	7
Retail	21.09%	31
Restaurant/Food Services	16.33%	24
Factory	2.72%	4
Outdoors	9.52%	14
Construction	2.72%	4
Automotive	0.68%	1
Service Industry	10.20%	15
Recreation	2.72%	4
Public Services	6.80%	10
Education/Childcare	9.52%	14
Agriculture	0.68%	1
With Animals	13.61%	20
The Arts	6.12%	9
Trade Work	1.36%	2
Technology Services	3.40%	5
Health Services	2.72%	4
Finances	0.00%	0
Writer	1.36%	2
Other (please specify)	42.18%	62
Total Respondents: 147		

Q5 Community Opportunities

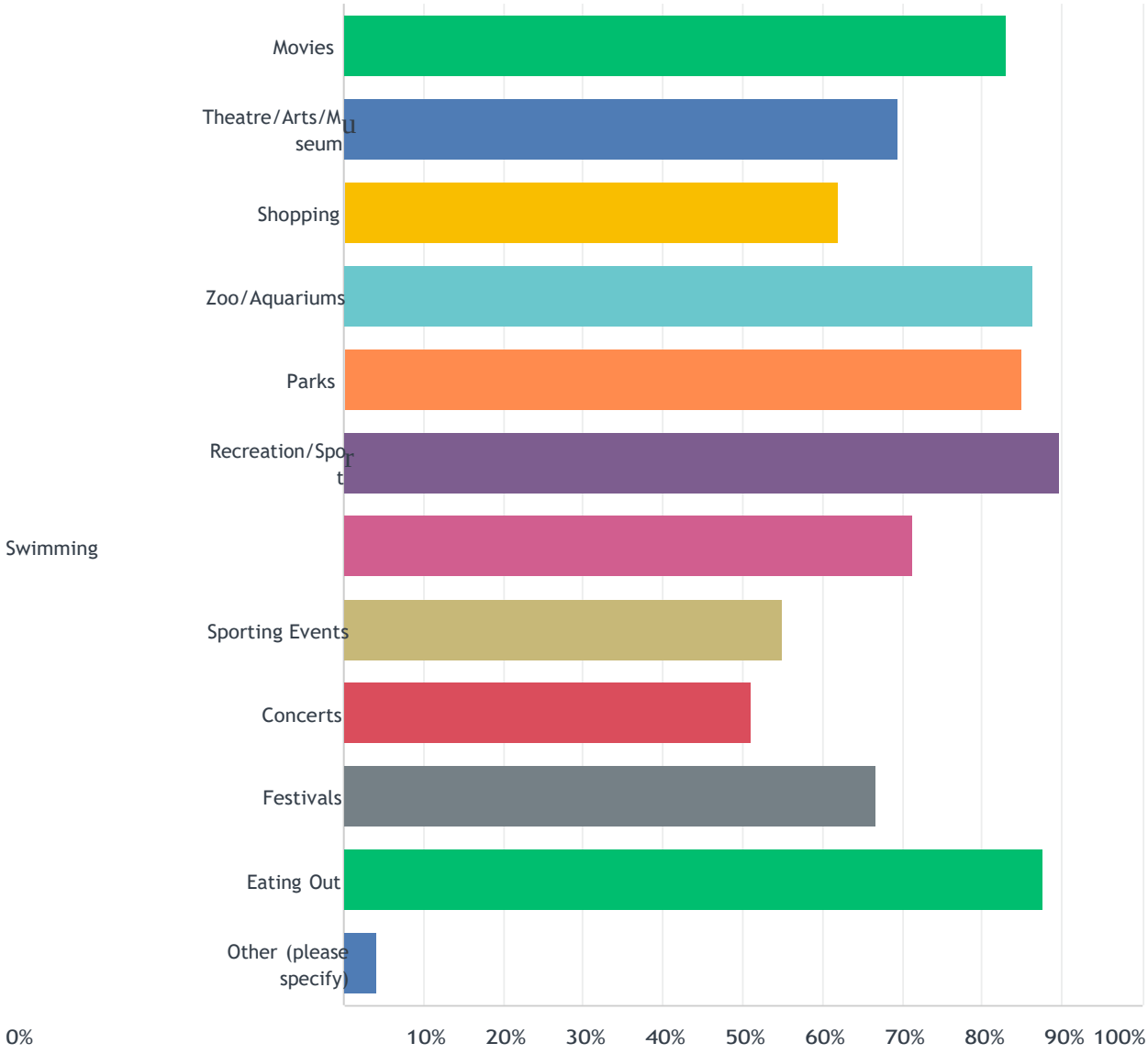
Answered: 146 Skipped: 1



ANSWER CHOICES	RESPONSES	
Continuing Education	15.07%	22
Champaign Urbana Special Recreation (CUSR)	68.49%	100
Best Buddies	23.97%	35
Special Olympics	56.16%	82
Church	47.95%	70
Groups and/or Clubs	52.74%	77
Gardening	32.88%	48
Health & Wellness	56.85%	83
YMCA	34.93%	51
Other (please specify)	9.59%	14
Total Respondents: 146		

Q6 Leisure

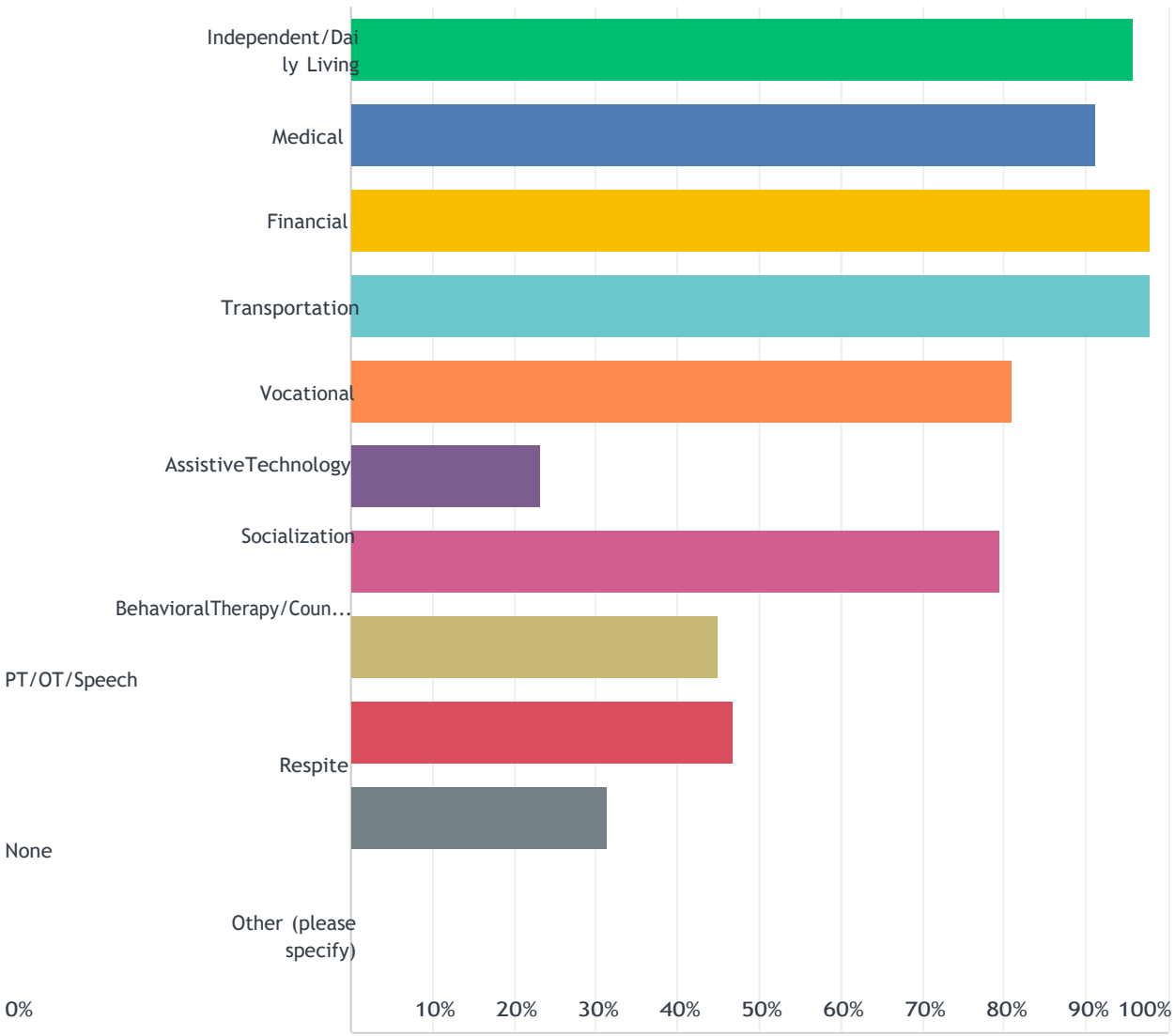
Answered: 147 Skipped: 0



ANSWER CHOICES	RESPONSES	
Movies	82.99%	122
Theatre/Arts/Museums	69.39%	102
Shopping	61.90%	91
Zoo/Aquariums	86.39%	127
Parks	85.03%	125
Recreation/Sports	89.80%	132
Swimming	71.43%	105
Sporting Events	55.10%	81
Concerts	51.02%	75
Festivals	66.67%	98
Eating Out	87.76%	129
Other (please specify)	4.08%	6
Total Respondents: 147		

Q7 What kind of supports do you need?

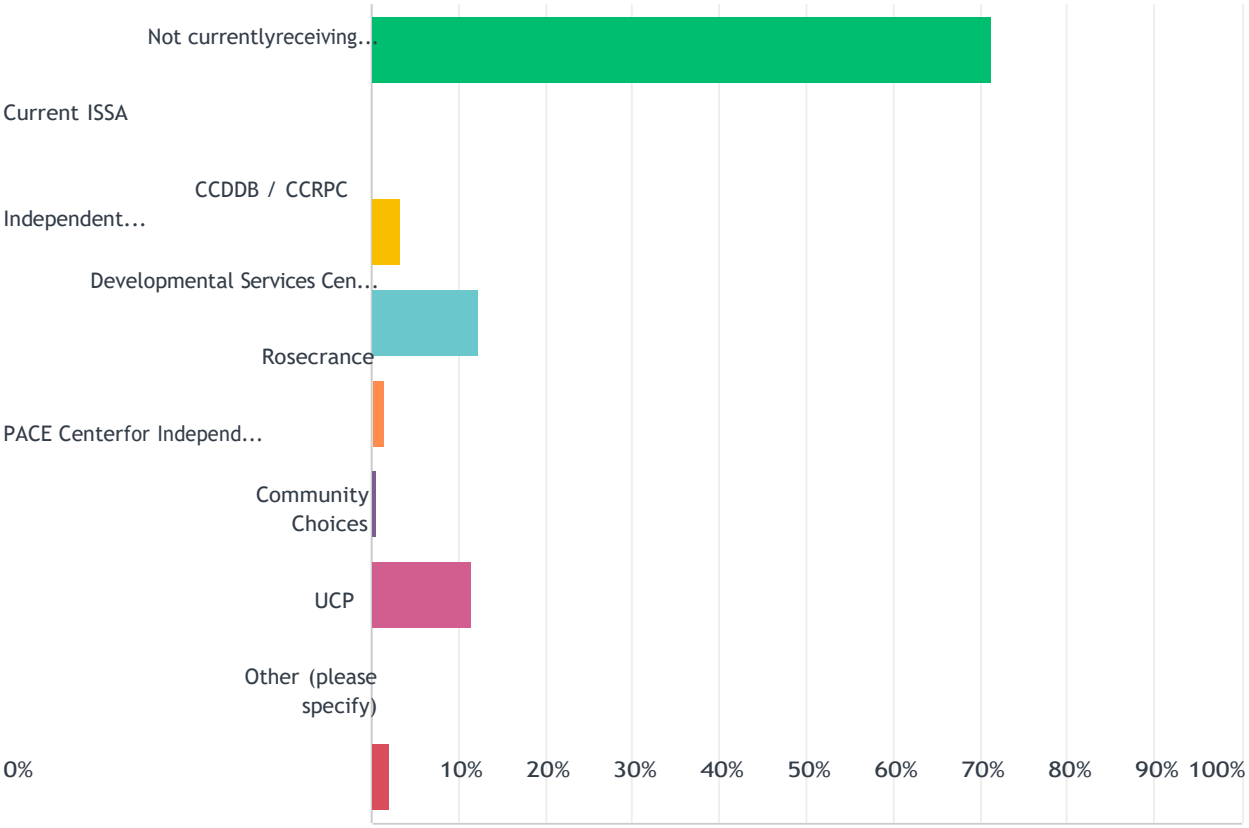
Answered: 147 Skipped: 0



ANSWER CHOICES	RESPONSES	
Independent/Daily Living	95.92%	141
Medical	91.16%	134
Financial	97.96%	144
Transportation	97.96%	144
Vocational	80.95%	119
Assistive Technology	23.13%	34
Socialization	79.59%	117
Behavioral Therapy/Counseling	44.90%	66
PT/OT/Speech	46.94%	69
Respite	31.29%	46
None	0.00%	0
Other (please specify)	0.00%	0
Total Respondents: 147		

Q8 Are you currently receiving case management services? If so, where?

Answered: 147 Skipped: 0



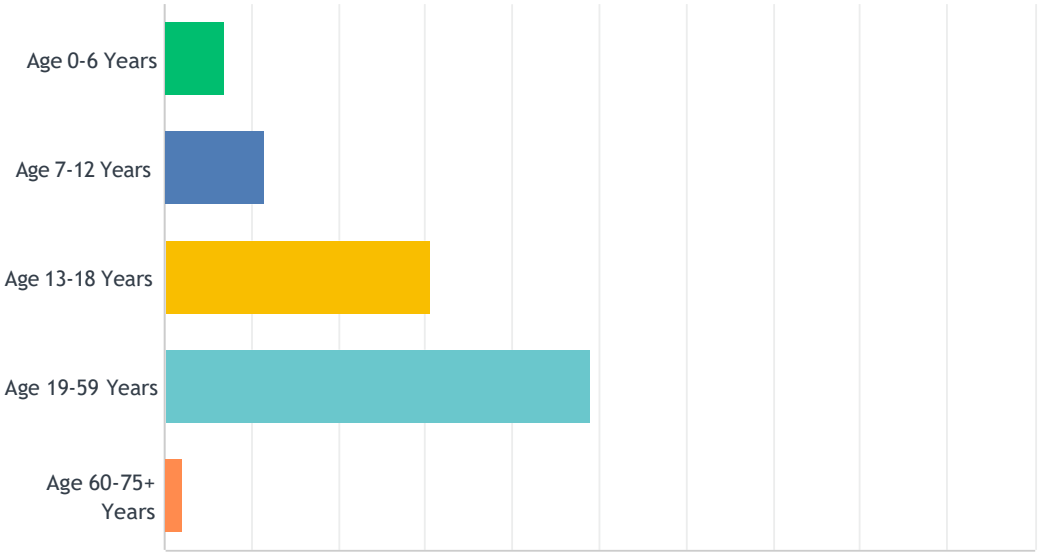
ANSWER CHOICES	RESPONSES	
Not currently receiving services	71.43%	105
Current ISSA	0.00%	0
CCDDB / CCRPC Independent Service Coordination	3.40%	5
Developmental Services Center (DSC)	12.24%	18
Rosecrance	1.36%	2
PACE Center for Independent Living	0.68%	1
Community Choices	11.56%	17
UCP	0.00%	0
Other (please specify)	2.04%	3
Total Respondents: 147		

Q9 Client's Full Name

Answered: 147 Skipped: 0

Q10 Age Group

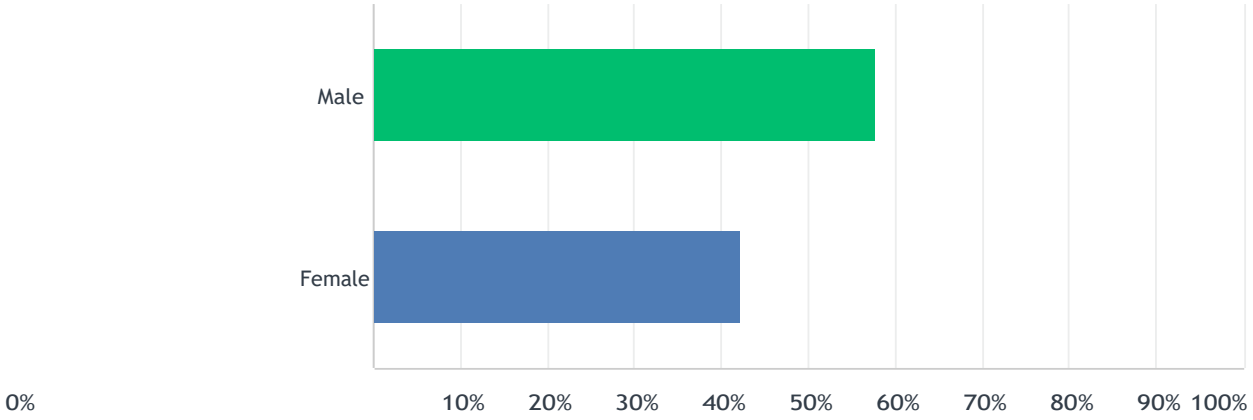
Answered: 147 Skipped: 0



ANSWER CHOICES	RESPONSES	
Age 0-6 Years	6.80%	10
Age 7-12 Years	11.56%	17
Age 13-18 Years	30.61%	45
Age 19-59 Years	48.98%	72
Age 60-75+ Years	2.04%	3
TOTAL		147

