Compiled Annual Performance Outcome Reports for All CCMHB Funded Programs, Contract Year 2021 (7/1/20 to 6/30/21)

Compiled Annual Performance Outcome Reports of CCMHB Funded Programs for Contract Year 2021

Agency	Program	Funding
Champaign County Children's Advocacy Center	Champaign County Children's Advocacy Center	$56,425
Champaign County Christian Health Center	Mental Health Care at CCCHC	$33,000
Champaign County Health Care Consumers	CHW Outreach & Benefit Enrollment	$80,274
Champaign County Health Care Consumers	Justice Involved CHW Services & Benefits	$77,394
CCRPC-Community Services	Homeless Service System Coordination	$51,906
CCRPC-Community Services	Justice Diversion Program	$207,948
CCRPC-Community Services	Youth Assessment Center	$76,350
CCRPC-Head Start	Early Childhood Mental Health Services	$326,369
Community Service Center of Northern Champaign County	Resource Connection	$68,609
Courage Connection	Courage Connection Program	$127,000
Crisis Nursey	Beyond Blue-Champaign County	$90,000
Cunningham Children's Home	ECHO Housing & Employment Support	$101,604
Cunningham Children's Home	Families Strong Together	$403,107
DREAAM House	DREAAM Big	$100,00
Developmental Services Center	Family Development Center	$596,522
Don Moyer Boys & Girls Club	CU Change	$100,000
Don Moyer Boys & Girls Club	CU Neighborhood Champions	$110,000

Don Moyer Boys & Girls Club	Community Coalition Summer Initiatives	$107,000
Don Moyer Boys & Girls Club	Youth and Family Services	$160,000
East Central IL Refugee Mutual Assistance Center	Family Support & Strengthening	$62,000
Family Service of Champaign County	Counseling	$30,000
Family Service of Champaign County	Self-Help Center	$28,430
Family Service of Champaign County	Senior Counseling & Advocacy	$162,350
First Followers	First Steps Reentry House	$39,500
First Followers	Peer Mentoring for Reentry	$95,000
GROW in Illinois	Peer-Support	$77,239
Mahomet Area Youth Club	BLAST	$15,000
Mahomet Area Youth Club	MAYC Members Matter	$21,905
Promise Healthcare	Mental Health Services	$350,117
Promise Healthcare	Promise Healthcare Wellness	$107,987
Rape Advocacy, Counseling & Education Services	Sexual Violence Prevention Education	$63,000
Rosecrance Central Illinois	Criminal Justice PSC	$304,350
Rosecrance Central Illinois	Crisis, Access, & Benefits	$203,960
Rosecrance Central Illinois	Fresh Start	85,409
Rosecrance Central Illinois	Prevention Services	$60,000
Rosecrance Central Illinois	Recovery Home	$200,000
Rosecrance Central Illinois	Specialty Courts	$169,464

UP Center of Champaign County	Children, Youth, & Families Program	($86,603
Urbana Neighborhood Connections Center	Community Study Center	$25,500

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 Children's Advocacy Center
Program name: Champaign County Children's Advocacy Center
Submission date: 9/1/21

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)

   Referrals to the CAC are made by law enforcement agencies and the Illinois Department of Children and Family Services in accordance with the CAC Protocol.

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

   The National Children's Alliance standards for accreditation and the Champaign County Children's Advocacy Center's Protocol for the Multi-disciplinary Investigation of Child Sexual and Physical Abuse revised in June 2020, require that children are only accepted for services through a referral from law enforcement entities or the Department of Child & Family Services where it is suspected that the child is a victim of sexual abuse or serious physical abuse. Champaign County CAC passed the re-accreditation visit in September 2020.

3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.)
   Direct referrals from law enforcement and the Department of Child & Family Services.

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

   The estimated number of service contacts for the year was 220 (95% of persons referred to the CAC will receive services from the CAC).

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

222 children (100%) who were referred for services received services. Of the 222 children 154 were opened as treatment plan clients and 68 were opened as non-treatment plan clients.

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

   24 hours

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

90%

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

98%

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

   2 days

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

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):

   6-12 months

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

6 months

Demographic Information

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

   none

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

   None collected specific to Champaign County for FY21

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. **Perceived neutral, safe, child and family friendly environment (goal 95%).**
   2. **Child attends counseling session based on trauma screening to initiate/facilitate the healing process (percentage of referrals who follow through with counselors & percentage of attendees who go to more than 1 appointment).**
   3. **Information gathered in a legally sounds manner (goal 80% of forensic interviews upheld at 115-10 hearing).**
   4. **Increased provision of medical exams when necessary (goal 85% of referred medical exams will receive exams).**
   5. **Caregivers know why they were at the CAC (goal of 90%).**

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

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

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

Outcome:	Assessment Tool Used:	Information Source:
1. Perceived neutral, safe, child and family friendly environment	OMS initial caregiver survey	Client: 94.7% of clients agreed that they felt safe while at the CAC.
2. Child attends counseling session based on screening results & those that attend that attend more than 1 session.	Attendance forms & spreadsheet from counselors	65% of clients (66/101) who's screening indicated the need for a referral to a counselor engaged in counseling services. Of the clients that engaged in counseling 80% (53/66) attended more than 1 session.
3. Information gathered in a legally sound manner.	115-10 court hearings where the forensic interview was upheld by a judge.	100% of the forensic interviews were upheld by a judge during the 115-10 court hearing.
4. Increased provision of medical exams when necessary	Report from Dr. Buetow, CARLE SANE & Dr. Reifsteck	During FY20, 16% of victims received a medical exam (49/300). During FY21, 22% of victims received a medical exam (49/222). This goal was met as there was an increase from FY20-FY21.

5. Caregivers know why they are at the CAC	OMS initial caregiver survey	94.4% of caregivers agree they understood the reason for their visit to the CAC.

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

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

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

N/A

8. How many total participants did your program have?

222 Champaign County participants

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

222 (100% of caregivers were given the opportunity to participate in the Initial visit caregiver survey)

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

43 (19%)

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

The information was collected after the completion of the post forensic interview caregiver meeting. Each parent was either given a paper copy of the initial visit caregiver survey, completed the survey on the tablet or emailed the survey (due to Covid). Caregivers were asked to place the paper surveys in the survey box after completing the form before they left the facility.

Results

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

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

A comparison of results from FY20 and FY21 parent survey results:

	FY20 CAC	**FY21 CAC**
My child felt safe at the center	**93.7%**	**94.7%**
The Center Staff made sure I understood the reason for our visit.	**100%**	**94.4%**
My questions were answered to my satisfaction.	**100%**	**100%**
The staff members at the CAC were friendly and pleasant	**100%**	**100%**
The center staff provided me with resources to support my child in the days and weeks ahead	**100%**	**100%**
I was given information about the services and programs provided by the Center	**96.9%**	**100%**

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

Yes

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

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

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

The CAC parent satisfaction rate is above the national recommendation and statewide results (98%).

(Optional) Narrative Example(s):

16. 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 CAC conducted an emergency after hours forensic interview for a 9-year-old girl from Tennessee. The girl had witnessed a friend of her father's murder her father in their car while pulled over on the side of the road. The Friend then kidnapped the girl and took her to a hotel in Champaign where he sexually abused her. The Illinois State Police (ISP) officers were able to locate the man and girl in Champaign, rescuing the girl and arresting the man. The girl was immediately taken for a medical exam and then brought to the Champaign County CAC for a forensic interview. The car where the girl's deceased father's body was located was in Douglas County, along with her 11-year-old brother who was sleeping in the back seat. ISP had located the stopped vehicle and took the 11-year-old to the hospital for a medical exam and then to the CAC in Coles County for a forensic interview. The deceased was taken to the coroner's office. The Coles County and Champaign County CACs collaborated with DCFS and the ISP to get the children interviewed. The children were understandably upset, tired, hungry, and scared. The multidisciplinary team was able to get them dinner as well as new clothes and shoes. The grandma of the children drove to Charleston, IL where she thought both of her grandchildren were located. A DCFS caseworker drove the girl to Charleston where the siblings were reunited with each other and their grandma. Their grandma insisted on driving back to Tennessee that evening. She had in her custody two other younger children (siblings to the two mentioned) and no paperwork to say she was permitted to have custody of the children. The children's biological mom is a drug user and grandma was scared she would try to come and collect the children if she found out that grandma was out of state (the family had kept mom away from the children due to her active drug addiction and unsafe lifestyle). The brother did not disclose what he saw in the car and the sister did not disclose what she saw or the abuse she endured (the medical exam indicated she had been assaulted). The children were not aware that their father was deceased, only that he had been wounded. The children were forensically interviewed again at a CAC once back in Tennessee and grandma met with counselors to inform the children of their father's death. ISP special agents who worked the case in Champaign and Douglas County were able to travel and be present for the 2nd interviews. The children gave minimal details regarding what happened. They were connected to local counselors to receive ongoing counseling.

There was a big team that was able to quickly come together after hours and provide help to the children and family. The team worked together to ensure the basic needs of the children were met, begin the investigation into the allegations, and ensure that the children were able to be reunited with their caregiver. The alleged perpetrator has been incarcerated in Champaign County since May of 2021 with a 5,000,000 bond. Although justice has not yet been served, the children have already started the healing process.

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

The CAC will offer a combination of paper and electronic surveys to parents to assess parent satisfaction. The CAC staff will make sure each parent/child knows that the CAC is a safe place at the beginning of their first visit to the center and that caregivers are aware of exactly whey they are at the CAC.

Utilization Data Narrative –

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

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

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

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

Treatment Plan Clients (TPC):

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

Non-treatment Plan Clients (NTPC):

Non-Treatment Plan Clients will include those children or youth who:
1. reside in Champaign County (including residential treatment facilities), AND
2. have been interviewed as potential non-victim witnesses to child sexual abuse or physical abuse OR are considered at risk of harm for child sexual or physical abuse, AND who did not disclose being victimized during the interview. (If the child discloses abuse, they become a treatment plan client), OR
3. Are over the age of 18 and have an intellectual, developmental, or behavioral disability, OR
4. participated in courtesy usage of the Champaign County CAC for out-of-county or federal investigations.

Community Service Events (CSE):

Community Service Events include the annual Child Abuse Prevention Month activities each April, public presentations (e.g., television and radio appearances, interviews for newspaper articles), consultations with community groups (e.g., presentations to other service providers, classroom presentations), and meetings with small groups to publicize or promote the program.

Service Contacts (SC):

Screening/Service contacts will be the sum of the Treatment Plan Client and Non-Treatment Plan Client categories. This total will reflect Champaign County resident children only.

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

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 Christian Health Center**
Program name: **Mental Health Care at CCCHC (2021)**
Submission date: 9/23/21

Consumer Access – *complete at end of year only*
Eligibility for service/program
rom 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) **Any person calling for an appointment or walking in that are either self-reported uninsured or underinsured is eligible. No written verification is required and there is no application form to gain access to services.**
low 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.)? **Self-reporting** **Additionally, those being seen in the primary care areas will be screened forpsychiatric services**
low did your target population learn about your services? (e.g., from outreachevents, from referral from court, etc.) **Potential patients for CCCHC are reached through various outreach events (i.e. Farmer's market), referrals from other health care facilities (i.e. Carle Hospital, OSF Hospital), word of mouth, and online media (i.e. Facebook).**
) *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): **50%**

b) *Actual* percentage of individuals who sought assistance or were referred whoreceived services: **Due to Covid, CCCHC numbers were down. However, through Telemedicine, CCCHCwas able to see all referred patients for mental health care needs that requested services or recommended by a provider** **)** *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application): **5 Days**
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): **100%**
c) *Actual* percentage of referred clients assessed for eligibility within that time frame: **As we did not have a waiting list and had lower numbers due to Covid, any patientneeding mental health care was seen within the 5 day timeframe**
) *From your application,* estimated length of time from assessment of eligibility/needto engagement in services (Consumer Access, question #7 in the Program Plan application): **0**
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): **100**
c) *Actual* percentage of clients assessed as eligible who were engaged in serviceswithin that time frame:

100 – We saw every patient needing services promptly once they were identified asneeding mental health services

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

Varies greatly as some patients come in one time only while others may be a patientfor years.

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

N/A

Demographic Information

n 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)

In addition to the required information, our demographic form also includes questions about income (categorical), visits to the ER in the past 3 months, and level of education (categorical).

lease report here on all of the extra demographic information your programcollected.

Due to Covid and not seeing people in person, this additional data (normally givenduring in person visits), was not collected and deemed intrusive to ask via telemedicine

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) Any patients receiving mental health care at CCCHC will report a 4 or better (out of 5 with 5 being the highest) on their patient satisfaction survey
2) Increase in the number of volunteer mental health providers from 0 to 3 including one psychiatrist, one psychologist, and one counselor

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.)

Due to using Telemedicine, we did not collect patient satisfaction surveys. However,we did not receive any patient complaints for services rendered

We are able to add one volunteer mental health practitioner to our program

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:
Score 4 or better on patient satisfaction surveys	Patient satisfaction survey	Patient (not completed due to telemedicine arrangements only)

Adding mental health practitioners	General observation; volunteer paperwork	Executive Director

Was outcome information gathered from every participant who received service, or only some? **No data collected**
f only some participants, how did you choose who to collect outcome informationfrom? **N/A**
5. How many total participants did your program have? **48**
6. How many people did you *attempt* to collect outcome information from? **N/A**
7. How many people did you *actually* collect outcome information from? **None**
low often and when was this information collected? (e.g. 1x a year in the spring; atclient intake and discharge, etc) **N/A**
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)

N/A

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

No

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

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

(Optional) Narrative Example(s):

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

Our composite case will be based on the global pandemic crisis. Post COVID, CCCHC service delivery is as follows:
Implemented Telehealth
Provided training for all staff and volunteers on telehealth
Provided training on new EHR system for deliverables

Provided our mental health, medical, nutritional, and spiritual services to the uninsured and underinsured patients in our community
Placed referrals as necessary
Completed follow-ups with patients

In what ways was the evaluation used to support changes in practice? What changeswere 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.

lease 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.

Any discrepancy between estimated and actual numbers would stem from Covidrelated issues, not allowing our patients to be seen in person and hampering ourability to treat walk-in patients for mental health care needs
While telemedicine allowed us to treat those that did seek care, it hampered ourability to reach the intended numbers
The same applied to reaching our target for mental health practitioners. Covidgreatly hampered our ability to recruit new volunteers

Treatment Plan Clients (TPC):

Treatment plan clients include patients who are seen by a healthcare provider and assessed as having at least one behavioral or mental health issue to address.
Non-treatment Plan Clients (NTPC): **Non-Treatment plan clients include those receiving health education information at outreach events and family members of patients who come to the clinic.**
Community Service Events (CSE): **For CCCHC, community service events can include screenings done at various community events, meetings with other healthcare providers to enhance care across the county, or presentations about the clinic at churches, training of parish nurses, and other venues.**
Service Contacts (SC): **Service contacts for CCCHC would include those that call about services and do not come in for a scheduled appointment because either they need services beyond CCCHC's capabilities or do not show for their appointment.**
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 Health Care Consumers (CCHCC)
Program name: CHW Outreach and Benefit Enrollment
Submission date: September 9, 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) **Individuals eligible for this program are residents of Champaign County who have mental illness and/or substance use disorders, as well as residents who are experiencing stress, anxiety, depression, or other conditions that affect their mental health and well-being, whether or not they identify or present themselves as individuals with mental illness and/or substance use disorders.**

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 determined eligibility criteria by first verifying that the client resides in Champaign County. We verified this through documentation of their mailing address and ID. Homeless clients typically use the CU at Home mailing address. The next criterion involves assessing whether the person meets the definition of an MHB client, which is someone who is experiencing homelessness, has mental health and/or substance abuse issues, and/or is experiencing stress, anxiety, depression, or isolation/loneliness that is affecting their mental health. We assessed this through client interviews, and also by the type of service/help the client was requesting. For example, a client might have come to us in order to get help filling a prescription which is for mental health issues. Or, some clients come to us seeking help finding mental health and/or substance abuse treatment services. We also identified MHB clients based on their presentation to us – for example, if they were very anxious, stressed, manic, depressed. Homeless clients are easy to identify because they present themselves as being homeless, and they typically stay at CU at Home. Other MHB clients are identified based on the referral source that connected them to us.

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

The target population learned about our services through our outreach and education activities, directed to the general public, but also to specific groups and organizations to whom we were able to do presentations. In addition, we spread information about our services through our referral networks and collaborations with various other community-based organizations. In addition, prior to the pandemic, one of our staff members went to Rantoul weekly to provide services there, and was able to do outreach and education in that community. We also participate in several networking groups that focus completely or partially on serving the MHB-defined population, including the Human Services Council, the Reentry Council, the Rantoul Service Providers group, and also the MHBDD Advisory Council. Most of these groups meet monthly and have been a great resource for our outreach and education efforts, and through those groups, we were able to develop or strengthen linkages with other community-based organizations with whom we can share referrals. In addition to these efforts, we also worked with traditional and social media for our outreach and education efforts.

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:

93%

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 day

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

90%

c) *Actual* percentage of referred clients assessed for eligibility within that time frame: **89% (working remotely during the pandemic necessitated more phone calls and voicemails, as opposed to in-person appointments, so some of the delay is due to "playing phone tag" with the clients.**
6. a) *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application): **1 day**
b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application): **80%**
c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame: **89% - with many clients, the process of doing the assessment of eligibility also led to starting services immediately such as Medicaid applications, SNAP applications, Rx Fund assistance, etc.**
7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application): **Months or years. Enrollment in public benefits must be done on an annual basis, and sometimes every six months. Once CCHCC has helped a client through complicated processes such as eligibility and enrollment, the client becomes "loyal" to CCHCC and knows they can continue to turn to us year after year, and they know that we know their "case" and have their personal documentation, which makes applications for public benefits easier than starting over brand new, each year.**
b) *Actual* average length of participant engagement in services: **The average length of participant engagement in services is approximately a year (and will most likely continue for several years). Benefits enrollment in Medicaid and SNAP requires a lot of contact with clients as they have to go through redeterminations, and having choose or change Medicaid Managed Care plans, or needing help from CCHCC's Rx Fund at various times throughout the year – therefore, our contact with clients is year-long, throughout the year, depending on the specific client's needs. Also, clients dealing with crises often turn to us, even if it is just to talk to someone who cares about them and will listen to them, and help them problem-solve.**

Demographic Information

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

In addition to the required demographic information, we also collect data on language preference/need, and homelessness. We do not collect data on immigration status, but we are frequently exposed to this information as a result of having to know what programs and benefits an individual may or may not be eligible for based on their status.

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

   In addition to the demographic information required by the MHB, we also collected information on language preference/need, as well as homelessness, and at times, immigration status (if relevant for client's eligibility for various public benefits).

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. **This program will serve approximately 150-200 unduplicated clients and will result in these clients gaining and maintaining health insurance, SNAP, and other benefits and services.**
   2. **As a result of gaining health insurance, clients will gain access to needed care and prescriptions, food, free phones, dental and vision care, hospital financial assistance, and other benefits and services.**
   3. **Each client, on average, typically requires assistance with two applications. We anticipate providing assistance with approximately 600 applications.**

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

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

Outcome:	Assessment Tool Used:	Information Source:
E.g. 1. Increased empowerment in advocacy clients	Measure of Victim Empowerment Related to Safety (MOVERS) survey	Client
1. Number of clients and types of services provided (Medicaid, SNAP, Rx Fund, etc.)	CCHCC's Intake Form, which identifies the client's needs, and our actions to assist them; applications for Medicaid, SNAP, Rx Fund assistance	In most cases, client provides their own information. In some instances, a family member is helping to provide the information.
2. Clients gain access to care, prescriptions, food, phones, hospital financial assistance, etc.	Applications for these various programs/benefits, which are filed in each client's folder.	The sources included both the client, as well as documentation in the form of approval letters from DHS, HFS, etc. when the client is approved for those benefits.
3. Most clients require assistance with more than one application/service.	The intake form that we use lists the various services and benefits for	The information on these applications comes from our intake forms, the actual applications we submit, and

	which we are helping the client apply.	the documentation the client provides to us when they receive notification of their approval for the services/benefits.

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

By the nature of our work – helping people apply for public benefits and helping them access prescriptions, etc. – we are able to gather information on every participant who received a service from us.

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?

The program had 161 total participants. 119 TPC clients, with 87 new, and 32 continuing. 42 NTPC clients with 25 new and 17 continuing.

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

We attempted to collect outcome information from 119 clients.

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

We collected outcome information from 119 participants. These were the TPC clients.

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

Information was collected at intake for all clients, and then it was collected throughout the year for each client, based on the applications with which we provided help. For some clients, this meant that we collected information from them 6-7 times throughout the year, as the clients were approved for Medicaid, then Medicaid Managed Care, SNAP, Rx Fund, hospital financial assistance, etc.

Results

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

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

We learned that for most clients, we submitted an average of 2.9 applications per client. We learned that many clients came to us for one thing, but upon intake, we found that they had multiple needs with which we could help them. For example, a client might present to us with the need for prescription drug assistance, but then we find that they need help getting insured, help applying for SNAP, and/or they need help with hospital financial assistance at Carle.

10. Is there some comparative target or benchmark level for program services? Y/N **No. But the client intake forms specify each client's needs, and our goal is to meet those needs for each client that have been identified on their intake forms.**
11. If yes, what is that benchmark/target and where does it come from? **N/A**
12. If yes, how did your outcome data compare to the comparative target or benchmark? **N/A**
(Optional) Narrative Example(s):

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

A typical case involves Ms. L who contacts CCHCC to get information about COVID testing. Ms. L is an elderly lady who is noticeably anxious on the phone. She is worried about the virus and testing and whether she should get tested, and she is also worried about how to pay for the testing and discloses that she is low-income, a cancer survivor of multiple cancers, and that she cannot afford some of her medications. The CCHCC Community Health Worker (CHW) who responded to Ms. L's call, let Ms. L know that covid testing was free and explained where to go for testing. In addition, the CHW asked Ms. L about her health insurance, and found that Ms. L is a Medicare beneficiary who is low-income and would therefore qualify for the Medicare Savings Program and the Extra Help Program, which, together would reduce Ms. L's out of pocket expenses for Medicare related services as well as prescriptions, and would pay her monthly Part B premium. The CHW also informed Ms. L about CCHCC's Rx Fund program which could help pay her prescription costs until her new Medicare Savings and Extra Help programs kicked in. Ms. L was grateful for the information and also did request the help that the CHW was offering. In the process of working with Ms. L, the CHW learned that Ms. L was interested in counseling services but was unable to afford those. The CHW worked with Ms. L to find affording counseling. Ms. L stays in regular contact with the CHW, sometimes just calling to ask about a news story on COVID that she heard, and to find ways to further protect herself. The CHW has become a sort of touch-stone or safety net person for Ms. L when her anxiety gets too high. Ms. L is now less anxious about financial issues, since she has been approved for the various programs for which the CHW applied her.

However, she has generalized anxiety about almost everything, and with all the bad news in the world during the pandemic, her anxiety reached sky high levels. The CHW would often encourage Ms. L to remember that she could turn off her TV and take a break from listening to the news in order to give herself some relief from the anxiety of news. The CHW even agreed to call Ms. L if any important news on certain topics broke while Ms. L was taking her occasional "breaks" from the news. The relationship between Ms. L and the CHW is ongoing, and when Medicare Open Enrollment rolls around in the fall, the CHW will certainly be working with Ms. L to help her choose an appropriate Medicare Advantage or Part D plan.

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

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):

TPC clients are those who require more than one contact and who may have case management needs. For the purposes of this program, this is majority of the clients who will be served. We estimated 120 new clients, and 40 continuing clients, for a total of 160 TPC clients.

We recorded 119 TPC clients – 87 new clients and 32 continuing clients.

Non-treatment Plan Clients (NTPC):

NTPC clients served through this program will be the clients who need a low-intensity of service, perhaps they simply need one contact and it is to get some information, guidance, or direction. Or they might be established clients who meet program criteria, but are very self-sufficient. We anticipate approximately 30-60 such clients.

We recorded 42 NTPC clients – 25 new clients and 17 continuing clients.

Community Service Events (CSE):

We anticipated providing approximately 6 to 8 CSEs through public presentations, presentations at adult education programs, meetings between agencies where we provide education and referral information, earned media from articles and interviews, and through distribution of informational materials.

Our actual number of CSEs was 25 – far greater than expected. This is because a) in our application we underestimated the number of opportunities we would have for CSEs; b) we gained many more opportunities as a result of being involved with MHB-related networking groups, such as the MHBDDAC, and the Rantoul Services Providers group; and c) the pandemic and the public's need for information presented new opportunities and needs for providing community based information, including about testing, vaccines, etc .

Service Contacts (SC):

We anticipated approximately 600 service contacts as a result of serving approximately 160 clients in FY2021 through this program. Clients frequently require assistance with enrollment in more than one program, and some programs, like Medicaid and Medicaid Managed Care require redeterminations and help choosing appropriate plans. Clients also frequently receive mail from DHS or Medicare that is confusing to them, and they bring us this mail or call us about it in order to get help understanding it and complying with requirements.

We recorded 790 SCs. Some of our clients have very intensive needs, and we stay in touch with many of these clients on a weekly basis – and sometimes on a daily basis – by phone, email, text, or (pre-pandemic) office appointments and walk-ins. The contact with these clients is not always specific to applications with which we are helping them. Oftentimes, the contact is simply to help

provide reassurance, alleviate loneliness or anxiety, or to help trouble-shoot random challenges that the client might be facing. Additionally, we had more contacts because of pandemic-related issues, including clients who reached out to us to find out about testing and vaccines.

However, one of the major drivers of the increase in number of contacts has to do with the CCHCC program from early 2021 through June 2021 to help medically fragile homeless individuals stay in motels paid for by CCHCC. Even before CU at Home went on "pause" with its shelter services, there were individuals, who, because of medical issues, were unable to stay at the shelter safely, or meet the shelter's requirements that they spend the majority of the daytime outside.

CCHCC applied for funding from the City of Urbana to help pay for motel stays for these indivudals. The funding was awarded and CCHCC's motel program required that anyone staying at the motel must work with CCHCC in order to work toward permanent, subsidized housing. This work is very challenging and required much more regular contact with those clients – weekly, and sometimes daily contact.

I'm happy to report that the majority of those clients in the motel program have been housed now. All of those particular clients qualify as MHB clients, per the eligibility requirements of MHB and CCHCC.

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 Health Care Consumers (CCHCC)
Program name: Justice Involved CHW Services & Benefits
Submission date: September 7, 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) **Individuals eligible for this program are residents of Champaign County who have mental health issues and/or substance use disorders and involvement with the criminal justice system. Clients are also eligible by virtue of referrals by Rosecrance and the County Jail, and these clients receive priority.**

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 determined eligibility by the source of the referral (Rosecrance, County Sheriff); the client's residency in Champaign County as documented by their ID's, mailing address, etc.; their mental health and substance abuse treatment needs, and their history of involvement with the criminal justice system, if they did not come to us at the County Jail. The staff at the Champaign County Jails screen all individuals booked into the jail for mental health and substance abuse. Some clients self-refer themselves, or find their way to us. In the course of working with them, we might find out that they have criminal justice involvement, along with mental/behavioral health needs. In that case, we would consider them individuals who meet our criteria, as long as they are Champaign County residents.

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

Our target population learns about our services through several different means. First, for those in the Champaign County Jails, they learned about us through personnel working for Rosecrance or the Champaign County Sheriff's personnel (corrections officers, or patrol officers). Some also learn about our services through word of mouth by fellow inmates who had gotten services from our staff member, Chris Garcia, who works in the jails. In addition, every person who leaves the jails gets a packet of information letting them know about our services, so that way, if we were not able to connect with them in the jail, they could still contact us after they were released. Beyond that, people learn about our services as a result of our outreach and collaboration with other community-based organizations serving the reentry population. For the population returning from prison, each person receives a phone call from the Rosecrance reentry caseworker, and many receive information about our services from this caseworker. We also do outreach at various events throughout the community where we might be more likely to reach the target population. Also, we get referrals through word of mouth.