Q11 Gender

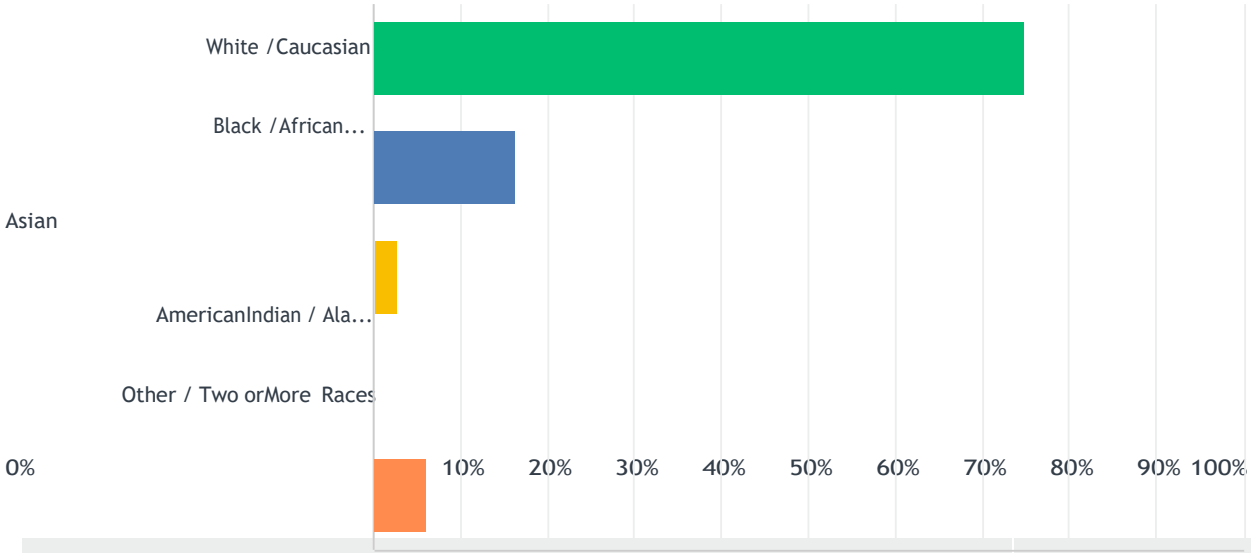
Answered: 147 Skipped: 0



ANSWER CHOICES	RESPONSES	
Male	57.82%	85
Female	42.18%	62
TOTAL		147

Q12 Race

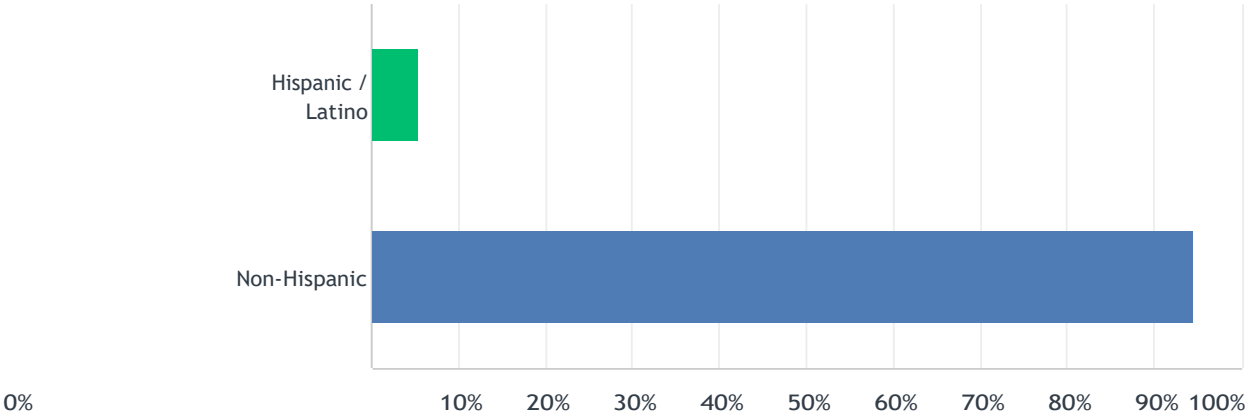
Answered: 147 Skipped: 0



ANSWER CHOICES	RESPONSES	
White / Caucasian	74.83%	110
Black / African American	16.33%	24
Asian	2.72%	4
American Indian / Alaska Native	0.00%	0
Other / Two or More Races	6.12%	9
TOTAL		147

Q13 Ethnicity

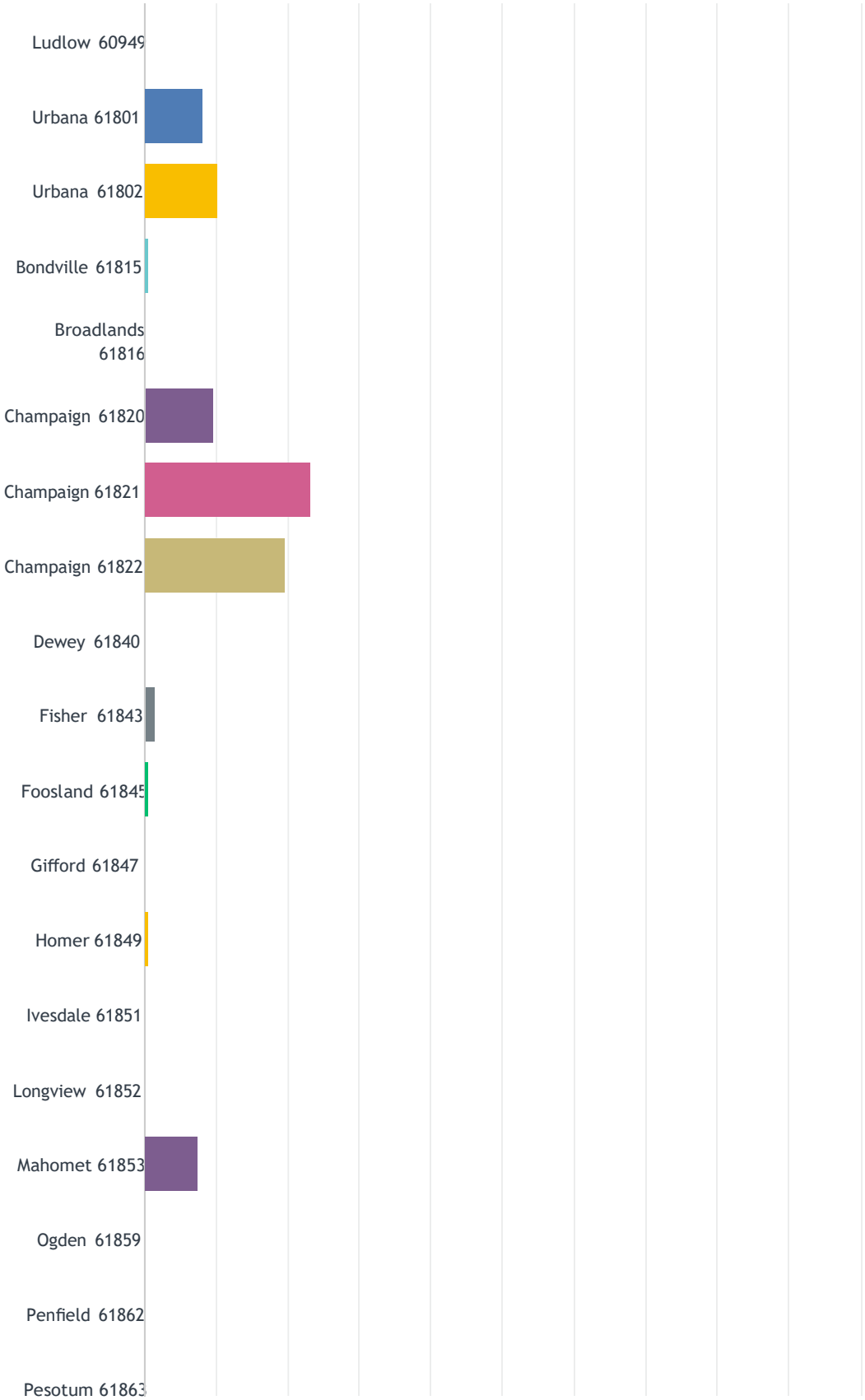
Answered: 147 Skipped: 0

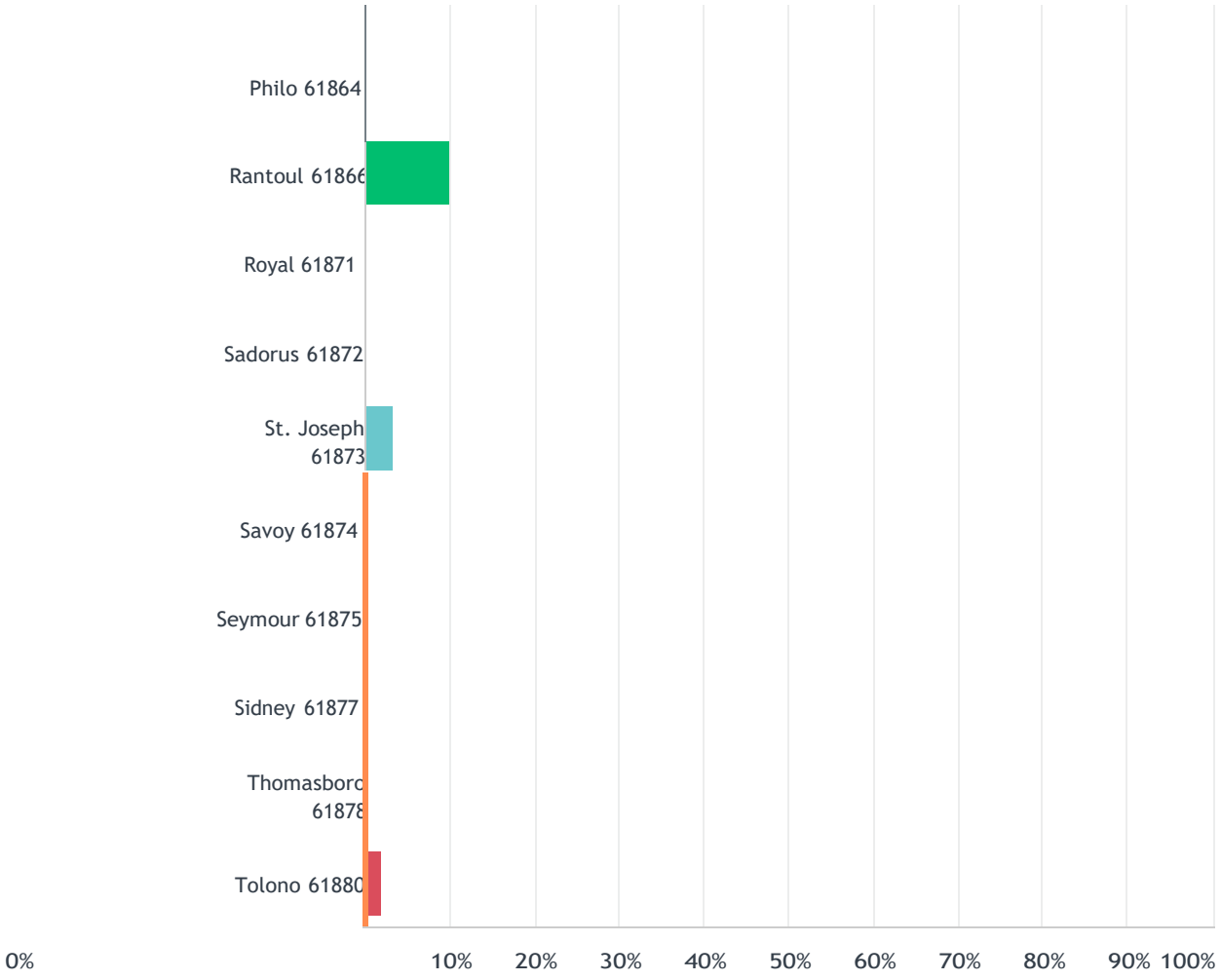


ANSWER CHOICES	RESPONSES	
Hispanic / Latino	5.44%	8
Non-Hispanic	94.56%	139
TOTAL		147

Q14 Zip Code

Answered: 147 Skipped: 0




Philo 61864
Rantoul 61866
Royal 61871
Sadorus 61872
St. Joseph 61873
Savoy 61874
Seymour 61875
Sidney 61877
Thomasboro 61878
Tolono 61880
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

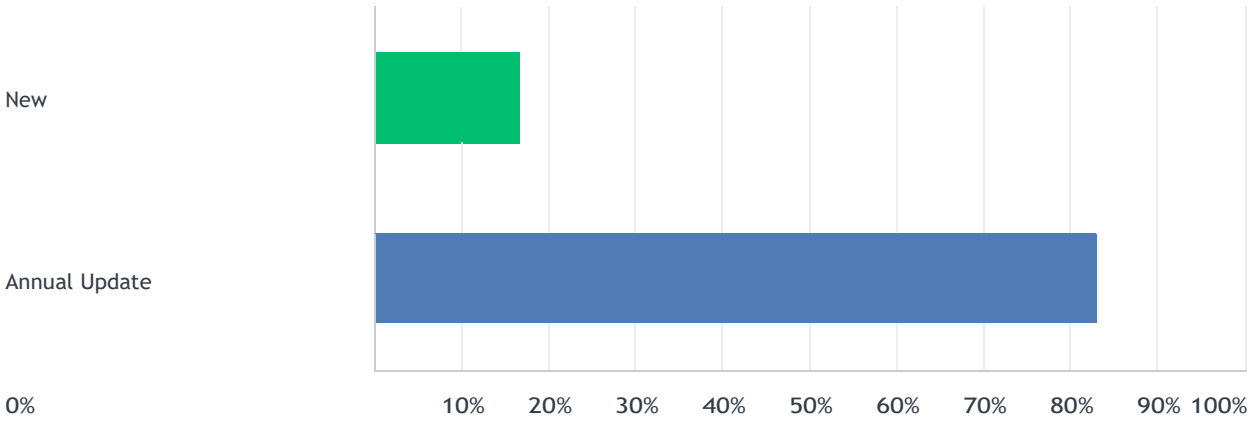
ANSWER CHOICES	RESPONSES	
Ludlow 60949	0.00%	0
Urbana 61801	8.16%	12
Urbana 61802	10.20%	15
Bondville 61815	0.68%	1
Broadlands 61816	0.00%	0
Champaign 61820	9.52%	14
Champaign 61821	23.13%	34
Champaign 61822	19.73%	29
Dewey 61840	0.00%	0
Fisher 61843	1.36%	2
Foosland 61845	0.68%	1
Gifford 61847	0.00%	0
Homer 61849	0.68%	1
Ivesdale 61851	0.00%	0
Longview 61852	0.00%	0
Mahomet 61853	7.48%	11
Ogden 61859	0.00%	0
Penfield 61862	0.00%	0
Pesotum 61863	0.00%	0
Philo 61864	1.36%	2
Rantoul 61866	9.52%	14
Royal 61871	0.00%	0
Sadorus 61872	0.00%	0
St. Joseph 61873	3.40%	5
Savoy 61874	1.36%	2
Seymour 61875	0.00%	0
Sidney 61877	0.68%	1
Thomasboro 61878	0.00%	0
Tolono 61880	2.04%	3
TOTAL		147

Q15 ISC Coordinator/Surveyor

TOTAL	147

Q16 Client's Current Preference Assessment Status

Answered: 147 Skipped: 0



ANSWER CHOICES	RESPONSES	
New	17.01%	25
Annual Update	82.99%	122
TOTAL		147

Performance Outcome Report Template

CU Able PY2021

CU Able Community Outreach – report missing

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: 8/24/2021

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.**
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, social 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.

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 1200 via survey collection through FB members

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 1x year for the 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 Template

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

Agency name: Champaign County Down Syndrome Network
Program name:
Submission date: July 5, 2021

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) **NO**
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.)? NONE REQUIRED
3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.) **WEBSITE OR 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): **N/A**

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

N/A

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

N/A

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

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

N/A

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

N/A

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

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

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

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

N/A

Demographic Information

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

WE DO NOT COLLECT DEMOGRAPHIC INFORMATION

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.

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

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

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

5. How many total participants did your program have?

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

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

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

Results

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

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

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

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

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

(Optional) Narrative Example(s):

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

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

Utilization Data Narrative –

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

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

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

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

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

Non-treatment Plan Clients (NTPC):
Community Service Events (CSE):
Service Contacts (SC):
For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

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: Social-Emotional Development Services
Submission date: 8/27/2021

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 if parents or staff refer. The Social-Emotional Development Specialist (SEDS) actively consults with the Social-Emotional Support Team throughout the referral process and service delivery, Eligibility is determined by team through observation, functional behavioral assessment, and data collection from families and staff.**
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.)? **Information is gathered by completing a holistic Social-Emotional history of child and family, observation, functional behavioral assessment, DECA results, and parent/teacher data collection. The findings are discussed with the parents and support staff and a collaborative determination is made on how to best support the child, teacher, and family.**

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

CCHS recruits throughout Champaign County at local libraries, elementary schools, door to door, grocery/convenience stores, town/village events, community agencies, and many other locations. CCHS has outreach at community events such as the annual Champaign County Disability Expo, Read Across America, Week of the Young Child and local school district child-find activities.

CCHS shares information with enrolled families about the social-emotional services provided by the 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

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

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):

7 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:
100

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

The average length of services by the Social-Emotional Development Specialist 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.

Income- Head Start/Early Head Start served:
356 families income below 100% FPG
108 families at 100-130% FPG

50 homeless families,
33 families in foster care
6 families public assistance
96 over income families

Children who speak the following languages:
English-538
Spanish-37
Middle Eastern & South Asian-39
African-3
East Asian-3
European & Slavic-38
Unspecified- 2

Education level:
Less than HS Diploma-66
Completed HS- 228
Associate degree or some college- 196
Advanced degree-75

Employment:
Employed-461
Unemployed- 83

Marital status:
Two parent home-156
Single parent home-417

Military status-3

Housing status:
Families that Acquired housing with our support this year- 8

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 with treatment plan served by the SSPC will have a reduction in frequency and duration of challenging behavior.