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

90

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

93%

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 day (except on weekends or holidays; but even then, in some cases, it is 1 day)

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

90%

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

94%

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

1 day

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

90%

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

89% - the pandemic made this a strange year. The County Jail was not able to make its referrals in the usual fashion because of pandemic related restrictions, fewer individuals incarcerated in the county jails, and personnel shortages and changes at Rosecrance. There were some delays in engagement in services for some clients who were first assessed for eligibility while they were in the County Jail. Chris Garcia had to make arrangements to assess and engage the clients by phone at the jail, and the phones were in high demand by attorneys, etc. In other instances, engagement in services happened very rapidly – within the first phone call or contact with Chris Garcia, especially if the prospective client was able to contact CCHCC directly, rather than through the jail process or some other referral source. In addition, Chris Garcia reached out to former clients to ensure that they still had Medicaid and SNAP. The response to this outreach effort was very positive and clients were engaged in services upon the first phone call when contact was made.

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

Months or years. Enrollment in public benefits must be done on an annual basis, and sometimes every six months. Some benefits, such as food stamps, require recertification every six months, depending on the clients' circumstances.

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

The average length of participant engagement in services is over a year (and will most likely continue for several years). Benefits enrollment in Medicaid and SNAP requires a lot of contact with clients as they have to go through redeterminations, and having to choose or change Medicaid Managed Care plans, or needing help from CCHCC's Rx Fund at various times throughout the year – therefore, our contact with clients is year-long, throughout the year, depending on the specific client's needs. Also, clients dealing with crises often turn to us, even if it is just to talk to someone who cares about them and will listen to them, and help them problem-solve. We also have many clients from the previous fiscal year who have turned to us for help this year with pandemic-related services, benefits, and resources.

Health insurance and other benefits are often challenging or complicated, so once a client has received our help, they often return to us year after year. Our services are free, and we have had a consistently staffed organization, so clients feel comfortable reaching back out to us for their various needs.

Demographic Information

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

In addition to the required demographic information, we also collect data on language preference/need, and homelessness. We do not collect data on immigration status, but we are frequently exposed to this information as a result of having to know what programs and benefits an individual may or may not be eligible for based on their status.

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

In addition to the demographic information required by the MHB, we also collected information on language preference/need, as well as homelessness, and at times, immigration status (if relevant for client's eligibility for various public benefits).

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.

This program will serve approximately 100 to 125 unduplicated clients and will result in:

1) **clients gaining and maintaining health insurance, SNAP, and other benefits and services.**
2) **As a result of gaining health insurance, clients will gain access to needed care and prescriptions, food, free phones, dental and vision care, hospital financial assistance, and other benefits and services.**
3) **Each client, on average, typically requires assistance with two applications. We anticipate providing assistance with approximately 200 to 250 applications.**

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

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

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

1. Number of clients and types of services provided (Medicaid, SNAP, Rx Fund, etc.)	CCHCC's Intake Form, which identifies the client's needs, and our actions to assist them; applications for Medicaid, SNAP, Rx Fund assistance	In most cases, client provides their own information. In some instances, a family member is helping to provide the information, especially for clients in custody in the county jail. We also get information from the State of Illinois – especially the ABE system and Medi – where we track the status of various state-based benefits, such as Medicaid and SNAP.
2. Clients gain access to care, prescriptions, food, phones, hospital financial assistance, etc.	Applications for these various programs/benefits, which are filed in each client's folder.	The sources included both the client, as well as documentation in the form of approval letters from DHS, HFS, etc. when the client is approved for those benefits.
3. Most clients require assistance with more than one application/service.	The intake form that we use lists the various services and benefits for which we are helping the client apply.	The information on these applications comes from our intake forms, the actual applications we submit, and the documentation the client provides to us when they receive notification of their approval for the services/benefits.

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

By the nature of our work – helping people apply for public benefits and helping them access prescriptions, etc. – we are able to gather information on every participant who received a service from us.

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?

The program had 102 total participants – 20 NTPC (16 new; 4 continuing), 82 TPC (59 new; 23 continuing).

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

We attempted to collect outcome information from all 102 clients. It is much easier to collect outcome information from Treatment Plan Clients, since they are engaged with our services much more intensely.

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

We collected outcome information from 82 participants. These were the TPC clients.

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

Information was collected at intake for all clients, and then it was collected throughout the year for each client, based on the applications with which we provided help. For some clients, this meant that we collected information from them 6-7 times throughout the year, as the clients were approved for Medicaid, then Medicaid Managed Care, SNAP, Rx Fund, hospital financial assistance, etc.

Results

9. What did you learn about your participants and/or program from this outcome information? Please be specific when discussing any change or outcome, and give appropriate quantitative or descriptive information when possible. For example, you could report the following:
    i. Means (and Standard Deviations if possible)
    ii. Change Over Time (if assessments occurred at multiple points)
    iii. Comparison of strategies (e.g., comparing different strategies related to recruitment; comparing rates of retention for clients of different ethnoracial groups; comparing characteristics of all clients engaged versus clients retained)

We learned that for most clients, we submitted an average of 2.7 applications per client. This was a slightly higher average than last fiscal year, and it is the result of pandemic-related benefits and resources, which many of our clients needed. We learned that many clients came to us for one thing, but upon intake, we found that they had multiple needs with which we could help them. For example, a client might present to us with the need for prescription drug assistance, but then we find that they need help getting insured, help applying for SNAP, and/or they need help with hospital financial assistance at Carle.

In addition, we learned what tremendous barriers there are for our Justice Involved clients who were seeking both temporary shelter and permanent housing. We had 7 such clients, for whom we purchased motel rooms. CCHCC approached the City of Urbana for funding for motel rooms for "medically-fragile" homeless clients who could not stay at the shelter at CU at Home (even before they suspended their services). CCHCC approached the City of Urbana for help with funding because every organization we turned to for help for these clients, including reentry organizations, could not come through to help cover the costs of motel rooms. Fortunately, we got the funding and then we began working with these clients to get them emergency shelter in motels, and then get them to go through the RPC's Central Intake process to help them apply for affordable housing through voucher programs and other resources.

In trying to assist these clients in obtaining subsidized housing, we learned that many (most?) landlords discriminate against individuals with felony convictions, as well as individuals with housing vouchers – even in the City of Urbana, where this kind of discrimination is prohibited. We also learned that most of the housing case managers who work for various organizations did NOT know that this type of discrimination is illegal in the City of Urbana, and they also did not know what to do about it in order to advance our clients' quest for subsidized housing.

Because of the delays in getting these clients housed, and because of their significant needs, we had an enormous number of Service Contacts with these particular clients. Our total service contacts for this fiscal year was 783.

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

No. But the client intake forms specify each client's needs, and our goal is to meet those needs that have been identified on each client's intake form.

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

N/A

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

N/A

(Optional) Narrative Example(s):

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

A typical case scenario (typical during the pandemic) – is this: An employee of the Sheriff's Office working at the jail contacts CCHCC's Chris Garcia. Chris is the CCHCC Community Health Worker dedicated to the MHB's Justice Involved program. The Sheriff's Office employee lets Chris know that there is a person in the Champaign County Jail who wants help with a Medicaid application. Chris arranges a time with the Sheriff's Office for when he can talk to this person on the phone and begin his application (if appropriate). Chris and the new client, Mr. R., have a phone meeting. During the phone meeting, the client informs Chris that he (Mr. R.) used to have Medicaid, but he thinks it went away because the last time he went to the pharmacy before being arrested and placed in the jail, his prescriptions were not covered. Chris works with Mr. R to get all of his relevant information for the purpose of investigating the dropped Medicaid coverage and reapplying if necessary. Chris finds out that Mr. R did not respond to the mail from DHS asking Mr. R to recertify for Medicaid. Chris tells Mr. R the mailing address that was used. Mr. R informs Chris that he moved away from there. Chris reapplies Mr. R for Medicaid while on the phone with him, and also asks him if he wants to apply for SNAP (food stamps). Chris applies Mr. R. for SNAP, and asks Mr. R to stay in touch regarding any mail he might receive from DHS.

After Mr. R is released from jail a few days later, he contacts Chris to give Chris his phone number. A couple of weeks later, Mr. R contacts Chris saying he was

approved for Medicaid but he needs to choose a Medicaid Managed Care plan. Chris works with Mr. R to help him figure out which plan is best for him. Mr. R is also approved for emergency food stamps. A few weeks later, Mr. R contacts Chris about an increase in his food stamps, and Chris informs him that it is a pandemic increase, and he lets him know how long it will last. Mr. R also tells Chris that he cannot afford his inhaler, even with his Medicaid – his specific inhaler is not covered. Chris uses CCHCC's Rx Fund to purchase Mr. R the inhaler he requires. To do this, Chris contacts the pharmacy with whom CCHCC works, and he makes sure that they carry that particular inhaler, and when the pharmacy tells him they do, then Chris works with the pharmacy to transfer Mr. R's prescription to the pharmacy so that it can be filled. CCHCC receives a bill from the pharmacy at the end of the month, and pays for Mr. R's prescription.

A couple of weeks later, someone new contacts Chris and says that his friend, Mr. R, told him about what Chris did for him. Chris is happy to work with Mr. R's contact, and he soon comes to find out that this man is also justice-involved, but he had been released from IDOC prison (IL Dept. of Corrections). Chris begins the process of working with this new client as well.

CCHCC has had some very intensive and non-typical cases, as well. But some of these are recorded in the narrative portions of the quarterly reports from this year.

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):

TPC clients are those who require more than one contact and who may have case management needs. For the purposes of this program, this is the majority of the clients whom we will serve. We estimate approximately 80 new TPC clients, with approximately 30 or more continuing from the previous year.

We recorded a total of 82 TPC clients – 23 were continuing, and 59 were new. We believe that this is an underestimate of the actual total number of TPC clients we served. Some TPC clients may have contacted us after release from the jail, but not have identified themselves as having been in jail. Also, the pandemic made it more challenging to conduct outreach and education about our services, so this affected our ability to meet our target.

Non-treatment Plan Clients (NTPC):

NTPC clients served through this program will be the clients who need a low-intensity of service, perhaps they simply need one contact with us, and it is to get some information, guidance, or direction. Or they might be established clients who meet program criteria, but are very self-sufficient. We anticipate approximately 12 to 20 such clients.

We recorded 20 NTPC clients – 4 were continuing and 16 were new. However, we also believe this number is an underestimate, for the reasons stated above, under the TPC client section.

Community Service Events (CSE):

We anticipate providing approximately 6 to 8 CSEs through public presentations, presentations at adult education programs, meetings between agencies where we provide education and referral information, earned media from articles and interviews, and through distribution of informational materials.

Our actual number of CSEs was 16 – greater than expected. This is because a) in our application we underestimated the number of opportunities we would have for CSEs; and b) we gained many more opportunities as a result of being involved with MHB-related networking groups, such as the MHBDDAC, and the Rantoul Services Providers group; and c) as a result of the pandemic, there were greater needs for pandemic-related information, and therefore there were new opportunities for outreach.

Service Contacts (SC):

We anticipate approximately 180 service contacts as a result of serving approximately 100 clients in FY2021 through this program. Instead, our Service Contacts exploded to 783! The biggest factor that accounts for this huge number of contacts from that many clients is the motel service CCHCC provided to medically-fragile homeless individuals. These are individuals with tremendous needs, who also, by virtues of receiving motel assistance, also had responsibilities for making progress toward their own permanent housing. As such, CCHCC staff had to do a lot of checking in with clients, and also dealing with various crises and challenges among the small number of clients from this program who received motel assistance.

In addition, clients frequently require assistance with enrollment in more than one program, and some programs, like Medicaid and Medicaid Managed Care require redeterminations and help choosing appropriate plans. Clients also frequently receive mail from DHS that is confusing to them, and they bring us this mail or call us about it in order to get help understanding it and complying with requirements.

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 Regional Planning Commission
Program name: Homeless Service System Coordination
Submission date: 8/4/2021

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)

Agencies and organizations, community members, and businesses that have an interest in preventing, addressing, and serving households in Champaign County that are homeless or at risk for homelessness, participating in the IL-503 Continuum of Service Providers to the Homeless (CSPH) as a member or affiliate.

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

The CSPH maintains a list of all agencies and organizations, community members, and businesses that have signed membership Memorandums of Understanding (MOUs). The CoC Coordinator outreaches to community agencies to grow the CSPH's membership. When targeting agencies for outreach, the Coordinator looks for agencies that have significant overlap with homeless services organizations or other entities that are people experiencing homelessness may utilize frequently.

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

The CoC Coordinator is present and active in most CSPH meetings and a variety of other community meetings focused on homelessness, such as meetings that occurred during the 'pause' in services of emergency shelter for single individuals. The Coordinator communicates with CSPH membership and affiliates regularly

through the CSPH e-mail list, and conducts 1:1 outreach with CSPH members and agencies interested in CSPH membership throughout the year. The CSPH Executive Committee is also instrumental in connecting interested agencies to the CoC Coordinator.

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):
   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):
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):

14 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):
Each member of the IL-503 Continuum will participate in at least 5 of 11 meetings each year.

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

10 meetings were held from July 2020 to June 2021. In July 2020, there were 30 MOU member agencies, in June 2021 there were 40 MOU member agencies. Please see the below table:

# of agencies overall who attended at least 5 out of the 10 meetings held: 23 (out of 40, 57.5%)

# of agencies, excluding those who were not MOU members long enough to meet 5 times, attended at least 5 out of the 10 meetings held: 23 (out of 36, 63.8%)

Demographic Information

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

The representation category of membership to the IL-503 Continuum of Service Providers to the Homeless (public/governmental entity, private/not for profit entity, business, or homeless/formerly homeless person).

2. Please report here on all of the extra demographic information your program collected.
Of MOU-members:
Public/Governmental Entity: 15
Private/Not for Profit Entity: 23
Business: 1
Homeless/formerly homeless person: 1

Consumer Outcomes – *complete at end of year only*

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

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

1. **Outcome #1**: Membership of the IL-503 Continuum of Service Providers to the Homeless will grow by 20%.
   Specific Outcome Goals: 100% of new members will complete an orientation. CSPH MOU-membership will grow by 20% (6).
   Description: The Coordinator will outreach to organizations outside the CSPH to spread information about the Continuum and to invite them to attend meetings. Organizations becoming new members will receive the New Member Orientation.
2. **Outcome #2**: The CSPH membership will be well informed of the local and national data and resources related to homelessness.
   Specific Outcome Goals: The coordinator will attend no less than 12 webinars and trainings addressing CSPH business and work, debriefing membership regarding the knowledge gained and necessary action items.
   Description: The HUD hosts webinars and calls addressing new policies, outcome data, initiatives, etc. The Supportive Housing Providers Association hosts a monthly call for homeless providers statewide. Annually, there is a HUD Peer to Peer conference. There are a variety of trainings that are provided throughout the year. The program coordinator will attend teleconferences, webinars, and trainings addressing CSPH business and work, and during monthly CSPH meetings, debrief the members regarding the knowledge gained and necessary action items.
3. **Outcome #3**: The CSPH membership will be well informed of the local, state, and national data and resources supporting an Open HMIS System.
   Specific Outcome Goals: The coordinator will attend no less than 4 webinars, trainings, and/or TA opportunities addressing how to transition to an Open HMIS system. The program coordinator will consult other Continuums across the State to understand their transition and how their Open systems work.
   Description: The Coordinator will coordinate training and education opportunities relating to the transition to an Open HMIS System. The Coordinator will advise the membership on action items that will facilitate the transition to an Open HMIS system.

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

Outcome #1 – The HSSC Coordinator facilitated 1:1 membership recruitment/consultation meetings and orientations. An informal small-group orientation was held on 10/27/2020 while planning for a larger orientation in 2021, which did not occur due to COVID. An update to the 2019 Full Membership Orientation is being planned. The HSSC Coordinator tracked the number of members at the start of the grant year and end of grant year, and reported new MOU members in Exec Committee meetings (reflected in minutes).

Outcome #2: The HSSC Coordinator periodically reports to the Exec the total number of webinars or calls in aggregate. The HSSC Coordinator attends debriefs and distributes information from such calls directly to relevant groups, such as the CSPH Executive Committee, ESG/ESG-CV Grant Fund Recipients and Subrecipients, and others.

Outcome #3: Continuum trainings were conducted primarily virtually in Q3 of the grant year, after adjustments were made for COVID. Attendance was tracked initially through zoom registration and then attendance in the meeting was recorded. Trainings relating specifically to Open HMIS systems were sparse, consultations with Continuums via phone were shared with the HMIS Administrator. Periodic updates on an Open HMIS Transition are reflected in the Executive Committee meeting minutes.

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

Outcome:	Assessment Tool Used:	Information Source:
E.g. 1. Increased empowerment in advocacy clients	Measure of Victim Empowerment Related to Safety (MOVERS) survey	Client
Outcome #1: Membership of the IL-503 Continuum of Service Providers to the Homeless will grow by 20%.	MOU & Attendance Tracking	MOU & Attendance Tracking
Outcome #2: The CSPH membership will be well informed of the local and national data and resources related to homelessness.	The Homeless Services System Coordination program coordinator will track and report to the IL-503 CSPH membership all	Program Coordinator

	webinars, call-ins, conferences, and trainings that were attended. This will be reflected in the Continuum meeting minutes.	
Outcome #3: The CSPH membership will be well informed of the local, state, and national data and resources supporting an Open HMIS System.	The Homeless Services System Coordination program coordinator will track and report to the IL-503 CSPH membership all trainings made available and the number of participants training, the number of 1:1 consultations relating to Open HMIS transition, the number of completed Open HMIS MOUs, and any news pertinent to the transition process. This will be reflected in the Continuum meeting minutes.	Program Coordinator, CSPH Executive Committee Meeting Minutes, CSPH meeting minutes

3. Was outcome information gathered from every participant who received service, or only some?
Feedback was sought and questions addressed in all 1:1 consultations for Outcome 1 and 3. For Outcome 2, feedback was not always received from organizations receiving the shared information.

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? **At the end of the program year, 40 organizations had signed membership agreements with the Continuum.**

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

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

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

Results

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 Homeless System Service Coordination program works to improve local conditions for people experiencing homelessness by facilitating more and more planful community partnerships and systematic intervention with local community partners. Throughout COVID, the role took more direct action than in the previous year, directly coordinating a variety of work. These include:

- Technical Assistance relating to the various new Emergency Solutions Grants and Emergency Solutions Grants – CARES (ESG-CV) grantees
- Managing the "Shelter to Housing C19 Staffing Group" staffing and tracking referrals into the Housing Authority's C-19 Temporary Preference Program
- Coordinating vaccination clinics for the local homeless community, in collaboration with the C-UPHD
- Crisis management following the "pause" at CU @ Home – including:
    - collating information from the HMIS, C19 Staffing Group, CU @ Home Attendance data, Homeless Vaccination Clinic Tracking, and local Township General Assistance
    - Recruiting volunteers from CSPH member agencies to form a Diversion Team
    - Leading the Diversion Team to meet with participants displaced by CU @ Home to provide diversion to any available resource (friends/family, hotels, shelters out of county)
    - Communicating with shelters across Illinois to secure shelter beds for some of the displaced individuals who were willing to be transported

- Working with the IDPH, CCEMA, IEMA, and IDHS to rapidly arrange for PCR COVID testing, and a separate vaccination clinic managed by IDPH
- Advocacy relating to affected clients in numerous meetings with CU @ Home and other community stakeholders
- Tracking the utilization of hotel rooms by some impacted clients, paid for by a myriad of agencies, and then assisting those agencies with seeking reimbursement from appropriate funding.

- Support/Facilitation related to the Coordinated Entry System Prioritization Guidelines, Coordinated Entry System MOU, Open HMIS MOU, the Emergency Housing Voucher MOU (June 2021)
- Supporting state-wide advocacy in which IL-503 Champaign County Continuum of Service Providers to the Homeless lead in advocating for flexibility around ESG funds to more effectively/efficiently serve people at-risk for experiencing homeless

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

N

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

N/A

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

N/A

(Optional) Narrative Example(s):

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

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

Utilization Data Narrative –

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

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

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

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

   The program exceeded targets for the second operating year. The program facilitated this with more community interest than expected, leading to much more successful new member recruitment than was anticipated (potentially due to the heightened atmosphere of community coordination during COVID). Trainings were also expected to be very difficult to meet this year, and indeed no trainings were held in the first two quarters. However, trainings facilitated in Q3 were highly attended, especially by front-line staff that lead to much higher turnout numbers. Meetings related to member recruitment, media interactions, and consultations around emergency shelters resulted in more CSEs than anticipated.

Treatment Plan Clients (TPC):

6 new members will join IL-503 Continuum of Service Providers to the Homeless (CSPH) organizations and will complete orientation.

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

Community Service Events (CSE):

Community Service Events will include the following:
•Number of contacts (meetings) to promote the program, including individual meetings with non-member entities focused on increasing membership, public presentations (including mass media shows and articles), consultations with community groups, school class presentations, and small group workshops.
•Number of Homeless Services System Coordination program coordinated trainings.
•Number of meetings related to the annual homeless Point in Time (PIT) count to inform the community about the event and the event results, solicit and train volunteers, and the actual event.

Service Contacts (SC):
Number of persons participating in trainings coordinated by the Homeless Services System Coordination program.

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

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 Regional Planning Commission
Program name: Justice Diversion Program
Submission date: 8/18/2021

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) Individuals and families in Rantoul, Illinois who have had Crisis Intervention Team (CIT) or domestic related police contact, no parameters are placed on the target population regarding gender, age, income, or race/ethnicity by the program.
2. How did you determine if a person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)? Participant will be referred by Rantoul police or have a police contact record.
3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.) Target population will be referred by police.
4. a) *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application):

50%.

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

16% of individuals received services. Out of 86 total individuals (TPC and NTPC clients), 14 received services (TPC clients). The program was severely impacted by the global pandemic mainly in Q3 and Q4. Participant engagement was low due to all in-person meetings being shifted to remote as well as significant decrease in client referrals.

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):

2 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):

0 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):

30%.

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

16% of individuals engaged in services within that time frame.

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

The average length of time that a participant will engage in services in 1 month.

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

The actual average length of participant engagement in services is 1 month. This data is reflective of the pandemic shutdown mainly in Q3 and Q4. Participant engagement was lowdue to all in-person meetings transitioning to remote as well as significant decrease in client referrals.

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 race, ethnicity, age, gender, and zip code information, household information such as composition and income will be collected.

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

No extra demographic data was collected.

Consumer Outcomes – *complete at end of year only*

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

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

1. Increase the individual's capacity to engage in treatment.
2. Decrease level of need for social emotional behavioral treatment. At least 20% of treatment plan clients with initial ratings of 2 or 3 will move to ratings of 1 or 0.
3. Increasing available services in Rantoul.
4. Reduce number of repeat calls to law enforcement for social emotional behavioral needs. No more than 25% of the requests for law enforcement assistance for behavioral needs during the program year, will be repeat requests.

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:
Increase individual's capacity to engage in treatment.	Following client enrollment, staff will enter treatment plan client data into the CCRPC's client database. Data reports will be pulled and monitored for accuracy on a monthly basis.	Client
Decrease level of need for social emotional behavioral treatment. At least 20% of treatment plan clients with initial ratings of 2 or 3 will move to ratings of 1 or 0.	Entry and exit ANSAs will be completed for all treatment plan clients. Staff will enter scores into CCRPC's client database. Reports indicating number and percent of clients with decreased level of needs will be pulled quarterly.	Client
Increasing available services in Rantoul.	Number of new providers offering services in Rantoul will be reported during the Rantoul Community Service Providers meeting, noted in	Rantoul Community Service Providers/CCRPC Staff

	minutes, and tracked and reported quarterly by the JDP Coordinator.	
Reduce number of repeat calls to law enforcement for social emotional behavioral needs. No more than 25% of the requests for law enforcement assistance for behavioral needs during the program year, will be repeat requests.	Number of repeat requests to RPD for social emotional behavioral needs will be tracked and reported quarterly by the JDP Coordinator.	Rantoul Police/CCRPC Staff

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

Outcome information was gathered from every participant who was a Treatment Plan Client. Repeat Police Contacts were also recorded.

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

Only individuals enrolled as treatment plan clients will have an exist assessment to compare change in level of need.

5. How many total participants did your program have?

86.

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

86.

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

14.

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

Once at discharge.

Results

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

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

CCRPC learned how effective the program was by increase or decrease in repeated calls for CIT incidents. The Justice Diversion Coordinator also learned reaching out to clients is very successful when responding on scene with officers. The JDP staff was part time during 3rd quarter—wrapping up cases and do light touch/referral-linkage NTPC services and the program was not in operation during the 4th quarter (no staff).

Despite the short tenure of the JDP staff, the case managers impact on the collaborative relationship with Rantoul Police Department was immense. RPD fully embraced the value of incorporating a social services professional into their community response and have invested additional resources to increasing the impact and reach, by dedicating a full time officer to work alongside the JDP Case Manager. The Justice Diversion Program was very strong upon initial implementation in 2018, has had ups and downs primarily related to staff turnover, but with the new program year start in July 2021 is on a solid track for success.

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 Justice Diversion Program Coordinator (JDPC) receives a referral from Rantoul Police Officers. The JDPC reaches out the participant to see if assistance is needed. If the participant needs further assistance, the participant will become a treatment plan client, in which the JDPC will work with them for roughly 3 months to provide services. The JDPC willmake referrals to other agencies that will be able to help the participant (i.e., counseling, senior services, psychiatry, etc.). If the participant feels they don't need assistance from theJDPC but would like information on other agencies, they will become a non-treatment plan client. These participants are met with once and information about agencies are given to them at this meeting.

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 was used to see if clients had changes in needs or strengths based off the initial assessment.

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):

Target: 42
Actual: 14

Individuals enrolled in short-term care planning, coordination and monitoring based on entry assessment results. Coordination and monitoring may continue for up to 3 months to ensure engagement. When service connection is not readily available, the Coordinator will provide support until individual is accepted into services, or needs have been met. Exit assessments will be completed to determine change in level of social emotional behavioral needs.

The program participation and engagement were severely impacted by the global pandemic mainly in Q3 and Q4. Participant engagement was low due to all in-person meetings being shifted to remote as well as significant decrease in client referrals.

Non-treatment Plan Clients (NTPC):

Target: 70
Actual: 72

Individuals whose assessment indicates that crisis can be resolved without further action from JDP or RPD and no plan for treatment is necessary. Staff will offer information and/ or resources to address the issue that precipitated the police involvement.

Community Service Events (CSE):

Target: 12
Actual: 44

Staff presentations; Rantoul Community Service Providers meetings, and community meetings/events.

Due to the pandemic, the program was significantly impacted by community service events in Q3, however towards the end of Q4 this participation started to increase.

Service Contacts (SC):

Target: 200
Actual: 137

Individuals and families who have had Crisis Intervention Team (CIT) or domestic related police contact, whether initiated by the family or due to a police response, who the JDP coordinator made attempts to contact, but was unable to contact or engage in services. Due to the pandemic, the program was significantly impacted by participation/client engagement. The actual number of Service Contacts was 69% of the annual target.
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 Regional Planning Commission
Program name: Justice Diversion Program
Submission date: 8/18/2021

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) Individuals and families in Rantoul, Illinois who have had Crisis Intervention Team (CIT) or domestic related police contact, no parameters are placed on the target population regarding gender, age, income, or race/ethnicity by the program.
2. How did you determine if a person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)? Participant will be referred by Rantoul police or have a police contact record.
3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.) Target population will be referred by police.
4. a) *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application):

50%.

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

16% of individuals received services. Out of 86 total individuals (TPC and NTPC clients), 14 received services (TPC clients). The program was severely impacted by the global pandemic mainly in Q3 and Q4. Participant engagement was low due to all in-person meetings being shifted to remote as well as significant decrease in client referrals.

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):

2 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):

0 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):

30%.

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

16% of individuals engaged in services within that time frame.

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

The average length of time that a participant will engage in services in 1 month.

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

The actual average length of participant engagement in services is 1 month. This data is reflective of the pandemic shutdown mainly in Q3 and Q4. Participant engagement was lowdue to all in-person meetings transitioning to remote as well as significant decrease in client referrals.

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 race, ethnicity, age, gender, and zip code information, household information such as composition and income will be collected.

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

No extra demographic data was collected.

Consumer Outcomes – *complete at end of year only*

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

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

5. Increase the individual's capacity to engage in treatment.
6. Decrease level of need for social emotional behavioral treatment. At least 20% of treatment plan clients with initial ratings of 2 or 3 will move to ratings of 1 or 0.
7. Increasing available services in Rantoul.
8. Reduce number of repeat calls to law enforcement for social emotional behavioral needs. No more than 25% of the requests for law enforcement assistance for behavioral needs during the program year, will be repeat requests.

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:
Increase individual's capacity to engage in treatment.	Following client enrollment, staff will enter treatment plan client data into the CCRPC's client database. Data reports will be pulled and monitored for accuracy on a monthly basis.	Client
Decrease level of need for social emotional behavioral treatment. At least 20% of treatment plan clients with initial ratings of 2 or 3 will move to ratings of 1 or 0.	Entry and exit ANSAs will be completed for all treatment plan clients. Staff will enter scores into CCRPC's client database. Reports indicating number and percent of clients with decreased level of needs will be pulled quarterly.	Client
Increasing available services in Rantoul.	Number of new providers offering services in Rantoul will be reported during the Rantoul Community Service Providers meeting, noted in	Rantoul Community Service Providers/CCRPC Staff

	minutes, and tracked and reported quarterly by the JDP Coordinator.	
Reduce number of repeat calls to law enforcement for social emotional behavioral needs. No more than 25% of the requests for law enforcement assistance for behavioral needs during the program year, will be repeat requests.	Number of repeat requests to RPD for social emotional behavioral needs will be tracked and reported quarterly by the JDP Coordinator.	Rantoul Police/CCRPC Staff

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

Outcome information was gathered from every participant who was a Treatment Plan Client. Repeat Police Contacts were also recorded.

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

Only individuals enrolled as treatment plan clients will have an exist assessment to compare change in level of need.

5. How many total participants did your program have?

86.

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

86.

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

14.

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

Once at discharge.

Results

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

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

CCRPC learned how effective the program was by increase or decrease in repeated calls for CIT incidents. The Justice Diversion Coordinator also learned reaching out to clients is very successful when responding on scene with officers. The JDP staff was part time during 3rd quarter—wrapping up cases and do light touch/referral-linkage NTPC services and the program was not in operation during the 4th quarter (no staff).

Despite the short tenure of the JDP staff, the case managers impact on the collaborative relationship with Rantoul Police Department was immense. RPD fully embraced the value of incorporating a social services professional into their community response and have invested additional resources to increasing the impact and reach, by dedicating a full time officer to work alongside the JDP Case Manager. The Justice Diversion Program was very strong upon initial implementation in 2018, has had ups and downs primarily related to staff turnover, but with the new program year start in July 2021 is on a solid track for success.

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 Justice Diversion Program Coordinator (JDPC) receives a referral from Rantoul Police Officers. The JDPC reaches out the participant to see if assistance is needed. If the participant needs further assistance, the participant will become a treatment plan client, in which the JDPC will work with them for roughly 3 months to provide services. The JDPC willmake referrals to other agencies that will be able to help the participant (i.e., counseling, senior services, psychiatry, etc.). If the participant feels they don't need assistance from theJDPC but would like information on other agencies, they will become a non-treatment plan client. These participants are met with once and information about agencies are given to them at this meeting.

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 was used to see if clients had changes in needs or strengths based off the initial assessment.

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):

Target: 42
Actual: 14

Individuals enrolled in short-term care planning, coordination and monitoring based on entry assessment results. Coordination and monitoring may continue for up to 3 months to ensure engagement. When service connection is not readily available, the Coordinator will provide support until individual is accepted into services, or needs have been met. Exit assessments will be completed to determine change in level of social emotional behavioral needs.

The program participation and engagement were severely impacted by the global pandemic mainly in Q3 and Q4. Participant engagement was low due to all in-person meetings being shifted to remote as well as significant decrease in client referrals.

Non-treatment Plan Clients (NTPC):

Target: 70
Actual: 72

Individuals whose assessment indicates that crisis can be resolved without further action from JDP or RPD and no plan for treatment is necessary. Staff will offer information and/ or resources to address the issue that precipitated the police involvement.

Community Service Events (CSE):

Target: 12
Actual: 44

Staff presentations; Rantoul Community Service Providers meetings, and community meetings/events.

Due to the pandemic, the program was significantly impacted by community service events in Q3, however towards the end of Q4 this participation started to increase.

Service Contacts (SC):

Target: 200
Actual: 137

Individuals and families who have had Crisis Intervention Team (CIT) or domestic related police contact, whether initiated by the family or due to a police response, who the JDP coordinator made attempts to contact, but was unable to contact or engage in services. Due to the pandemic, the program was significantly impacted by participation/client engagement. The actual number of Service Contacts was 69% of the annual target.
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 Regional Planning Commission
Program name: Youth Assessment Center
Submission date: 8/25/2021

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)

The Youth Assessment Center serves Champaign County youth ages 10-17 who are exhibiting behavioral issues, including youth who have had police contact. The CCMHB funding particularly supports more intense case management services for youth who have had more than one referral to the YAC and assessed moderate to high risk on the Youth Assessment and Screening Instrument YASI.

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

Youth assessed as moderate to high risk on the Youth Assessment and Screening Instrument (YASI), and referred two or more times to the YAC, by police departments, school districts, community agencies and families in Champaign County.

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

YAC staff provide community presentations to inform the public about the services. Outreach includes social service agencies, public forums and meetings, schools, local police departments, etc. Target populations also learn about the program through direct referrals from other service providers, brochure distribution, referrals from school professionals, and referrals from other program participants and their families. YAC program information is available on the CCRPC website, in the CCMHB/DDB resource guide, and the United Way's 211 system.

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

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

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

37% of individuals who sought assistance were referred and received services. Of those individuals, 63% who met criteria declined services/was unable to make contact/ineligible. This data is attributed to the global pandemic as there was a decrease in referrals as well as temporary closure of agency site. All job duties were completed remotely.

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

The amount of time for engagement for youth who are referred to the YAC to when they are assessed for eligibility occurs within three weeks (21 days) of receipt of the referral.

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

Within 21 days from referral, 75% of those referred will be assessed.

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

79% of youth were assessed for eligibility within that time frame.

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

Estimated length of time from assessment of eligibility/need to engagement in services: 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):

Within 90 days of assessment, 60% of those assessed will engage in services.

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

Within 90 days of assessment, 56% of eligible youth were engaged.

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

The estimated average length of service engagement will be 3-6 months.

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

The average length of engagement time was 3 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)

In addition to race, ethnicity, age, gender, and zip code information, household information such as composition and income will be collected.

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

20% of the clients served provided documentation that their household income met the 200% Federal Poverty Level (FPL).

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.

1. Diversion of youth from justice system.
   The YAC aims to divert youth from the justice system, for both youth who have had police contact and been referred for station adjustment services and youth exhibiting behavioral issues.
   The YAC strives to divert at least 90% of youth from a juvenile court adjudication within one year of their YAC services.
2. Increase in the level of protective factors for youth upon program exit.
   The goal is at least a 10% increase in the percentage of youth assessed with Moderate/High Protective Factors at exit as compared to the percentage at intake.
3. Increase of resiliency within the youth referred.
   Service connection based on needs assessment will support individualized, meaningful services. Individuals/ families will be better informed of the services and resources available to assist them leading to increased utilization of services.

At least 90% of participants will endorse having been informed of resource options and 50% will report successful linkage and utilization of recommended 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:
The YAC strives to divert at least 90% of youth from a juvenile court adjudication within one year of their YAC services.	Court Services Records/Database: A comparison of juvenile court records tracked through court services with YAC Client Database to determine how many have been adjudicated during the fiscal year.	State's Attorney Office
The goal is at least a 10% increase in the percentage of youth assessed with Moderate/High Protective Factors at exit as compared to the percentage at intake.	The Youth Assessment Screening Inventory (YASI) tool is used to measure difference in level of risk, along with protective factors, at intake and exit The YASI system's reporting tool provides aggregate data for youth risk levels and protective factors at entry and at exit. An annual comparison of protective factors at intake compared to protective factors at discharge will be used to evaluate program impact.	Client.

At least 90% of participants will endorse having been informed of resource options and 50% will report successful linkage and utilization of recommended services.	The YASI will be used to identify individualized needs and guide the recommended service referrals. A pre and post service survey will be used to evaluate participants' increased knowledge of services available to address their needs. Utilize YAC Client Database to track service connections for clients.	Case managers record progress and outcome data for each individual client.

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

Outcome information is gathered for each participant who receives services.

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

N/A.

5. How many total participants did your program have?

In FY21, YAC had 194 referred participants of which 21 were assessed at moderate/high with 69 matching the eligibility criteria for repeat referrals.

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

The YAC attempted to collect outcome information from 194 participants.

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

The YAC collected outcome information from 194 participants.

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

Information was collected at client intake and exit.

Results

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

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

During FY 2021, the YAC saw a decrease in treatment plan participants with two or more referrals to the YAC assessed at a moderate to high level. However, the non-treatment plan participants assessed at a moderate to high level was slightly higher than the target.

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?

From July 2015 – June 2021, all of the youth served over those 3 years, 94% of youth served by the YAC did not have a juvenile court adjudication following their Youth Assessment Center intervention.

From July 2018 – June 2021, all of the youth served over those 3 years, 96% of youth served by the YAC did not have a juvenile court adjudication following their Youth Assessment Center intervention.

** Our data system evaluates any juvenile adjudication post YAC services.

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

Of the youth served July 2019 – June 2020, 98% have not been adjudicated through June 30, 2021.
Of the youth served July 2020 – June 2021, 100% have not been adjudicated through June 30, 2021.

(Optional) Narrative Example(s):

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

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

Utilization Data Narrative –

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

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

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

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

Treatment Plan Clients (TPC):

These clients are re-referred youth who are assessed to be moderate to high risk and provided service referral and linkage.

Target: 55
Actual: 12

RPC's projection was higher than the number of TPC's. This can be attributed to the pandemic shutdown during primarily Q3 and Q4. The YAC site temporarily moved to remote sessions only impacting client engagement and participation. Lastly there was a significant decrease in client referrals during Q3 and Q4.

Non-treatment Plan Clients (NTPC):

These clients are re-referred youth who are assessed to be no to low risk, indicating structured treatment services are not necessary.

Target: 13
Actual: 14

Community Service Events (CSE):

CSE are activities related to program outreach, networking, staff development and program management, including staff presentations, trainings, partner meetings/activities, volunteer recruitment/training events and community meetings/events.

Target: 50
Actual: 39

Community Service Events initially started out very low due to the onset of the global pandemic. As we entered the 4th quarter, community service events significantly increased as there were more opportunities.

Service Contacts (SC):

SC are repeat referrals that the YAC team makes attempts to engage, but is unable to contact and/or engage in services.

Target: 40
Actual: 29

Client contacts for repeat referrals that staff are unable to make contact and/or engage in services was linked to declined participation from either the client and/or the guardian(s), unwillingness to participate due to prior unsuccessful outcomes, and/or difficulty reaching the client and/or guardian for unknown reasons. It should also be noted that the pandemic resulted in declined participation primarily in Q3 and Q4.

Other:

Youth who are first time referrals to the YAC, regardless of assessed risk level that are provided service referral and linkage.

Target: 50
Actual: 14

The actual number is lower than the target due to a decline in overall referrals.

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 Regional Planning Commission Head Start
Program name: Early Childhood Mental Health 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 the Social-Emotional Development Specialist (SEDS) child observation indicates the child needs additional support.

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

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

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

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

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

90

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

98

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):

95

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):

1 day

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

95

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

100

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 Skills and Prevention Coach is 9 months.

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

8 months

Demographic Information

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

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

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

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)

The child is given time to acclimate to the new classroom environment and form relationships with the people in that space. If the teaching staff, behavior team and/or caregiver of the child see the need to refer for social-emotional services, that process will begin by: SSPC observing the child in the setting requested by the staff/behavior team. After the observation is complete, the SSPC will discuss their findings with the SEDS. If not already signed, the child's caregiver will sign the consent form for the SEDS to observe next. The SSPC will meet with the teaching staff and SEDS to discuss specific goal(s) or need(s) this child may currently have. Depending on the specific need or goal, it may require the SSPC to take that child out of the classroom. Both in classroom and out of classroom interventions could consist of: sensory breaks/integration practices, social skills groups, kindergarten ready group, 1-on-1 skill building sessions, etc.

The SSPC will schedule these sessions based on availability, classroom schedules and other caseload children. For myself, I try to schedule each child for a 30 minute session twice a week. Ideally, these sessions will be held outside of the classroom for the most authentic experience for that child or children. Once the goals are met and that child has gained the necessary skills, the time with the SSPC will likely decrease and teaching staff will continue helping that child maintain those skills in the classroom. If it's determined that the child no longer needs the services provided by the SSPC, the team will meet again to assess and discuss removal from the SSPC caseload. All parties will sign off on this decision unanimously.

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: 33

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: 80
Actual: 45

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: 5 Actual: 66
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: 1800 Actual: 1815
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 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:
3. Reduction in frequency and duration of challenging behavior	Self-Report and observation through Practice Based Coaching Sessions	Teacher and Coach
4. 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 Service Center of Northern Champaign County
Program name: The Resource Connection
Submission date: 8/26/2021

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) Residents of the nine northernmost townships of Champaign County, with focus on low income households and people with disabilities. No restriction on clients seen by other programs using our offices.
2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)? We verify residence thru an ID card and another current document such as a utility bill. Income information and other demographics are collected at time of intake.
3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.) Word of mouth, referral from other agencies, outreach events and social media.
4. **a)** *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application): Given the nature of our services it is not often that people are not served in one way or another, but we do not track that data. Based on our count of unmet needs from information and referral inquiries, only about 4% are classified as unmet needs, a decrease of 3.8 percentage points from the previous year.

b) *Actual* percentage of individuals who sought assistance or were referred who received services: See 4a.
5. **a)** *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application): N/A
b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application): N/A
c) *Actual* percentage of referred clients assessed for eligibility within that time frame: N/A
6. *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
a) *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
b) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame: N/A
7. *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application): N/A
a) *Actual* average length of participant engagement in services: N/A

Demographic Information

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

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

   N/A

Consumer Outcomes – *complete at end of year only*

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

1. *From your application,* what impact on consumers did you expect your program activities to have? That is, what outcome(s) did you want your program to have on the people it is serving? (Consumer Outcomes, question #1 in the Program Plan application)
   The program's impact is its ability to enhance access to a variety of services, whether directly or through another agency's services. Basic needs and related services are provided directly thru the program and others are referred or given information about services available elsewhere. More specific outcomes will be determined once the new needs assessment form and the annual consumer satisfaction survey have been implemented for at least 1 year.
   We interrupted the needs assessment process once the pandemic struck and we've had minimal contact with clients until July of this year. We consulted with a member of the evaluation team, revised our consumer survey and completed 138 responses this spring. However, we determined that the needs assessment tool which required face to face contact, and was quite time consuming, was not practical to continue.

2. For each outcome, what specific survey or assessment tool did you use to collect information on this outcome? (Please remember that the tool used should be evidence-based or empirically validated.)
   We used the revised evidence based consumer satisfaction survey developed by the U of I outcome evaluation staff. The needs assessment was discontinued for reasons mentioned above.

3. Who provided the information about participant outcome(s)? (Participant, participant guardian, clinician/service provider, other program staff (if other program staff, who? ___The participants_____))
4. Was outcome information gathered from every participant who received service, or only some? With the new survey document we surveyed around 20% of all program participants.
5. If only some participants, how did you choose who to collect outcome information from? Random choice
6. How many total participants did your program have? 669 households, significantly less than projected in the program plan.
7. How many people did you *attempt* to collect outcome information from? Up to 140
8. How many people did you *actually* collect outcome information from? 138 participants
9. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc) It was collected this past spring and annually from now on.
Results

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

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

Considering the type of services we provide and that we use a satisfaction survey, what we can report is that our satisfaction score was 4.9 on a scale of 1-5 with a standard deviation of 0.32, compared to 4.8 previously. 55% of respondents used 2 or more services from our program or other programs available in our building. Our average cultural competence score was 4.25 on a scale of 1-5, slightly lower than 4.3 the last time. The PWI well being score was 73%. We are still sifting through the results of the new survey document results to get more detailed information regarding client needs and overall provision of services.

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

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

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

(Optional) Narrative Example(s)

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

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

15. In what ways was the evaluation used to support changes in practice? What changes were made based on evaluation findings?
The evaluation process began in PY20, but is still incomplete due to the pandemic situation. The changes in practice implemented primarily involved COVID related safety measures as far as physical contacts with clients. However, over time we have noted that clients that come in initially for help with basic needs inform us of other, often mental health related needs that we are able to help them access.

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

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

1. Please copy and paste the definitions of service categories your program specified in your program plan application in the sections below**. You will report the actual outcomes of service categories in the Part II Utilization/Production data form (located on the online system).** If your estimated service category outcome significantly differs from your actual service category outcome, you may give a narrative explanation for that discrepancy here.
We lowered our estimate of the number of new and continuing NTPCs for PY21. Both actual counts are even lower than expected, particularly the new NTPCs. We attribute this to the continued downturn in services throughout PY21 due to the pandemic and increased client resources through governmental financial aid.

Treatment Plan Clients (TPC):
N/A

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

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

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

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

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: Courage Connection
Program name: Courage Connection
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)

Individuals who are interested in accessing services with our domestic violence programs do so through walk-in or by contacting our 24/7 domestic violence hotline. Eligibility is based upon self-report of domestic violence; all individuals who self-report experiencing domestic violence in the past or present are eligible for our 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.)?

This is determined by the individual's self-report. This is based on the definition of domestic violence as defined by the Illinois Domestic Violence Act and as laid forth by the Illinois Coalition Against Domestic Violence (ICADV).

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

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

4. **a)** *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application): 100%

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): 100% of individuals who are seeking services will be able to contact the 24/7 domestic violence hotline and speak with a client advocate immediately. This is made possible by policy that ensures the hotline is accessible by staff at all times, and with practices to ensure back-up staff in the case of primary staff being occupied with assisting a client.

b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application): 100%

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

100% of individuals who contacted our hotline for any reason were able to speak to an advocate immediately. The hotline is directed as the primary responsibility of all who work within our domestic violence program. In the rare case of our phone lines going down, the hotline is forwarded to the National Domestic Violence Hotline or the Illinois State Domestic Violence Hotline.

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): 72 hours

95% of individuals who are eligible for services will be contacted by a Counselor to set up an intake assessment within 72 hours.

b) *From your application,* estimated percentage of 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:

98% of individuals who are eligible for service will be contacted by a Counselor/Therapist within 72 hours.

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

This varies significantly by the specific service used and the needs of the client: 1 day to multiple 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 collect data related to language spoken, veteran status, sexual orientation, and pregnancy status.

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

***Languages Spoken(Outside of English) for FY21: Spanish (26)**
***Veterans for FY21: 8**
***Sexual Orientation for FY21: Heterosexual: 411, Homosexual: 9, Bisexual: 20, Queer: 3, Not Reported/Refused: 31**
***Pregnant Clients for FY21: 40**

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) Ensuring survivors of domestic violence achieve an improved sense of safety and self-empowerment as a result of receiving services is the primary goal of our services.
2) At a community level, we aim to increase understanding around domestic violence, as well as how to best assist victims.

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).

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

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

Outcome:	Assessment Tool Used:	Information Source:
"I know more ways to plan for my safety." Answered Yes: 100%	Survey; the survey may be completed by an adult participant	Client/Participant
"I know more about community resources." Answered Yes: 100%	Survey; the survey may be completed by an adult participant	Client/Participant

"I feel safer from abuse by getting out of the abusive environment while in shelter." **Answered Yes: 100%**	Survey; the survey may be completed by an adult participant	Client/Participant
"I feel more hopeful about my future." **Answered Yes: 100%**	Survey; the survey may be completed by an adult participant or a child from age 6 to 17	Client/Participant
"I have a better understanding of the effects of abuse on my life." **Answered Yes: 100%**	Survey; the survey may be completed by an adult participant or a child from age 6 to 17	Client/Participant
"I have a better understanding of the effects of abuse on my children's lives." **Answered Yes: 100%**	Survey; the survey may be completed by an adult participant	Client/Participant

4) Was outcome information gathered from every participant who received service, or only some?
Only some – we do attempt to survey every client.

5) If only some participants, how did you choose who to collect outcome information from?
We ask every client that comes through the program. But we allow them to self-select if they would like to fill out the surveys or not. They are not mandatory so if they do not want to, they do not fill out the outcome measure information.

6) How many total participants did your program have?
625

7) How many people did you *attempt* to collect outcome information from? **100%**

8) How many people did you *actually* collect outcome information from?

200

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

For residential clients, we survey clients within their first week. For counseling/therapy clients, we survey them after their 3rd or 4th session. For legal clients, we survey them at the time of intake.

Results

10) What did you learn about your participants and/or program from this outcome information? Please be specific when discussing any change or outcome, and give appropriate quantitative or descriptive information when possible. For example, you could report the following:
    i. Means (and Standard Deviations if possible)
    ii. Change Over Time (if assessments occurred at multiple points)
    iii. Comparison of strategies (e.g., 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)

A. Means: Surveys, deviation in the clients who are eligible versus those clients that complete the surveys
B. Change Over Time: We sent out monthly to biweekly (at program team meetings) reminders sent out to direct service staff who complete these surveys with their clients to keep these surveys getting completed as much as possible.
C. Comparison of strategies: The Grants' department counted each survey throughout the year and sent out an email with the number of surveys each staff member completed in the first 3 quarters of the fiscal year in efforts to gain enlightenment about where we can possibly improve our surveying. The Grant Manager met with individual programs to also remind them the importance of these surveys.

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

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

We are guided by state regulations of exit survey data – we are required to survey clients.

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

Our outcome data met and exceeded our projections for FY21.

(Optional) Narrative Example(s):

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

15) 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.

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

A residential client who has opened a new case in the quarter and has been in shelter for at least 3 days, or a non-residential client who has opened a new case in the quarter and has received at least 3 services in the quarter. "New" means the client has not been previously engaged as a client in the operating FY.
Non-treatment Plan Clients (NTPC): A residential client who has opened a new case in the operating quarter and has been in shelter for less than 3 days in the operating quarter *and* had less than 3 non-residential services during the operating quarter, or a non-residential client who has opened a new case in the operating quarter and received less than 3 services in the quarter. "New" means the client has not been previously engaged in the operating FY.
Community Service Events (CSE): The number of contacts that promote the program and serve to inform the public about domestic violence, including public presentations, consultations with community groups and/or caregivers, and school class presentations, as well as any media in which our staff engage for the same purpose.
Service Contacts (SC): The number of phone contacts received via our 24/7 domestic violence hotline, or calls initiated/returned in response to a referral, that do NOT involve a current or former client.
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: Crisis Nursery
Program name: Beyond Blue
Submission date: 8/27/21

Consumer Access – *complete at end of year only*

Eligibility for service/program

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

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

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

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

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

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

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

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

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

Crisis Nursery Family Specialists, working in the Beyond Blue program, made numerous connections with agencies and service providers in the rural and Champaign/Urbana communities during fiscal year 2021. During the pandemic, staff members spoke virtually at several community and agency events about the Beyond Blue program and distributed brochures and program materials at social service agencies throughout the community. Presentations were made regarding Beyond Blue to the Perinatal Connect Virtual Health Fair, Carle OBGYN department, Human Services Council, Champaign Child Abuse Prevention providers, Courage Connection staff, CU Cradle to Career Kindergarten Readiness group, Early Intervention Providers, Birth to Three Coalition, Home Visiting Consortium, Cunningham Township, disABILITY Expo, Family Advocacy, Local Area Network providers, and Rantoul Service Providers. Crisis Nursery was also interviewed on WCIA and shared about the Beyond Blue program. These activities supported the robust partnerships we have with many community agencies, enabling us to better serve our clients.

Thanks to the program's longevity in the community we have established solid working relationships and protocols with referrals sources based in and serving both urban and rural Champaign County, including CUPHD's WIC/Family Case Management program (Rantoul/Champaign), Carle, Christie, OSF Heart of Mary Medical Center, and Promise Healthcare. Beyond Blue's Family Specialists keep in regular contact with WIC/Family Case Management in both Champaign and Rantoul to gather referrals.

Ongoing outreach occurs to reach Carle, OSF Heart of Mary Medical Center, and other healthcare providers. We provide program information and materials for Carle and OSF Heart of Mary Medical Center's Labor and Delivery patient packets. Appropriate social service agencies and community organizations, such as Community Service Center of Northern Champaign County, Head Start, community churches, and medical professionals that also serve rural and urban Champaign County also receive program information.

Crisis Nursery's Beyond Blue program is an integral part of the coordinated intake referral system and will be available for reaching these mothers identified by Healthy Beginnings nurse's and supervisors as at risk of postpartum depression.

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

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

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

In FY21, Family Specialists fully engaged a total of 27 clients; 16 CU and 11 rural. There were 6 open spots for rural families that were not utilized in FY21. Our team continued to actively recruit in rural Champaign County throughout the ongoing pandemic that provided challenges throughout the year in reaching families in person.

Crisis Nursery's Beyond Blue Program continued to be work with the Community Services Center of Northern Champaign County, the Multi-Cultural Center, and the Rantoul Service Providers group in FY21. Though in person groups and home visits were not an option in FY21, Family Specialists found success in holding virtual groups for families that had greater success and higher attendance that in person groups had pre-pandemic. We anticipate offering a combination of in person and virtual groups and visits in the future to engage families in the way that is most beneficial to them.

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

Since Crisis Nursery is open 24/7, critical telephone referrals can be made and are responded to within 24 hours. Clients often receive their first home visit within 2 days. Supervisory staff monitors the speed of consumer access by reviewing Crisis Nursery response data.

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

An estimate 80% of clients are assessed for eligibility within this time frame.

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

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

Nearly 80% of families were contacted within 48 hours and assessed for eligibility within this time frame**.**

In response to the COVID-19 pandemic, Crisis Nursery still adhered to the 48-hour contact guidelines, however with a follow up call or virtual visit scheduled via Zoom, with the family. The ability to maintain these contacts during times when we must be socially distant

continues to be a strength of the Beyond Blue program with ongoing enrollment happening virtually.

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

Clients often receive their first home visit within 7 days of referral.

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

An estimated 50% of referred clients receive their first home visit within this time frame.

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

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

Approximately 80% of families referred to the Beyond Blue program were offered a virtual home visit within the first three days of contacting the client. The remaining families were offered visits within seven days. In response to COVID-19, all families are contacted within 48 hours and offered a regular recurring call or virtual visit based on their particular needs and treatment plan.