2. Children served by the SSPC 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. 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. Reduction in frequency and duration of challenging behavior	Self-Report and observation through Practice Based Coaching Sessions	Teacher and Coach

2. Improvement in social skills and resilience	Teaching Strategies GOLD	Classroom Teacher

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

All of them.

4. If only some participants, how did you choose who to collect outcome information from?
Outcome information would not be able to be collected from children who were within drawn from the program before the checkpoint occurred.

5. How many total participants did your program have?
33 treatment plan clients and 45 non treatment plan clients

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

We collect this data from every child who is in a classroom regardless of whether they qualify for social-emotional services or not. It is a program requirement.

7. How many people did you *actually* collect outcome information from?
Winter checkpoint: 305
Spring checkpoint: 369
Summer checkpoint: 298 (Savoy site closes in June and does not complete summer checkpoints)

8. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc)
This information is collected four times a year: Fall, Winter, Spring, and Summer. However this year there was a problem with the software and checkpoints were not documented during the fall.

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)

In both the Early Head Start and Head Start groups we saw an increase in the development of social skills over the course of the year. In the Head Start group the January checkpoint noted that 60% of students met or exceeded the benchmark for developmentally appropriate social skills for their age. In the final checkpoint taken in July 72% of Head Start students met or exceeded the benchmark for developmentally appropriate social skills. This was a 20% increase of students reaching this benchmark over the course of the year.

In the Early Head Start group the January checkpoint found that 85% of the students evaluated met or exceeded the benchmark for developmentally appropriate social skills for their age. In the final checkpoint taken in July, 88% of EHS students met or exceeded the benchmark. This was a 3.5% increase of students reaching this benchmark over the course of the year.

For each TPC we received biweekly reports from teachers about progress regarding decrease in challenging behaviors. We saw a decrease in behaviors over the span of the year, typically with the greatest decrease happening in the first 2 months of coaching and support for teachers.

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?

Described in the answer to question 9.

(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)

If a child has been referred to me for observation the teachers have already received support from their site manager, social skills and prevention coaches and have spent two weeks trying strategies in their classroom. If the behavior has not reduced I will go to the classroom to observe the child and meet with the teachers and parents to hear from them about the child, their strengths and challenges, what is happening or has happened in their lives, medical history, and relationships in the classroom. If the behavior was significantly unsafe early on, there is no need for a waiting period. Teachers are asked to collect data on frequency and duration of behaviors. Parents and teachers fill out the DECA and a functional behavior assessment. Following the observation and assessments I will meet with all the stake holders to facilitate a conversation about the child and we come up with a hypothesis regarding the function of their behavior (i.e. what is the behavior communicating/what needs are the child trying to meet with this behavior). After we make our best guess regarding function we come up with a plan for building skills of the child and teacher, identify a replacement behavior we want the child to learn to do instead of the current challenging behavior and we think about how to encourage this new behavior. Ideally, I then meet with the teachers weekly/biweekly to provide reflective consultation to support the implementation of their plan. We then collect data along the way to identify improvement or lack of improvement.

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.

   While we reached our goal for service contacts this year we did not reach our goal for numbers of clients served. We believe this is because enrollment at Head Start was significantly reduced this year due to COVID. Even with effort towards recruitment our sites operated at about 50% capacity for the time frame we had students onsite. Parents were hesitant to send children to sites for care during the COVID-19 pandemic.

Treatment Plan Clients (TPC): Represents a student or a parent who needs ongoing intensive support.

Estimated: 50
Actual: 25

Non-treatment Plan Clients (NTPC): Represents a student or a parent who needed a brief consultation or intervention but doesn't yet require a support plan.

Estimated: 50
Actual: 90

Community Service Events (CSE): Each data point represents a Mental Health/stress-management/parenting related practice, workshop, or resource shared virtually through Facebook or Zoom.

Estimated: 20 Actual: 14
Service Contacts (SC): Each data point could represent a meeting, an individual or group intervention, an observation, a screening, a consultation, or a Practice Based Coaching session. These contacts are done with a student or parent or on the behalf of a student or parent but with a staff member. Estimated: 600 Actual: 729
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
Submission date: 8.27.21

Consumer Access – *complete at end of year only*

Eligibility for service/program

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

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

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

Enrollment on the PUNS Database, which requires a screening assessment through the CCRPC, will be used as an eligibility determination tool. Program staff will meet with the individual requesting services to determine if the Community Transitional Support Program is a good fit for their needs and goals.

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 Community Living 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 and the Northern Champaign County Community Resource Fair.

There was one new person added to this program this year. He was a long time Community Choices member and reached out for additional services through the Community Living department after the death of his mother.

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):

This is a small program, so referral data have been kept informally. In the past year no individuals who have requested services have been turned away.

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):

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:

We had one person referred to this program. His referral came many months before he was able to return to the area and begin services. When he moved to town, his services began within 7 days.

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

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):

95%

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

100% - the one referral to this program was a previous client, so eligibility had already been determined.

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 2-3 years, but can increase with changes in circumstances. Classes are 8 weeks.

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

There were 13 continuing clients in this program. Three of those are in our "consultation" phase where they are not working on specific goals, but accessing services and resource coordination as needed. This leaves 10 individuals. They have been in the program an average of 4.2 years. Those who have been in the program over 3 years have all experienced significant life events that increased the need for our supports. The trend of many people needing more than 2-3 years worth of support to live sustainably in the community was a catalyst for the Community Living expansion that we are starting in FY22.

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.

We collected all the demographic information listed above.

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 planning and support individuals with I/DD can live in community based locations and build social connection.**

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

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

   GOALS:
   - 4 individuals develop person-centered goals focusing on a move-out plan and needed skills
   - 4 individuals successfully complete the planning phase by moving into a community-based living situation of their choice.

3. Consumer Outcome B - **MOVE-OUT:** ***Individuals with I/DD develop the skills needed to live independently.***
   GOALS:
   - 6 individuals successfully complete the Move-Out phase by:

- meeting their self-determined goals
- improving their POM score in at least one area
- showing the ability to complete needed areas on the Independent Living Skills Checklist.

  - Individuals will update their plans and goals annually

4. Consumer Outcome C - **REACH-OUT:** ***Individuals with I/DD develop connections to people and community.***
   - 5 individuals successfully complete the Reach-out phase by:
     - meeting their self-determined goals
     - improving their initial POM score in at least 2 areas
     - regularly engaging in 1 new activity

5. Alternative Outcome – **RESOURCE CONNECTION**: ***Individuals in need will be connected to resources to maintain or better their ability to live safely in the community.***
   - Individuals are directly connected with resources for
     - Food
     - Housing
     - Other critical needs

6. Consumer Outcome D - **PERSONAL DEVELOPMENT CLASSES:** ***Individuals with disabilities will develop their independent living skills***
   - 15 individuals with I/DD will participate. 5 courses will be offered. Individuals can participate in multiple courses.
   - 100% of participants will indicate growth or skill development based off the course assessment.

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

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

Data Collection: The survey will be presented to all participants and families. Full participation is encouraged.

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

Data Collection: All participants in the planning phase will complete assessments

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

Data Collection: All program participants in the move-out phase will complete these assessments.

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

Data Collection: All participants in the reach-out phase will complete these assessments

5 -Assessment: Regular meetings with participants will serve as an indicator for needed resource connection. Service notes will track resources and supports provided.

Data Collection: All program participants will complete receive service notes.

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

Data Collection: Assessments will be given to all participants, completion is not mandatory.

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- Program Outcome: **With planning and support individuals with I/DD can live in community based locations and build social connection.** GOAL: o 75% of participants will report that participation supported their efforts to live independently. 70% will indicate that participation helped them to connect with others and community. ACTUAL OUTCOME: The response rate for our survey did improve overall this year, increasing from 32 total responses in FY20 to 47 responses in FY21. However, of those who completed it, only 5 indicated that they participated in the Community Living Program during FY21. Of those 5 responses: - 80% indicated that the program 'Very Much' helped them to live more independently. - 80% indicated that the program 'Very Much' helped them to learn new skills and build self-reliance. - 60% felt the program 'Very Much' helped them to be more connected with people, places and groups. 40% felt the program 'A Little' helped them to be connected.	Community Choices Annual Member and Participant Survey	Participants and/or th families of participant In this case responses were from participant with disabilities.

2 - Consumer Outcome A - **PLANNING:** ***Individuals with I/DD plan and develop community-based living options.*** GOALS: ○ 4 individuals develop person-centered goals focusing on a move-out plan and needed skills ○ 4 individuals successfully complete the planning phase by moving into a community-based living situation of their choice. ACTUAL OUTCOME: Four individuals all developed goals relating to moving out or the skills needed to sustain community-based living. Goals included finding affordable housing, household management, moves out of the area, and finding sustainable housing while managing a transitional living arrangement. Three active participants also moved in to desired living arrangements during FY21. One found housing and planned for a move which took place in July of '21. Additionally two long-term program participants (those using as-needed supports) also moved into more desirable housing.	Individual planning assessments - POM, Independent Living Skills Checklist and participant plans.	Program Participants, staff observation and notes.
3 - Consumer Outcome B - **MOVE-OUT:** ***Individuals with I/DD develop the skills needed to live independently.*** GOALS: ○ 6 individuals successfully complete the Move-Out phase by: ▪ meeting their self-determined goals ▪ improving their POM score in at least one area	Individual planning assessments - POM, Independent Living Skills Checklist and participant plans.	Program Participants, staff observation and notes.

▪ showing the ability to complete needed areas on the Independent Living Skills Checklist. o Individuals will update their plans and goals annually ACTUAL OUTCOME: Self-Determined Goals: Five participants met goals they had defined for themselves. These included several cooking and transportation goals, as well as smart phone use. POM Score: Four participants had increases in their scores. The average increase was 3.75. Two participants had their POM score drop at an average of 5.5. One person's score remained the same. Independent Living Skills: All seven participants showed growth in their independent accomplishment of living skills critical to their circumstances. Many participants opted to defer updating their plans during the pandemic when fewer community options were available to them. When day to day life began normalizing in the Spring of 2021, program staff began working with participants to do those updates.		
4 - Consumer Outcome C - **REACH-OUT:** ***Individuals with I/DD develop connections to people and community.*** o 5 individuals successfully complete the Reach-out phase by: ▪ meeting their self-determined goals ▪ improving their initial POM score in at least 2 areas	Individual planning assessments - POM, Independent Living Skills Checklist and participant plans.	Program Participants, staff observation and notes.

▪ regularly engaging in 1 new activity ACTUAL OUTCOME: Self-Determined Goals: Four participants met goals related to social networks and community building. These included finding people to walk with, organizing a lunch group, participating in book clubs, and simply finding ways to spend time with others. POM Scores: Of the participants focused on the Reach-Out phase of this program, only one had a POM score to compare to a previous one. This person's score dropped by 4. The other four individuals in this group opted to postpone updating their POMs and plans until things began to normalize with the Pandemic. New Activities: Four participants began or sustained engagement with regular social or community activities, despite the social distancing limitations of this past year. Activities included a walking group, a friendship with neighbors, virtual bookclubs, and a lunch group.		
5 - Alternative Outcome – **RESOURCE CONNECTION**: ***Individuals in need will be connected to resources to maintain or better their ability to live safely in the community.*** o Individuals are directly connected with resources for ▪ Food ▪ Housing ▪ Other critical needs	Participant reports, staff observations and notes	Participant and staff notes

ACTUAL OUTCOME: Given the uncertain nature of much of this past year, a great deal of energy was giving to ensuring people in the program had their basic needs met and/or received support to manage resources and day to day needs in a time when that was much more complicated. Extensive support was given to 8 of the program participants in such areas as, support accessing affordable housing, managing and troubleshooting significant SSA problems, managing utilities, accessing emergency food support from the Bucket Brigade, accessing COVID testing and vaccinations, general housing advocacy, banking support (set up and routines), managing SNAP, medicaid, and other types of insurance, and supporting police reports and follow from being a victim of crime. There were three individuals whose housing was insecure or unsustainable at some point during FY21. In all three instances, program staff was able to support those individuals to find the resources or options to stabilize that situation. Solutions were found through transitional shared housing with another CC member, financial support for rent from a CC donor, and collaboration with the person's extended family to ensure independent living was viable after the death of a primary support person.		
6 - Consumer Outcome D - **PERSONAL DEVELOPMENT CLASSES:** ***Individuals with disabilities will develop their independent living skills*** ○ 15 individuals with I/DD will participate. 5 courses will be	Pre-Post class survey assessments	Participant responses

offered. Individuals can participate in multiple courses. ○ 100% of participants will indicate growth or skill development based off the course assessment. ACTUAL OUTCOME: 25 unique individuals participated in a total of 10 classes. Because many in person options were limited because of COVID, we offered additional classes. The following topics were offered: A Practical Guide to Friendships, Current Events, Healthy Relationships, A CC Book Club, A Crafting Sampler, a Happy Lifestyles Sampler, Foods and Nutrition, History of Disability, Women's Group, and Cooking - It's Dinner Time. An average 85% of responding participants indicated that they learned, built confidence, or increased understanding of the topic based on pre/post surveys. A challenge was ensuring that all participants were present and willing to complete both of the assessments. In two of the 10 classes there were no corresponding pre-post surveys completed to be included in this overall score.		

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 chose to 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 47 total surveys were completed. Of these 5 belonged to participants from the Community Transitional Support Program.
- Surveys were sent to approximately 160 member contacts and 50 non member contacts.

Consumer Outcome information related to our Community Transitional Support program was gathered from all participants actively working in the planning, move-out, or reaching out phase. After an individual has moved into the consultation (as-needed, informal support), they no longer have a formal plan and goals for which data is collected. For these individuals, service contact reports are kept to document support. Some individuals opted to wait to renew their full formalied plans until after COVID restrictions had lessened. They either continued working on their current self-determined goals needing attention or set new goals informally. Progress and activity for these was tracked regardless.

Consumer Outcome information related to Personal Development Classes is requested from all people who participate in classes. It is optional but strongly encouraged. It is frequently limited by inconsistent attendance by some 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?

The Community Transitional Support program served a total of 14 people. Two additional people were closed in early FY21.

Classes served a total of 25 people. Some Community Transitional Support participants also participated in classes.

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

Program Outcome Surveys were sent to approximately 160 Members and 50 Non-Member Participants.

Community Transitional Support outcome information was collected for all 14 individuals.

Class Pre-Assessment data was collected from 67 responses (all those willing a present during the registration or 1st day of class).

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

We received 47 Survey Responses, 5 of which were from Community Transitional Support participants.

We received various outcome assessment results from all 14 Community Transitional Support participants.

Of the 67 initial class assessments, we received 43 post- assessments. This decrease is generally due to fluctuating attendance from class to class or from individuals opting out of responding.

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

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

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

Personal Development Class Evaluations – These are gathered at the beginning and end of each class throughout the year.

Results

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

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

General:
Over the past few years we have been reflecting on the structure of our Community Living Department and the phase-based process that we built into it. As mentioned in the past several Outcome Reports, we have not felt that the needs and priorities of our participants could be accurately evaluated or reported into these rigid stages. This was particularly true this year, while living through the early height of COVID-19 and it's corresponding restrictions. Given this situation, the prospect of a clear Planning, Moving Out, and Reaching Out stages was definitely interrupted. In many cases the goals individuals had set for themselves were no longer applicable, had changed significantly, or were simply no longer a priority. Instead, dealing with day to day concerns, anxieties, and the increased bureaucratic burdens of closed offices, limited transportation, and other constraints were often the focus of our Community Living Staff.

While a clearly challenging time for everyone, it was a period where we were able to pin down the details of what we hoped our Community Living Department could become and the ways that we could evaluate it. Rather than a prescribed, straight path through and out of the program, we wanted a system of supports that was flexible and able to be pieced together to create a foundational support structure that would allow all our participants to be successful.

What we knew would not change were the key long-term outcomes that we wanted to make possible for our participants. Namely that people would be able to live in the community, find preferred and sustainable housing, and to grow and develop new skills and personal connections. The outcome that we realized needed to be added, however, was that people can identify support other than their parents. In so many cases, despite our involvement and efforts to build natural supports, participants often remain deeply reliant on their families for the structure that allows community-based living to be successful.

In the coming year (FY22), we are excited to move into a new structure and clearer set of priorities that will hopefully better match those of our participants and their families. While much of our day to day work with our members won't change, the ways that we define and

evaluate it will. It will be more personalized and better measure the real impact that we hope our participants feel.

Community Transitional Support:
In reflecting on the specific data from FY21, there are a number of trends. First, the risks and barriers that our participants had all faced in previous years, seemed to have those amplified due to the pandemic.

Housing - The individuals who had always lived with fewer financial resources and been closer to unsustainable housing situations found themselves in more dire need. Two individuals very nearly experienced homeslessness. In these instances, all our efforts went towards addressing these situations at the expense of supporting other self-determined goals. Positively however, the natural supports that we had helped these individuals connect to over the past few years were able to make a significant impact on finding a more sustainable situation for each person.

Three other individuals were able to move out for more desirable reasons and through the planning that we had supported in the preceding years. This included two moves into awaited affordable HACC housing, and planning with natural supports. Happily, the pandemic did not significantly interrupt these long term plans.

Resources - Support that we have frequently provided in coordinating resources often took significantly more time due to pandemic restrictions. What might have once been an 1-2 hour visit to the social security office, for example, turned into a months long series of phone calls and written correspondence. These delays then further negatively impacted the person's financial and housing situation.

Connections - This year was a period that was very isolating for most people. This was no different for the participants in this program. Individuals with goals to get connected to community activities, businesses, or classes had to put those on hold in most cases. We did notice that participants living with others either grew their friendships with their roommates or neighbors in a positive way or had rocky relationships deteriorate to the point of needing to move urgently to avoid building interpersonal conflict. This was the case for one participant and nearly the case for someone else.

Some of the bright spots in this domain of the program were the small groups and connections that were able to function in the restrictive COVID environment.

Plans and Quantitative Data - As noted above, there were quite a few people who requested that we put updating their plans and formal goals on hold due to the lockdown restrictions. This did limit the number of POMs that we completed and the total count of plans updated during the year. When things began to open up, many people began that planning and updating process. The POM data that we did receive was very scattered. In many years people's scores

often only change by one or two points in either direction. This year, the changes seemed to swing more significantly. One person's went up by 6, for example, while another person's dropped by 7. We explain these variations by the polarizing effect that the pandemic had on many people. For those who were able to tackle big changes like moving into affordable housing or other set ups, these impacts had a cascading positive effect on other areas of their lives. For others who were already isolated, or working towards greater community integration and connection, their scores had a cascading downward trend.

Personal Development Classes:
Also impacted by the Pandemic were our Personal Development Classes. Because many other in person activities and events were inaccessible, we opted to provide additional classes, as these could be safely and effectively presented over Zoom. Class topics were in most cases chosen based on our participant requests. Our frequent Zoom meet-up sessions proved to be an excellent place to learn about member interest and needs. Themes from members' lives this past year tended toward learning ways to maintain relationships, learn new skills and hobbies to pass time and manage stress, as well as cooking and processing the many significant current events affecting us all.

Participation in all our classes was very strong this year and feedback was overall quite positive. Depending on the class we gathered pre and post assessment data connected to skills, confidence, or knowledge on key areas around the topic. 85% of respondents indicated that at least one of these areas had grown or improved for them. In some cases this data was limited to only a partial set of the full class, as attendance was never completely consistent from the first day to the last. We were also encouraged with the ongoing requests for classes and the strong enrollment as additional indicators that participants were finding the experiences worthwhile.

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

No

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

N/A

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

N/A

(Optional) Narrative Example(s):

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

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

Example 1: All goes as Planned

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

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

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

Example 2: All does not go as planned

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

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

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

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

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

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

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

These are examples that we have shared in the past but they continue to reflect the real life experience of many people who are part of the Community Transitional Support program.

In FY22, we will be initiating additional supports within this program that will address each of these circumstances as well as additional options for people whose situations require other types of support structures.

Example 1 - Things Go as Planned - With New CL Supports

In this situation, Person A is likely to experience the same type of support and process that is described in the initial example.

Example 2 - All Does not go as Planned - With new CL Supports

In this situation, Person B would be given the option of working with a team of support staff in the Sustained Supports wing of the Community Living department. There, they would have a dedicated team give them guidance and assistance in more domains of their lives. Someone would be able to focus specifically on finding and maintaining affordable housing and the local benefit systems that would support that. Someone else could support general life coordination, setting up routines, finding reliable transportation, and keeping important documents and benefits programs running. Someone else would be able to offer hands-on instruction for new skills and guidance on growing other natural supports. Though the overall goals for this person might be the same, the depth of support available to them would ideally reduce the likelihood of adverse life outcomes such as homelessness.

Example 3 - Cyclical Supports - With new CL Supports

In this situation, Person C and D have had several years of support from the department. When they move into the new apartment, they find that there are still a few skills and setups where they need some assistance. Rather than start the Transitional Support process from the beginning again, the participants may be able to simply use some hand-on skill building support from our Sustained Support team. They could opt-in for whichever ala carte supports they identified as needing in their move-in process. This new structure and set of options would honor all the work they had already done, while still providing the few supports they may still need in their new living situation.

Example 4 - Support for More People
A - Ala Carte
In this example, Person E and their family have been discussing what type of community-based living might be an option. They have found that the biggest barrier this person is facing is that they are not able to fill their own medication box and keep prescription refills organized. They also have a habit of overdrawing their account, so their family is concerned that unless they become very involved in their person's day to day life, any community living set up will be a failure.

With the new structure of the Sustained Community Living Supports, this family would be able identify these barriers in our planning process and pinpoint what type of involvement would be critical for Person E. In this case it would likely be support with Health and Medications as well as financial supports. Everything else Person E and their family feels confident they can handle themselves. Community Choices is able to step in and help this person find an effective system for medication organization including reminder alarms and offer a weekly meeting about

budgeting and finances. Person E is excited to move out into their new apartment and their family is confident that not only their person will be successful, but that their role and dynamic can be that of a proud parent of an adult, not a family-case manager.

B - Full Support
Person F has been living in their own apartment for a couple of years. Though they've used some supports from agencies, their family has still done a large share of managing that support. They've made sure Person F's benefits with public aid, social security, and the ISCs have been consistent. They've helped them make a weekly schedule and have planned out how transportation and communication will work between all the patchwork of community jobs and groups the person is active with. Things are going OK, when the family unexpectedly experiences a change in their own circumstances and are not able to continue to be as actively supportive in their family member's life. In this situation, the Sustained Support program would be able to step in and provide most of the supports the person might need to maintain their integrated and well-loved community-based life. Rather than the person needing to move back in with family or to a more restrictive setting, they are able to keep their apartment and the life they've built for themself.

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)

Ongoing Evaluation was critical to the development of the new supports we're offering in this program. FY21's data again reflected a disconnect between how people's lives and support needs are structured and how our program has been designed. Rather than a linear process, we'll be moving to a set of support domains that people can opt into on a full or ala carte basis. We'll also be focusing on evaluating the outcomes that are critical to ongoing success, such as if the person's housing is sustainable, if they are learning valuable skills, building connections, and if they are accessing the supports they feel they need.

These program changes were also strongly impacted by communication with our members individually, through our surveys, and during the Strategic Planning Session that we held in February of 2020. In that meeting we heard much of what we had already observed - that participants and their families were looking for more robust and intensive supports to ensure the sustainability of community-based living with or without consistent family support. The domains, planning features, and the clear set of options we've developed are all directly built off of the feedback, requests, and observed needs of our members and participants.

We are enthusiastic to see how these new structures work in the coming year and what impact they have on the lives of the people we serve.

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 Community Transitional Support Program.
Goal: 15 TPCs will be served

ACTUAL OUTCOME: 14 TPCs were served.
Though there was some interest from new participants in the program, most decided to defer move-out and changes to their situations until after COVID restrictions had been lifted.

<u>Non-treatment Plan Clients (NTPC):</u>
This includes adults with I/DD who participate in Personal Development Classes.
Goal: 15 NPTCs will be served

ACTUAL OUTCOME: 25 NTPCs were served
Because fewer in-person options were available due to COVID, we offered additional classes this year.

<u>Community Service Events (CSE):</u>
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 live in the community.
Goal: 2

ACTUAL OUTCOME: 3 CSEs

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 directly connected to providing support (including connecting to resources, collaborating with families and natural supports, and documenting the support provided). Service contacts for NTCPs will be reported in the traditional format (total count of contacts).

Goal:

Community Transitional Support – 1170 Service Contacts

Personal Development Classes – 250 Service Contacts

ACTUAL OUTCOME:

Community Transition Support - 864 Claims

Fewer Community Transition Support Claims that estimated is a result of the interruption in services and routines caused by COVID 19

Person Development Classes - 329

Additional Class Service Contacts is a result of additional classes being offered.

Other: Direct Hours

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:

Community Transitional Support – 1482 Direct Hours

Personal Development Classes – 180 Direct Hours

ACTUAL OUTCOME:

Community Transitional Support - 1223 Direct Hours (reported as claims)

Fewer hours is also a result of service interruptions caused by COVID 19.

Personal Development Classes - 712

Additional hours are a result of additional classes being offered. The time dedicated to those classes was also increased due to the content - such as cooking, which was a longer sessions with additional prep and support. For several classes we also delivered materials to people's homes and offered additional sessions to work on ongoing projects.

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

Performance Outcome Report Template

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

Agency name: Community Choices
Program name: Customized Employment
Submission date: 8.27.21

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 are 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.

There were 10 new participants starting services in our Customized Employment program this year using CCDDB funding.

Six were previous Community Choices members. Of the other four, two were referred by other parents, one by a local therapist, and one from a CCDDB-funded ISC.

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 indicate a desire to use our services after an informal meeting to explain the program and eligibility, it is estimated that over 95% of individuals will eventually receive services.

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

There were 24 total people who joined the waiting list to begin a job search during FY21. 16 of these were to be funded through the CCDDB grant. In total we began services with 18 of them or 75%. Of the 16 funded by the CCDDB, we began services with 56% of them. It is worthy to note that most of the individuals seeking employment support through CCDDB funds reached out for services within the final 6 months of FY21. Those who did not start services in FY21, will begin them in FY22.

We have made a goal to begin Discovery with individuals on the waiting list within 30 days.

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

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

95% - This refers to the percentage of people who will work with our Membership Coordinator to determine eligibility by contacting the PAS agent at CCRPC within 14 days.

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

100% - Community Choices does not assess individuals. That is done by CCRPC, generally before they ever reach out to us for services.

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

60 days - This refers to the length of time that a person will wait on the waiting list before beginning 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):

75% - This indicates that 75% of clients on the waiting list will begin services within 60 days.

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

44% of the people served this year were served with in 60 days. The average length of time on the waiting list for individuals engaged/served this year was 63 days. This year was odd, as employment services were quite limited and few referrals came during the first part of the year. So when we began more actively working with people during the 2nd half of the year, we were able to start quickly with many people.

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:

Discovery lasted an average of 46 days. Job Matching lasted an average of 150 days. Participants kept their jobs for an average of 413 days (though the spread was very wide). Participants who are doing well at their jobs after 18 months are closed from services.

Demographic Information

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

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.

The above data was collected from participants in this program.

Consumer Outcomes – *complete at end of year only*

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

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

- 100% of participants with I/DD will report engagement and support in the employment process.
- 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 off interests and strengths.**

GOAL:

- 20 individuals will complete Discovery and agree on a personal employment profile based on their strengths and interests.

3 - Consumer Outcome B - **JOB MATCHING: Individuals will acquire community based employment based upon their strengths and interests.**

GOAL:

- 13 Individuals will obtain paid employment,
- 7 individuals will obtain volunteer jobs or internships.
- [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:

- 20 individuals will receive job negotiation and coaching leading toward greater independence when at their jobs.
- [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:

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

6 - Consumer Outcome E - **SUPPORT MODEL DEVELOPMENT: CC will develop a model of employment delivery for people with a wider range of needs**

- CC attends 3 employment-related conferences
- CC shadows 3 progressive employment programs around the state
- CC conducts 1 forum with employment providers
- CC prepares a program design for supporting people with more complex needs

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.)

1 - 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.

Data Collection: The survey will be presented to all participants and their families (if they are involved). Full participation will be encouraged.

2 - Assessment: 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.

Data Collection: All individuals initiating employment support and completing the discovery process will develop a plan.

3 - Assessment: All job offers for people using employment supports will be tracked and communicated through regular meetings.

Data Collection: Staff will collect job offer information from all participants.

4 - Assessment: 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.

Data Collection: Employment staff will use contact notes to track support need and participant progress.

5 - Assessment: 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.

Data Collection: Employment staff will use contact notes to track support need and participant progress.

6 - Assessment: Tracking of events attended related to program development.

Data Collection: Project elements will be recorded and combined into a final summary along with the program model design.

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 - 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: ○ 100% of participants with I/DD will report engagement and support in the employment process. ○ 85% will report that their strengths and interests are important to the employment process. ACTUAL OUTCOME: The response rate for our Participant/Member Survey improved this year. It went from 32 responses in FY20 to 47 responses this year. Of those 47 people who responded, 26 indicated that they had participated in our Customized Employment Department. 15 of those were members/participants with a disability and 11 were family members of participants. - 85% of respondents indicated that they were Very Much or Somewhat engaged and supported in the employment	CC's Annual Participant/Member Survey	Participants, Participant Family Members

process (70% indicated "Very Much"). - 15% indicated they were only "A Little" or "Not at All" engaged and supported in the employment process (only 1 person, 4%, said they were not at all engaged). - 84% of respondents said that their interests and strengths were "very important" to the staff supporting them in their job search. 12% said that this was "Somewhat" important. 4% (one person), said that it was only "A Little Important". No one said that it was "Not Important". Additionally: - 81% of respondents indicated that they were "Very Much" or "Somewhat" learning skills to support their employment goals. - 12% said they were learning "a little" and 8% said "not at all".		
2 - Consumer Outcome A - **DISCOVERY: Individuals develop a personalized employment plan based off interests and strengths.** GOAL: ○ 20 individuals will complete Discovery and agree on a personal employment profile based on their strengths and interests. ACTUAL OUTCOME:	Discovery Documentation/ Questionnaires/ Staff Notes	Participant Responses, Staff Notes

- 17 People completed the discovery process and agreed upon employment goals.		
3 - Consumer Outcome B - **JOB MATCHING: Individuals will acquire community based employment based upon their strengths and interests.** GOAL: ○ 13 Individuals will obtain paid employment, ○ 7 individuals will obtain volunteer jobs or internships. ○ [NOTE: An additional 5 individuals will achieve this outcome with DRS funding] ACTUAL OUTCOME: - 10 Individuals found paid employment - 1 person found volunteer employment - 5 people found paid employment funded through our DRS contract	Observation, Communication with participants, Job Placement Tracking Documents	Participant report, Staff report
4 - Consumer Outcome C - **SHORT-TERM SUPPORT: Individuals with I/DD, negotiate and learn their duties to be successful at their jobs.** GOAL: ○ 20 individuals will receive job negotiation and coaching leading toward greater independence when at their jobs. ○ [NOTE: An additional 5 individuals will achieve this outcome with DRS funding] ACTUAL OUTCOME:	Staff Notes/ Documentation	Staff

- 16 People received support with negotiation or job coaching - 5 individuals received this support through DRS funding		
5 - Consumer Outcome D - **LONG TERM SUPPORT: Individuals with I/DD maintain their jobs through ongoing support and job expansion.** GOAL: o 30 individuals receive on-going support according to their needs. o 70% of individuals keep their jobs for at least 1 year. ACTUAL OUTCOME: - 20 People received long-term support to maintain jobs. - Looking back at everyone hired at a job with our support since FY19, their average length of employment was 413 days. - Of the people working at the start of FY21, 71% were still employed at the end of FY21. 75% of those not working, lost their jobs due to COVID directly or indirectly through a lack of business.	Staff Notes/ Documentation	Staff
6 - Consumer Outcome E - **SUPPORT MODEL DEVELOPMENT: CC will develop a model of employment delivery for people with a wider range of needs** o CC attends 3 employment-related conferences	Staff Notes and Documentation, Training records	Staff

○ CC shadows 3 progressive employment programs around the state ○ CC conducts 1 forum with employment providers ○ CC prepares a program design for supporting people with more complex needs ACTUAL OUTCOME: - 3 Virtual Employment-Related Professional Development events were attended - 0 Provider Visits were made (due to COVID) - 0 Employment Forums were held (due to COVID) - 1 program design was developed to support first time job seekers and those with more complex needs.		

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 chose to 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 47 total surveys were completed. Of these, 26 belonged to people who had participated in our Customized Employment Department.

- Surveys were sent to approximately 160 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?

We supported a total of 46 participants in some capacity during FY21.

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

All 46 participants.

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

We received Overall Program Outcome data from 26 individuals (15 Participants with I/DD, 11 Family Members). We collected Consumer Outcome data from all 46 participants.

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

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

All other data is collected throughout each participant's employment support process. As they move through the various stages, the corresponding evaluation/documentation is used.

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)

Program Outcomes:
We are unexpectedly very proud and impressed with the Employment outcomes that this program was able to achieve this year, despite its *many* challenges and barriers. Our overall program data paints a generally rosy picture of peoples' experience in the program. Participants overwhelmingly felt that they were getting the support they needed and were engaged in the employment process They also strongly indicated that their strengths and preferences were important to those supporting them. This, combined with the job match numbers compared to last year, all feel like a strong endorsement that the service we are offering is valuable to people and helping them to achieve their desired outcome of community-based employment.

At the beginning of FY21, the prospects and projections for they type and level of support this program would be able to provide was at best unknown, and at worst very pessimistic. During the initial months of the pandemic, many of our participants lost their jobs, were furloughed, or decided to step back in the interest of their and their family's health. Few new people were reaching out to us to begin job searches. We were able to continue to support those still employed and those still interested in finding new work, but the general slow pace of things continued into much of the fall and winter. But shortly after the vaccines began to roll out, interest in the program began to grow. New participants were reaching out to us, and those who had put things on hold began discussing restarting services. Referrals from DRS began to surge as well - we received more in the FY21 than in several of the past few years combined.

Also exciting was our ability to begin work with these interested parties right away. For many years, the capacity of our program has not been able to match the need for our services. Because we had so many people discontinue services in late FY20 and early FY21, our Employment Specialists had openings and availability to engage people in service more quickly than other times, capturing people's enthusiasm and motivation to find employment. This pandemic-induced slump in our services also allowed us to re-think a few of our internal processes that we are hopeful will help to continue these positive trends. Most importantly, we have set a goal to begin discovery with all new participants within 30 days of them being on the waiting list. In some cases they may have to shift to a "stand-by" list following discovery until an

Employment Specialist has the capacity to begin regular 1:1 meetings. The benefit, however, is that instead of waiting unengaged and with our staff knowing little about the person's preferences and strengths, we will have a great deal of information about what an ideal job looks like for that person. This will allow us to keep them in mind for job leads that arise, widen the pool of potential applicants we can suggest when businesses have some carved potions, and give the person and their family resources and ideas for skills to practice while they wait to begin their personalized job search. We acknowledge that people may experience a wait, but we hope we are making that wait a more productive one.