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

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

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

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

Demographic Information

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

N/A

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

N/A

Consumer Outcomes – *complete at end of year only*

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

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

Objectives identified included the following:

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

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

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

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

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

The ARCH CR1 is used by 7 Crisis Nurseries across the state to evaluate outcomes for adult clients. Developed by ARCH, a national resource center for crisis and respite care, it measures a client's sense of

well-being and his/her acquisition of parenting skills. The scale is based on a client's reported level of stress, risk of maltreatment, and parenting skills. It is administered interview style and clients are surveyed annually.

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

Outcome:	Assessment Tool Used:	Information Source:
E.g. 1. Increased empowerment in advocacy clients	Measure of Victim Empowerment Related to Safety (MOVERS) survey	Client
Improved depressive symptoms	Edinburgh Postnatal Depression Scale (EPDS)	Parent
Improved developmental progress	Ages and Stages Questionnaire (ASQ),	Family Specialist & Parent
Decreased parental stress	ARCH CR1	Parent
Reduced risk of maltreatment	ARCH CR1	Parent
Improved parenting skills	ARCH CR1	Parent

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

Information for the EDPS is gathered on every client, the ARCH CR1 survey is attempted with every client but they have the right to decline the survey, and the ASQ is offered as a need is identified case by case. Additionally, Crisis Nursery gathers the Protective Factors Survey in order to assist in identifying immediate concrete needs in order to build more long term protective factors alongside the family.

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

Families have a choice whether or not to participate in the ARCH CR1 and the ASQ is offered at intake with families as well as at six months following the date of intake. Families with additional concerns or questions may request an ASQ for developmental or social emotional related purposes as frequently as every two months. The EDPS is provided to every participant. During FY20, Crisis Nursery began working on further development of measurement tools related to gathering of outcome information. So far these tools include the PICCOLO assessment of parent-child interaction, an assessment of risks within the environment in the home, as well as two tools from the Mothers and Babies Curriculum developed by Northwestern University to gauge the impact of the program for mothers, as well as the assessment of the participant's level of engagement in the program from the perspective of the Family Specialist. Unfortunately, we were unable to implement these tools during the pandemic and will be implementing them in FY22 instead.

5. How many total participants did your program have?

27

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

27 (See parameters above)

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

EDPS: 22
ARCH: 20
ASQ: 11

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

ARCH is collected once per FY, EPDS is collected at least every quarter and the ASQ is offered at least every six months, or with more frequency (as often as every two months) based on the needs of the family.

Results

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

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

Crisis Nursery and the other six Illinois crisis nurseries use a program outcome survey developed by ARCH, a national resource center for crisis and respite care. This survey is used to measure the impact our programming has on the stress levels of our clients, how our services have impacted their parenting skills, and to what degree they feel our services reduce the risk of harm to children. Of our Beyond Blue clients who completed the survey in FY21:

- 55% showed a decrease in their level of stress after using services,
- 90% felt there was an improvement in their parenting skills, and
- 90% believed that our services reduced the risk of harm to children.

Typically we see families reporting about a 70-75% decrease in their stress level after using our services. During the past year in a pandemic, we found this number to be significantly lower as families continued to encounter high levels of stress related to isolation, employment, and the many unknowns that COVID-19 brought with it.

Groups, even virtual, continue to be one of the most impactful ways we work with clients in the Beyond Blue program. Based on the evidenced-based intervention *Parents Interacting with Infants*, our Infant Parent-Child Interaction groups provide Family Specialists with the opportunity to model and support positive parenting interactions Throughout FY21 we held 8 successful virtual Infant Parent-Child Interaction Groups. While marketed to our Beyond Blue clients, our Infant Parent-Child Interaction Groups are open to any community member with a child under the age of 1. We believe this strategy benefits Beyond Blue mothers, as they can witness non-depressive mothers model positive interactions with their infant.

We also offer a Beyond Blue Support Group, which provides the space for our Beyond Blue clients to connect with their peers, share their experiences, and expand their support network. In FY21, we offered 7 Beyond Blue virtual support groups. Beyond Blue Support Groups were well attended utilizing a virtual platform during the pandemic.

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)

Family Specialist Kelli Bertram reflecting on the impact of empathy and using empathy as a tool to support families engaged in our program during the pandemic (March 2021):
I have been meeting with a family enrolled in Beyond Blue for a couple of months. The parents are from Nepal and both are maintaining full-time employment and caring for their children with little outside help or support aside from the Nursery. During a recent visit, mom was expressed she had been feeling overwhelmed due to working from home with two young children and, again, not having many supports. Mom had been doing this for almost a year, and it became increasingly more exhausting as the time continued. Mom would reach out to her family in Nepal looking for support and understanding, but due to cultural differences mom typically left these conversations feeling as though her family did not understand. One of the biggest challenges for Mom in these conversations is feeling as though she is not receiving any empathy from her family when she needs it most. When exploring this with Mom, she stated due to the cultural differences and the focus on surviving the day in Nepal, she does not feel as though being empathetic is something that is taught or often used in her home country. She further explained that empathy was something that she did not learn until adulthood and finds it extremely valuable both in giving and receiving, which draws her to our program. While in our home visits, Mom states she receives the empathy she has been searching for, and it allows her to feel heard, understood, and validated. Mom expressed having someone to talk to in this way allows her to feel as though she is not alone and she can continue to give her young children the love and support needed, because she is receiving the same support from our program.

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

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.

   During FY21, there is a deficit within the service contacts with 522 projected and 300 actually taking place. As a result of the pandemic, all services were provided virtually. While families continued to engage in services, it was much more challenging to complete screenings and home visits virtually than in person. Additionally, Crisis Nursery's Safe Children program, where families are able to access respite as well as crisis care, administers the EPDS to all mothers within the Beyond Blue program, however, in response to COVID-19, Crisis Care services were greatly reduced, causing a reduction in the number of screenings administered with families, overall.

   Due to the pandemic, support groups and Parent Child Interaction groups were reduced since they could not take place in person. Additionally, rural Champaign County numbers were down with 6 open spaces not being utilized this year. Despite ongoing outreach, we were unable to recruit enough families for these openings which reduced the overall number of possible service contacts.

Treatment Plan Clients (TPC):

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

27 Treatment Plan Clients were served: 11 rural and 16 Champaign-Urbana mothers were deemed "at risk" of PD. There were 6 open spots for rural families that were not utilized in FY21. Our team continued to actively recruit in rural Champaign County throughout the ongoing pandemic that provided challenges throughout the year in reaching families in person.

Non-treatment Plan Clients (NTPC):

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

71 Non-Treatment Plan Clients were served (31 rural and 40 Champaign-Urbana).

Community Service Events (CSE):

128 Community Service Events are projected. Community Service Events include: 18 Parent Child Interaction groups for the mother/baby dyads (6 rural, 12 Champaign-Urbana) and 32 perinatal depression support group meetings (8 rural, 24 Champaign-Urbana). Other events include: 20 meetings

with referral sources (11 rural and 9 Champaign-Urbana); 46 presentations to community groups (24 rural and 22 Champaign-Urbana); 2 media contacts; and a Beyond Blue page on the Crisis Nursery website with a link to Facebook page.

104 Community Service Events occurred. Community Service events include: 8 Parent-Child Interaction groups for the mother/baby dyads and 7 perinatal depression support group meetings. Other events include: 89 outreach events including meetings with referrals sources; presentations to community groups; media contacts; and a Beyond Blue page on the Crisis Nursery website with a link to Facebook page with over 4,500 followers.

Service Contacts (SC):

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

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

Other:

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

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

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

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: **Cunningham Children's Home**
Program name: **ECHO (Empowering Connections through Hope and Opportunities)**
Submission date: **08/27/21**

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) **ECHO serves individuals and families considered homeless or at-risk of homelessness as defined as:** • **Lacking permanent housing including those with residence in a shelter or transitional housing program.** • **Living on the streets, abandoned building/vehicle, or in any other unstable/non-permanent situation.** • **Considered "doubled up," referring to a situation where individuals are unable to maintain housing and are forced to stay with a series of friends and/or extended family members.** • **Previously homeless individuals released from prison or hospital if they do not have a stable housing situation to which they can return.** • **Individuals and families at imminent risk of becoming homeless.**
2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)? **When potential clients or individuals contact our program directly regarding services, we always direct them to contact Centralized Intake at Regional Planning Commission. As a result, most clients accepted for program enrollment come through the Centralized Intake**

process. This referral stream provides a gatekeeping function to ensure that appropriate clients are referred to our program.

At times, we have clients that are not eligible for services based on Centralized Intake criteria, but are at significant risk of homelessness or living in less than ideal situations. When we serve clients outside of the Centralized Intake process, we rely on self-report information as well as information from the referring agency (when applicable) that verifies their homeless status. We obtain documentation of SSI/SSDI eligibility when available.

Due to the urgency of client needs, we no longer maintain a program waitlist. If an individual is seeking services and we don't have program capacity, we actively work to refer clients to other providers that can provide needed services, supports and address immediate needs (e.g., shelters that serve both men and women are now open throughout the year). Cunningham also opened a Runaway Homeless Youth (RHY) program in the fall of 2019 to serve young adults between the ages of 18-24 who are homeless or at risk of homelessness. As applicable, clients or providers who contact ECHO program may be referred to RHY. As community providers who serve homeless populations (and understand eligibility criteria) have become more familiar with our programs, we increasingly receive calls from these agencies.

Note: The men's and women's shelters were closed during the last 6 weeks of FY21 due to some staffing and security concerns which increased inquiries and service needs. The shelters have since re-opened.

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

We have participated in several community service events to ensure that our community partners are aware of the services offered by the ECHO program. We believe these events have been instrumental in facilitating our referrals. During FY21, we participated in 34 community service events regarding the ECHO program. An example of a few of these stakeholders/events included Habitat for Humanity, Daily Bread, DCFS, Courage Connection, Crisis Nursery, Housing Authority, LGBTQ and Homelessness Panel, Point in Time, Rosecrance, etc.

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

50%

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

15% (10/66) clients who were referred/sought assistance in FY21 were enrolled in the ECHO program. Because we understand the urgency of the needs of those individuals who are referred to us, we are not maintaining a wait list and actively work to connect individuals we cannot serve with other providers in the community who can meet their needs.

Due to local shelters needing to pause programming from May 2021 until August 2021, there was an increased need for immediate housing. Many individuals seeking assistance were trying to contact Cunningham Township for emergency vouchers and may have mistakenly contacted the ECHO program. Those individuals were referred to the Regional Planning Commission and other resources since the ECHO program is not designed to provide immediate housing.

Note: The Mental Health Board asked that we monitor the number of clients served in the ECHO program who were former Cunningham clients. In FY21, we served two clients who had been served in Cunningham programs previously (both clients enrolled in FY 21).

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

30 days

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

80%

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

100% (10 of 10) clients that enrolled in FY21 were assessed for eligibility within 30 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):

30 days

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

50%

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

70% (7 of 10) of clients who enrolled in FY21 were TPC clients within 30 days.

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

Estimated length of service is one year with a follow-up contact one-year post-discharge.

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

There were 11 discharges in FY21. The average length of stay for these participants was 276 days (9.1 months).

Demographic Information

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

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

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

A total of 25 clients were served in the ECHO program in FY 21. This information was self-reported by clients at the point of program intake:

- **Receiving SSI/SSDI: 9**
- **Receiving Medicaid: 13**
- **Other social services: Regional Planning Commission (14), SNAP (12), Rosecrance (4), Courage Connections (2), ALLSUP (1), Austin's Place (1), Champaign County Health**

Care Consumers (1), CU at Home (1), Restoration Urban Ministries (1), Salvation Army (1), WIOA (1)

- **Primary Language: English (25)**
- **Marital Status: Single (21), Divorced (4)**
- **Religion: None (12), Protestant (7), Catholic (1), Other (5)**
- **Grade level completed: Less than high school (6), High School diploma/GED (4), Some college (8), Trade School (1), Bachelors (4), Graduate Degree (2)**
- **Disability: None (3), Physical (5), Mental (11), Both Physical and Mental (6)**

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. **Obtain Permanent Housing: At least 65% of individuals will obtain permanent housing within 120 days of assessment.**
2. **Housing Stability: At least 75% of participants who obtain permanent housing will maintain this housing for more than 90 days. Participants who request program discharge prior to 90 days will be excluded from this outcome.**
3. **Employment or Other Stable Income: At least 75% of individuals will obtain employment within 90 days of assessment and/or will have secured applicable social security benefits prior to discharge.**
4. **Life Skills Mastery: At least 90% of clients receiving both pre- and post- life skills assessment will show improvement in life skill mastery.**
5. **Financial literacy: At least 90% of clients receiving both pre/post financial literacy assessments will show improvement in financial skills mastery.**
6. **Participant Surveys: At least 70% of participants will complete a satisfaction survey. 90% of survey respondents agree or strongly agree with positive service quality statements.**

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

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

Outcome:	Assessment Tool Used:	Information Source:
1. Obtain Permanent Housing	**Information regarding changes in housing status are tracked via Service Documentation System (SDS)**	**Staff observation as well as client and/or collateral reports**
2. Housing Stability	**Information regarding changes in housing status, including relevant dates, is collected using SDS**	**Staff observation as well as client and/or collateral reports**
3. Employment or Other Stable Income	**Information regarding achievement of employment, any successive employment changes, and eligibility in SSI/SSDI is collected using SDS**	**Staff observation as well as client and/or collateral reports**
4. Life Skills Mastery	**Life Skills Assessment (pre and post) is administered at within 30 days of enrollment, every six months, and discharge**	**Case manager collaborates with client on completion**
5. Financial Literacy	**Financial Literacy Assessment (pre and post) is administered within 30 days of enrollment and after completion of financial literacy training**	**Case manager collaborates with client on completion**

6. Participant Surveys	**Participant Satisfaction Survey (developed by Cunningham)**	**Client**

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

Housing stability and employment status (including SSI/SSDI eligibility) was tracked for every client.

While our goal is to collect Life Skills Assessment and Financial Literacy for every client, we were not successful in collecting this data for all discharges. Most often the discharge measure was not completed due to the client not maintaining contact with their ECHO worker.

Satisfaction surveys were provided to all discharged clients (when possible) and we also offered a survey to all clients who were enrolled in the program in May 2021. A discharge survey may not have been possible if the client lost contact with our program staff.

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

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

5. How many total participants did your program have?

25

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

We attempted to collect housing, employment, SSI/SSDI and Life Skills Assessment data on all 25 clients.

We attempted to collect participant satisfaction survey for all 11 discharged clients, but only 5 clients completed a survey at discharge. We were unable to request a survey from some clients as they were no longer maintaining contact with staff.

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

We were successful in collecting housing, employment and/or SSI/SSDI information on all 25 clients.

We were successful in collecting pre- and post-Life Skills Assessment data for 4 of 11 discharged clients.

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

Housing, employment and SSI/SSDI data is evaluated through ongoing contacts with documentation of status made during monthly supervision meetings. This data has been incorporated into a program dashboard that is completed monthly by QI and submitted to program supervisors for review, feedback and program monitoring.

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

The participant satisfaction survey is offered to clients at discharge as well as a point in time administration to all current clients one month of the year (May 2021).

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)

1. **Obtain Permanent Housing: At least 65% of individuals will obtain permanent housing within 120 days of assessment.**

   Of the 25 clients served, 21 (84%) obtained permanent housing during program enrollment. The average length of time to secure permanent housing was 50 days (range of 1 to 261 days).

   - **18 of the 21 (86%) obtained permanent housing within 120 days of program enrollment.**

- **8 of 11 clients who were discharged in FY21 were in a permanent housing situation.**

At the close of FY21, 13 clients resided in permanent housing and 1 client was in a temporary housing situation.

Lessons Learned/Strategies:

ECHO program staff have used creative strategies throughout the pandemic to continue providing quality services and help participants establish housing. Despite working from home and limited face-to-face contact with program participants, ECHO staff have been able to use our established relationships with landlords and other service providers to continue meeting participant needs and exceeded this outcome. ECHO staff were able to assist with dropping off food for participants and have furniture and other needed supplies delivered to participant homes.

2. **Housing Stability: At least 75% of participants who obtain permanent housing will maintain this housing for more than 90 days. Participants who request program discharge prior to 90 days will be excluded from this outcome.**

   Of the 21 clients who obtained permanent housing, 20 (95%) maintained permanent housing for more than 90 days. One (1) of the 21 clients enrolled on 5/20/21 and secured permanent housing but was enrolled less than 90 days at the close of FY21.

   Lessons Learned/Strategies:

   The results of this outcome are particularly impressive given an increase in the enrollment of participants with significant mental health concerns. As a result of the pandemic and impact on the operations of our community partners, the ECHO program received referrals for individuals that would have typically been served by other agencies. Staff used strategies such as working in teams, communicating with participants via text and other means to safely and effectively meet the needs of program participants to support housing stability.

3. **Employment or Other Stable Income: At least 75% of individuals will obtain employment within 90 days of assessment and/or will have secured applicable social security benefits prior to discharge.**

   Of the 25 clients served, 16 (64%) obtained employment or secured applicable social security benefits.
   - **Seven (7) of those 16 obtained employment**
   - **Nine (9) of those 16 secured social security benefits**

Of those 16 clients, 13 (81%) obtained employment or secured applicable social security benefits within 90 days of assessment. Two clients were employed at the time of program enrollment.

The remaining nine clients applied for SSI/SSDI and/or are appealing SSI/SSDI denials. Of those nine clients, two received TANF and two received Cunningham Township monies for monthly assistance.

Lessons Learned/Strategies:

Social security benefits are difficult for participants to access and frequently require use of the appeals process. The challenge of accessing these benefits has been amplified by the closure of the local Social Security office since May, 2020. While social security staff are still accessible via phone, the process of obtaining benefits and services (e.g., social security card) has been more difficult.

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

   Of the 25 clients served, 23 have a pre-test measure for the Life Skills Assessment completed as part of intake paperwork. Two NTPC clients did not fully engage in program services and did not complete the Life Skills Assessment. The range of scores on the pre-test was 150 to 186 (with 186 being the maximum score). The average pre-test score for all clients was 175 (94%).

   Four (4) of 11 clients had completed at least two Life Skills Assessments at the time of discharge.
   - **Three (3) of four clients (75%) demonstrated an increase on the measure with an average increase of eight points.**
   - **One (1) client had the maximum score of 186 at pre- and post-test so no change occurred.**

   Lessons Learned/Strategies:

   ECHO staff are skilled at addressing immediate needs of participants. When a low score is identified on the Life Skills Assessment, staff focus on supporting the participant in developing or improving that particular skill.

5. **Financial Literacy: At least 90% of clients receiving both pre/post financial literacy assessments will show improvement in financial skills mastery.**

Lessons Learned/Strategies:

After further evaluation of the Financial Literacy curriculum, we have determined that the requirements are not a good match for the ECHO program. The Financial Literacy curriculum involves a 4-hour, in-person course. Due to the high needs of clients served in the ECHO program (many of whom have mental health issues, housing instability, lack income and/or have other significant needs), this course is not feasible (or relevant) for many participants.

The COVID-19 pandemic further complicated attempts to address this outcome. While Financial Literacy could be taught in a group setting, COVID precautions did not allow for in-person learning, and many ECHO participants do not have access to technology that allows for stable internet connectivity or Zoom capability.

6. Participant Surveys: At least 70% of participants will complete a satisfaction survey. 90% of survey respondents agree or strongly agree with positive service quality statements.

Five (5) of 11 clients (45%) who were discharged from the ECHO program completed a participant satisfaction survey upon discharge. The survey consists of 18 items rated on a scale of 1-5 (5 being the highest). The overall item average on the survey was 4.75 (out of 5).

In addition to the discharge survey, a point in time survey was conducted to obtain feedback from participants during program enrollment. The survey was offered to ECHO participants in May 2021. Sixteen (16) participants were enrolled in the program at time of administration. Thirteen (13) of 16 participants (81%) completed a survey. The overall item average on the survey was 4.93 (out of 5).

Lessons Learned/Strategies:

Participate satisfaction remains high. While fewer discharged clients completed the survey, the point-in-time survey provides meaningful information from program participants. As we apply for the grant in FY22, we will likely discontinue the discharge survey in favor of a point-in-time administration. This allows for program participants to have a formal feedback mechanism while they are receiving services.

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?

Data from FY20 was used as benchmark data.

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

Outcome	FY21	FY20
Obtain Permanent Housing	**84% of clients obtained permanent housing during program enrollment.** **Same as FY20 benchmark.**	**84% of clients obtained permanent housing during program enrollment.**
Housing Stability	**95% of clients who obtained permanent housing maintained this housing for more than 90 days.** **Percentage of clients obtaining and maintaining permanent housing exceeded the benchmark from FY20.**	**81% of clients who obtained permanent housing maintained this housing for more than 90 days.**
Employment/ Other Income Stability	**64% of clients obtained employment or secured social security benefits.** **81% of those clients obtained employment or benefits within 90 days of assessment.** **Percentage of clients with employment and/or SSI/SSDI was about 10% lower than in FY20. COVID-19 may have impacted employment opportunities and/or level of comfort with employment.**	**72% of clients obtained employment or secured social security benefits.** **89% of those clients obtained employment or benefits within 90 days of assessment.**
Life Skills Mastery	**75% of clients showed an increase on the Life Skills Assessment at the time of discharge.** **Slight increase from FY21.**	**71% of clients showed an increase on the Life Skills Assessment at the time of discharge.**
Financial Literacy	**N/A**	**N/A (new outcome for FY21)**
Participant Survey	**45% of discharged participants completed a satisfaction**	**60% of discharged participants completed a satisfaction**

	survey. Overall average was 4.75 (out of 5). **81% of participants completed a point-in-time survey. Overall average was 4.93 (out of 5).**	**survey. Overall average was 4.99 (out of 5).** **69% of participants completed at point-in-time survey. Overall average was 4.79 (out of 5).**

(Optional) Narrative Example(s):

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

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

Utilization Data Narrative –

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

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

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

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

Treatment Plan Clients (TPC):

Defined as those individuals actively accepting services and meeting with a case manager resulting in a service plan. It is estimated that this program will have 20 TPC over the course of the year.

We served a total of 22 TPC over the course of the year.

Non-treatment Plan Clients (NTPC):

NTPC include the following:

- **Eligible individuals that enroll in program services, but do not engage in the assessment and service planning process; and**
- **Eligible individuals referred or identified through street engagement efforts who have contact with program staff (and may receive some referral or hard services), but do not enroll in the ECHO program.**

We projected that we would serve 24 NTPC clients in FY21; however, only 4 NTPC clients were enrolled in the program and reported in our grant data. Note: One of these clients was counted as NTPC at the end of the quarter, but became TPC in the quarter that followed. As a result, only 4 clients were NTPC throughout program enrollment.

In addition, we received inquiry calls involving an additional 56 unique individuals in FY21. Calls were made as self-referrals or by providers in our local community. Individuals were most often referred to Centralized Intake at RPC; however, many received referrals for additional services to meet immediate needs (e.g., Austin's Place, Courage Connection, Land of Lincoln, Rental Assistance, CU at Home, Daily Bread, etc.). Program capacity impacted our ability to serve additional clients.

Community Service Events (CSE):

There is an estimated 25 Community Service Events (CSE) for outreach and referral development to temporary housing resources, food kitchens, other potential referral sources, and homeless advocacy efforts, as well as distribution of materials to promote the program. Anticipated community Service Events for the FY 21 period include meetings with police departments, human service agencies, landlord and/or tenant groups, Mental Health and Disabilities Council, Human Services Council, Champaign County Continuum of Service Providers to the Homeless, the PACE disABILITY Expo and various other contacts with local agencies and resources relevant to the needs of the homeless population.

Our program staff participated in 34 Community Service Events in FY21, which exceeded our projection. This count does not include participation in a number of community stakeholders (Continuum of Service Providers to the Homeless, Supportive Housing Committee, Shelter Care Plus Quarterly Partners Meeting, etc.).

Service Contacts (SC):

Defined as the number of TPC clients (20) multiplied by 26 contacts (assumes an average estimated weekly service contacts for the first four months, twice monthly for the next two months and monthly for the next 6 months). This results in an estimated 520 TPC Service Contacts for TPC clients. Service Contacts include both direct service provision and collateral contacts (e.g., originating referral source, family member).

The service contacts for NTPCs (24) will vary, but are estimated at a minimum of 2 contacts each (48 contacts total).

We served a total of 22 TPC clients across the course of the year which slightly exceeded the grant projection. The average number of clients served on any given day was approximately 16 clients. We exceeded the projected service contacts by documenting 882 services. The nature of services (reduced face-to-face contacts) continued to be impacted by COVID-19.

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: **Cunningham Children's Home**
Program name: **Families Stronger Together**
Submission date: **08/27/21**

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)

Eligible youth:

- **Will live in Champaign County;**
- **Will be aged 10 through 17;**
- **Will have become involved, or are at risk of becoming involved, in the juvenile justice system;**
- **May be experiencing:**
  - **o Emotional/Behavioral concerns**
  - **o Truancy**
  - **o Domestic Violence**
  - **o Probation**
  - **o Pattern of chronic offenses**
  - **o Felony charge**

Potential exclusionary criteria will be carefully assessed based on current level of risk, functioning, and engagement in other services intended to address these concerns:

- **o Substance use**
- **o IQ below 65**
- **o Juvenile sex offenses**
- **o Murder conviction**
- **o Gang involvement**
- **o Active psychosis**

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

The needs of each youth and their family who are referred to this program will be evaluated on a case by case basis to determine if their needs can best be met by this program. The Associate Director and the Intake & Admissions Specialist from Cunningham will determine eligibility for each referred youth and their family. The possible exclusionary criteria will be considered carefully based on the scope of the training, education and experience of the program staff at that time and the other services that the family is receiving to address these concerns.

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

People in the target population will learn about the program through our community partners who send referrals, by our staff's engagement and outreach efforts within the community, through fliers that will be distributed in public spaces throughout Champaign County, and online through Cunningham's website.

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

80%

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

80% - the FST program received 41 referrals representing 37 unique youth in FY21. Thirty-three (33) admissions occurred as a result of these 41 referrals (31 in FY21 and 2 at the beginning of FY22).

Note: One youth who was referred twice was referred in 07/20, but the referral was closed due to the youth/family no longer seeking services. This youth was subsequently re-referred in 08/20 and was admitted to the FST program.

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

30 days

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

80%

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

68% (21 of 31) of youth admitted to the FST program in FY21 were assessed for eligibility with 30 days of program referral. The average program admission timeframe was 21 days.

Note: The timeframe for program admission in the spring was significantly longer than in the fall due to some program shifts (staff turnover, supervisor absence, etc.). The program is fully staffed as of 06/30/21. The average length of time from referral to program admission was 7 days (n = 17 admissions) in the first 6 months of FY21 compared to 38 days (n = 14 admissions) in the latter 6 months of FY21.

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

30 days

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

50%

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

Sixteen (16) of 27 clients (59%) engaged in the full program (i.e., became TPC clients) within 30 days of program enrollment. Eleven additional clients became TPC clients, but exceeded 30 days to do so.

Four (4) additional clients enrolled in brief services (NTPC clients), but did not enter the full program. Three were discharged due to lack of engagement and one was discharged due to requesting different services.

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

7 months

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

A total of 22 youth were discharged from FST in FY21. Eighteen (18) youth were Full Program (TPC) clients and four (4) youth were Brief Service (NTPC) clients.

For TPC clients the average length of stay was 181 days (6 months).

Demographic Information

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

Demographic information beyond those required by the grant may include: other system involvement (e.g., DCFS, DJJ, Medicaid, Social Security), grade level completed, language, and religion.

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

All 35 clients identified English as their primary language.