In additional reflection, previous years we have noticed and reported that the preferences and support needs of those coming to us for services was shifting. We were receiving many more referrals for young adults right out of high school and from people who were older but first time job seekers. This is an excellent trend and indicator of how people's mindsets about the capacity of people with I/DD to work meaningful community jobs is improving. It is also a more challenging set of variables for an Employment Specialist to address in their job search. This has made job searches for these folks last longer and pushed our employment staff to build additional tools and learning opportunities into our process. These will surely help all our participants and we are poised to begin this work more intensively as will be discussed below. It is worth noting, however, that during FY21 we had fewer referrals and potential participants coming directly from school or to look for a first job. This is not surprising, people in these situations are often younger and still enmeshed with their families, making the income from a job less of a critical need than some others that we are working with. This trend in the profiles of those using our support this year does align with our lower than expected rate of volunteer job matches. These types of placements are often of more interest to younger or new job seekers. It also seems to support the hypothesis from previous years, that the increased support needs of our new participants made the estimations of our program outcomes somewhat unrealistic. It is also an interesting and important factor to remember when we look at the many ripples of how COVID-19 has affected people with I/DD.

Hopefully, the pandemic will not continue to push young people with I/DD and folks with more complex needs farther from community life. Almost ironically, COVID did give us some additional time to build tools we were needing to support people in these circumstances, even if they weren't there to use them initially. We are hopeful that our new service options and tools can be a bridge to support people to enter, or re-enter the workforce.

Our intention had been to spend the year visiting other employment programs and speaking with other providers in the lead up to designing new supports that could specifically serve people with more complex needs or those unsure about the responsibilities of work. These steps proved to be challenging to accomplish in the height of the pandemic and when so many providers around the state were struggling to fight outbreaks and staffing shortages, not to mention vastly limited employment supports. Instead we decided to focus on building a

program based on principles that we knew worked with those we've supported and are reflected in research and practice.

The program that we have designed has three main components.

1) Classroom Learning with a focus on key soft skills and a clear breakdown on the critical aspects of keeping a job. Topics will cover Workers Rights under the ADA, Employer Expectations, Routines and Priorities, Attitude and Enthusiasm, Getting the job done (managing tasks and managing downtime), Getting along with coworkers and supervisors, TIme Management, and Problem Solving (employee needs, and interpersonal issues).

2) Real-Life Experience. Many people do not have a good sense of what jobs actually entail or the wide variety of tasks that exist in the community. When starting on a job search with someone who hasn't had these experiences or seen what they're like, it is difficult for them to know if it is something that they are going to enjoy, excel at, or find desperately boring. To address this, we're partnering with Urbana Park District and the Channing Murray Foundation to give program participants the opportunity to shadow and try many different jobs in many different fields.

3) Reflection and Integration. Each week we will be reflecting on the skills taught and the experiences participants had. They will have the chance to discuss the real-world application of the classroom learning and their on-the-job learning to develop a better understanding of their own strengths and interests.

This program will run 3 days a week for a 12 week session. Job Shadowing groups will be no larger than 3. Everyone will have the opportunity to shadow for 6 weeks with each partnering organization. Typical workplace expectations will stand for all aspects of the program, such as prompt arrival, management of break times, and willingness to try. At the end of the program, participants will have the option to begin our customized employment process, starting with discovery or not. Those that do choose to move forward with employment will be doing so with additional skills and experiences while those who opt out, will have made a more informed choice about where their interests and priorities lie.

We're very excited to start this program in FY22 and are very hopeful that it will be a valuable tool to give people with I/DD an additional path to build confidence in themselves and the possibilities open to them in a community-based life.

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

No

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

N/A

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

N/A

(Optional) Narrative Example(s):

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

These are examples that we have shared in the past, but they continue to be reflective of the experiences of participants in this program.

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

After about 3 months they were next on the list and a CC employment staff person gave the family a call to say they'd be ready to start in the next couple of weeks. They have a brief meeting to start things out and go over the process. From 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 the Person A's family to make sure that there aren't other issues that need to be addressed. As Person A builds their confidence, the CC staff fades out more. Check ins move back to weekly and after a couple of months, they become less frequent. After 3 months, though the employer gets a new manager. The CC staff learns this when they call in to check with the supervisor about how things are going. At this point they come back in more frequently to make sure that routines and accommodations haven't changed and help to reaffirm the relationships that have been built between all parties. Check ins continue and the CC staff is available as needed if Person A or the employer have questions or concerns.

<u>Things do not go as planned:</u>
Person B is 35 and has just started the process of finding a job for the first time. They are excited to be making money and want to start right away. Their parents are totally on board and are also ready for them to start working right away. Person B is interested in computers and enjoys comic books. They were referred to Community Choices through someone at their church. After about 4 months on the waiting list with 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 its important and encourages the person to give it a try. They arrange a first meeting and it goes well. At the end they set a date for the second meeting, but when the day comes, Person B doesn't show up. The CC staff follows up and talks with Person B's parents. They said they forgot and reschedule. This continues for the next few weeks with Person B missing several meetings, sometimes because they were sick, because they planned something else during that time, or simply because they forgot.

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

Eventually after working on applying for jobs Person B gets an interview. Unfortunately they doesn't show up. Their parents are very upset. Person B says they still want a job and a new appointment

communication routine is put in place. Things go pretty well for a few weeks and they get another interview in the book department of a store that sells graphic novels. The interview goes well and Person B gets the job. The first two weeks go well and the CC staff person supports and helps to get logistics and routines set up so that success can continue. This includes a plan to go over the schedule each week and plot out shifts on a white board calendar in Person B's apartment. After a few weeks Person B no call no shows for work and is fired.

<u>Some Program Changes to Support Participants:</u>

- Our goal to begin Discovery within 30 days will hopefully encourage participant motivation and engagement and allow us more opportunities to find potentially good job matches.
- Weekly department meetings will be used to review themes for people currently engaged in job development/job matching and those in stand-by and job openings, supportive employers, and other job leads for everyone in the program.
- Zoom has proven to be a useful tool to support participants filling out online job applications. The screen share option is very useful for coaching a person in filling out forms and using online portals, both skills that many participants find challenging. It also gives participants additional options for meeting when transportation is a barrier.
- Our new First Time Job Seekers program, "Workforce Empowerment", will teach critical skills and help those unsure about employment and work responsibilities make informed choices.

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 development of new programs, processes, and internal systems are all the result of direct or indirect evaluation. We have been observing trends both in our outcome data as well as in the demographic information about our participants. This has led us to build our new job skills program as noted above. We have also made changes to our Discovery process, internal collaboration, and in the materials that we share with families about our program after analyzing data on satisfaction and success in the program.

We are also tracking additional data on the length of time that participants spend in any phase of our program and hope to find additional ways to apply this data in the future. It has already proven helpful in observing employment trends over time and will get better the longer we are able to collect it in an effective way.

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 Customized Employment program.

GOAL: 42 TPCs will be served

ACTUAL OUTCOME:
47 participants were served in some capacity

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

NTCPs will be defined as other service providers who engage with us to design better support models for people with more complex needs.

GOAL: 5 NTCPs will be engaged

ACTUAL OUTCOME:
0 - Due to the COVID Pandemic, we were not able to engage with other providers

<u>Community Service Events (CSE):</u>

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: 5

(4 will be focused on sharing information on our support options to the community. 1 will focus on engaging providers in a dialog about employment program design options)

ACTUAL OUTCOME:
4 CSEs held

Provider Engagement CSE not held to do pandemic

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 directly connected to providing support (including connecting to employers, collaborating with families and natural supports, and documenting the support provided).

GOAL: 1824 Service Contacts

ACTUAL OUTCOME:
902 Claims

Fewer claims are a likely result of service interruption due to COVID as well as staff under-reporting.

Other:

This reports direct hours by staff supporting 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 OUTCOME:
1019 Hours (via Claims)

Fewer hours/claims are a likely result of service interruption due to COVID as well as staff under-reporting.

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: Self-Determination (Connect)
Submission date: 8.27.21

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, will be used as an eligibility determination tool ..... The Membership Coordinator will meet with the individual 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 Community Living 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 and the Northern Champaign County Community Resource Fair.

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

Formal data on referrals has not, to date, been collected. No individuals who 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:

90% of members with disabilities participated in services during FY21. If we include family members, 81% of members participated in services and supports throughout the year. Additional family members also participated in events and opportunities that were open to the public.

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

Engagement in all Community Choices services begins with referral (formal or informal) and an intake meeting with the Membership Coordinator. 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):

14 days

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 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 actively part 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 are able to participate in program activities immediately. Services/supports in this program are opt-in, so new members have the opportunity to participate in what is happening right away.

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

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

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

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

Between FY20 and FY21, 88% of members renewed their membership.

The renewal period occurs during the spring. Members returning after a membership lapse may also be asked to come in for a renewal meeting with the Membership Coordinator depending on changes to their circumstances. 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 ~ 45 individuals reached.
   - 4 Family Parties ~ 20 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
     - 2-3 Pilot Opportunities for Scaffolded Community Engagement (Park District Classes, Cooking classes, community-based ½ day social groups)
   - Personalized Community Connections
     - 15 CC members complete Connection Exploration process
     - 3 new Co-Op clubs, 3 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, Advocacy Initiatives Board, Media Engagement, 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:
Program Outcome: Participation with CC leads to greater supportive networks and connections. **EXPECTED OUTCOMES** 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	Annual Member Survey	Members with I/DD and their family members

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. **ACTUAL OUTCOMES:** Members with I/DD: 88% indicate they made a friend and 48% of those friendships will be defined as at least somewhat close. 84% indicate that CC provides them with a supportive community. Family Members: 78% indicate they connected with another family member and 28% of those connections were meaningful. 94% indicate CC provides them with a supportive community.		
FAMILY SUPPORT AND EDUCATION: ***Members support each other and gain knowledge of the DD service system*** **EXPECTED OUTCOMES:** 5 Co-op meetings ~ 45 individuals reached. 4 Family Parties ~ 20 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	The number and attendance rate of Quarterly Co-Op meetings, Family Parties, and Support Groups will be recorded. The Family Support Group will use a post course evaluation to determine the outcomes of participation. Formative assessments via informal feedback from members will be used to direct the content of groups and resources	Attendance data and program evaluations.

ACTUAL OUTCOMES: 5 Co-op meetings ~ 45 individuals reached. 3 Family Parties ~ average of 19 members attend each. 3 Family Support Group Sessions ~ 9 unique family members participate. Did not distribute evaluations to Family Support Group members due to limited number of meetings.	offered by Community Choices.	
BUILDING COMMUNITY: ***Members with I/DD engage with each other and community-based groups and opportunities*** **EXPECTED OUTCOMES:** *Community Social Opportunities* 48 Routine Social Opportunities 2-3 Pilot Opportunities for Scaffolded Community Engagement (Park District Classes, Cooking classes, community-based ½ day social groups) *Personalized Community Connections* 15 CC members complete Connection Exploration process 3 new Co-Op clubs, 3 continuing clubs ~ 17 members participate 3 Open Champaign Individual Connections ~ 3 members participate	Number and attendance rate of routine and scaffolded social opportunities; pre-post model assessment using a modified Relationships Map will be completed by participants Annual Member Survey	Attendance data; Members who organize co-op clubs and participate in 1-1 connections

2 Open Champaign Events ~ 12 members participate **ACTUAL OUTCOMES:** *Community Social Opportunities* 16 Routine Social Opportunities *plus 366 zoom opportunities 1 Pilot Opportunities for Scaffolded Community Engagement (Park District Classes, Cooking classes, community-based ½ day social groups) *Personalized Community Connections* 3 CC members completed Connection Exploration process *5 began the process but chose to put it on hold due to COVID 1 new Co-Op clubs, 2 continuing clubs ~ 14 members participated 4 Open Champaign Individual Connections ~ 7 members participated 2 Open Champaign Events ~ 13 members participated **Additional Data From the Member Survey:** Members with I/DD: 100% indicated that Community Choices encouraged them to build their community connections at least “A Little”. 71% indicated that we did this “Very Much.” (n=24)			

Family Members: 100% indicated that we did this at least “A Little”. 69% indicated that we did this “Very Much”. (n=17)			
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** 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, Advocacy Initiatives Board, Media Engagement, or other leadership activities. **ACTUAL OUTCOMES:** 1 Leadership course offered - 80% (⅘) of participants indicated an example of a leadership skill or mindset that they gain or increase confidence in. 9 unique members participated in 12 opportunities to demonstrate leadership growth by participating in Mentoring, Advocacy Initiatives Board, Media Engagement, or other leadership activities. **Additional Data from the Member Survey:** Members with I/DD: 96% indicated that participation helped them to	Number of leadership/self-advocacy events and their attendance; assessment questionnaire for those participating in the Step up to Leadership Course and other self-advocacy activities Annual Member Survey	Class participants, mentors, advocacy initiatives board members, and other engaged in advocacy projects	

gain advocacy, knowledge, or leadership skills at least “A Little”. 58% indicated they gained these skills “Very Much” and 17% indicated that they gained these skills “Somewhat”. (n=24) Family Members with I/DD: 100% indicated that participation increased their advocacy, knowledge, or leadership skills at least “A Little”. 59% indicated they had gained these skills “Very Much”. 29% indicated that they had gained these skills “Somewhat”. (n=17)		

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

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

Evaluations for the Step Up to Leadership Course were distributed during the final session date. Not all participants were present on that date.

Due to the complications of COVID, the Family Support Group did not meet as often as planned and evaluations and surveys were not distributed to group participants. The group transitioned to meeting through zoom, but attendance was very low. We decided to take a break from meeting until it was safe to do so outside in April and May.

Circles of Support tools were also not distributed to Co-op Club organizers and members who participated in personalized connections. This was due to COVID and Community Choices staff revamping programming to meet through zoom. Two continued clubs transitioned to meeting through zoom once a month. One new club began during FY21 and has only met through zoom.

Some of the information above reflected data gathered from our member survey. The survey is structured to skip questions about programs or supports that the person or their family member does not use. This year we used only an online option for completing the annual survey, instead of a paper or online version. This was due to the COVID restrictions and guidelines which corresponded with the time period when we distribute the survey annually. Although we did mail paper copies of the annual membership survey to any members who requested it. The survey was sent to 194 members. We

received 47 responses from members. This is an increase from FY20, when we only received 32 responses.

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

Evaluations for the Step Up to Leadership Course were distributed during the final session date. Not all participants were present on that date.

Due to the complications of COVID, the Family Support Group did not meet as often as planned and evaluations and surveys were not distributed to group participants. The group transitioned to meeting through zoom, but attendance was very low. We decided to take a break from meeting until it was safe to do so outside in April and May.

Circles of Support tools were also not distributed to Co-op Club organizers and members who participated in personalized connections. This was due to COVID and Community Choices staff revamping programming to meet through zoom. Two continued clubs transitioned to meeting through zoom once a month. One new club began during FY21 and has only met through zoom.

Participants self-selected if they wanted to respond to the annual member survey. It was not mandatory. We typically offer an opportunity for members to complete the annual member survey at our Spring Member-only Co-op Meeting. Due to COVID health guidelines, we had to hold this meeting through zoom. We were not able to collect survey responses in person, only through mail or online, which we believe decreased participation.

5. How many total participants did your program have?

194 – This includes members with disabilities, their self-selected family members, and family /community members who attend our public education and community events. Of this: 72 were members who have a disability, the rest were family members.

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

Due to the nature of this year's events, our normal routine for collecting information about Family Support Group, Co-op Clubs, and personalized connections was interrupted.

Step Up to Leadership: 5 members with disabilities participated in the course. Two were in attendance on the last session date and received evaluations and a request to complete at the zoom class. The 3 additional class participants received the link for submitting the class evaluation online, 2 completed the evaluation.
4 people completed class evaluations

Member Survey: The member survey was sent to 194 people. This included members with disabilities and family members of those individual members with disabilities.

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

Step Up to Leadership: 4 evaluations were returned.

Member Survey: 47 responses were collected.

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

Due to the nature of this year's events, our normal routine for collecting information about Family Support Group, Co-op Clubs, and personalized connections was interrupted.

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

Member Survey: This is completed once per year in the spring. We were not able to give paper copies to members at the Annual Member Meeting this year, as it was held through zoom. Due COVID, staff was also not having regular in-person meetings with individual members, which is another way we have distributed surveys in the past. An online (Google forms) version is also available and emailed to all members. We also mailed paper copies to any members who requested a hard copy.

Results

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

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

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

Although we used only an online option for completing our annual membership survey, we received more responses this year (47) than we did in FY20 (32). The pattern that we have seen develop over the past years still holds true. That pattern indicates 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. Members with I/DD and family members who respond indicating that they are involved in none, one or few Self-Determination supports and programs tend to also respond that they have not made a meaningful connection or friend over the past year, and do not feel a part of a supported community.

This year we offered as many in-person programs and opportunities for connection as we could within the COVID guidelines. In addition, we also offered 366 opportunities for members with I/DD to connect through zoom. We saw many members (reported as 88% in our annual survey) develop connections with each other through regular interaction at the zoom meetings. This holds true with the trend we've seen of people highly involved in programming reporting that they feel more connected to a person, place or activity. While a lot of our programming and opportunities to connect had to be through zoom in FY21, we see these results as evidence that the more people with I/DD interact with and are involved in their communities regularly, the more connected they will be to their community around them.