Clients were in the following grade levels:

- **4th grade – 2 clients**
- **6th grade – 4 clients**
- **7th grade – 4 clients**
- **8th grade – 7 clients**
- **9th grade – 9 clients**
- **10th grade – 3 clients**
- **12th grade – 6 clients**

Clients/families/referral partners reported involvement with the following systems, agencies and programs:

- **Youth Assessment Center – 14 clients**
- **Therapy/Counseling Services (multiple providers) – 13 clients**
- **DCFS (past or present) – 6 clients**
- **READY Program – 6 clients**

- **Social Service Agencies (no specific service identified) – 4 clients**
- **SASS – 3 clients**
- **Boys & Girls Club – 3 clients**
- **Juvenile Detention Center – 2 clients**
- **Medicaid – 2 clients**
- **No Limits – 2 clients**
- **SSI – 2 clients**
- **Vineyard Church – 2 clients**
- **Champaign County Probation – 1 client**
- **CU 1:1 Mentoring Program – 1 client**
- **Empty Tomb – 1 client**
- **FSOOY Foundation – 1 client**
- **Regional Planning Commission (emergency shelter program) – 1 client**
- **Restoration Church – 1 client**

Religious affiliation was captured for 20 clients. These clients reported the following religious affiliation:

- **Catholic – 1 client**
- **Protestant – 6 clients**
- **Other – 3 clients**
- **None – 10 clients**

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.

This program provides therapeutic services to families of youth, age 10 through 17, who have become or who are at risk of becoming involved with the juvenile justice system in Champaign County. The program will provide youth and their families with trauma-informed, culturally sensitive therapeutic services intended to promote resiliency through the use of the Attachment, Regulation, and Competency (ARC) treatment framework. The program will strengthen the trauma-informed caregiving skills of caregivers. The program will help these youth and their families understand the impact that past experiences of trauma have had on their current level of functioning and/or

behaviors that have brought them to the attention of the juvenile justice system. The impact of this program will extend beyond the 75 youth that will be served because the entire family can be included in services. We will track the total number of participants at the time of case closing so this can be measured. Additionally, the impact of this program will extend to the community partners working in the fields of mental health, education and juvenile justice in Champaign County. The program will strengthen the trauma-informed knowledge of community partners through collaborative efforts when serving families. Additionally, trainings will be provided by the ARC developers and trainers. These trainings will reach more than 100 community members.

We expect that the impact of this program will be positive outcomes for youth in the areas of decreased trauma symptoms and delinquency behaviors and increased positive connections and protective factors. Outcomes will include:

Outcome 1: Presenting problems of the youth positively change over time

Outcome 2: Trauma-informed caregiving skills strengthened

Outcome 3: Increased identification/utilization of natural supports by family

Outcome 4: Improved protective factors for family

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. **Presenting problems of the youth will positively change over time**	**Strengths and Difficulties Questionnaire**	**Caregiver and Youth**
2. **Trauma-informed caregiver skills strengthened**	**ARC Tool***	**Therapist/Family Support Specialist**

3. Increased identification / utilization of natural supports by family	Protective Factors Survey (PFS-2) Youth Connections Scale	Caregiver Youth
4. Improved protective factors for family	Protective Factors Survey (PFS-2) Youth Connections Scale	Caregiver Youth

*** Attachment, Self-Regulation & Competency (ARC): Per our grant proposal we worked with Dr. Margaret Blaustein and her team to develop a tool to measure caregiver strengths. The tool has been implemented and we are currently considering additional feedback from Dr. Blaustein on its use/interpretation.**

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

Attempts were made to gather outcome information for every participant at intake and at discharge for TPC clients. Due to lack of engagement by some participants at discharge, we were not able to collect this data for every participant.

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

N/A – our goal was to collect outcomes information from all discharged TPC clients.

5. How many total participants did your program have?

A total of 35 unique clients (representing 37 program spells*) participated in the FST program in FY21:

- **Six clients had been admitted in FY20 and continued services into FY21. All 6 clients were discharged in FY21;**
- **Nineteen clients engaged in full program services (TPC clients) during FY21;**
- **Eight clients were enrolled in brief services (NTPC clients) at the close of FY21 (all have since transitioned to TPC clients in FY22);**
- **Four clients were enrolled in brief services (NTPC clients) in FY21 and discharged without engaging in the full program.**

***Note: Two clients were discharged and re-admitted during FY21 and thus count as two distinct program spells.**

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

Attempts were made to collect outcome information from all enrolled clients at the point of intake and all TPC clients at discharge.

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

Eighteen (18) TPC clients were discharged and eligible to complete discharge measures. Note: The ARC Tool is completed in alignment with the treatment/support plan, which is due at the 4th, 7th and 10th months. Based on length of stay, 7 discharged clients would have had two or more treatment plan/support plans due.

The amount of outcome information collected varied by assessment type.

- **Outcome 1/Strengths and Difficulties Questionnaire: Three (3) clients completed intake and discharge questionnaires**
- **Outcome 2/ARC Tool: Two (2) clients completed quarterly and discharge assessments**
- **Outcome 3 & 4/Youth Connections Scale: Three (3) clients completed intake and discharge scales**
- **Outcome 3 & 4/Protective Factors Survey: Two (2) clients completed intake and discharge surveys**

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, 3, 4 data: intake & discharge

Outcome 2 information: quarterly & upon discharge

Results

9. What did you learn about your participants and/or program from this outcome information? Please be specific when discussing any change or outcome, and give appropriate quantitative or descriptive information when possible. For example, you could report the following:
    i. Means (and Standard Deviations if possible)
    ii. Change Over Time (if assessments occurred at multiple points)
    iii. Comparison of strategies (e.g., comparing different strategies related to recruitment; comparing rates of retention for clients of different ethnoracial groups; comparing characteristics of all clients engaged versus clients retained)

During FY21, there were 18 discharges of 17 clients (one client discharged, then re-enrolled, then discharged again within FY21). The most common reason for discharge was lack of engagement (9) followed by transfer to another mental health provider (3), completion of program goals (2), entry into detention/corrections facility (2), admission to a residential program (1), and moving out of the service area (1). Lack of engagement and other unplanned discharges made collecting discharge data a challenge.

1. **Outcome 1: Presenting problems of the youth change positively over time**

   Of the 18 discharged clients, twelve clients had an intake SDQ assessment.
   - **Three (3) discharge assessment were completed by clients.**
   - **Two (2) of the three clients reported a decrease in difficulties from intake to discharge and one client reported no change (average change was -2.0).**
   - **Two clients reported a decrease on the prosocial behaviors scale and one reported no change. The average change was -1.0. An increase was expected in prosocial behaviors.**
   - **None of the outcomes were met for the SDQ.**

2. **Outcome 2: Trauma-informed caregiving skills strengthened**

   The ARC assessment is completed quarterly, typically at the third or fourth month of enrollment. Of the 18 discharged clients in FY21, six clients would have been eligible for two ARC assessments based on length of stay.
   - **Three (3) clients had initial and discharge assessments completed.**
   - **Two (or 67%) of the caregivers had strengthened caregiving skills (as measured by the ARC tool) at discharge.**

3. **Outcome 3: Increased identification/utilization of natural supports by family**

   Of the 18 discharged clients, 12 clients completed an intake Youth Connections Scale.
   - **Three (3) discharge Youth Connections Scales were completed.**

- **One youth (33%) reported an increase in the number of supportive adult connections as well as an in their Youth Connections score.**

4. **Outcome 4: Improved protective factors for family**

   Of the 18 discharged clients, 12 clients completed an intake Protective Factors Survey.
   - **Two (2) discharge Protective Factors Surveys were completed.**
   - **One (or 50%) saw an increase in their PFS-2 score.**

A number of lessons were learned in this first full year of programming although many of these lessons are not directly related to our outcome measures and use of assessment tools:

- **COVID-19 impacted the program in a number of significant ways:**
  - **While we anticipated that the clients and their families would have significant case management needs, these needs were amplified by COVID-19. Many families required assistance with housing, job searches, health insurance, food, clothing and other needs that were not well captured by our identified assessment tools.**
  - **Collaboration with families was impacted adversely by COVID-19. While telehealth was invaluable to engaging with our clients and their families, it is not the same as meeting face-to-face and building those relationships while working together toward common goals. Not meeting with families face-to-face made it more challenging to ensure that pre- and post-measures were completed.**
  - **Many community partners (potential referral agents as well as service providers) were not open or had adapted their operating procedures which impacted the referral of clients as well as the services to be delivered.**
  - **Documentation, in general, has been a challenge throughout the pandemic due to the number of staff working remotely and the lack of face-to-face contact with clients and their families. These challenges include ensuring completion of documentation, obtaining necessary signatures (staff, supervisor. client and/or guardian) as well as maintaining hard copy files.**

Due to the small number of pre- and post-measures, we are still evaluating if these are the right tools as well as whether projected outcomes are realistic. Lessons learned with regard to our chosen assessment measures as well as outcomes measurement in general:

- **We have some staff training needs around the use of some measures to ensure the data gathered is reliable and valid. One of our staff members has been working on a scoring tool to support consistent/accurate scoring by all staff. We anticipate this tool will be completed in September, 2021.**

- **The projected change for some measures may have been unrealistic based on how the tool is scored. This type of concern will be evaluated over the next 6 months and addressed (as applicable) in the FY22 grant application process.**
- **We are developing a program dashboard to monitor various aspects of the FST program (census, service contacts, assessments, etc.) to provide ongoing (monthly) monitoring of program implementation (including completion of outcomes measures).**

In addition, staff turnover as well as the absence of the program supervisor for 3 months in the spring provided an added layer of challenge to the issues described above.

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

No, we have not identified a comparative target or benchmark for this program to date.

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)

Cunningham staff receive a referral from a school social worker for a teenage girl who has recently been arrested for an incident of domestic violence in which she was aggressive towards her parent. The FST program staff contact the school social worker to clarify the referral information and schedule an intake appointment and warm hand-off with the teenage girl and her parent.

During the intake session, the FST Family Support Specialist explains client rights, privacy practices, and grievance procedures for the program. The FST Family Therapist then interviews

the young woman and her parent to gather information about their strengths and needs as well as creating a plan to meet their most urgent needs over the next 30-60 days. The FST Family Therapist also works with the family to complete a crisis plan.

Within the first 60 days, the FST Family Support Specialist helps to meet the most immediate needs of the family by making necessary service referrals (e.g outpatient counseling; community-based mentoring program) and purchasing therapeutic supplies (e.g., weighted blankets, journals, noise-canceling headphones, etc.). During this time, the FST Family Therapist works with the youth and parent to complete program assessment tools (Strengths and Difficulties Questionnaire, Youth Connections Scale and Protective Factors Survey). The FST Family Therapist contacts several important providers in the teenage girl's life (e.g., primary care physician, school social worker, public defender), so that the Mental Health Assessment conveys a holistic picture of this young woman and her needs. An Individualized Treatment Plan is then completed which identifies relevant goals, objectives and outcomes specific to this teenage girl.

The FST Family Therapist and Family Support Specialist collaborate to provide mental health services to the youth and her parent over the next 6 months. The Family Therapist provides individual therapy to the teenage girl at her school. The Family Therapist also provides family therapy to the teenage girl and her parent in an office at Cunningham that has been prepared with COVID-19 precautions in mind (i.e., a plexiglass shield placed along the length of a conference room table). The Family Therapist also provides support services to the parent to help her understand the key role that she plays in helping her daughter to make safe and successful choices. As part of this work, the parent learns to modulate her own feelings first, before addressing her daughter's needs or behaviors. All therapy services, as well as caregiver support services are provided through the application of the Attachment, Regulation, and Competency (ARC) treatment framework.

During these 6 months, the FST Family Support Specialist makes a referral for this teenage girl to community-based mental health provider that will continue services post-discharge from FST. This allows the teenage girl to receive therapy services throughout the time she is on the waiting list for the community-based provider, which is typically 3-4 months long. The Family Support Specialist provides additional psychoeducation services, also while implementing the Attachment, Regulation, and Competency (ARC) treatment framework, until the youth can be matched with a mentor through a community-based mentoring program. These additional psychoeducation services provided by the FST Family Support Specialist typically involves teaching this youth about self-regulation and co-regulation skills so that she can learn to manage her emotions in healthy ways and make better choices at home, school, and in the community.

In preparation for case closure, the FST Family Therapist conducts a warm hand-off through joint therapy services with the receiving outpatient mental health provider. The FST Family Support Specialist completes a warm hand-off with the teenage girl and the new community-based mentor. The FST Family Therapist repeats program assessment tools at the point of case closure to measure the family's progress, as well as our FST program outcomes. The FST Family Support Specialist conducts a client satisfaction survey with both the teenage girl and her parent. The case is then successfully closed.

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.

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

Treatment Plan Clients (TPC):

Definition: Full Service Cases are offered to families who, upon referral, have made a commitment to engaging in services, or who clearly would benefit from the full service array offered by this program. Youth and their families, who receive Full Services from this program, will be considered either the treatment (or intervention) plan clients.

Cunningham served a total of 25 TPC clients in FY21. We had an annual target of serving 50 clients. As noted in our quarterly reports, the number of TPC clients was adversely impacted by COVID-19 during the first half of the year. The operations of agencies identified as potential referral sources (Youth Assessment Center and schools) were impacted dramatically during this time period. During the second half of FY21, we had some staff turnover and the absence of our program supervisor (due to an unanticipated leave of approximately 3 months) impacted the number of admissions.

Non-treatment Plan Clients (NTPC):

Definition: Brief Service Cases are offered to families who, upon referral, have either appear to be resistant to engaging in services, or whose needs may be able to best be met through other services offered in the Champaign County community. Brief Service Cases allow staff time to either make appropriate referrals or to creatively engage these families in culturally responsive ways, including possibly recruiting the support of other community partners, so that a subsequent Full Service Case may be successfully opened. Youth and their families, who receive Brief Services from this program, will be considered the non-treatment plan clients.

At the close of FY21, we had a total of 12 NTPC clients (target was 25). Four (4) of these 12 clients did not engage in services and were discharged from the brief services component of the program primarily due to lack of engagement. Eight (8) of the 12 clients were admitted close to the end of FY21 and transitioned into FY22 as NTPC clients. All 8 clients will be transitioning to TPC clients as we begin reporting for FY22. The lower than expected number of NTPC clients is also related to a lower number of referrals than anticipated.

Community Service Events (CSE):

Definition: Cunningham will promote this new program by visiting with community partners to explain this new program, invite new referrals, and strengthen trauma-informed practices county wide. These community partners include, but are not limited to, the Youth Assessment Center, the State's Attorney, and Probation and Court Services. Cunningham intends to complete 10 Community Service Events during the expanse of the coming year.

Cunningham participated in / facilitated a total of 20 Community Service Events in FY21.

Service Contacts (SC):

Definition: Full and Brief Service Cases service contacts will preferably be provided through three in-person sessions per month. Services will minimally be provided through two in-person sessions and one phone call per month. This year, as we build our program, at least 75 youth (50 Full & 25 Brief) will be served.

A minimum of 1125* service contacts with caregivers or youth will be completed:
•50 Full x 3 contacts per month x 7 months = 1050
+
•25 Brief x 3 contacts per month x 1 month = 75

Cunningham documented a total of 931 contacts with caregivers, clients and collaterals. An additional 384 attempted contacts were documented. While we did not meet the projected target of 1125 due to fewer clients than projected, we exceeded the average number of monthly contacts expected for each clients. While we predicted approximately 3 contacts per month per client, we averaged approximately 6 contacts per month. This average is based on an average daily census of 13 clients in the FST program.

Note: As a result of COVID-19, many contacts were completed via Zoom and/or phone instead of in-person.

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: DREAAM Opportunity Center
Program name: Dream Big!
Submission date: August 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)

   DREAAM targets both boys and their families through a comprehensive service array of evidence-based and culturally responsive programs. During FY21, the plan is to expand to serve and support a cohort of girls to examine the effectiveness of DREAAM programming with girls. These programs align with the sustainability goals of the ACCESS Initiative and continue the work of the system of care development and expansion efforts.

   The primary target population is marginalized youth between the ages of 7-13 and secondary is their parents and caregivers meeting the following criteria:

   1. Youth who are experiencing emotional, academic, and behavioral challenges with a moderate to high risk of involvement with the special education, mental health, and/or child welfare systems.
   2. Youth with an incarcerated parent and/or experiencing father deprivation.
   3. Youth without access to physical activity and opportunities to improve health and wellness.
   4. Parents/caregivers of youth ages 7-13 experiencing and/or at-risk of developing challenging behavior and/or with a diagnosed mental health disorder.
   5. Parents/caregivers living with chronic stress and low emotional and social support.

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

Eligibility was determined through a several methods. We used the Strength & Difficulties Questionnaire (SDQ) to screen for challenging behavior. SDQ is completed by the parent and/or teacher. We used a cut-off score of above 2 for behavioral difficulties and difficulties getting along with other children, above 5 for hyperactivity, and above 3 for emotional distress. This instrument measured social, emotional, and behavioral development at home and school.

Parent incarceration history/status and chronic stress were self-reported. Report cards were collected on a quarterly basis to assess for literacy skills. In addition, parent responded to essay questions to collect the parent perspective on the child's needs.

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

Parents learned about the program through outreach events, social media, school referrals, and parent referrals/networks.

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

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

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

In FY20, the actual percentage was 65% received services.

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

Application estimated the length of time would be 5 days from referral to assessment of eligibility/need.

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

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

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

The actual percentage was 75%.

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

An estimate of 5 days to engage clients in services after eligibility/need was determined.

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

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

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

We achieved 80% engagement within that time frame.

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

Estimated length of time is one year in services.

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

Program participants are engaged for 1 year in 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)

During the referral/assistance-seeking phase, the following demographic data will be collected.
1. Income
2. System involvement (special education, mental health, foster care)
3. Incarcerated parent status
4. Family size

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

A vast majority of families are in the low-income range and experienced unemployment and reduced wages during COVID-19. A small percentage of DREAAMers are enrolled in special education services and/or receiving mental health services and medications. The SDQ indicated high levels of attention deficit behaviors and stress among DREAAMers. Average family size is four.

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.

Expected impact:
1. Increase in positive friendship skills
2. Increase in ability to identify and apply anti-violence strategies in school and in the community
3. Increase in emotional literacy
4. Increase in academic skills and resiliency to overcome risk factors
5. Decrease in stress levels among parents
6. Increase emotional and social supports among parents

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

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

Outcome:	Assessment Tool Used:	Information Source:
E.g. 1. Increased empowerment in advocacy clients	Measure of Victim Empowerment Related to Safety (MOVERS) survey	Client
1. Increase in positive friendship skills	*Strengths and Difficulties Questionnaire (SDQ)* *Staff observations*	*Parent* *Teacher* *Staff*
2. Increase in ability to identify and apply anti-violence strategies in school and in the community	*Survey* *Staff observations*	*Participant* *Staff meeting/case notes*
3. Increase in emotional literacy	*An online tool and observations were used to measure emotional literacy over time.*	*Participant*
4. Increase in academic skills and resiliency to overcome risk factors	*Strengths and Difficulties Questionnaire (SDQ) and school report cards; Non-evidence-based tools were staff case note, teacher feedback, and tracking of homework completion while at DREAAM*	*Participant* *Parent* *Teacher*

5. Decrease in stress levels among parents	*Self-report*	*Parent*
6. Increase emotional and social supports among parents	*Self-report*	*Parent*

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

The outcome information was collected 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?

TPC: 165
NTPC: 76

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

83

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

82

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

Data were collected once in May when school ended and, in some cases, twice during the program year from in September and May.

Results

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

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

The program continues to have a focus on Developmental Assets and building positive friendship skills to prevent violence. Participants had a significant increase in assets: adult role models, positive peer influence, access to art, and responsibility. In addition, the program continues to have success in developing positive friendship skills and increasing academic resiliency. Parents reported lower levels of stress, due to in-person program operations during remote learning. The program continues to show progress in the asset of Positive View of Personal Future. These outcomes were assessed through parent self-report, participants' self-report, observations, and teachers' feedback.

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

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

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

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

(Optional) Narrative Example(s):

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

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

Utilization Data Narrative –

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

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

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

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

Treatment Plan Clients (TPC):

Youth participants who are enrolled in two or more program services during one year of engagement. Parents are included in this category and will receive services along with youth TPC.

Non-treatment Plan Clients (NTPC):

Youth participants who are enrolled in at least one program service during one year of engagement. Parents are included in this category and will receive services along with youth NTPC. For example, a parent may only attend a parenting workshop and not take advantage of other services.

Community Service Events (CSE): ***This category includes the number of parent meetings/support groups, outreach events, and community presentations.***
Service Contacts (SC): ***This category includes the number of service activities (after-school, summer, and athletic supports), screenings, school advocacy, parent workshops, support groups, parent coaching sessions, and family engagement events.***
For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

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 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: Don Moyer Boys & Girls Club
Program name: C-U Change
Submission date: August 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)

The C-U Change program is open to all youth and families in Champaign County. Eligibility criteria for services are:

- Residents of Champaign County as shown by address;
- Have evidence of a need or service based upon an assessment;
- Have limited financial resources to meet the cost of their care.
- Youth referred will have 3 or more risk factors identified in the Target Population section.

Referrals are accepted from Juvenile Probation, Local School Districts, Champaign County Youth Assessment Center, and other community organizations serving youth at risk. Program Staff meet with families, in their home when necessary. The program is inclusive of all child serving systems, social agencies, family support organizations, faith-based organizations, civic/social groups and community-based entities that have a vested interest to improve outcomes for youth and families, including those located in rural areas.

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

With the program being based upon referrals, many of the program referrals come from Champaign Youth Probation Services, the Youth Assessment Center, the READY Program, Champaign County School Representatives (i.e., administration, social workers, counselors, school resource officers, etc.) and other community organizations that may serve youth-at-risk from Mahomet, Rantoul, Urbana and Champaign. With the programs

referral base coming from a variety of community- based sources throughout Champaign County, CU Change is inclusive of all youth-at-risk serving systems and entities.

The program admissions process is as follows:

Step 1 - The Referral

Referral Forms will be distributed to agencies via program presentations, school meetings and community events. Referral based programs will complete the CU Change Referral Form for prospective youth and submit to the CU Change Coordinator.

Step 2 - The Family Contact and Conference

Upon receiving referral, the CU Change Coordinator contacts the parent/guardian of the prospective youth to schedule a family conference. During the conference the CU Change coordinator discusses the dynamics of the referral to the program. Youth and the parent/guardian have the opportunity to describe challenges at home, school, peers and/or social issues. Throughout this process risk factors are identified and determined. The CU Change Coordinator then explains the program expectations and parameters which include the following:

- Youth must be a resident of Champaign County as shown by address
- Must show need for services by assessment, income and/or referral
- Have limited financial resources to meet the cost of their care.
- Youth must have 3 or more risk factors identified in the Target Population section.
- Youth must be between the ages of 11-18.
- Youth must engage and participate in required classes throughout the school day.
- Youth must be involved in required programs (i.e., counseling sessions, classes, groups, etc.)
- Youth must follow all respective school rules and the DMBGC Code of Conduct
- Parents/Guardians or Caring Adult Mentor are required to attend a quarterly student progress meeting with CU Change Coordinator throughout the year
- Parents/Guardians or Caring Adult Mentor are required to participate in at least 3 parent engagement activities throughout the year.

Upon agreement, the CU Change Coordinator administers the Screening Instrument, finalizing this step.

Step 3 - The Advisory Team Discussion

Referrals to the CU Change Program are approved by the CU Change Advisory Team which consists of the CU Change Coordinator and the Director of Teen Services. The team reviews the information collected from the Family Contact and Conference and determine admission into the program. Upon admission the family is contacted for Intake and Orientation.

While the CU Change program is designed for youth-at-risk, the safety of all youth at Don Moyer Boys & Girls Club is of the utmost importance. The CU Change Program and Don Moyer Boys & Girls Club cannot service youth referred with violent or aggressive tendencies or offenses.

Step 4 – Intake and Orientation
Before program support services begin, program families are required to attend a group or individual orientation meeting with the CU Change Coordinator. Orientations are held on a case-by-case basis to provide access. This orientation covers and reiterates expectations, the Club's core ideals, programming, discipline procedures, case management, etc.

Step 5 - Placement
After completion of the Intake and Orientation, is placed in the program and assigned a caring adult (mentor) within the Club for the duration of the program. The goal of the mentor is to develop a healthy relationship with the youth to focus on grade promotion and graduating high school on time with a plan for the future. New students are admitted as graduation occurs or as open slots become available.

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

To assure consumer access, Don Moyer Boys & Girls Club works with the Local School Districts (Champaign, Urbana, Rantoul and the Regional Planning Commission), Police Departments (Champaign, Urbana, Rantoul and University of Illinois), Champaign County Youth Assessment Center, Champaign County Juvenile Court Services and Juvenile Probation, Community Services Center of Northern Champaign County, as well as community organizations to build awareness of the program and its services. A major focus of the program services, are to meet the needs of the youth and families in their respective schools, homes and community environments. The program uses community engagement events (fairs, workshops, etc.) as some mechanisms for referrals.

Referral Forms will be distributed to agencies via program presentations, school meetings and community events. Referral based programs will complete the CU Change Referral Form for prospective youth and submit to the Director of Teen Program Services.

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

70%

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

5 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:

89%

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):

95%

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

81%

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

36-48 Months

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

18 months or less

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)

   Household Income
   Household Type

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

Household Income

9,999 or Below	5	9%
10,000 – 14,999	8	14%
15,000 – 22,999	22	37%
23,000 – 33,999	9	16%
34,000 – 49,999	12	21%
50,000 – 74,999	0	0%
75,000 and Above	2	3%

Household Type

1 Parent	49	84%
2 Parents	6	11%
Foster Family 1 Parent only	2	3%
Foster Family 2 Parents	1	2%

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?

1. 30 of 40 participants will demonstrate Improved Educational Achievement and Progress.
   Actual outcome 36 of 43 84%.
2. 30 of 40 participants will demonstrate Improved School Attendance and Behavior.
   Actual outcome 36 of 43 84%
3. 26 of 40 participants will demonstrate Improved Social-Emotional Skills.
   Actual Outcome 33 of 43 77%
4. 32 of 40 participants will demonstrate Improved Use of Free Time and Sense of Community.
   Actual Outcome 40 of 43 93%
5. 32 of 40 participants will demonstrate Improved Beliefs/Value System and Future Orientation (Goal-Setting).
   Actual Outcome 35 of 43 82%
6. 32 of 40 participants will demonstrate Reduced Aggression and Acts of Violence. Actual Outcome 11 of 11 100%
7. 32 of 40 participants will demonstrate Improved Decision Making and Self-Concept.
   Actual Outcome 36 of 43 84%
8. 32 of 40 participants will demonstrate Improved Leadership and Peer Relationships.
   Actual Outcome 33 of 43 77%
9. 34 of 40 participants or 80% of applicable youth will demonstrate Reduced involvement with the Juvenile Justice System (If Applicable).
   Actual Outcome 3 of 3 100%
10. 36 of 40 participants will demonstrate Increased Support System (via immediate family or caring adult).
    Actual Outcome 38 of 43 88%

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:
36 of 43 or 84% participants will demonstrate Improved Educational Achievement and Progress	CANS/FANS Assessment and Intensive Case Management	Report Cards/Case Manager/Client
36 of 43 or 84% participants will demonstrate Improved School Attendance and Behavior	CANS/FANS Assessment, Case Management, Progress Reports and Report Cards	Report Cards/Case Manager/Client
33 of 43 or 77% participants will demonstrate Improved Social-Emotional Skills	CANS/FANS Assessment and Intensive Case Management	Case Manager/Client
40 of 43 or 93% participants will demonstrate Improved Use of Free Time and Sense of Community -	CANS/FANS Assessment and Intensive Case Management.	Report Cards/Parent-teacher Conference/IEP Meetings and Client
35 of 43 or 82% participants will demonstrate Improved Beliefs/Value System and Future Orientation (Goal-Setting) -	CANS/FANS Assessment and Intensive Case Management	Report Cards/Parent-teacher Conference/IEP Meetings
11 of 11 or 100% participants will demonstrate Reduced Aggression and Acts of Violence -	CANS/FANS Assessment, Case Management, School Districts and Champaign County Probation Services.	Case Manager/Client
36 of 43 or 84% participants will demonstrate Improved Decision Making and Self-Concept -	CANS/FANS Assessment and Intensive Case Management	Case Manager/Client

33 of 43 or 77% participants will demonstrate Improved Leadership and Peer Relationships	CANS/FANS Assessment and Intensive Case Management	Case Manager/Client
3 of 3 participants or 100% of applicable youth will demonstrate Reduced involvement with the Juvenile Justice System	CANS/FANS Assessment, Case Management and Champaign County Probation Services.	Report Cards/Parent-teacher Conference/IEP Meetings
38 of 43 or 88% participants will demonstrate Increased Support System (via immediate family or caring adult)	CANS/FANS Assessment and Intensive Case Management	Parent Update Meetings, Client, Case Manager

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

- Yes, outcome information was collected from every youth based upon Referral, Intake, Case Management, Family Contact and Conference.

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?

- We had a total of 58 Clients for the year.

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

- 58 Clients were contacted in an attempt to collect outcome information from.

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

- Outcome information was collected from 43 out of 53 Clients.

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

- This information was collected at the intake, during case management sessions, quarterly via report cards and progress reports, at parent/teacher conferences, during virtual zoom sessions, during home visits and at discharge.

Results

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

During FY21 CU Change families and clients faced many challenges due to the state of the pandemic and inability to be in person for programming for the majority of FY22. While unable to be in person due to stay at home order issued by the state of Illinois it caused more stressors, trauma triggers and concern for our clients that needed the in-person experience and support. Most of these teens were greatly impacted by this stay at home order changing the in-person experience that is much needed for clients successfulness with this program. However, CU Change Case Managers created strategic, safe and COVID-19 safe plans to meet the needs and to engage with clients via virtual sessions, DMBGC Totes on the Go, phone calls, home visits, court appointments and food distribution. Once the stay-at-home order was lifted CU Change Case Managers held in person programming and case management sessions in person. Client and Case Managers relationships grew much stronger and closer upon the return to in person services.

By comparison of FY 20 'Performance Outcome Report' to FY 21 'Performance Outcome Report' there are some significant differences that occurred:

- In section A of the Program Outcomes to promote and develop life skills education report Social- Emotional Skills increased from 59% in FY 20 compared to 84% in FY 21

- In Section C of the Program Outcomes to demonstrate School Attendance and Behavior increased from 59% in FY20 compared to 84% in FY21

- In Section A of the Program Outcomes to improve Social-Emotional Skills increased from 59% in FY20 compared to 77% in FY21

- In Section A of the Program Outcomes to improve Beliefs/Value System and Future Orientation (Goal- Setting) increased from 59% in FY20 to compared 82% in FY21.

- In Section A of the Program Outcomes to demonstrate Reduced Aggression and Acts of Violence increased from 59% in FY20 compared to 100% in FY21.

- In Section B of the Program Outcomes to demonstrate Improved Decision Making and Self-Concept increased from 59% in FY20 compared to 84% in FY21.

- In Section C of the Program Outcomes to demonstrate Improved Leadership and Peer Relationships increased from 59% in FY20 compared to 77% in FY21.

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

Yes.

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

Based upon the last year's areas of need and outcomes of individuals in our program. Improvement of educational goals has been revealed through report cards and attendance reports and compared to previous year. The goal for CU Change program is for each youth admitted into the program to fully participate in the program for 36-48 months.

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

The outcome describe shows that the program is working for all active clients due to the support and programming that is being offered to each client based upon their goals and needs for the program. Clients are being given tools and resources to help them be as successful as they can be academically, social/emotionally, mentally and physically.

(Optional) Narrative Example(s):

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

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

Utilization Data Narrative –

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

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

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

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

Treatment Plan Clients (TPC): Unduplicated Number of Youth Enrolled in Program.

- Estimated - 40
- Actual - 58

Non-treatment Plan Clients (NTPC): Total Unduplicated Number of Parents, Family Members or Individuals connected to the Treatment Plan Client and involved in program related activities.

- Estimated - 40
- Actual -144

Community Service Events (CSE): Number of meetings between agencies, public presentations, school presentations and/or school staff meetings (i.e., referral meetings/conversations, meeting with School Social Worker/Teacher/Dean/SRO/Counselor, presentations to Champaign County Juvenile Probation Department, Community Resource Fairs, Youth Assessment Follow-Ups, Probation Officer Check-Ins, Etc.).

- Estimated - 144
- Actual - 157

Service Contacts (SC): Number of case management sessions, counseling sessions. Unduplicated Participation in Programs (i.e., Positive Action, Passport to Manhood, SMART

Girls, Career Launch, Diplomas2Degrees, Power Hour, SMART Moves, etc.), Field Trips (i.e., college tours, team-building trips, family outings, etc.), and Mentor Meetings.

- Estimated - 550
- Actual – 594

During FY20 CU Change Program created a multitude of ways to provide support and services to all clients while faced with the challenge of COVID-19. Case management sessions were held via Zoom, during home visits and at Don Moyer Boys and Girls Club. While facing the challenge of COVID-19 CU Change Program Managers continues to use all sources of connection such as: telephone, email, social media and Zoom platform to stay connected to every CU Change client in order to be engaged and provide services. CU Change Program Managers were able to direct provide one on one services which enabled each client to gain more life lessons and support. CU Change Program Managers were also able to attend court hearings, meetings with Probation & Court Services, assist with placement for additional wrap around services with community referral resources and agencies. CU Change also partnered with Tinervin Foundation to distribute 421 food boxes and Central Illinois Produce to distribute dry goods, fresh produce, and dairy boxes to families that were in need. CU Change continued to provide transportation to and from the club for all active CU Change clients in order to attend one on one case management sessions, programming, court appointments, school registrations, and community service opportunities. CU Change Program Managers were also able to provide transportation to CU Change clients in order to attend Summer Camp at Don Moyer Boys and Girls Club where they actively participated in youth development programming, community service, Book Club and STEM activities. CU Change Program Managers were able to provide 14 virtual program sessions to promote and encourage coping skills and sense of free time by leading Positive Actions program. CU Change Program Managers were able to provide 22 sessions of the following programs: Passport to Manhood, SMART Girls, Diplomas to Degrees, Career Launch, and Street SMART virtual and in person sessions during FY20. During these sessions clients were given tools such as: test taking strategies, everyday life skills and intervention techniques.

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: Don Moyers Boys & Girls Club
Program name: CUNC (CU TRI)
Submission date: 30 July 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)

(a) Young adults, caregivers (seniors & mothers), & families with young children/school-age children who have been inappropriately & adversely impacted by high rates of community violence & adversity. These are the majority of the people we serve and support. We will be working with Garden Hills, the Historic North End (First Street to Goodwin East & West), University & Bradley (North & South), & East Urbana. Fresh Start participants, their families & partners, could also be served.
(b) Community-level peer leaders & "natural helpers" such as parents, grandparents, individuals in the faith community, school volunteers, local business leaders, & others.
(c) Organizations & providers committed to becoming more trauma informed & improving their policies, procedures & practices to create better outcomes for their clients & the community.

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

By location, referral and/or self identification.

3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.)Outreach to community partners, hosting community events, social media, the CU-TRI show, referrals from schools, service provider (social workers), health care providers, and/or resident managers.

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: 90% **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): 2 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): 75%
c) *Actual* percentage of referred clients assessed for eligibility within that time frame: 84% (COVID sometimes made it hard to connect/or challenging to find a secure location)
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): 5 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: 89%
7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application): 12-15 weeks

b) *Actual* average length of participant engagement in services: 4-48 weeks (an average of 28 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)

NA

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

NA

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) Referrals to the Program – individuals/families impacted by community violence/adversity will be referred for group-based services and supports. Referrals will continue to come from Carle ER, law enforcement, community partners, schools, Youth Assessment Center, HeadStart, the Alliance, DREAAM, mentoring programs, and other community & self-referral sources. 75 individuals will attend/participate in a psycho-education group.

(2) Information, Linkage & Engagement Contacts (150) – Every individual/family referred to the program will receive some resource or a connection to a resource or support.
(3) We will be conducting a trauma symptom screening and a resilience assessment: 75% of participants who participate in at least 4 weeks of support will report:
- Improvements in trauma-related symptoms – we do not have baseline data but will look to identify a measure of change,
- Feeling supported & reconnected back to their community,

- Having new useful coping skills/distress tolerance skills,
- An identified natural or community resource, and
- 100% will receive information about trauma, toxic stress, PSTD & will understand these things better.
- We anticipate we will refer 20 individuals for more intensive services and supports and everyone will receive at least 2 referrals to community-based services/resources and/or supports.

Other communities have been able to document reductions in recidivism, significant changes in community violence or gun violence related crimes, & better engagement with other services that help address substance abuse, education, mental health & other needs.

Learning Collaborative:

1. 90% of those participating in the learning collaborative organizational assessment/training process will report improvements in their understanding of trauma, having more tools to respond to people impacted by trauma, and are more able to avoid retraumatizing themselves and others.
2. All the organizations participating in the learning collaboratives will identify a change plan with 2-3 targeted goals with clear implementation strategies & timelines.

For each of these outcomes, list the specific survey or assessment tool to be used to collect information on the outcome, and indicate who will provide the data. Associate each with a Numbered Outcome. (300 word limit)

Direct Service

(1) Referral data will be collected via referral forms

(2) Trauma screenings and resilience assessments will be collected either before an intervention occurs or during the first week of a group/individual intervention

(3) Evaluations are conducted at the end of every individual session and the end of every intervention/group session

(4) Participants receiving a trauma informed intervention (individual or group) will complete a pre-post KAB assessment to help us evaluate the intervention's outcomes

Trauma Informed Organizational Assessment:

The tool used is based on Fallot & Harris's Creating Cultures of Trauma Informed Care Organizational Assessment that is aligned to measure an organization's knowledge about trauma/trauma informed care & cultural competency; use of trauma informed practices; alignment & use of trauma informed practices related to the following domains: safety, trustworthiness, collaboration, peer leadership/consumer voice, & empowerment. The trauma informed organizational assessments also help organizations reflecton how their policies, procedures & practice might traumatize or retraumatize the communities they serve, their staff, & their clients

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).

***See page 10 for summary of outcomes from Training & Social Media**

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)Increased organizational capacity to be trauma informed *We did not to follow ups because organizations either experienced turn over during COVID and/or did not have the capacity because of other COVID demands to participate int the follow up process.	Revised assessment based on Fallot & Harris Trauma Informed Care organizational assessment	Staff

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? It was a function of convenience; and the participants interest and capacity. Participants who attended our virtual workshops and trainings completed surveys and evaluations between 20-50% of the time even though we made the link accessible and reminded them frequently to complete the assessments. Only those who needed CEU's were compliant. For participants who received information and referral services our work with them was not significant enough to monitor them. We also have a staffing and capacity issue to do follow up after the referral and connection to another program has been completed.

5. How many total participants did your program have?

- **Healing Solutions Training participants:** total of 155 individuals
- **Social Media/Online participants**
- The shows have ranged from 100-3,000 views (on average we receive 400 views per episode streamed on Facebook). As of right now our Facebook page has 1,200 followers and 1,040 likes and 440 followers on our Instagram Page.
- **Direct Service & Group Supports participants**: 114 NTPC
- **Learning Collaborative Attendees:** 27 unique participants in the monthly groups. (Average meeting 6 participants)

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

We attempted to collect outcome data from 60% of our virtual/online training participants. (These were primarily professionals)
We did not attempt to collect outcome data from our NTPC

7. How many people did you *actually* collect outcome information from? 87

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

We collect evaluation data at the end of our trainings.

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?

We use our prior year's program data as our target/benchmark. However, the past year has been so unusual and required so many adapations that we do not feel like it is an accurate measure.

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

See above

(Optional) Narrative Example(s):

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

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.

- (0) - Treatment Plan Clients (TPC)
- Non-Treatment Plan Clients (NTPC)

  NTPC: Individuals who receive psychoeducation, trauma informed intervention or group-based supports
- Community Service Events (CSE)
- Service Contacts (SC) (100 word limit)

  Linkage & Referrals contacts to other programs/services

  Referrals to our program for screening & assessment

<u>Treatment Plan Clients (TPC): (0 projected/2 actual)</u>

<u>Non-treatment Plan Clients (NTPC): (75 projected)/ 114 Actual</u>

<u>Community Service Events (CSE): (250 projected)/ 183 Actual)</u>

*Because we provided more support to clients we held fewer CSE.

Our Learning Collaborative process was also disrupted because of our staff capacity and the organizations we worked with became overwhelmed and have staff turnover.

<u>Service Contacts (SC): (250 projected/243 actual)</u>

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).

In the past fiscal year we have hosted a total of 4 Virtual Healing Solutions Training sessions, including Summer 2020, Fall 2020, Spring 2021, and Summer 2021. As a part of our commitment to increasing neighborhood engagement in Champaign-Urbana, our two last twotraining sessions have been targeted to train more community members, identified as "neighbors," to be able to recognize and respond to individuals impacted by trauma, adversityand community violence.

We have had a **total of 155 individuals** participate in the trainings, of which 58 identified themselves as "neighbors" or attending because they were directly impacted by adversity and/orhad a desire to improve the wellbeing of their community. Additionally, 97 participants identified themselves as "professionals," or attending to increase their knowledge and skills to promote healing within their work environments and/or communities. 16 of the training participants that attended our Spring and Summer training sessions this year have joined our Healing Communities Neighborhood Effort and community violence response effort, or are joining our Hear 4 U Mental Health Support Network.

Participant Breakdown

Summer 2020 "Healing Solutions Training with added COVID Module" - 48

Fall 2020 "Healing Solutions: COVID & Justice Initiative" - 49

Spring 2021 "Healing Communities Effort" - 35

Summer 2021 "Healing Communities Effort" - 23

Race Ethnicity

African American/Black - 62 (40%)

Asian - 6 (~4%)

Caucasian/White - 65 (~42%)

Hispanic/Latinx - 11 (~7%)

Multi-racial - 9 (~6%)

Other - 2 (~1.3%)

Location

Champaign-Urbana Residents - 124 (80%)

Outside of C-U Residents - 31 (20%)

Gender Identity

Female - 133 (~85.8%)

Male - 22 (~14.2%)

Age Range

>18 - 8 (~5%)

18-29 - 42 (27%)

30-49 - 74 (~48%)

50+ - 31 (20%)

Training Evaluation Feedback

After each training session we provide participants with an evaluation, of which includes 4 Likert-scale questions and 5 open-ended responses to gauge what was most beneficial for participants and how we could improve the training and/or material covered. We received a totalof 210 evaluation responses, averaging 40 completed evaluations per training session.

Summer 2020

42 evaluations were submitted, of which 78% of respondents "strongly agreed" that their knowledge of the subject matter/topic increased after attending the session, they received information that they can use in their work, practice, or family, and they would want to attendanother training held by our organization.

Response Highlights/ Most Beneficial Information Acquired

- ➢ The importance of listening, trust, credibility, and relationship building in the healingprocess
- ➢ Core skills for Psychological First Aid and Skills for Psychological Recovery
- ➢ The difference between responding to people in immediate crises versus those withcomplex trauma or PTSD; learning how to respond to the crisis and not the

story

- Learning specific support techniques and strategies and various approaches to implementthem; additional ways to engage and support staff, families, and the community

- ➢ Learning more about trauma and the importance of dealing with past trauma

Fall 2020

80 evaluations were submitted, of which 82% of respondents “strongly agreed” that their knowledge of the subject matter/topic increased after attending the session, they received information that they can use in their work, practice, or family, and they would want to attend another training held by our organization. Additionally, 42% stated that they would like to stayinvolved with our organization by joining our listserv, volunteering, or getting involved in our community violence response effort.

Response Highlights/ Most Beneficial Information Acquired

- ➢ Practical communication skills and techniques - how to engage in active listening toevoke change behavior
- ➢ Crisis and de-escalation techniques
- ➢ Strategies for reflective processing and how to resist re-traumatization
- ➢ How to manage and mediate personal and professional stress
- ➢ How to utilize motivational interviewing and psychological first aid
- ➢ Increased knowledge and vocabulary for trauma informed practices and howunderstanding neurobiology of stress and trauma helps in the healing process

Spring 2021

48 evaluations were submitted, of which 91% of respondents “strongly agreed” that their knowledge of the subject matter/topic increased after attending the session, they received information that they can use in their work, practice, or family, and they would want to attend another training held by our organization. Additionally, 80% stated that they would like to stayinvolved with our organization by joining our listserv, volunteering, or getting involved in our community violence response effort.

Response Highlights/ Most Beneficial Information Acquired

- ➢ Holistic approaches to healing trauma and toxic stress
- ➢ Understanding the impact and relevance of intergenerational trauma
- ➢ Trauma informed policy reform and trauma informed community building

Summer 2021

40 evaluations were submitted, of which 92% of respondents “strongly agreed” that their knowledge of the subject matter/topic increased after attending the session, they received information that they can use in their work, practice, or family, and they would want to attend another training held by our organization. Additionally, 98% stated that they would like to stayinvolved with our organization by joining our listserv, volunteering, or getting involved in our community violence response effort.

Response Highlights/ Most Beneficial Information Acquired

- ➢ Learning more community approaches to healing trauma, specifically various trauma-informed community building models
- ➢ Practical engagement and relationship building skills
- ➢ Strategies for addressing and responding to trauma
- ➢ Practical healing and crisis response techniques
- ➢ How to engage in reflective processing and the importance of understandingneurobiology in the healing process
- ➢ Motivational interviewing and psychological first aid

Post Training Practice Sessions

At the end of our Summer 2021 training session we decided to host post-training practice sessions for individuals to connect with others (past and recent training attendees) and engage inskill-building practice workshops to increase their understanding of how to utilize the practical strategies covered in the training. These included, active listening, motivational interviewing, psychological first aid, skills for psychological recovery, and healing and resilience-building strategies. We decided to host these sessions because past participants have expressed a desire tohave additional opportunities to dive deeper into the skills and be able to practice them in preparation for engaging with individuals and families in their communities.

The sessions were well-received by participants and we intend to continue to offer these after ourHealing Solutions Trainings moving forward. There were a total of 23 participants who attended over the 5 post-training practice sessions, averaging 9-14 participants present per session. All attendees stated that they enjoyed the session and at the end of each day felt more comfortable utilizing the skills on their own. Additionally, everyone expressed a desire to engage in more practice session opportunities in the future and approximately 30% stated that they wanted to help facilitate at a later date.

Performance Outcome Report Template

Don Moyer Boys & Girls Club/Champaign County Community Coalition – Summer Initiative Program

Performance Outcome Report
Summer 2021 (May 1 –
September 30)

Don Moyer Boys and Girls Club served as Administrative Agent to support the efforts of the Champaign County Community Coalition to create a unified community effort to address youth and community violence by providing the following: youth unemployment, structured and adult led youth activities, and activities and training to assist community members in developing neighborhood support groups and dealing with trauma.

- 692 Youth Participated in Partnership Programming
- 25 males participated in a weekend Historically Black College experience in Indianapolis Indiana. Experience included interactions with students, faculty, and attending football game.
- 21 youth participated in weekly financial literacy classes which included a team Stock Market competition. Top performing teams received financial support to start a Robinhood investment account.
- 50 female youth received academic enrichments support and activities focusing on STEM, University Tour, academic assessments and planning for the upcoming school year.
- 29 Rantoul youth participated in weekly work program and "community cleanup" activities.
- 12 High school youth provided with 8 weeks of employment and employment skills training
- 50 Teen Girls participated in weekly academic support programming including STEAM activities, college tours, academic planning for the coming school year, college readiness activities, cooking and nutrition activities, etc.
- 65 youth participated STEM focused "Hip Hop Express" mobile recording studio construction combined with a variety of social justice community activities
- 300 youth participated in peer to peer and group activities designed to reduce violence and promote positive peer relationships and interactions.
- 180 youth participated in neighborhood block parties and anti-violence activities.
- 15 Youth participated in "Girls Only" program focusing on social and emotional skill development and reading comprehension and fluency skills.
- 540 participated in "Hip Hop Express" related STEM activities, remote control car assembly and racing, creativity workshops, and team building activities throughout the community
- 300 community members participated in a series of networking events for today's professionals.

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: Don Moyer Boys & Girls Club
Program name: Youth & Family Services
Submission date: 9/10/2021

Consumer Access – complete at end of year only
Eligibility for service/program
rom 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 eligibility criteria for Youth & Family Services is for the family to have a child who has been clinically diagnosed with a social, emotional or behavioral disorder and/or who is exhibiting social, emotional or behavioral challenges that negatively impact academic performance, healthy socialization, or family/community relationships.
IHow 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.)? Criteria is met based upon self-disclosure that the child has a clinical diagnosis and/orexpressed concern that their child's academic, socialization, or family/community relationships are being negatively impacted by the child's behavior.
ow did your target population learn about your services? (e.g., from outreachevents, from referral from court, etc.) Families learn about our program through word of mouth, community service events,the Alliance website, Facebook and organizations we have MOU's with. We will continue to pursue MOU's with other family and child serving agencies in the area.

) 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): We estimated that 60% of persons who sought assistance or were referred wouldreceive services.
b) Actual percentage of individuals who sought assistance or were referred whoreceived services: 69% of persons who sought assistance or were referred received services from ouragency.
) 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): Eligibility is determined during our first contact with a client after referral. Weestimated length of time of referral /assistance seeking to assessment of eligibility/need to be 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 theProgram Plan application): We estimated that 70% of referred clients would be assessed for eligibility within the14-day time frame.
c) Actual percentage of referred clients assessed for eligibility within that time frame: 88% of referred clients were assessed for eligibility within the 14-day time frame.
) From your application, estimated length of time from assessment of eligibility/needto engagement in services (Consumer Access, question #7 in the Program Plan application): We estimated length of time from assessment of eligibility/need to engagement inservices to be 14 days. For our agency, this would be the time from first contact toacceptance of 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 thePrograM Plan application):

We estimated that 70% of eligible clients would be engaged in services within the 14-day timeframe.

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

100% of eligible clients engaged in services within the 14-day timeframe.

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

We estimated average length of time of participant engagement in services to be 9-18months.

b) Actual average length of participant engagement in services:

At the end of this program year, the average length of participant engagement inservices was 311 days (approximately 10 months).

Demographic Information

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

The additional information we collect is primary and secondary systems involvement (education, juvenile justice, child welfare, developmental disability, mental health) and mental health diagnosis, if applicable.

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

We collected primary system involvement based off referral source:

- 13 referrals were received from the mental health system.
- 4 referrals were received from the child welfare system.
- 7 referrals were received from the education system.
- 1 referral was received from the juvenile justice system.

- 1 referral was received from the developmental disability system.

We collected secondary system involvement based off referral source:

- 6 referrals were received from the mental health system.
- 5 referrals were received from the child welfare system.
- 6 referrals were received from the education system.

Please note that not every referral will have a secondary systems involvement.

Consumer Outcomes – complete at end of year only

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

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

We use the FAST (Family Assessment Tool) to assess families and measure the impactof our program activities on consumers. Specifically, we expected the following outcomes:

- Types of Support: 75% Parents/caregivers will report a greater breadth of types of supporters they have access to when facing the challenge of raising a youth with emotional behavioral needs
- Presence of Support: 75% of parents/caregivers receiving peer parent support will report greater consistency of support from important people in their life
- Acceptance of Support: 75% of parents/caregivers will report greater acceptance from people in their lives with regards to their life choices and decisions
- Systems self-efficacy: 75% of parents/caregivers will report greater efficacy when interacting with systems when voicing ideas to professionals
- Coping with Stress: 75% of parents/caregivers will report greater coping with stress when they face challenges in their lives

or each outcome, what specific survey or assessment tool did you use to collect information on this outcome? (Please remember that the tool used should be evidence-based or empirically validated.)

The peer supporter assists the parent/caregiver with completing the FAST (Family

Assessment Tool; developed by the National Wraparound Implementation Center (NWIC)). This tool has six domains designed to help the peer supporter and parent/caregiver to determine the type and array of support needed for their family.Listed below are the domains and the rationale.

Types of Support: Breadth of possible supports that a family has access to

- Presence of the Family's Support System: The presence of a strong social support network associates with increased resiliency (i.e. spouse/significant other, friend, family member, neighbor, faith community etc.)

- Acceptance of the Family's Support System: Isolation blame and shame can have an impact on the entire family. The focus on acceptance results in more confidence, which in turn results in a greater ability to manage challenges successfully

- System Receptivity: A major predictor of desired outcomes in family-centered care in is the amount of "voice" families have in service planning. If you want a good outcome, families need to be listened to and heard

- Coping with Stress: Stress is associated with a wide of range of physical and emotional ailments. Reducing caregiver stress is increasingly a focus of both medical and behavioral health systems research

3. Who provided the information about participant outcome(s)?
(Participant, participant guardian, clinician/service provider, other program staff (ifother program staff, who?_____)

Information regarding participant outcome(s) was provided by the participants themselves as well as the Parent Peer Support Partner.

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

Outcome information was not gathered from every participant who received service.

only some participants, how did you choose who to collect outcome informationfrom?

Outcome information was gathered from treatment plan clients only.

6. How many total participants did your program have?

Our program had a total of 26 participants (21 TPC and 5 NTPC).

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

We attempted to collect outcome information from all of our treatment plan clients.

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

100% of our treatment plan clients completed the initial FAST.

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

Information was collected at client intake. Each participant engaged in services differently (frequency of contacts, length of time, level of intensity) therefore assessment administration varied at the individual client level based on need and progress. Our goal was to collect information during our initial assessment at time ofenrollment and then 60 days following for those we were able to.

Results

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

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

We use the FAST (Family Assessment Tool) to assess families and measure the impactof our program activities on consumers. Specifically, we expected the following outcomes:

- Types of Support:
  - 60% of parents/caregivers receiving peer parent support reported when facing challenges, they could turn to their spouse/significant other for support.
  - 70% of parents/caregivers receiving peer parent support reported when facing challenges, they could turn to their family members for support.

- 60% of parents/caregivers receiving peer parent support reported when facing challenges, they could turn to their friends for support.
- 10% of parents/caregivers receiving peer parent support reported when facing challenges, they could turn to others (not specified) for support.
- 25% of parents/caregivers receiving peer parent support reported when facing challenges, they could turn to their faith community for support.
- 5% of parents/caregivers receiving peer parent support reported when facing challenges, they could turn to their neighbors for support.

- Presence of Support: 90% of parents/caregivers receiving peer parent support reported greater consistency of support from important people in their life.

- Acceptance of Support: 95% of parents/caregivers reported greater acceptance from people in their lives with regards to their life choices and decisions.

- Systems self-efficacy: 85% of parents/caregivers receiving peer parent support reported when working with professionals in their child and family's life they felt like their voice was heard.

- Coping with Stress: 80% of parents/caregivers receiving peer parent support reported greater ability to deal with the things that happen to them when faced with challenges.

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

No

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

NA

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

NA

(Optional) Narrative Example(s)

NA

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

Through the year, we saw a vast improvement in our data collection measures. At thesame time, we realized that we need to figure out how we can better administer the FAST at the 60-day benchmark.

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

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

lease copy and paste the definitions of service categories your program specified in your program plan application in the sections below. You will report the actual outcomes of service categories in the Part II Utilization/Production data form (locatedon the online system). If your estimated service category outcome significantly differsfrom your actual service category outcome, you may give a narrative explanation for that discrepancy here.

Treatment Plan Clients (TPC):

Treatment Plan Clients are parents/caregivers who have completed our intake and enrollment process with the development of a service plan.