We have also discovered that people respond to Connect Services because they have built a trusting relationship with one of the Connect Staff who act as a bridge to Self-Determination supports and programs in the Connect Department. Community Choices members have been divided between the three Connect Staff. Each Connect Staff contact the members on their list at various times to ensure they are aware of program and support opportunities within the Connect Department, recommend a

program that may be of particular interest to a specific person, or check in about starting to work on an individualized connection with a person, group or location. We believe that this was one of the factors in having high and regular attendance at our zoom sessions and online personal development classes.

Family Support and Education

Helping families support each other, learn about the services systems, and advocate for what they are looking for is an important element of this program. We offered 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 how Community Choices had decided to expand and grow the Community Living Department, based on the strategic process members were invited to participate in during FY20. Co-op meetings that had topics such as: "Medicare/Medicaid and Open Enrollment," "Getting Ready for Employment," and "Demystifying Waiver Services and HBS," attracted not only Community Choices members to attend, but also members of the community at-large.

Our Family Support Group was not able to meet as many times as planned during FY21. Meeting through zoom provided very low attendance - possibly because people were "zoom-ed out." But when the group was able to meet in-person a few times outside in the spring, many people indicated they were happy to see each other again. Impromptu conversations about HBS services, how to navigate Able Accounts, and voting rights for people with I/DD were had, along with the necessary "How are you surviving these times?" conversations.

Quantitative data from our Membership Survey supports these more informal or qualitative reports and records. 78% of family members indicated that they connected with another family member and 28% of those connections were found to be meaningful. Both of these percentages are an increase from FY20. 94% of family members responded that being a member of CC provides them with a supportive community.

Building Community

During FY21 we continued to offer regular social opportunities to our members with disabilities when we felt it was in line with COVID guidelines and we felt it was safe to do so. These were in both group opt-in settings and in smaller, personalized, and person driven settings.

For our group social opportunities we continued to emphasize community events that would be welcoming and fun, but also ones that pushed people to explore options slightly outside what their normal activities might be, or ones that we could see people being able to become "regulars" at. During the summer months we were able to offer some opportunities to participate in trivia and other events being held outdoors at local establishments. We limited the number of participants at social opportunities so we could practice social distancing and other COVID guidelines.

Community Choices also offered 366 opportunities for connection through zoom. We saw relationships form between people through regular zoom interactions. Relationships that may not have happened in in-person opportunities. We plan to support these relationships to continue in-person. We see these relationships between members as evidence that the more people regularly interact with the people, groups, and places in their community, the more connected they will be and the more they will feel a sense of belonging in their community.

We were able to provide 2 modified events with partner organizations. We continued a partnership with CUSR that allowed us to partner on a zoom game night. Community Choices members were able to create new connections with CUSR participants and staff. We also partnered with The Urbana Park District and developed a crew of Community Choices members for their Community Clean Up Day.

In our Membership Survey, we asked individuals with disabilities if Community Choices encouraged and helped them to build their community connections. Respondents indicated that 71% of members with I/DD felt that we did this "very much", while 69% of family members felt that we did this "very much".

<u>Leadership and Self-Advocacy</u>
Members with disabilities had opportunities to demonstrate their leadership growth through events and opportunities to take on new roles in their lives, within the organization, and the community. While it was a challenging year to do this in-person, there were many ways members demonstrated their leadership growth through zoom and online. Our Human Rights and Advocacy group, which is made up of Community Choices members and community members with disabilities, continues to be co-facilitated by one of our members with I/DD. This same person also gave virtual presentations at the Going Home Advocacy Meeting and Arc of Illinois Rally Day. Additional Community Choices members also led zoom breakout discussions and presented at these events.
Our Connect staff have also supported members to plan and lead some of our social opportunities. Members have led workshops on baseball, journaling, letter writing, and music. Leading these workshops give people an opportunity to experience leadership in a small group and we hope in turn encourages them to become involved in additional leadership opportunities at Community Choices and in the community at-large.

We offered our Step Up to Leadership course once in FY20, during the summer. 80% of the class participants indicated that they increased their leadership skills.

In looking at the quantitative data from our membership survey, 58% of members with disabilities felt that opportunities CC offered helped them gain advocacy, knowledge or leadership skills "very much." 59% of family member respondents indicated that participation helped them gain advocacy, knowledge or leadership skills "very much."

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

No

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

N/A

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

N/A

(Optional) Narrative Example(s):

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

Members of Community Choices have full freedom to participate or not in the supports and opportunities that we provide. As explained above, our goal is to help people be more connected and to build their relationships, self-determination, and social capital. This has looked very different during FY21 due to COVID. 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 when our services did not look like they typically do.

<u>Highly Engaged Participant</u>

Member A and their family members have been members at Community Choices for over 3 years. Before the pandemic, 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.

During the pandemic, Member A transitioned to participating in Community Choices' daily zoom check-ins and twice a week zoom programs. They also participated in multiple Community Choices personal development classes through zoom. Through attending the regular zoom meetings, Member A connected with a new Community Choices member, Member C. Member A and Member C began texting each other on a regular basis. When Community Choices began offering in-person outdoor social opportunities, Member A and Member C coordinated going together. Then they made plans to hang out on their own outside of Community Choices programming.

<u>Limited Engagement Person</u>

Member B is new to Community Choices and joined during the pandemic. They and their family were excited to hear the Community Choices was offering regular zoom sessions during the week. Member B attends 2-3 zoom sessions each week. They initiate a few interactions, but look happy to answer questions when other members initiate conversations with them. Member B and his family participated in a POM with a member of the Connect staff. The Connect staff recommended additional zoom future opportunities that Member B may be interested in attending. At this time, Member B and his family decided to put the Exploration process on hold due to COVID, and focus on connecting with other members through zoom. Member B is very interested in meeting people who would like to go see live music together. Member B plans to attend one of Community Choices' zoom dance parties to find out what kind of music other people are interested in. Then maybe connect with those people in person when COVID restrictions are lifted.

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. We've learned that our membership survey questions are general enough to apply to all of our program participants, but we are not asking the questions that allow us to capture data that is reflective of the highly individualized work we do. But we have seen a pattern develop over the past few years that has remained. The pattern indicates 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. Members with I/DD and family members who respond that they are involved in none, one or few Self-Determination supports and programs tend to respond that they have also not made a meaningful connection or friend over the past year, and do not feel a part of a supported community.

In response to this pattern, we have begun to implement a new "Exploration" process within our Connect Department. The Self-Determination/Connect program is an opt-in program. We believe that the Exploration process will help new members learn how to become involved in the Connect program, be aware of support options, and a chance to explore potential interests. Exploration begins with meeting with one of the Connect Department staff to conduct an informal Performance Outcome Measure (POM). The POM is a tool recommended by The Council on Quality and Leadership. By completing a POM and having conversations with the person entering Community Choices services and their family member, we hope to gain knowledge of where the person with I/DD wants supports in their life, and how Community Choices can assist with those supports. Connect Staff will work with the person and their family to create some options for connecting the person to additional people, groups, or locations and/or exploring a new or enhancing a known interest. The person with I/DD can choose to opt-in to these supports and work with a Connect Staff on their individualized connection. The person can also choose to wait and complete this at a later time.

Due to COVID, we were not able to implement this process to the fullest in FY21, completing the process with only 3 members. Connect staff completed a POM with 5 additional new members who all decided to put the process on hold and not pursue individualized connections this year due to COVID.

We have also discovered that people respond to Connect Services because they have built a trusting relationship with one of the Connect Staff who act as a bridge to Self-Determination supports and programs in the Connect Department. During FY21 Community Choices members were divided between the Connect Staff. Each Connect Staff contacts the members on their list at various times to ensure they are aware of program and support opportunities within the Connect Department, recommend a program that may be of particular interest to a specific

person, or check in about starting to work on a personalized connection with a person, group or location. In FY21, Connect Staff remained in close virtual contact with the members on their list. This was one of the factors that led to high participation in our 3 day/week zoom opportunities and personal development classes held through zoom.

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>

N/A

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

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

Goals:

75 NTCPs with I/DD
85 NTCPs without I/DD (Family/Community Members)

Actual Outcome:

72 NTCPs with I/DD
122 NTCPs without I/DD (Family/Community Members)
Total of: 194

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:
4 CSEs

Service Contacts (SC):

Service Contacts are direct interactions with participants or activity directly related to their support.

Goals:

Community Building – 1374 Total

- Social Opportunities: 384 SCs
- Scaffolded Opportunities: 115 SCs
- Co-op Clubs: 275 SCs
- Open Champaign Events: 125 SCs
- Open Champaign 1:1 Connections: 75 SCs
- Informal Support/Referrals: 400 SCs

Leadership and Advocacy – 330 Total

- Leadership Class: 80 SCs
- Additional Advocacy Opportunities: 250 SCs

Family Support and Education - 425

- Co-op Meetings: 115 SCs

- Family Support Group: 70 SCs
- Family Parties: 100 SCs
- Informal Support/Consultation: 140 SCs

Grand Total: 2129 Service Contacts

Actual Outcomes:
4845 Service Contacts *More SCs than expected were held as a result of our 3x daily Zoom sessions open to members during the COVID stay at home period.

Other (100 word limit)

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

Goals:

Community Building –1195 TOTAL

- Social Opportunities: 300 DHs
- Scaffolded Opportunities: 140 DHs
- Co-Op Clubs: 230 DHs
- Open Champaign Events: 200 DHs
- Open Champaign 1:1 Connections: 75 DHs
- Informal Support/Referrals: 250 DHs

Leadership and Advocacy – 302 TOTAL

- Leadership Class: 40 DHs
- Additional Advocacy Opportunities: 262 DHs

Family Support and Education – 216 TOTAL

- Co-op Meetings: 24 DHs
- Family Support Group: 42 DHs
- Family Parties: 60 DHs
- Informal Support/Consultation: 90 DHs

Grand Total: 1713 Direct Hours

Actual Outcomes:
2144 Direct Hours *Here again our use of 3x daily zoom sessions significantly increased the amount of staff time directly interacting with members as part of this program. This increased number could account for some of the discrepancy in our other Direct Hours and Service Contact/Claim totals in other

programs as staff were leading these sessions instead of their supports that were made impossible during COVID.
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).

FY 21 Performance Outcome Report Template

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: **Developmental Services Center**
Program name: **Clinical Services**
Submission date: **FY 21**

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, 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: **4/12 (33%) 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: **12/12 100%**

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: **2/4 for 50%. Two people engaged in services within 30 days. One individual chose not to pursue services. One person waited two months for services with the counselor.**

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 12 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.

91% of those receiving services have an intellectual disability; 19% have been diagnosed as on the autism spectrum, and 37% have a diagnosed mental illness.

Referral Sources have included physician, DSC team members, families, and individual requests about services. This year 2/12 were referrals from families. The other 10 were referred from DSC Team Members.

37% have a court appointed 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.

<u>Outcome 1:</u> Clinical Manager will conduct quarterly reviews regarding the assessment, progress, and frequency of appointments for all people receiving counseling support.

<u>Outcome 2:</u> 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.

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. Quarterly reviews for those receiving counseling.	**Quarterly reviews are maintained.**	**Clinical Coordinator**

2. Review of patient progress to reduce medications	**Psychiatric notes are maintained.**	**Clinical Coordinator**

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

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? **67**

6. How many people did you *attempt* to collect outcome information from? **67**

7. How many people did you *actually* collect outcome information from? **67**

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.**

Results

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

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

The 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 52 unduplicated people received counseling this fiscal year and quarterly reviews were completed on all 52 for 100%.

Outcome 2 results: A total of 21 unduplicated people received psychiatry services this fiscal year and patient progress was reviewed at least quarterly on 100%.

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 both outcomes is 100%. The target was established based on past program evaluation of these outcomes.

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

Both outcomes had targets of 100% and both were met at that percentage.

(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 counselors and psychiatrist provided through DSC's Clinical Services support individuals through all types of personal issues, transition challenges, dealing with frustrations and anxiety, as well as getting through significant losses. When an individual experiences a traumatic event such as losing a parent unexpectedly, finding out a close family member has a terminal illness, or is a survivor of assault, the DSC Team is keenly aware of supports that the person may need and often seek out clinical services immediately. This past year there have been three such instances of individuals losing a parent unexpectedly. Two of the individuals were referred to outside clinical services. One individual had a previously established relationship with a DSC provided counselor so a connection was re-established with this counselor after the Clinical Manager processed the referral. The Clinical Manager reached out to the counselor and within a couple of days, the counselor was able to meet with the individual via phone and then set up regular visits via a telehealth therapy application. The DSC Community Living Specialist assisted the individual in setting up the telehealth counseling sessions each week, sometimes twice a week. Once the technology was set up, the staff would wait outside of the person's apartment ensuring they had a private space to talk with their counselor. Once the counselor started in-person sessions, DSC Staff provided transportation to/from the counseling sessions at the counselor's office. Over the course of a few months, the counselor had been able to decrease the face-to-face sessions as the individual progressed through the therapy experience. Unfortunately, this individual experienced another traumatic event and the counselor immediately increased support and was able to see the person weekly to process through the events. The counselor will fade out the extra sessions as able. Each quarter the counselor provides a summary of progress along with recommendations for continuation and/or planning for discharge. The individual is making great progress with counseling support and has been successful at establishing a new routine for herself that doesn't include her parent, creating natural supports through church and family friends, and maintaining her independence within her home.

14. In what ways was the evaluation used to support changes in practice? What changes were made based on evaluation findings?

The Clinical Manager is continually evaluating services by reviewing quarterly summaries, speaking with individuals and their families, and communicating with the counselors/psychiatrist. Throughout the last year many changes were made based on current data regarding COVID transmission in our area. In the beginning of the pandemic lock down, services were occurring over the telephone and then moved to telehealth with video, which proved to be a better medium of support. Schedules were adjusted and staff helped individuals learn how to utilize new technology for their counseling and psychiatric services. As the pandemic lock down progressed and most individuals grew tired of not being able to work or participate in their usual community activities an increase in counseling services was warranted. Individuals felt great loss of purpose, loss of enjoyment, and isolation from friends and family, which presented as increased agitation and aggression at times. Counseling and psychiatry services helped by being a positive outlet to discuss feeling and learn coping skills. This was a difficult year for all.

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 64 received services (one person counted as a continuing TPC, was closed, and then reopened).

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 three received services. (one person transferred from TPC to NTPC during the fiscal year and was counted in TPC count)

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 met with zero Community Service Events being completed mainly due to the pandemic.
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 12 service contacts 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).

FY 21 Performance Outcome Report Template

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: **Developmental Services Center**
Program name: **Community Employment**
Submission date: **FY 21**

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) **An individual is deemed eligible with a formal diagnosis of a developmental disability as defined by the State of Illinois and enrollment on the PUNS list. Additionally, he/she must be 18 years of age or older and desire help finding a job or maintaining a job.**
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 below 70 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 the Department of Rehabilitation Services, school programs, Champaign County Transition Planning Committee, Champaign County Transition Services Directory, community events such as the disAbility Resource Expo, family meetings through the Employment First program, and current employers. 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:

Of the 16 people who sought assistance, 10 people received services during this fiscal year. Two of the 16 ended up not needing services and three were added to the wait list as looking for services in the future, not immediately. So, for those 11 who wanted services, 10 were opened for 91%. The last person was added to the wait list at the end of June and services to hopefully be offered in August.

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:
There were 14 new people opened for Community Employment services in FY 21. All were opened within 90 days of assessment of eligibility except for one for 93%.

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 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 themselves, families, and their teams. The primary disability of those in the program is an intellectual disability. Nine percent have a diagnosis of autism and 15% have a documented mental illness. Thirty 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.

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. 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 engaged 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?

Seventy-two people funded by DDB participated in the program in FY 21.

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

For outcomes 1-3 all are counted. For outcome 4, satisfaction surveys were offered to 40 people.

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

Seventy-two people served in the FY with DDB funding.

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: Twelve people participated in job development activities.
Outcome 2: Twenty-five people participated in supported employment.
Outcome 3: 98% maintained employment.
Outcome 4: 100% were 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 not met with 12 people participating in job development activities.

Outcome 2: Target of 26 was not met with 25 people participating in supported employment.

Outcome 3: Target of 90% was met with 100% indicating they were satisfied on returned surveys.

(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)

Kelly moved into C-U Independence early in the fiscal year. She was new to the area and was referred to both the Community First Program and Community Employment Program to help her get established in the community. At first Kelly was adamant all she wanted to do was volunteer. The thought of being in the community working was too overwhelming for her and she was closed to any and every option the Employment Specialist (ES) presented. The ES continued the discovery process at a pace that was comfortable to Kelly. After several meetings the young woman said, "Isn't there something I could do with plants?" This was the first option Kelly was open to. The ES found this to be a breakthrough and a good starting point. The ES continued to work with this young woman, helping Kelly identify what she liked and didn't like. The ES learned about her work shift preferences, and what were her "deal breakers" (cleaning bathrooms!). The ES paid special attention to what she was telling her about her routine and the things that are important to her. This young woman spoke several times about pets and children, so when a job became available at a local gym in the childcare area they applied. Being new to the area meant some bus training was needed and being fairly new to the job market meant interview skills were practiced. After all was said and done, the young woman was offered the job and is thriving. The ES supported Kelly as she learned the responsibilities of the job, established a good foundation between Kelly and her co-workers and bosses, and then began fading support. Kelly's supervisors call her, "a valuable part of the team". The ES has maintained a presence so she can act as a liaison between management and Kelly if there are issues, areas for improvement, or new responsibilities Kelly can assume. Ongoing face-to-face check-ins by the ES are important to provide support to Kelly to ensure she continues towards success on the job and grows in confidence and self-reliance.

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):

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 exceeded with 72 people receiving supports and 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. Also includes representation at community outreach events such as the disAbility Expo and the TPC Roundtable. Target of two was met.

Service Contacts (SC):

Service contacts includes contacts with people or anyone in their support network seeking information about the Community Employment Program. Target is fifteen. Fourteen service contacts were documented.