We served 20 treatment plan clients during this program year. Our goal was 35. We believed that once the state and schools opened back up services would ramp up quickly. Unfortunately, in school learning didn’t resume until August 2021 and it has taken several months to rebound from the momentum, we had gained in 2019.

Non-treatment Plan Clients (NTPC):

Non-treatment Plan Clients parents/caregivers who may have completed our intake and enrollment process but haven't developed a treatment plan; these families will still have access to linkage and engagement services this includes short-term community support services (ie. attend IEP meetings; court hearings; review IEP's; apply for public assistance etc.); parents/caregivers who contact us via phone or the website for linkage and engagement information).

We served 6 non-treatment plan clients during this program year. Our target was 20. We would have met this goal, but COVID-19 slowed down the frequency of referrals we got. In addition, the types of support received by non-treatment plan clients are more in public settings and involve attending meetings, court dates, etc. with these families. Once the state opened back up we still proceeded with caution with face-to-face meetings.

Community Service Events (CSE):

Community Service events consist of public presentations, stakeholder meetings, agency meetings, etc.

We held 16 community service events this program year. Our target was 10. We exceeded this goal by 6.

Service Contacts (SC):

Service contacts are the number of unduplicated face-to-face and phone contacts.

We had 463 service contacts this program year. Our target was 400. We exceeded our target by 63 contacts.

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: East Central Illinois Refugee Mutual Assistance Center
Program name: Family Support & Strengthening
Submission date: September 02, 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) All immigrant residents of Illinois are eligible for our services, but the vast majority of our clients reside in Champaign County. Less than .03% percent reside outside the county. On occasion, we distribute information in surrounding counties when asked. While there are immigration status and income requirements for receiving benefits, we encourage anyone who needs assistance to meet with a case worker/translator.
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 assist all immigrants who contact us. There are immigration status and income requirements for receiving public benefits, which our staff evaluates prior to assisting with an application. However, all other services at The Refugee Center are available to any immigrant or resident seeking bilingual assistance.
3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.) Clients learn about our program through client and former client word of mouth, social service provider referrals like IDHS, DCFS, WIC, workshops, Immigrant Student Support program, school visits, local churches, employers, Adult Diversion Program, and our

multilingual outreach to refugee/immigrant populations through mass outreach events, social media, flyers, and public benefits sessions. While we hoped to increase the public benefit sessions and workshops after we moved to a larger facility, COVID-19 prevented us from completing these goals for FY21.
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): 99%
b) *Actual* percentage of individuals who sought assistance or were referred who received services: 99% **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): 2 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): 99%
c) *Actual* percentage of referred clients assessed for eligibility within that time frame: 99%
6. a) *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application): 2 days

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

c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame: 95%

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

b) *Actual* average length of participant engagement in services: Eighteen 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)
   We collect demographic data on the languages spoken.

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

Consumer Outcomes – *complete at end of year only*

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

1. *From your application,* what impact on consumers did you expect your program activities to have? That is, what outcome(s) did you want your program to have on the

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

1. Application(s) for Social Service Benefit(s) completed.
2. Obtain Permanent Employment.
3. Improve Quality of Life.
4. Improve Outlook on Life.
5. Improve Relationships with Others.
6. Improve Connections with the Community.

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

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

Outcome:	Assessment Tool Used:	Information Source:
E.g. 1. Increased empowerment in advocacy clients	Measure of Victim Empowerment Related to Safety (MOVERS) survey	Client
1. Application(s) for Social Service Benefit(s) completed.	Case Notes	Client and Staff

2. Obtain Permanent Employment.	Case Notes	Client and Staff
3. Improve Quality of Life.	Not measured	
4. Improve Outlook on Life.	Not measured	
5. Improve Relationships with Others.	Not measured	
6. Improve Connections with the Community	Not measured	

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

Information on Social Services, health and legal referrals and public benefits received is recorded in case notes for every client.

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

5. How many total participants did your program have?
Our program serviced 1,975 unduplicated individuals in FY21.

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

Heads of households completed intake, so approximately 425 households completed information for social services received and employment information.

7. How many people did you *actually* collect outcome information from?
Approximately 425 households completed information for social services received and employment information.

8. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc)
One time per year at intake, then case notes thereafter. Varies with every client.

Results

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

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

Our intake form and case notes reveal how many clients were able to successfully obtain public benefits, how many were referred to other services like health care and legal providers and other social service agencies, how many translations and/or interpretations were completed on behalf of the client, and how many clients were assisted with other miscellaneous issues. Change over time is recorded in case notes. This has been a difficult period due to COVID. Many of our clients that were employed lost their jobs or are experiencing reduced hours due to COVID.

10. Is there some comparative target or benchmark level for program services? Y/N No.
11. If yes, what is that benchmark/target and where does it come from?
12. If yes, how did your outcome data compare to the comparative target or benchmark?
(Optional) Narrative Example(s):
13. Describe a typical service delivery case to illustrate the work (this may be a "composite case" that combines information from multiple actual cases) (Your response is optional)
14. In what ways was the evaluation used to support changes in practice? What changes were made based on evaluation findings? (Your response is optional)

An example of a typical service delivery case is when a client comes to us for assistance in applying for a public benefit like SNAP, All Kids Health Insurance or Medicaid. During the intake process, the staff identifies any additional needs the family might have at that time. They will then evaluate whether the client qualifies for additional benefits or services, like WIC. Often, the staff member will recommend and make medical appointments for the client at Promise Healthcare or CUPHD. In addition, clients often have immigration legal issues that need to be addressed. If a client needs help translating paperwork, staff assists. If the client needs a referral to an Immigration Law provider, we refer to other agencies. Clients also need assistance with other legal issues. Staff will accompany a client to the courthouse to assist with their understanding of the process. Staff also assesses any food and other basic needs and refers clients to food pantries and similar organizations to help meet their needs. Often, staff accompanied clients to medical appointments and school related appointments as well, to serve as an interpreter and liaison. During FY21, much of our service delivery centered around the various grants for COVID direct assistance that we received from state and private sources. A lot of staff time was occupied by helping clients apply for rental and/or utility assistance. Many documents were collected, phone calls made, checks printed and sent. Within the Family Support & Strengthening program, we also assisted clients through crisis management services, including helping them handle COVID-19 illnesses and deaths in the family, quarantining & testing if they were exposed, receiving school meals & food pantry items remotely, and getting vaccinated through CUPHD.

Utilization Data Narrative –

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

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

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

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

categories significantly differ from your actual numbers, you may give a narrative explanation for that discrepancy here.
Treatment Plan Clients (TPC):
Non-treatment Plan Clients (NTPC):
Community Service Events (CSE): 98
Service Contacts (SC):
For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

Performance Outcome Report Template

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

Agency name: Family Service of Champaign County
Program name: Counseling
Submission date:

Consumer Access – *complete at end of year only*
Eligibility for service/program
1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application) **The Counseling program provides services to any individual as young as age 5 through the lifespan residing in Champaign County. Services are initiated by direct contact from a prospective client or a referral from an outside source. When an individual contacts the Counseling program, they receive a brief phone screening to discuss their issues and determine if their needs are within the scope of practice of our therapists. If their needs are beyond our scope, individuals are referred to more appropriate resources.**
2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)? **The Counseling program determines if a person meets criteria by self-report of a potential client. No proof of income is required to be provided. As the therapist and client share information while completing the mental health assessment and social history, the therapist determines whether the client's needs and treatment will be within the scope of clinical practice offered by our therapists.**
3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.) **People learn of our Counseling program through our outreach efforts at community fairs such as Jettie Rhodes Day and the Disability Expo. We distribute Family Counseling program brochures and bulletin board flyers to organizations that**

provide other services such as housing and food assistance to people in the target population. The Counseling program is also promoted on the Family Service website that individuals can access through computers at the public libraries.

4. **a)** *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application):
85

b) *Actual* percentage of individuals who sought assistance or were referred who received services:
72% of the individuals who called Family Service received a phone intake. 75% of the individuals for which a phone intake was completed received services. 7% of the callers received appointments for services but no showed their appointment. 18% were referred elsewhere.

28% of individuals who called Family Service left a message; however, they did not receive a phone intake due to not returning our messages or were unreachable due to leaving incomplete contact information or their voicemail box was full or not set up.

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):

2

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:
86% were assessed for eligibility within that time frame. 14% of referred clients did not return phone calls within 2 days. Once the referred client talked with a therapist, the assessment was completed.

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):

5

b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application):
85

c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame:
75% of clients were scheduled for appointments within the 5 day time frame. With social distancing guidelines in place, clients are mailed initial paperwork which is completed prior to their first appointment. Prior to COVID-19 this paperwork was completed in the office at the time of the client's first appointment. Some clients took a week or more to return the paperwork. Clients then make the decision determining when they wanted their counseling appointments as it matched the availability of the counselors.

7. **a)** *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application):
Length of engagement varies greatly, from one session to several years; it is difficult to average.

b) *Actual* average length of participant engagement in services:
N/A
There are no limits to the number of sessions available to a client.

Demographic Information

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

We collect information regarding gross family income for purposes of the sliding fee schedule.

2. Please report here on all of the extra demographic information your program collected.
14% of the counseling clients used the sliding fee scale. The average income of those individuals was $31,921.

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 goal of counseling is to improve the client's level of functioning. Depending on the client and the presenting problem, this may include reducing stress, depression or anxiety; reducing relationship conflicts; improving parenting or communication skills or ending an abusive relationship.

Outcome 1. Individuals receiving our services will report improvement in four areas of functioning: individual, relational, social and overall.

Outcome 2. Individuals receiving our services who have a treatment plan will meet the treatment goals that they established with their therapist.

Outcome 3. Individuals receiving our services who have a treatment plan will have improvement in their functioning over the course of treatment.

Outcome 4. Individuals who are Drug Court clients will complete a relationship assessment with the therapist. The therapist will make recommendations for additional services if appropriate.

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

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

Outcome:	Assessment Tool Used:	Information Source:

E.g. 1. Increased empowerment in advocacy clients	Measure of Victim Empowerment Related to Safety (MOVERS) survey	Client
1. Individuals will report improvement in four areas of functioning (individual, relational, social and overall).	**Outcome Rating Scale (ORS)**	**Client**
2. Individuals will meet the treatment goals they established with their therapist.	**Treatment plan review**	**Client and Therapist**
3. Individuals will have improvement in their functioning over the course of treatment.	**Global Assessment of Functioning (GAF)**	**Therapist**
4. Drug Court clients will have a better understanding of the state of current important relationships in their lives.	**Relationship Assessment**	**Client**

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

Only some.

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

Outcome information (#1 – #3) was only collected on those clients who had a developed treatment plan. Outcome information (#4) was only collected on Drug Court clients who completed a Relationship Assessment.

5. How many total participants did your program have?

49

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

We attempted to collect outcome information from 49 clients.
However, Four (4) clients did not continue counseling past one or two sessions so they did not complete a treatment plan.

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

Outcome information for outcomes 1 – 3 was collected from 36 of 36 treatment plan clients and outcome information for outcome 4 was collected from 9 of 9 Drug Court clients.

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

For Outcome 1, the ORS information is obtained when the treatment plan is reviewed. This typically occurs quarterly. It is also requested that the client complete the ORS at completion of services.
For Outcome 2, treatment plans are typically reviewed and revised quarterly. When a client terminates services, the therapist uses the most recent treatment plan to determine the client's success with goal completion.
For Outcome 3, the GAF is assessed during the initial mental health assessment. A new GAF score is determined whenever a plan is reviewed or the case is closed.
For Outcome 4, a Relationship Assessment is completed with each Drug Court client when they are moving to level 4 in their program before they graduate.

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)

With all of our outcomes, we hope to observe client change over time.

Our therapists want to see the ORS scores move close to 40 over time.

Our therapists want to see on-going progress made on the client's identified objectives and goals.

Our therapists want to see improvement of the GAF scores from the initial assessment at each treatment plan review and at case closure with more treatment plan clients reaching GAF scores above 91 at case closure.

Our therapists want to see each Drug Court client as they near graduation from Drug Court to assess the need for further services.

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

Yes.

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

Outcome 1: The benchmark for the ORS is a total score of 35-40. This means that a client is feeling that they are doing very well in all areas of their life. This benchmark is established by those who developed the tool.

Outcome 2: The treatment goals benchmark is that progress has been made on objectives and treatment goals have been met at time of case closure. This is an internal benchmark developed by our program.

Outcome 3: The benchmark for the GAF is a score of 91-100 at time of case closure. This score represents superior functioning in a wide range of activities. This benchmark is established by those who developed the tool.

Outcome 4: The benchmark for the Drug Court relationship assessment is that clients referred from Drug Court will successfully complete their relationship assessment. This is an internal benchmark developed by our program.

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

Outcome 1: As assessed at the end of the fiscal year: 25% of the treatment plan clients who had both an initial and subsequent ORS score showed at least some improvement in their score during their treatment. 67% made no change yet. 8% showed a decrease in their score. One client reached the benchmark score of 35 – 40. Six treatment plan clients were minors and minors are not asked to complete the ORS.

Outcome 2: Looking cumulatively at all objectives for treatment plan clients whose case was closed during FY21, 23% of objectives we fully met, there was improvement on 67% of objectives but they were not fully met, and there was no progress or the clients were unable/unwilling to address 10% of objectives at the time the case was closed. For treatment plan clients whose case was still open as of 6/30/21 33% of their objectives and goals have been met and progress has been made on 45% of their objectives and goals. The remaining 22% of objectives and goals are for treatment plan clients whose case was still open as of 6/30/21 and will have their first treatment plan review during the first quarter of FY22 to evaluate their progress with their objectives and goals.

Outcome 3: As assessed at the end of the fiscal year based on the most current or final (if cased closed) GAF score for treatment plan clients: 32% of clients increased their GAF score by 5 or more points. 14% of clients increased their GAF score by less than 5 points and 54% of clients had no change in the GAF scores. No clients reached the GAF benchmark score of 91 – 100 when their case was closed; the highest score achieved prior to case closure was a score of 80. Six treatment plan clients were minors and GAF is not assessed on minors.

Outcome 4: 100% of Drug Court clients who called to schedule an appointment for a Relationship Assessment completed their appointment.

(Optional) Narrative Example(s):

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

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

Utilization Data Narrative –

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

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

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

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

Treatment Plan Clients (TPC):

In FY 21 our target was to serve 40 treatment plan clients.
We had 36 TPC in FY 21.

Non-treatment Plan Clients (NTPC):

In FY 21 our target was to serve 35 non-treatment plan clients.
We had 13 non-treatment plan clients. Nine NTPC were Drug Court clients who completed a relationship assessment.

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 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: Family Service of Champaign County
Program name: Self-Help Center
Submission date:

Consumer Access – *complete at end of year only*
Eligibility for service/program
1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application) **The Self-Help Center does not have any eligibility criteria. However, all of our outreach efforts and dissemination of information focuses on residents of Champaign County. The Self-Help Center is unique in the nature of the services it provides in that the Self-Help Center, as an information clearinghouse, does not provide direct service to clients.**
2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)? **Since the Self-Help Center does not have any eligibility criteria for use of its services there is no determination criteria.**
3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.) **People learn about the Self-Help Center from our website, newsletters, the directory and from the flyers that are posted in the various locations such as libraries, community bulletin boards, churches, community fairs and forums. Information about the various groups is also sent to area mental health providers, area hospital social workers and school social workers. The Self-Help Center Coordinator is an active participant with several area coalitions and partnerships such as the Alliance for the Promotion of Acceptance, Inclusion and Respect and the Disability Expo Steering Committee. This involvement and leadership with creating, planning and participating in events assists the Self-Help Center to ensure**

that information relevant to the needs of diverse populations is delivered to those who can most benefit. A Support Group Directory is published every other year and is distributed to professionals, group leaders and members on an ongoing basis. The 17th edition was distributed in FY20. It contains information about more than 200 local and regional self-help and support groups. The online edition of the support group directory is continually updated as information about groups frequently changes. A quarterly newsletter is published for group leaders, support group members and community professionals.

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

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

100% of the people who called received information.

5. **a)** *From your application*, *estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application):
The speed of consumer access is generally within 24 hours if a call or email occurs during business hours. Internet access is immediate. A log is kept to record the date of all phone calls and responses given.

b) *From your application*, estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application):
N/A: The Self-Help Center does not have any eligibility criteria.

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

6. **a)** *From your application*, estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application):
The Self-Help Center serves as an information clearinghouse. It links individuals to resources. There is no assessment for eligibility or time frame for engagement of services.

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

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

7. **a)** *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application):
When someone consults the Self-Help Center for assistance, the length of engagement varies depending on individual need. A person seeking to start a new group may require more technical assistance and support compared to an experienced group leader who is having issues of maintaining membership. The coordinator may spend a few minutes with an individual or could have several meetings that last an hour or more.

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

Demographic Information

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

Due to confidentiality and anonymity issues, limited information is collected on the information and referral calls except for the topic and if the person is a professional or a lay person. Data is collected from the conference and workshop registration forms as it applies to age, gender, ethnicity, lay or professional registrant and zip code.

2. Please report here on all of the extra demographic information your program collected.
Of the 40 participants for the SHC Biennial Conference, 8 chose to let us know they were professionals. Of the 20 participants of the fall workshop, 13 chose to let us know they were professionals.

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: Through the Self-Help Center, individuals and families will be made aware of the existence of self-help groups and will be provided information and/or referral to a group(s) appropriate to address their needs (when one is available).
   ****Participation in public awareness activities, which include informational fairs, conferences, public education presentations, media events, and publications.**
   ****Continual update of the on-line version of the Support Group Directory, the Specialized Lists and the website.**
   ****The rural libraries and churches in Champaign County will receive hard copies of the directory and other meeting notices.**

   Outcome 2: Through the Self-Help Center, individuals wanting to start a group and group leaders experiencing difficulties will be able to effectively start and lead groups and group visibility will increase.
   ****Consultation services will be available to individuals wanting to start a group or to group leaders experiencing difficulties.**
   ****Training opportunities will be provided through the biennial Self-Help Conference and the workshops.**
   ****Resources are available through the Self-Help Center lending library to help with group development and understanding of group dynamics.**

   Outcome 3: Through the Self-Help Center, professionals will be able to locate self-help groups to which they can refer their clients and will know how to work effectively with groups.
   ****Distribution of the printed Support Group Directories, Specialized Lists, quarterly newsletter and website information to group leaders and professionals.**

   Outcome 4: Through the Self-Help Center, the coordinator will monitor and track the existence of the support groups in Champaign County to better know and understand the demographics of the groups and maintain relationships with group leaders.

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

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

Outcome:	Assessment Tool Used:	Information Source:
E.g. 1. Increased empowerment in advocacy clients	Measure of Victim Empowerment Related to Safety (MOVERS) survey	Client
1. Increased awareness of the existence of self-help groups and provision of information and/or referral to a group(s) appropriate to address their needs (when one is available).	**Participation in public awareness activities, which include informational fairs, conferences, public education presentations, media events, and publications.** **Continual update of the on-line version of the Support Group Directory, the Specialized Lists and the website.** **The rural libraries and churches in Champaign County will receive hard copies of the directory and other meeting notices.**	**Self-Help Center Coordinator**
2. Increased ability for individuals wanting to start a group and group leaders	**Consultation services available to individuals wanting to start a group or to group leaders experiencing difficulties.**	**Self-Help Center Coordinator;** **Self-Help Center Advisory Council members**

experiencing difficulties to find and receive training to be able to effectively start and lead groups for their group visibility to improve.	Training opportunities provided through the biennial Self-Help Conference and the workshops and the Support Group Needs survey. Resources available through the Self-Help Center lending library to help with group development and understanding of group dynamics.	
3. Through the Self-Help Center, professionals will be able to locate self-help groups to which they can refer their clients and will know how to work effectively with groups.	Distribution of the printed Support Group Directory, Specialized Lists, quarterly newsletter and website information to group leaders and professionals; post-event evaluation of conference from attendees.	Self-Help Center Coordinator; Attendees at conference and workshop
4. Increased monitoring of the demographics of the self-help groups in Champaign County	Support Group Survey, e-mails, and phone calls	Self-Help Center Coordinator

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

Outcome information was gathered on some participants.

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

We did not choose from whom to collect information. Workshop and conference participants chose whether to complete a survey about the workshop or conference. Self-help group leaders and participants chose whether to complete a Support Group Needs survey.

5. How many total participants did your program have?

In FY2021, there were 9 consultations, 21 information and referral calls, 4,466 website views, 1,117 emails, 52 printed directories distributed, 1 information fair at which the SHC staff participated, 2 presentations given by SHC staff, 4 newsletters distributed to the SHC mailing list, the fall Self-Help Center workshop with 20 attendees (with 3.5 CE credits available), the biennial conference with 40 attendees (with 6.5 CE credits available), and 6 respondents to the Support Group Needs Survey. The SHC staff served as members on several different service organizations or committees including the Human Services Council, Senior Task Force, and the DisAbility Expo committee. The SHC maintained information on approximately 210 support groups available to Champaign County residents. The 17th edition of the hard copy of the Support Group Directory was distributed. The 18th edition of the Support Group Directory is in the final editing stage and will be printed and distributed in the 1st quarter of FY22. Due to ongoing health issues of the SHC Coordinator, the updating and distribution of the Directory is slightly delayed.

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

20 participants who attended the fall workshop (workshop evaluation form)
40 participants who attended the biennial conference (conference evaluation form)
200 support group leaders (Support Group Needs survey)

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

8 participants from the fall workshop but not all responded to every survey question (workshop evaluation form)
10 participants from the biennial conference but not all responded to every survey question (conference evaluation form)
6 support group leaders but not all responded to every survey question (Support Group Needs survey)

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

Workshop evaluation data was collected from the Fall 2021 Self-Help Center workshop attendees. Conference evaluation data was collected from the Biennial Conference attendees. Support group data was collected in a survey conducted by the Self-Help Center.

Results

9. What did you learn about your participants and/or program from this outcome information? Please be specific when discussing any change or outcome, and give appropriate quantitative or descriptive information when possible. For example, you could report the following:
    i. Means (and Standard Deviations if possible)
    ii. Change Over Time (if assessments occurred at multiple points)
    iii. Comparison of strategies (e.g., comparing different strategies related to recruitment; comparing rates of retention for clients of different ethnoracial groups; comparing characteristics of all clients engaged versus clients retained)

The low return rate of the Support Group Needs survey was a disappointment but some valuable information was obtained. Respondents were asked to describe the demographics of their groups, services offered within their groups, and challenges faced. In addition, facilitators were asked which SHC services they use.
Here are some of the results obtained from the 6 respondents:

a) Six of the respondents were group leaders/facilitators.

b) Three of the respondents had been group members/leaders for more than 5 years.

c) Of the reporting groups 50% had an average attendance of up to ten members per meeting, 33% of groups had an average attendance of 10 – 20 members per meeting, and 17% had an average attendance of 25 or more per meeting.

d) The topic most commonly addressed within their groups was mental health (67%). Other topics addressed were addiction, disability, bereavement, caregiving, health, depression, and cancer.

e) The Self Help Center services used by the Support Groups were the Self-Help Center Website (80%), Newsletter (75%), Self-Help Center Biennial Conference (75%), Support Group Directory (60%), and the Self-Help Center Workshops (50%).

f) Of the reporting group facilitators, the most frequently provided services besides the face to face meetings were on-line communication (100%), phone support between meetings (83%) and a lending library (33%).

g) The top five ways in which people found out about a group according to the reporting facilitators were: 1) by a family/friend (83%) 2) by a professional referral (83%), 3) information gleaned from the internet (50%) and 4) Referral from State or National Chapter (50%), and 5) Self-Help Center referral (33%).

h) Of the reporting facilitators, the groups utilized professionals in capacities such as facilitators (50%) and as guest speakers (50%).

i) As identified by the reporting facilitators, the top six issues presenting challenges to the group as a whole and affecting the group's ability to function smoothly were:
Attracting new members: 80%
Difficulty with transportation to the meeting for members: 67%
Retaining Members: 50%
Getting members involved in sharing the work of the group: 50%
Obtaining a meeting space that is accessible and affordable: 33%
Obtaining money for group programs and activities: 33%

10. Is there some comparative target or benchmark level for program services? Y/N
Yes, for our workshops and conference.

11. If yes, what is that benchmark/target and where does it come from?
We set a benchmark in 2005 to obtain a good or excellent rating from all attendees of the workshops or conference regarding acquisition of skills, knowledge, satisfaction, networking opportunities and implementation of information presented by the speaker(s). This means we need to achieve 100% to meet that benchmark.

12. If yes, how did your outcome data compare to the comparative target or benchmark?
We met our benchmark in all areas.

From the Fall workshop, we obtained the following results from the 8 respondents:
100% of the respondents stated that the presenters provided their content clearly.
100% of the respondents stated that the presenters met their stated objectives.
100% of the respondents stated that the program met or exceeded their expectations.
100% of the respondents stated that the program expanded their knowledge of the topic.
100% of the respondents stated that the program provided them with skills they can use in their work.
100% of the respondents stated that the information provided will improve the quality of care/services.
100% of the respondents stated that they would like to hear from these presenters in the future.

From the Biennial Conference, we obtained the following results from the 10 respondents:

100% rated the overall conference as Excellent or Very Good.
100% rated the Key Note Speaker, Kim Bryan, as Excellent or Very Good.
100% rated Nancy Neukomm as Excellent, Very Good or Good.
100% rated Roxanne Grantham as Excellent or Very Good.
100% said that the information presented at the conference expanded their knowledge.
100% said that the information presented at the conference provided them with skills and information they can use in their groups and/or their professions.

(Optional) Narrative Example(s):

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

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

Utilization Data Narrative –

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

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

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

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

Treatment Plan Clients (TPC): N/A
Non-treatment Plan Clients (NTPC): N/A
Community Service Events (CSE): **289 Community Service Events were completed by the Self-Help Center in FY 2021. We were very close to our goal of 300 CSEs. COVID-19 made it impossible to meet in person and participate in many of the fairs and presentations in which we participated in previous years. We continued to meet the needs of many people searching for groups and making active use of the webpage for seeking information. Conference attendees provided great ideas for the workshops that will be held in the fall and spring.**
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: Family Service of Champaign County
Program name: Senior Counseling & Advocacy (2021)
Submission date: August 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)

Senior Counseling & Advocacy (C&A) services are available to any Champaign County resident age 60 or older living in a domestic setting. Some services are available to adults with disabilities. Clients must have one or more assessed needs addressed by the program: anxiety, depression, isolation, grief, or other mental health issue; neglect, abuse, exploitation, or self-neglect; and/or the need to access financial or material services or benefits. Priority is given to those with limited resources; no fees are charged so that income does not become a barrier to receiving needed 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.)?

Staff use standardized and interview assessments along with presenting need to determine eligibility. They also collect demographic information including income information for some financial assistance programs. An on-going or periodic assessment of need is done as required. A score of 1 or more on the PHQ2 initial PEARLS screening makes a person eligible for an in-depth PEARLS assessment. Unless the person has a disqualifying issue as per the PEARLS program s/he is eligible for PEARLS.

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

People learn about our programs through word of mouth; referral by other social service agencies; brochures and other printed materials distributed throughout the community; at health fairs and other community events; from their faith community, doctor, banker, or first responders; or through media such as phone book ads, Facebook, Instagram, and our website.

Staff do concerted outreach in the rural areas of the county and in residential areas of the county that have a large concentration of lower income seniors. They also participate in community events that allow us to highlight our services and to provide on-the-spot information and referral.

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

All people eligible for services are able to receive service. We estimated that 95% of those people would choose to follow through with service.

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

All Treatment Plan Clients who sought assistance received services. Some Non-Treatment Plan Clients were waitlisted and triaged based on need.