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).

FY 21 Performance Outcome Report Template

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: **Developmental Services Center**
Program name: **Community First**
Submission date: **FY 21**

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 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:

Fourteen people sought services this fiscal year. Five were opened into the program. However, four people decided not to pursue joining the program, three wanted added to the wait list as still in high school, more diagnosis information is needed for one individual, and one person was added to the wait list as want a specific site which does not currently have capacity.

In summary, of the seven people who wanted services right away, five were opened for 71%.

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 five people opened in the program in FY 21, 100% were opened within 180 days.

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 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 this fiscal year have a primary diagnosis of an intellectual disability. Eighteen percent have a diagnosis of autism and 19% have a documented mental illness.

Referrals for this fiscal year came from families and the ISC. Twenty-five percent of those served during the fiscal year have an appointed 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:

1. People will participate in at least one new group.	**1. Group rosters are established at the beginning of each trimester noting the group, the leader, and the group participants.**	**1. Direct Support Professionals**
2. People will become a group 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?
52 people received services in this program in FY 21.

6. How many people did you *attempt* to collect outcome information from? **52**

7. How many people did you *actually* collect outcome information from? **52**

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: Thirty-nine people participated in at least one new group over the fiscal year.
Outcome 2: Five people became a group co-leader over the fiscal year in the card-making, fan club, music, 'What's the News?', and podcast groups
Outcome 3: Four people were opened in Community Employment from this program.

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 estimates of targets.

12. If yes, how did your outcome data compare to the comparative target or benchmark?
Outcome 1: Target of 25 was exceeded with 39 people trying at least one new group during the fiscal year.
Outcome 2: Target of five was met with five people being group co-leaders.
Outcome 3: Target of five was not met with four people opened in Community Employment from this program.

(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)

Kevin participated in community groups until Covid brought an abrupt halt to all community activity. He lives at C-U Independence Apartments and started participating in some of the groups offered at that location following the soft reopening in September. He tends to avoid large, noisy, or chaotic environments and is a very sensitive person, so he soon gravitated to a small group of people who shared his interest in podcasts. Their enthusiasm led to the formation of Beyond Ability, a podcast dedicated to exploring topics and interesting people in Champaign-Urbana. The first few months were spent formalizing their vision, the roles everyone felt comfortable with, a mission statement, and expectations for working together. The team meets two times per week to plan upcoming episodes. Each episode requires the team to agree on a topic and guest or guests to interview. They research the topic, develop questions they will ask, decide who will ask the questions, and practice the interview. The staff person helps with contacting guests and navigating the logistics of the zoom meeting. As

their comfort level has increased, each team member has assumed more responsibility for all aspects of the podcast. Kevin solidified his natural role as co-leader when one topic, the local music scene was suggested for the upcoming podcast. Music, rap music in particular, is his passion and brings him out of his shell. (He even sang a rap song he wrote at a poetry reading event in the past.) Kevin's confidence has continued to grow as the podcast production feeds his dream to write and record his own music professionally someday.

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):

Champaign County residents with I/DD participating in the program who do not receive state funding for these services. Target was 55, and 52 people participated in the program in FY 21.

Non-treatment Plan Clients (NTPC):

Peers who accompany the TPCs for activities and events. Target of 50 was met with 75 people accompanying for activities.

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 and TPC. Target of three was met.

Service Contacts (SC): **Meetings with prospective participants and tours of the program by those interested in services. Target is five was exceeded with 14 service contacts made this quarter.**
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).

FY 21 Performance Outcome Report Template

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: **Developmental Services Center**
Program name: **Community Living**
Submission date: **FY 21**

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 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.) **Some of the ongoing outreach efforts occur via the Champaign County Transition Planning Committee Roundtable, disAbility Expo, 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: **Four people requested services this quarter and were presented to DSC's Admissions Committee. Three of the four were opened during the fiscal year (75%) and one person was deferred as more diagnosis information is needed.**

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): **90%**
c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame: **Three people were assessed, presented to Admissions, and engaged in services within 90 days for 100%.**
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 is nine 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. **90% of those provided services in this program have an intellectual disability and 22% have autism. Referrals for those opened in the program in FY 21 were from the Independent**

Service Coordination Unit and families. Eight people supported by the program 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: Individuals will make maintain/make progress toward their defined outcomes.
Outcome 2: Individuals will be given opportunities to explore special interests and/or participate in new 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. Individuals will maintain/make progress toward their defined outcomes. Program activities are expected to support people to live in the community rather than a more restrictive setting while achieving self-identified outcomes.	**1. A person-centered plan detailing strengths, needs and wants is developed using assessments and requests for support expressed by the individual. The progress made on these personal outcomes identified in this plan are reviewed quarterly. Information will be collected via staff report in monthly reviews and contact notes.**	**1. Data collected by staff and reviewed by program manager and Director of Program Assurance.**
2. Individuals will be given opportunities to explore special interests and/or	**2. A list of new hobbies and participation in new activities/events is**	**2. Individual receiving services reported to program staff.**

participate in new activities.	**maintained via staff and participant report.**	

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

Only some for outcome 1 as random goals are reviewed every quarter.
All participants are asked for outcome 2. Information is reported on those who respond or staff may report on something they know occurred.

4. If only some participants, how did you choose who to collect outcome information from? **Randomly chosen for outcome 1.**

5. How many total participants did your program have?

During FY 21 the program supported 56 people funded with DDB funds.

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

Outcome 1: 65 goals were reviewed for this outcome.
Outcome 2: All program participants were considered for the outcome of this goal.

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

56 people

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: 49 out of 65 goals reviewed showed progress or maintenance of skill.
Outcome 2: Participants reported exploring or participating in 46 new activities or hobbies.

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?

Benchmarks/targets are derived from the annual Program Evaluation process based on results from previous year.

12. If yes, how did your outcome data compare to the comparative target or benchmark?
Outcome 1: Target of 85% was not met with 75.4% of those goals reviewed showing progress or maintenance of skills.
Outcome 2: Target of 40 opportunities was exceeded with 46 being reported.

(Optional) Narrative Example(s):

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

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

Utilization Data Narrative –

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

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

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

Treatment Plan Clients (TPC):
Individuals receiving support through the Community Living Program funded by the Champaign County Developmental Disabilities Board. Target is 56 people and 56 people received support and services in FY 21.

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 and ten service contacts were recorded.**
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).

FY 21 Performance Outcome Report Template

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: **Developmental Services Center**
Program name: **Connections**
Submission date: **FY 21**

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 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.) **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 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): **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: **100%**
7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application): **180 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.

Interest in the activities offered at the Crow through this grant are almost always expressed from individuals supported through the Community First Program. All individuals' primary disability is a developmental disability. Of the 21 participants this fiscal year, five have legal 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: Number of people participating in classes at The Crow will be recorded.
Outcome 2: Record of events hosted will be maintained.
Outcome 3: DSPs develop a format for new groups outlining instructional information to be shared each week. This information is kept in a central location that all DSPs can access in the event a substitute is needed to lead group. Service hours are documented in the CCDDB service hour database as well as in a monthly contact note in the person's case record. Lastly, a group schedule is maintained electronically for each trimester.

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. At least 25 people will participate in artistic activities, classes, or events at The Crow at 110.	**List of those participating every quarter.**	**Program staff**

2. Four special events will be hosted at The Crow at 110.	**List of events hosted.**	**Program staff**
3. Four new classes/groups will be developed.	**List of new classes/groups.**	**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? **21**

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: 21 people participated in activities
Outcome 2 results: Four events were hosted.
Outcome 3 results: Two new classes/groups were introduced based on participant suggestions.

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 participants was not met with 21 attending activities.
Outcome 2: Target of four events was met.
Outcome 3: Target of four new classes/groups was not met with two new classes introduced during the fiscal year.

(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)

Ginny participated in art focused groups at The Crow five days per week prior to closure due to Covid. She continued to participate virtually when in person participation was paused. One of Ginny's favorite groups was card-making. She was one of five people who continued card making during the shutdown. The group leader made card making kits for multiple sessions that she had planned in advance and delivered them to participants' homes. Participants would log in via zoom and follow along as the group leader provided instructions. The cards were picked up and were offered for sale during the virtual holiday open house for The Crow holiday sale. These were also included in a large special-order holiday gift box. Cards included traditional Christmas, as well as Hanukkah cards. When in person services resumed at The Crow, Ginny continued to participate virtually as she was extremely fearful of needles and thus resisted getting the vaccine and was not comfortable wearing a mask. Ginny became a co-leader for the group virtually while others returned in person. The group leader would meet virtually with Ginny to review techniques and special instructions so Ginny could confidently lead the group. The zoom meeting was connected to a tv at The Crow so all participants could see Ginny. Ginny's mom shared that this seemed to lift Ginny's spirits until she was able to get the vaccine and also practice wearing a mask consistently and finally return to in person participation with her friends.

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):

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 not met with 21 participating.

Non-treatment Plan Clients (NTPC):

People participating in activities who are not receiving county funding. Target of 12 people was not met with only two participating. Capacity was limited in the space due to Covid precautions.

Community Service Events (CSE):

The number of events hosted at The Crow at 110. Target of four was met with three virtual events completed and selling at the Farmer's Market.

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 Template

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: **Developmental Services Center**
Program name: **Employment First**
Submission date: **FY 21**

Consumer Access – *complete at end of year only*
Eligibility for service/program
1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application) **All businesses in Champaign County who want to receive disability awareness certification through the LEAP training are eligible for the training at no charge.**
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 LEAP Coordinator networking at Chamber of Commerce and Champaign Center Partnership events, presentations to Rotary clubs, referrals from other employers, social media, and cold calls from staff.**
4. **a)** *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application): **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. One scheduled training was canceled multiple times by the business and has not been rescheduled.**

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. The length of time from when a business voices interest and the actual training varies and depends upon the business's schedule for the most part.**
b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application): **100%**
c) *Actual* percentage of referred clients assessed for eligibility within that time frame: **100% - Any Champaign County business requesting to participate in the training is able to do so.**
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. LEAP and Frontline Staff training is scheduled at the convenience of the business.**
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% of businesses who requested LEAP or Frontline Staff training were able to participate. One scheduled training was canceled multiple times by the business and has not been rescheduled.**
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 one hour. Follow-up will occur within four months unless the 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 zip code, the number of employees who attend the sessions, and the business sector for each company.

2. Please report here on all of the extra demographic information your program collected.
   - **Business – Other**
     - **Champaign Center Partnership, 61820; One employee**
     - **Champaign County Chamber of Commerce, 61820; Two employees**
     - **L M Thomas Group, 61822; One employee**
     - **Rogards, 61822; One employee**
   - **Education/Youth**
     - **Mahomet Area Youth Club, 61853; Approximately 35 employees**
   - **Hospitality/Food and Beverage**
     - **Lodgic Everyday Community, 61820; One employee**
   - **Industrial/Manufacturing**
     - **Hyundai Transys, 61822; Three employees**
   - **Public**
     - **Champaign-Urbana MTD, 61802; One employee**
     - **City of Champaign HR Dept, 61820; One employee**
     - **U of I AITS Client Services Desk, 61820; One employee**
     - **Urbana Park District, 61801; One employee**

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. **One individual/family informational meeting will be held this fiscal year.**
2. **Customized Employment training will be organized by LEAP Coordinator.**
3. **LEAP trainings will be scheduled with interested employers.**
4. **Front-line training for businesses will be conducted to inform about natural supports.**
5. **Follow up contact will be made 3-4 months after initial LEAP training for all businesses receiving certification.**
6. **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:
1. Information family meeting to be held.	**List and date of meeting maintained.**	**Program Staff**
2. Customized Employment training to be coordinated.	**Documentation of training.**	**Director of Program**
3. Businesses will engage in LEAP training.	**List and dates of LEAP trainings maintained.**	**LEAP Coordinator**
4. Front-line staff trainings for businesses will be conducted.	**List and dates of frontline trainings maintained.**	**LEAP Coordinator**
5. Training follow-up contacts will be made.	**Documentation of contacts.**	**LEAP Coordinator**
6. Newsletter will be provided for employers every quarter.	**Copies of newsletters.**	**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?

Eleven businesses completed training this fiscal year.

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

Information was collected from all 11 businesses. More than 335 people in Champaign County were introduced to the LEAP program via e-mail, virtual meetings, and in-person events in an attempt to solicit participation in the trainings.

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: Family information meetings in previous years have historically had low turnout. Considering that, as well as the uncertainty of when in-person events would be allowed, the increasing rate of Zoom fatigue in the community, and the irregular school year (with which information meetings are generally aligned), the decision was made not to hold a family information meeting this year.

Outcome 2: Staff participated in two 24-hour virtual trainings on job development and customized employment that were presented by Marc Gold & Associates.

Outcome 3: The LEAP training content was updated in Q2 and screened by the Disability Access Network to ensure that those with lived experience approved of what we were teaching employers. Transitioning to virtual outreach and training resulted in lower employer participation than hoped. In total, eleven employers were reached through LEAP trainings via virtual and in-person delivery.

Outcome 4: The Frontline Staff training was updated in Q3 to align with updated LEAP content. Two versions (30-minutes and 45-minutes) were created to provide employers with options. Though we have had businesses expressing interest in hosting the Frontline training, business's staff shortages and employers' busy Q4 schedules resulted in only one training being held.

Outcome 5: Follow-up contact was made 3-4 weeks post-training with ten out of the eleven employers. Additional follow-up was made 3-4 months post-training with four of the employers. For an additional six employers, it has not yet been four months since the training.

Outcome 6: Newsletters were distributed for each of the first two quarters. Following the second issue, we looked at readership statistics for the previous year 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. The LEAP Coordinator is in the process of reconnecting with previously-trained LEAP businesses during which he will identify who wishes to continue receiving the newsletter and what content would be most relevant and beneficial for recipients.

It is difficult to provide quantitative data on the number of hires that occurred due to LEAP training and outreach because not all hiring occurs through our organizations and employers may not inform us about external jobseekers. Impact highlights include:

- **One employer hired one of our jobseekers immediately following a LEAP training this year;**
- **Another hire occurred this year with an employer who attended LEAP training in a previous year; and**
- **A referral from a Q3 training attendee resulted in another employer being trained in Q4**

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?

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 one informational meeting was not met.
Outcome 2: Customized Employment training was attended by staff leading to multiple employees becoming ACRE-certified (Association of Community Rehabilitation Educators (ACRE).
Outcome 3: Target of 15 LEAP trainings was not met. Eleven were completed.
Outcome 4: Target of 15 Front-line staff trainings was not met. One was completed.
Outcome 5: Target of 8 follow-up contacts at 3-4 months post-training was not met. Four were completed. There was no opportunity to meet this target as the bulk of trainings occurred near the end of the year and the four-month window has not yet been reached.
Outcome 6: Target of distribution of quarterly newsletter was not met. Two were distributed before the newsletter was paused for re-evaluation.

(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 who requests it. Outreach primarily occurred virtually this past year and included attendance at meetings and events by the Champaign County Chamber of Commerce, Mahomet Area Chamber of Commerce, Champaign Center Partnership, and two local Rotary clubs. 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.

Once a training is requested, the LEAP staff exchange emails with the business to determine topic (LEAP or Frontline Staff), format (in-person or virtual), approximate number of attendees, and the date and time of the training. We hold LEAP training sessions online every 4th Thursday that are open to anyone interested. Sometimes, an employer opts to attend one of these sessions instead of scheduling a private training at another time.

Prior to the LEAP training, attendees fill out an online registration form that asks what accommodations they may need. If they request an advance copy of the presentation slides, those are sent a couple of days before the training. Otherwise, the slides and handouts are emailed no more than 24 hours after the training as part of a thank you message. A link to an online feedback survey is emailed the following day. In addition, a thank you card is mailed to the business within a week of the event.

Two to three weeks after the training, the LEAP Coordinator visits the business to deliver a framed certificate and window decal, ask if the employer has had any questions arise regarding the training, and take a photo 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 questions we can help with. 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 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 that 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 will offer virtual and in-person options moving forward.

Following publication of the second newsletter, we looked at readership statistics for the previous year 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. The LEAP Coordinator is in the process of reconnecting with previously-trained LEAP businesses during which he will identify who wishes to continue receiving the newsletter and what content would be most relevant and beneficial for recipients.

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 businesses that attend the LEAP training as well as the number of businesses represented at Frontline Staff training. Target is 15 for each of the two different trainings equaling 30 total Community Service Events.

Eleven businesses completed the LEAP training during the fiscal year and one business completed the Frontline Staff training for a total of 12 Community Service Events.
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 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: **Developmental Services Center**
Program name: **Family Development**
Submission date: **FY 21**

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.

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, 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 make 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: **100%**

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: **20 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 language spoken, primary disability, and referral source.

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

- **For those receiving services in FY 20, 86% of the families primarily spoke English in their homes, Spanish was the primary language in 10% of the homes; the remaining 4% consisted of French, Arabic, Mandarin, Korean, and Russian.**
- **The primary disability reported for children receiving services was 56% for at risk of a developmental disability. Twenty-eight percent were referred because of speech delay and nine percent for overall delay.**
- **Twenty percent of referrals came from physicians, 15% from daycares, and 34% from parents.**

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.

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

<u>Outcome 2:</u> 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:
<u>Outcome 1:</u> Families will identify progress in child functioning in everyday life routines, play and interactions with others.	**Quarterly file review of parent report regarding the child's functional skills, play skills, and interactions as recorded on the home visit contact note.** **Family surveys**	• **Families** • **Quarterly file reviews** • **Service Notes** • **Family Surveys** • **Parent input and feedback**

<u>Outcome 2:</u> Children will progress in goals identified on their Individualized Family Service Plan (IFSP).	**Review of assessments quarterly.**	• **Program staff reviews of developmental assessments.** • **IFSP notes** • **Quarterly File Reviews**

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

Only some.

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

A random sample of files were chosen for review.

5. How many total participants did your program have?

828 children were provided services in FY 21.

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%. Parents reported appreciating activities and strategies to use at home as well as supplies, visual schedules, and activity bags being taken to the homes.

Children made progress in identified goals in 60/60 files reviewed.

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?

Comparative targets were established from averaging past results.

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

Outcome 1: Target of 90% was met with result of 100%.
Outcome 2: Target of 90% was met 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)

Hailey was evaluated by Illinois Early Intervention examiners in August 2020 during the Covid pandemic with evaluations conducted virtually. She was found eligible for developmental and speech therapy. It was also recommended that she be evaluated for occupational and physical therapy. Hailey started receiving developmental therapy from one of DSC's therapists. Three months later she started receiving speech therapy from DSC's speech therapist. She developed interest in toys and simple play routines with an increase in attention to her therapists during sessions. Hailey started crawling and then she started vocalizing. She was also diagnosed with a rare genetic disorder during this time. Hailey has started understanding her name, Mama, Papa, bye-bye, baby, go and kiss. She is starting to imitate some simple gestures including activating a toy with her index finger, an important fine motor skill for activating keys on a speech-generating device. Trials for speech-generating devices have been initiated. Hailey recently started walking independently. She is very curious and enjoys exploring her home with this new skill. Hailey's mother reports that Hailey engages in back and forth vocal play carrying on vocal "conversations" with them. Hailey's parents are happy with her progress and they have connected with a group of parents with children with Hailey's syndrome on Facebook.

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):

All children receiving FD program services, living in Champaign County. Target was 655. In FY 21, 828 children received 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, Read Across America, Ready Set Grow, and the CUPHD fair. Target was four and 21 were attended virtually.

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 was 200 and 189 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).

Performance Outcome Report Template

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: **Developmental Services Center**
Program name: **Individual and Family Support**
Submission date: **FY 21**

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 for the PUNS list. Children and adults with intellectual and developmental disabilities (I/DD) residing in Champaign County are eligible.

Requests 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; 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: **Nine out of ten people received services in FY 21 for 90%. The other one will receive services in FY 22 as request was made at the end of June.**
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: **Eight out of nine were engaged in services within 180 days for 89%. One family had a delayed time in enrolling a provider so the engagement time was longer than 180 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: **The average length of participant engagement 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 21 came from families. Over 72% of those receiving services are people under the age of 18 so are still under parental guardianship as minors.

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.

<u>Outcome 1</u>: All individuals receiving day services and requesting community activities, will participate on a weekly basis.

<u>Outcome 2</u>: 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:
1. Community Activities	**Documentation of activities will be maintained.**	**Program Manager**
2. Satisfaction with services	**Satisfaction Survey**	**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?

Fifty-two people received services funded by DDB during the fiscal year.

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

Outcome 1: Five people receiving day support.

Outcome 2: Eighteen surveys were distributed to some of those receiving Intermittent Direct Support.

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

Outcome 1: Five people receiving day support.

Outcome 2: Six surveys were returned from those receiving Intermittent Direct Support.

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: 100% of those receiving day support were able to access the community at least once a week.

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

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

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?
Previous program evaluation results.

12. If yes, how did your outcome data compare to the comparative target or benchmark?
Outcome 1: Target of 85% was exceeded with 100% accessing the community at least once a week.
Outcome 2: Target of 90% was exceeded with 100% of the surveys returned being positive.

(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)
Staff supported families in a number of ways even though traditional services were limited due to families not being comfortable having individuals return full time because of various concerns about Covid. Staff assisted a number of families so they could get yard work done and go to the store as well as other activities. Driving by people's houses with others so they could connect from a distance with their friends and maintaining connections through virtual means still continues for some.

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 seek information from families on how to adjust services and supports to meet their needs as circumstances change for them.

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. Sixteen individuals were provided services in FY 21.

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 exceeded with 36 people receiving support in FY 21.**
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. Target of two. One Community Service Event was completed in FY 21.**
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 five was exceeded with eleven service contacts being completed in FY 21.**
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 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: **Developmental Services Center**
Program name: **Service Coordination**
Submission date: **FY 21**

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 below 70 or a documented developmental disability with deficits in three life skill areas. The person must 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.) **People learn of services through the disAbility Expo, 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: **Twenty-six people were presented to Admissions for opening into the agency. Sixteen were opened. Of the ten not opened, two decided to seek services with another provider, more information was requested for three people, and two requested services after high school graduation. The remaining two were added to wait lists. 16/18 = 89%**

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: **Twelve of the sixteen people opened in the fiscal year were done so within 30 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): **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.

Eighty-five percent of those served have an intellectual disability with 22 % having autism. Besides having a developmental disability, 10% have a documented mental illness. This fiscal year referrals came from families and the ISC.

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.

<u>Outcome 1:</u> People will actively participate in the development of their personal outcomes driving the content of the implementation strategies documented by assigned QIDP.
<u>Outcome 2:</u> People will participate in POM (personal outcome measures) interviews.
<u>Outcome 3:</u> 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:
Outcome 1: participates in developing personal outcomes	**Personal Plan will be reviewed and documented at annual meeting, with monthly QIDP notes recorded in each individual's records and by Service Coordination staff in monthly notes. Self-report on will be documented.**	**Individual**
Outcome 2: People will participate in POM (personal outcome measure) interviews.	**POM interview booklets will be maintained. Participation in interview will be documented in the person's file.**	**Spreadsheet maintained**

Outcome 3: People will maintain/make progress toward their chosen outcomes.	**Progress toward meeting personal outcomes is documented on a monthly basis and twenty-five random files will be reviewed each quarter to review progress.**	**Documentation maintained**

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?
257 people were provided services in this program in FY 21.

6. How many people did you *attempt* to collect outcome information from?
60 for outcome one and 51 for outcome 3.

7. How many people did you *actually* collect outcome information from?
60 for outcome one and 51 for outcome 3.

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: Four POM interviews were completed during the fiscal year.
Outcome 3: 45/51 (88%) of people maintained or made progress toward their chosen outcomes.

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?

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 35 was not met with four POM interviews being completed. Loss of trained staff to interview and Covid affected the results for this outcome.
Outcome 3: Target of 80% was exceeded with 88% maintaining or making progress on their chosen outcomes.

(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)

Examples of services provided through this program:

- **DSC Case Coordinator assisting a person new to the agency apply for and navigate various community resources including Social Security, Medicaid, SNAP, and finding a safer place to live.**
- **DSC Case Coordinator assisted individual with defining Implementation Strategies once Personal Plan was created. Action steps are being outlined and assistance is being provided as needed as this person desires to retain their rights and no longer have a legal guardian.**

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

The evaluation continues to emphasis the importance of building connections and improving communication. This last fiscal year with Covid-19, communicating with people face-to-face was limited making it more challenging for people to connect with team members. Focus for next fiscal year is to strengthen communication in hopes of improving working relationships so people can achieve their chosen outcomes.

Utilization Data Narrative –

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

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

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

Treatment Plan Clients (TPC):

Individuals with case records and a formal Personal Plan and Implementation Strategies funded by CCDDB. Target of 280 with 257 being served in the program.

Non-treatment Plan Clients (NTPC):

Individuals receiving services and supports without a formal Personal Plan and Implementation Strategies funded by CCDDB. Target of 36 with 39 provided support during FY 21.

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. Target of two with one being completed.

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 of 75 with 20 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).

Performance Outcome Report FY2021

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: 08/30/2021

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 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.**

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

We 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.

3. 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 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 and Illinois Worknet.

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):
   This item does not apply. Our program works with NTPC.

b) *Actual* percentage of individuals who sought assistance or were referred who received services:
12 consumers received PSW referrals in FY21.

5. **a)** *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application):
   1-2 weeks after the orientation. Due to the pandemic, we have switched to online orientations. The materials are available in the PACE foyer for perspective PSW's to pick up. Conversations and invitations for upcoming orientations where done via email and phone calls. 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 those services.

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

7. **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.

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

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

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

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

1). Number of Potential/actual Personal Support Workers (PSWs) who went through orientation.
32
2). Number of PSWs hired through our referral.
9 PSW's were hired through this program in FY21.
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 FY21 a total of 34 PSW referrals were sent to 12 PSW consumers who received referral names.

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
All consumers are NTPCs in this program, therefore no official outcomes		

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

All NTPCs in this program, therefore no official outcomes

An unofficial outcome of this program was the matching of 9 PSWs with individuals seeking to hire a PSW

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

All NTPCs in this program, therefore no official outcomes

3. How many total participants did your program have?
All NTPCs in this program, therefore no official outcomes

4. How many people did you *attempt* to collect outcome information from?
0

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

6. 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

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

i. Means (and Standard Deviations if possible)
ii. Change Over Time (if assessments occurred at multiple points)
iii. Comparison of strategies (e.g., comparing different strategies related to recruitment; comparing rates of retention for clients of different ethno racial 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 FY21: We had a goal of 12 CSE's and exceeded our target goal for a total of 20. Our SC of 200 was exceeded by completing screening contacts for 409 potential PSW's.
In FY 21 PACE had a goal of 30 NTPC's. We exceed our goal with 32 NYCP's.
Other was targeted as 3. We exceeded this goal with a total of 9.

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

Y

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

The comparative data comes from our 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**

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

The PSW program met or exceeded all goals.

(Optional) Narrative Example(s):

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

PACE advertises regularly on Facebook and Indeed to attract people to attend the PSW orientation so they can be put on our registry. After a person comes across our posting, they send us a Facebook Message, and it starts a conversation about the position. The person then attends the PSW orientation, gets checked to make sure they are eligible for the registry, and if all goes well, they get matched with a consumer looking to hire a PSW

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

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.

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 program has no TPCs due to the participants be funded by CCDDB are people seeking employment as PSWs, and therefore are not typically people determined to be PUNS eligible.

Non-treatment Plan Clients (NTPC):

Target: 30 Actual: 32

Community Service Events (CSE):

Target: 12 Actual: 20

Service Contacts (SC):

Target: 200 Actual: 409

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

Performance Outcome Report Template

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

Agency name: Rosecrance Central Illinois
Program name: Coordination of Services DD MI
Submission date: 8-27 -21

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 target population are individuals who are 18 years of age or older who reside in Champaign County and who are dually diagnosed with both a developmental and mental health disability.
2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)? All consumers receiving services must have a Mental Health Assessment which indicate their need for coordinated services. While the services are available to any consumer or family meeting eligibility requirements, special emphasis will be placed on serving consumers that: • Are presently residing in residential settings for persons with developmental disabilities. • Are living in other settings (families, friends, or self) but are struggling in caring for self in these environments. • Are at-risk of hospitalization or homelessness due to inadequate supports for their co-occurring conditions.

Some of the consumers screened may have limited financial resources or another

type of insurance that does not cover case management services. The grant will be used to support the costs of their services until which time Medicaid services can be obtained. These cases will be prior approved by the Champaign County Mental Health & Developmental Disabilities Board.

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

Referrals come from developmental disabilities providers, mental health providers, pre-admission screening (PAS) agents, physicians, community members or families.

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

We estimated 80% of persons who sought assistance or were referred would receive services.

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

12 new clients were screened and 1 client entered into services therefore 8% of the target was met. There were 5 who did not qualify for PUNS, 1 had a Traumatic Brain Injury, 1 had no Mental Illness, 1 was from out of county, 1 went on our waiting list till new Service Coordinator was hired and 1 was approved for services. The 11 who were referred out were provided with other community resources.

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

The clinician engages consumers within two weeks or sooner from the time of the referral unless otherwise requested by client of their family. The clinician works with community partners and adjust~~s~~ schedule to accommodate meetings/opportunities offsite to introduce the program, consult on potential referrals, and make service entry for new clients welcoming and with ease. This includes school systems which has older, special education students who meet criteria and need to transition into case management services. Families are also involved in these meetings.

	b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application): The estimated percentage of referred clients who will be assessed for eligibility within the 2 week time frame would be 75%.
	c) *Actual* percentage of referred clients assessed for eligibility within that time frame: 100% or 12 clients were screened within the time frame for services.
6.	**a)** *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application): Per Medicaid Rule 132, the maximum length of time from assessment of eligibility (mental health assessment) to engagement (treatment plan development) is 45 days. Our goal is within 20 days.
	b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application): The estimated percentage of eligible clients who will be engaged in services within this time frame would be 75%.
	c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame: 100% or 1 out of 12 that were screened and found eligible were engaged in services within 20 days.
7.	**a)** *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application): The estimated average length of participant engagement in services is 18 months.

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

The actual length of participant engagement in services was 5.69 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)

   We will be collecting only the demographic information that is required.

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.

   By participating in this program we want clients to experience improved mental health and increased access to services and supports. We will demonstrate this by conducting the following surveys on admission of any new clients this FY and at discharge of any existing clients:

   1. We will measure the overall improvement in mental health by administering the Global Assessment of Functioning (GAF) Scale. Clients are scored based on a 1-100 point range with 100 representing superior functioning. The clinician assigns a score based on the psychological, social and occupational functioning of the client. This assessment score is required by the State of Illinois for any client receiving Rule 132 Medicaid services.
   2. We will measure improved Access to Services by administering the Self-Sufficiency Matrix, created by the Snohomish County Self-Sufficiency Taskforce. The Matrix

includes a range of dimensions (i.e., In-Crisis, Vulnerable, Stable, Safe, and Thriving) to score the clients progression on this life domain.

While neither the GAF Scale nor the Matrix are validated tools, given the extensive purposes for which they have been utilized historically, we believe them to be a dependable tool with which to measure change in clients' functioning and provide program outcome data.

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
10 point improvement on the GAF Scale for 75% of clients at initial screening and discharge.	Global Assessment Functioning (GAF) Scale	Client
1 Level Improvement on the Matrix for 75% of the clients who have participated in services for at least 6 months (at initial screening and discharge).	Self-Sufficiency Survey Matrix	Client

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

Outcome information was gathered only from clients who were discharged from the program during the FY

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

Since this was a new Outcome Instrument we were using this FY and last we decided to complete them only on new admissions or discharges from the program.

5. How many total participants did your program have?

25. 24 carry-over cases from FY 20 and 1 new case.

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

8

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

8

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

At the time of the initial mental health assessment and discharge from the program.

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)

Eight clients were discharged from services during this program year. 2 or 25% required a higher level of care than what this program or their families could provide and were transferred to residential group homes out of the area. 1 client or 12% achieved their goals in the program and requested discharge from the program, 1 client or 12% transferred to another provider, 2 or 25% additional clients moved out of county/family to live, 1 or 13% lost Medicaid and 2 or 13% failed to engage in services after numerous attempts to engage them.

GAF Scoring: GAF scores were collected during FY 2020 for clients who were in services for 6 months or longer. Results showed that 14 clients GAF scores remained the same, 2 clients GAF scores increased by 3-4 points and 3 clients GAF scores decreased by 2-4 points.

The Self-Sufficiency Matrix: During FY20 we were to report the Self-Sufficiency Matrix scores at the initial mental health screening and at discharge of any new clients starting in this program. 8 clients were discharged from this program during the FY. 6 of these clients were admitted to the program prior to FY19, so we do not have admission data to report for comparison in relation to an increase in level of improvement to occur. 2 clients were admitted during FY20. Scores remained unchanged due to lack of engagement of one and one client requiring a move to a higher level of care.

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

No

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

N/A

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

N/A

(Optional) Narrative Example(s):

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

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)

We will be revising the way the Outcomes are collected. We will be collecting the GAF score twice a program year and the Self-Sufficiency Scores at admission and discharge for any new clients (FY21) to the program. We feel this will better describe our Outcomes.

Utilization Data Narrative –

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

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

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

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

   Treatment Plan Clients: 25 verses 28
   Community Service Events: 7 verses 12
   Service Contacts: 12 verses 12

   The reasons these projections were not met was due to 2 things. First, COVID -19 outbreak continued to slow things down and hindered receiving new referrals to this program. The Service Coordinator worked from her home during periods of time this year as was mandated by our agency. She continued providing services to her existing clients via telephone or audio. The outbreak also hindered the Community Service Events she was able to provide. Secondly, the Service Coordinator resigned on 3-19-21 and her replacement had to be hired, trained and oriented to the agency. Ashley Parsley, began on 5-10-21 and assumed responsibility for this caseload as of the last week of May. During the transition time, services to the clients on this caseload continued to be provided by existing Community Support case managers who attempted to see the clients at intervals recommended by the previous Service Coordinator.

Another thing we have found in working with this DD MI population is that they make small steps in making progress toward reaching their goals. It takes a great deal of time, patience, practice and repetition in teaching them the skills they need to move them toward more independence, so we expect their progress to be much slower. There are also other extenuating circumstances where clients move to a higher level of care (group homes, nursing homes, families out of town, etc.) or where a client receives a waiver resulting in their putting in alternative services, which results with them ceasing services in this program.
Treatment Plan Clients (TPC): Consumers with a completed Mental Health Assessment and a Treatment Plan. We projected 20 Continuing TPC's, 8 New TPC's for a total of 28 TPC's.
Non-treatment Plan Clients (NTPC): N/A
Community Service Events (CSE): The number of contacts (meetings) to promote the program including speaking engagements, presentations at workshops, consultations with community groups and/or caregivers, meetings between agencies to plan community service events, interviews with media and attendance at open houses of other agencies to share information about services provided. We projected participating in 12 CSEs.
Service Contacts (SC): Engaging in a phone call or face-to-face contact with consumers who do not have a completed MHA, information and referral contacts, initial screenings/assessments, or crisis services. This may also include contacts for non–case specific consultations. We projected completing 12 SCs.
For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).