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

All potential clients will be assessed for eligibility during the initial call or contact. No one is put on the list to be assigned a caseworker who does not qualify for service. Those who are not eligible (out of county, not a senior or an adult with a disability) can still receive referral to other possible service agencies that may be able to help them. We estimated a length of 25 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):

All potential clients will be assessed for eligibility during the initial call or contact. We estimated that 90% of clients would receive assessment of eligibility/need within 25 days.

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

It is policy that all potential clients are assessed for eligibility during initial contact. With a caseworker on phone shifts during all business hours, all potential clients received an assessment of needs within 25 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):

We estimated 7 days from time of assessment of need to engagement in services.

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

95% of eligible clients will engage in services within the identified timeframe.

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

All clients that desired to do so were engaged in services within the 7 days. Due to COVID, the majority of services occurred telephonically, with select services and emergency needs occurring in person on a per case basis.

* At this time, we are redesigning a system which will allow us to more accurately provide the length of time between these two activities.

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

Non-treatment plan clients are those receiving and completing short-term service- generally 2 to 3 contacts. Treatment plan clients can remain active clients for several years if necessary.

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

Non-Treatment Plan Clients engaged in services for an average of 66 days.
Treatment Plan Clients engaged in service an average of 81 days for APS participants and an average of 1.61 years for counseling clients.

Demographic Information

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

Financial on some people, living arrangement, living status (alone or with others), marital status.

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

TPC

Living Arrangement
Apt. or elderly housing: 38
Unknown: 225
Home of relative: 1
Own Home: 46
Other: 6
Marital Status
Unknown: 235
Divorced: 14
Married: 15
Separated: 2
Single: 26
Windowed: 24
Living Status
Unknown: 99
Alone: 316
Child: 19
Non-relative: 18
Other relative: 23
Spouse: 47
Financial
Unknown: 13
$1-$9,999: 257
$10,000-$14,999: 26
$15,000-$24,999: 26
$25,000-$34,999: 5
$35,000-$49,999: 1
$50,000-$74,999: 1
$75,000+: 0

NTPC

Living Arrangement
Apt. or elderly housing: 203
Unknown: 120
Home of relative: 16
Nursing Home: 2
Other: 29
Own Home: 152
Marital Status
Unknown: 157
Divorced: 52
Married: 60
Separated: 16
Single: 124
Windowed: 113
Living Status
Unknown: 225
Alone: 71
Child:2
Non-relative: 4
Other relative: 1
Spouse: 13
Financial
Unknown: 133
$1-$9,999: 121
$10,000-$14,999: 125
$15,000-$24,999: 96
$25,000-$34,999: 28
$35,000-$49,999: 13
$50,000-$74,999: 4
$75,000+: 2

Consumer Outcomes – *complete at end of year only*

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

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

Outcome 1: People will be referred to needed services for anxiety, depression, and/or social isolation.

Outcome 2: People will have reduced anxiety, depression, and social isolation scores.

Outcome 3: Seniors and adults with disabilities receiving protective services will have reduced risk scores.

Outcome 4:. PEARLS clients will have reduced PHQ9 scores. Outcome

5: People will have their presenting need addressed.

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

Outcome 1: People will be referred to needed services for anxiety, depression, and/or social isolation.
*Geriatric Anxiety Scale, Geriatric Depression/PHQ-9, UCLA Loneliness Scale.

Outcome 2: People will have reduced anxiety, depression, and social isolation scores.
*Geriatric Anxiety Scale, Geriatric Depression Scale/PHQ-9, UCLA Loneliness Scale.

Outcome 3: Seniors and adults with disabilities receiving protective services will have reduced risk scores.
*State risk assessment tool.

Outcome 4: PEARLS clients will have reduced PHQ9 scores.

*PHQ-9

Outcome 5: People will have their presenting need addressed.
*Outreach referral sheet- completed by caseworker

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

Outcome:	Assessment Tool Used:	Information Source:
People will be referred to needed services for anxiety, depression, and/or social isolation.	*Geriatric Anxiety Scale, Geriatric Depression Scale, PHQ-9, Geriatric Perceived Social Isolation Scale	Client
People will have reduced anxiety, depression, and social isolation scores.	*Geriatric Anxiety Scale, Geriatric Depression Scale, PHQ-9, Geriatric Perceived Social Isolation Scale,	Client
Seniors and adults with disabilities receiving protective services will have reduced risk scores.	*State risk assessment tool.	Client
PEARLS clients will have reduced PHQ9 scores.	*PHQ-9	Client
People will have their presenting need addressed.	*Outreach referral sheet.	Client

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

Outcome information was gathered for Treatment Plan Clients, demographics information was gathered for Non-Treatment Plan Clients.

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

Due to the brevity of the interaction with non-treatment plan clients, there is little opportunity to measure accurate change over time. With this in mind, Treatment Plan Clients have long enough casework involvement to accurately measure change.

5. How many total participants did your program have?

Our program has 522 Non-Treatment Plan Clients and 316 Treatment Plan Clients.

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

We attempted to collect information from all Treatment Plan Clients. We also attempted demographics information for all non-treatment plan clients.

7. How many people did you *actually* collect outcome information from?Risk Assessment information was collected from all Protective Service clients.
Anxiety, depression, loneliness scales were collected from a number of counseling participants.

Demographics information was gathered from all clients.

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

Risk assessment scores are collected at intake, at 30 days, at 90 days, and every 90 days after that for 15 months or until closure.
Depression, anxiety, and social isolation scales are collected every 6 months.Demographics information is gathered once at intake.

Results

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

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

Looking at Change over Time of PHQ-9s, we began our sessions of PEARLS with an average baseline score of 15.3, indicating moderate depression. At the end of our sessions we had an average score of 11.3, indicating mild depression.

We are currently undertaking a significant restructure of how and where these anxiety, isolation, and depression scales are tracked.

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?

For PEARLS Services, there is a minimum score needed to be eligible for services. Because it is an evidence-based program, the benchmark is developed through comparison to other scales. The benchmark score of 5 denotes a likelihood of depression.

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

Clients had an average baseline score of 15.3, and a post score of 11.3.

(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.

Category	Targe	Actual	Explanation (if needed)
TPC	350	316	The number of clients was diminished in part, likely, due to the pandemic. For instance, many

			PEARLS clients decided to put a hold on the program, not wanting to start or continue over the phone. The program is built on an in-home visit model.
NTPC	500	522	
SC	3,500	1,910	Due to 211, an increase in online searching for resources, and other factors, service contacts have been on the decline.

Treatment Plan Clients (TPC):

These seniors receive long-term supportive counseling, advocacy, referral, and follow-up. Supportive counseling uses multiple methodologies including but not limited to: PEARLS evidence-based program to empower older adults with mild depression to manage symptoms and improve quality of life; solution-focused therapy; empathic support; and reality therapy approaches. Family interventions and developing/implementing natural community and/or family supports is another methodology often used. We also offer several evidence-based healthy aging programs to our clients and the community including Chronic Disease Self-Management, Diabetes Self-Management, and Matter of Balance falls prevention. Advocacy includes help accessing services addressing poverty, isolation, chronic health concerns and other unmet needs that can lead to depression and anxiety. Staff refer people to community services for which they qualify, working with them until services are engaged.

Non-treatment Plan Clients (NTPC):

With the client's presenting request, caseworkers use interview and standardized assessments such as the Geriatric Depression Scale, Geriatric Anxiety Scale, Geriatric Perceived Social Isolation Scale, and the Independent Activities of Daily Living Scale to start a person-centered plan of services and supports. Clients may receive very short-term supportive counseling as well as advocacy and referral. People become Treatment Plan clients if staff believe they might benefit from extended services and if the seniors are interested.

Community Service Events (CSE):

Service Contacts (SC): Service contacts provide information, referrals, assistance with warm transfers to other providers, and/or referral to one of our caseworkers for further assessment.
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: First Followers
Program name: First Steps Community Reentry House
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) Men recently released from prison with a determination and plan to turn their life around with a demonstrated need for housing.
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.)? Application, phone conversations and references while the person is still incarcerated.
3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.) Written publicity, social media, word of mouth.
4. **a)** *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application): 10

	b) *Actual* percentage of individuals who sought assistance or were referred who received services: 15
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): 180 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): 5
	c) *Actual* percentage of referred clients assessed for eligibility within that time frame: **60**
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): 3 months to one year
	b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application):
	c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame: 5
7.	**a)** *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application): 3 months to two years.

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

9 months

Demographic Information

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

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

   Number of children, history of employment, history of mental illness

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.
   Provide a stable living situation
   2. Enhance opportunities to find employment
   3. Connect to social services agencies
   4. Build connections to the community
   5. Provide economic security
   6. Provide access to long-term housing opportunities

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.)
Personal interview for all outcomes

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
Stable living situation	Interview	Staff and client
Enhance employment opportunities	Interview, observation	Staff
Connect to social service agencies	Interview, observation	Staff and client
Build connections to the community	Observation, interview	Staff and client
Provide economic security	Interview	Client
Access to long-terms housing opportunities	Interview	Client

3. Was outcome information gathered from every participant who received service, or only some? Yes
4. If only some participants, how did you choose who to collect outcome information from?
5. How many total participants did your program have? 5
6. How many people did you *attempt* to collect outcome information from? 5
7. How many people did you *actually* collect outcome information from? 5
8. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc) Monthly
Results

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

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

We found that each individual had their own path to transition. Some quickly adapted to the need for employment; others were reticent to look for work or accept work they didn't think was appropriate. The COVID situation severely limited the ability of residents to build connections to the community beyond FirstFollowers. We provided connections to appropriate social service agencies for all individuals as far as possible during the pandemic. Economic security was also disturbed by the pandemic but we did steer people to opportunities which they seized.

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

11. N

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

13. N

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

15. NA

(Optional) Narrative Example(s):

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

A resident moves into our house. We provide them with case management and a community navigator who will ensure they have transportation to employment opportunities and social services agencies. We also ensure that everyone in the house has their ID, a LINK card, and other social assistance as appropriate, including Medicaid. We also incorporate them into the daily life of FirstFollowers, inviting them to drop-in center hours and to our events. At times we find them employment within our organization. However, we find different people have different attitudes toward our support systems. Some make ample use of them. Others prefer to act on their own. 80% of our residents are totally success stories, meaning that they have found economic stability and some social connection in the community. We have a 0% recidivism, though we don't consider not going back to prison as a total success rather a small part of success.

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

Utilization Data Narrative –

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

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

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

1. Please copy and paste the definitions of service categories your program specified in your program plan application in the sections below**. You will report the actual**

numbers of clients/contacts/community events for each reported service category in the Part II Utilization/Production data form (located on the online system). If your estimated number of clients/contacts/community events for reported service categories significantly differfrom your actual numbers, you may give a narrative explanation for that discrepancy here.
Treatment Plan Clients (TPC): Residents in house
Non-treatment Plan Clients (NTPC): Applicants to house
Community Service Events (CSE): Events for the people in the house
Service Contacts (SC): Interviews with employers and social service providers in the community
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: First Followers
Program name: Peer Mentoring
Submission date: August 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) Anyone in Champaign County impacted by the criminal justice system by a felony conviction and/or incarceration.
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.)? Personal interview
3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.) Social media, word of mouth, outreach events, referral from court and marketing in the community.
4. **a)** *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application): 80

b) *Actual* percentage of individuals who sought assistance or were referred who received services: 80
5. **a)** *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application): 5
b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application): **80**
c) *Actual* percentage of referred clients assessed for eligibility within that time frame: **70**
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): Drop-In 5 days; workforce development 5 months
b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application): 75
c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame: 70
7. **a)** *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application): Varies depending on services.

b) *Actual* average length of participant engagement in services: this varies from one day to the entire year.

Demographic Information

1. *In your application* what, if any, demographic information did you indicate you would collect beyond those required (i.e. beyond race/ethnicity, age, gender, zip code)? (Demographic Information, question #1 in the Program Plan application) Disability, housing stability, employment status, education level, criminal justice system involvement

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

   Disability – 20% of participants; housing instability- 75%; employment status- 70% unemployed; education level-60% lack high school diploma, 95% have criminal justice system involvement

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. *Access to employment, education and housing*
3. Access to services
4. Enhanced self-esteem
5. Basic building skills, public speaking, critical thinking, basic math

6. 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.)
We generally use personal interviews and focus groups to capture this data. We were not able to do this for FY 21 due to COVID restrictions. We relied on follow up phone calls which were highly unreliable due to inconsistent phone access among our clientele.

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
Access to services	Follow up calls	Client
Enhanced self-esteem	Unable to assess	
Building skills	Observation	Staff
Public speaking, critical thinking, basic math	Observation	Staff

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

8. If only some participants, how did you choose who to collect outcome information from? Those who were available via phone or who returned for follow up.

9. How many total participants did your program have?
20

10. How many people did you *attempt* to collect outcome information from?
12

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

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

Results

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

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

This was very difficult to assess during COVID. Our data was very minimal. Our main measure was how many people we assisted in accessing housing, either temporary (hotel) or with rental assistance. Availability of employment opportunities was minimal and stimulus checks plus unemployment attacked the extent of need and demand. This could not be measured effectively.

14. Is there some comparative target or benchmark level for program services? Y/N
For FY21. No-conditions beyond our control.

15. If yes, what is that benchmark/target and where does it come from?
The best benchmark is number of people who secured employment, housing and improvement in state of mind. Since we had very little interaction with clients all of this was not really subject to calculation

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

(Optional) Narrative Example(s):

17. Describe a typical service delivery case to illustrate the work (this may be a "composite case" that combines information from multiple actual cases) (Your response is optional)
An individual comes home from prison during the pandemic. They have not had a vaccine or a COVID test in prison. Our center is not open so we connect with them via phone or text. We take them to the testing site and put them in a hotel until their test results come back. If the results are negative, we engage with them assisting them with housing and other service access. However, the city offices are closed so we can only contact people in those office by email and voice mail. We contact landlords but many of them are refusing to rent due to the eviction moratorium. We provide assistance in helping our clients apply for their stimulus checks. In the meantime, they live in the shelter but at a certain point the shelter closes so they are on the street or living with loved ones. Most low wage employment is of limited availability due to COVID. These are the real challenges we faced. People coming home from prison have enormous challenges in normal times but the COVID situation made it worse. Our staff continued to work through this, trying to keep social distancing and masking but not all our clients were aware of this or willing to adapt to the situations. This is a composite of our service delivery experience in FY 21, the most difficult year we have yet faced.

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

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): Support group participants
Non-treatment Plan Clients (NTPC): Drop-In center clients
Community Service Events (CSE): Focus groups and public education events
Service Contacts (SC): Meetings with employers and landlords about access to serivces
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: GROW In Illinois
Program name: Growth to Maturity
Submission date: September 10, 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) **We serve anyone 18 years or older, while participation by anyone under 18 years old would need a parent's approval. There is no other criteria needed to attend GROW's Program of Growth to Maturity.**
2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)? **Phone call and discussion with parent for those under 18 years of age.**
3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.) **From the recent survey taken June-July 2021, we found that 18% of participants heard about GROW through professional referral, 73% through family and friends, and 9% through other means (advertisement, Champaign County Jail, hospital stay).**
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):

In the application for this year, we did not estimate the length of time from referral/assistance seeking to assessment of eligibility/need. This is because the person requesting admittance is welcomed immediately.

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

There is no time between referral/assistance seeking (phone call) an assessment of eligibility (no eligibility besides age). In other words, assessment of eligibility occurs immediately following referral/assistance seeking.

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

100%

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

n/a In the application for this year, we did not estimate the length of time from assessment of eligibility to engagement in services.

b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application):
In the application for this year, we did not estimate the percentage of eligible participants engaged in services within a specified time frame.

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

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

Varies. Jail inmates may only participate for a few weeks. Community GROWers may participate for years.

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

At the time of the most recent survey taken June-July 2021, 8% of participants had attended GROW for less than 1 month, 8% attended for 6 to 9 months, 6.3% attended between 6 months to 1 year, 25% attended between 2-5 years, 8% attended between 5-10 years, and 50% attended for 10 years or longer. Some of the participants were inmates of the jail and may reside there for only a brief period.

Demographic Information

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

   Our survey sample, collected demographic information on religion in addition to race/ethnicity, age, gender, military service, and zip code.

2. Please report here on all of the extra demographic information your program collected. **We found that 8% of participants identified as agnostic, 25% as spiritual, 58% as religious, 8% unsure, and 0% identified as atheist.**

Consumer Outcomes – *complete at end of year only*

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

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

   We did not include all of these outcomes in our application. However, we created a theory of change logic model that included the following outcomes of interest:
   1. **decreased hospitalization frequency**
   2. **decreased medication use**
   3. **reduced alcohol and substance abuse**
   4. **increased employment**
   5. **increased volunteer work**
   6. **increased personal growth and recovery from mental illness.**
   7. **increased wellbeing and helping others to recover from mental illness.**

8. **number of participants in leadership roles**

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

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

Outcome:	Assessment Tool Used:	Information Source:
1.decreased hospitalization frequency	GROW survey	GROWERs
2.decreased medication use	GROW survey	GROWERs
3.increased social resources	GROW Survey (2-Way Social Support Scale and the NIH Toolbox Emotional Support Survey	GROWERs
4.increased personal growth	GROW survey	GROWERs
5.increased wellbeing	GROW Survey (Personal Wellbeing Index)	GROWERs
6.high number in leadership roles	GROW Survey	GROWERs
7. satisfaction with GROW	GROW Survey	GROWERs

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

   All outcomes are ordinarily collected from only those who consented to the GROW survey and were present at a survey collection session. Because of pandemic restrictions, unfamiliarity of GROWers with online surveys, and to preserve confidentiality, surveys were administered individually on an iPAD by a GROW Fieldworker. We are working to educate participants how to use online and

computer-aided data entry and expected to reduce format errors and expedite analysis.

4. If only some participants, how did you choose who to collect outcome information from?
   The pandemic restricted access to some participants, others decided not to participate, some were otherwise not contacted to administer a survey. Many who were contacted agreed to take the survey.

5. How many total participants did your program have?

   Our program had Unduplicated: 180 people; Duplicated: 691 people
   GROW had 51 unique participants in FY21. We had 28 newcomers to groups.

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

   Approximately 15 unduplicated were contacted for FY 21 surveys

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

   Outcome was collected from 12 participants. At least two persons left to take jobs and were unavailable.

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

The survey is being administered at the end of the fiscal year [usually in May-June]. We are continuing to fine tune the system of tracking performance measures over time in consultation with the UUC Psychology Department. This year we produced our survey entirely on-line [no written surveys]. We had originally hoped to reach more individuals who attended online meetings when the survey was being administered. During the pandemic quarantine GROWers who were computer savvy enough were able to take the survey safely from home. However, many of the surveys were taken with assistance from a field organizer who gave the GROWer a tablet computer showing the survey. We intend to continue to administer the survey yearly both in group [when in-person meetings are permitted] and make the survey available on-line. We intend to help participants overcome discomfort and unfamiliarity with computer technology to take the survey online.

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)

(iii) <u>NOTE</u>. The inability to hold in-person meetings during the 2020-21 global pandemic skews the ethnoracial demographics and outcomes of the reduced survey data for FY20-21. GROW is anonymous and confidential nevertheless we are working with the UIUC Psychology Department to develop a method for comparison of strategies and outcomes while preserving anonymity of participants. Many GROWers are unfamiliar or uncomfortable with electronic technology, we are working to help participants to overcome anxiety and learn technology together through friendly help.

1. Decreased hospitalization frequency

GROWERs who completed the FY21 baseline survey reported only a single hospitalization in the past year [9%]. Participants reported a range of lifetime hospitalizations: 36% reported no hospitalizations, 36% reported 3—7 hospitalizations, 18% had 10-12 hospitalizations, and one had 30 [9%] hospitalizations.

1. Across their lifetimes they had an average of 6 lifetime hospitalizations.
2. Last year on average, GROWERs who completed the baseline survey reported 0.44 hospitalizations in the past year. Across their lifetimes, they reported an average of 1 hospitalization.
   On average, GROWERs who completed the follow-up survey reported 0 hospitalizations in the past year. Across their lifetimes, they reported an average of 6.5 hospitalizations.
3. There was a reduced need for hospitalizations, only a single person was hospitalized in the past year during a global pandemic and isolation from in-person meetings and group activities, is encouraging.

2. Decreased medication use

Of those who completed the FY21 baseline survey 30% of GROWERs who filled out the FY21 baseline survey reported currently taking 0 medications; 50% took 1-2 medications; and 20% reported taking 5 or more medications.

(i) Mean = 3

(ii) Last year 89% of GROWERs who filled out the baseline survey reported currently taking 0 medications [compared with 30% this year] and 25% reported taking 2 medications [compared with 50% taking 1-2 meds], and 0% taking 1, 3, 4, or 5 medications [compared with 20% taking 5 meds this year].

(iii) n/a

.

3. Drinking & substance abuse
   None of the GROWers reported drinking or substance abuse interfering with other people in the past 6 months.
   (i) n/a
   (ii) We know from anecdotal accounts that the FY20-21 data is not representative of all participants because many in some groups that were unable to take a survey had reported alcohol and substance abuse.
   (iii) n/a.
4. Employment
   73% of GROWers reported no change in employment status since starting but 27% had gained employment. Only 9% reported that they were able to work but not trying to find employment, 45% said that they were currently employed, and 45% reported that they were not working because they were retired, homemaker, student or SSDI. One was enrolled parttime in school or job training, three became employed.
   (i) On average, about one-half were currently employed. 75% reported that they were unemployed during the past 6 months which was during a global pandemic.
   (ii) One-quarter of participants had gained employment over the past year.
   (iii) Since the jail groups were unable to meet this data is skewed to community groups whose members are not incarcerated and have ability to perform paid and volunteer work.

5. Volunteer Work
   42% of respondents said that they were performing unpaid volunteer work, 58% were no performing unpaid volunteer work.
   (i) About one-half of respondents said that they were doing volunteer work.
   (ii) Since the jail groups were unable to meet this data is skewed to community groups whose members are not incarcerated and have ability to perform paid and volunteer work.
   (iii) See note above. This is also part of the leadership development.

6. Increased personal growth and recovery from mental illness.
   One person (8%) enrolled in school or a job training program.
   (i) 90% said that they agree or strongly agree that participation in GROW has helped me. A single person stated that s/he neither agreed nor disagreed.
   (ii) This is a new question. Previously we reported overall observations and specific examples of personal growth. There is no 'graduation' from the GROW program, rather participants advance in leadership, leave for paid/volunteer work, or cease participation.
   (iii) One person (8%) enrolled in school or a job training program. 45% are performing volunteer work.

7. Increased wellbeing and helping others to recover from mental illness.
   Participants described that they had someone that they trusted to discuss their problems, feelings, and help in dealing with a problem; sometimes 8%, Usually 42%, and always 50%.
   (i) Respondents said that they were able to talk with and obtain friendly help with problems or when upset, usually or always from fellow GROWers, 92% of the time. 92% of the respondents said that they always or usually look for ways to cheer up those who are down.
   75% of the respondents [100% of those who answered this question] said that they were working on changing their thinking and behavior. All said that they were satisfied or wish that they had attended more meetings.
   (ii) The previous average wellbeing score from the Personal Wellbeing Index for GROWERS who filled out a baseline survey was 56.3 on a scale of 0 to 100 (with a standard deviation of 25.01). The average wellbeing score from the Personal Wellbeing Index for GROWERS who filled out a follow-up survey was 70 on a scale of 0 to 100 (with a standard deviation of 21). The Wellness Indices for this year are skewed because of the absence of jail population.
   (iii) The results of this question are likely skewed because of the COViD pandemic.

8. Number of participants in leadership roles
   Learning and exercising leadership is a key part of the GROW program for personal growth and recovery from mental illness.
   (i) 58% of respondents replied that they were participating in GROW in a leadership capacity. Participating in a leadership capacity is part of recovery that builds self-esteem, empowers personal accountability and responsibility, and directs a path [steps] to recovery.
   (ii) Previously only 22% of participants who filled out a baseline survey had leadership role in GROW.
   The increased participation is skewed because GROW was unable to meet in the jail for most of the past year consequently, community residents participated over a longer period of time.
   (iii) Community residents tend to have more severe mental illnesses that require hospitalization and sustained medical and professional treatment.

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

1. Yes
2. Yes
3. No
4. Yes
5. No
6. No

7. Yes
8. No

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

1. *We set an arbitrary target of 1 or fewer hospitalizations in the past year.*
2. *A 2001 report from the National Association of State Mental Health Program Directors describes some of the risks of taking multiple psychiatric medications at the same time, such as risks of interactions, side effects, and costs. For this reason, we aimed for less than 10% of participants to be taking 5 or more medications for mental health reasons.*
3. *No benchmark.*
4. *Although no specific benchmark was set, we aimed to encourage at least one GROWer to become employed at paid or volunteer work.*
5. *No benchmark.*
6. *No benchmark.*
7. *As we described in our FY20 application, the normative range for adults in Western nations [whole population] is between 70 and 80 points (International Wellbeing Group, 2013). Our benchmark is for GROWers to score within 10 points of the average wellbeing score collected on data from the International Wellbeing Group, with an aim for a score of 70. While the International Wellbeing Group surveyed adults at random, participants coming to GROW are often enduring mental health problems in living, we anticipated lower baseline wellbeing scores, with the expectation that participation in GROW would increase wellbeing scores to within a 10 point range of normative data. Similarly, a 2012 study by Shirli Werner in Israel found that adults living with serious mental illness had an average wellbeing score of 61.6, about 15 points lower than the average score in the general population.*
8. *No benchmark.*

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

1. Met the 1 hospitalization or fewer goal.
2. This was slightly higher than last year however, GROW encourages participants to follow medical and professional directions including taking prescribed medications.
3. New question.
4. New question.
5. N/A
6. N/A
7. The FY20-21 Wellness Index is higher than last year likely because the jail group was not surveyed and a limited number of GROW participants were surveyed using a tablet computer.
8. 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)

This past year has posed a challenge to GROWers who rely upon person-to-person friendships for mutual help in recovery, maintenance of mental health, and personal growth. Nevertheless GROWers have exercised friendly leadership to adapt to virtual group meetings and exercise masking and social distancing at churches and other locations. It has been gratifying to see how the GROWers reach out to help each other [and staff] during a time of increased turmoil.

One example of this initiative is a GROWer who has begun training as a GROW field organizer succeeding a field worker who announced her intention to leave the area. The new field organizer was described as uncaring in her appearance, wore soiled clothing and was lagging in active recovery. After being hired, the person dressing neatly, performing duties well, and is taking initiative in learning computer skills for self-improvement. The new field organizer has been helping participants who have difficulty with electronic devices including tablet computers, phones and attendance at Zoom meetings. A long-time GROWer described her as 'blossoming' in recovery from numerous hospitalizations and mental health challenges.

We also observed how GROWers helped each other with unfamiliar electronic technology such as tablet computers linked to WiFi and cellular telephones, regularly call to check on wellness, organize social gatherings outdoors with recommended precautions, and provide transportation during intervals when immune compromised GROWers were anxious about health risks for riding in public transit.

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 added open-ended qualitative questions confirm that friendship is valued in support of recovery and social gatherings are important to wellbeing.

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): 0
Non-treatment Plan Clients (NTPC): 287
Community Service Events (CSE):
Service Contacts (SC): 691
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: Mahomet Area Youth Club
Program name: BLAST/Kids Club
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) **All youth of elementary age in the Mahomet School District are eligible to participate in Kid's Club and BLAST. Youth that require scholarships are reviewed based on the free and reduced lunch guidelines.**
2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)? Scholarship recipients must submit household income information or have the existing district free/reduced lunch determination
3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.) Kids Club (and BLAST when it's happening) is primarily promoted through the school district parent information sources like emails. Traditionall, there is also lots of word of mouth information sharing.
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): **7**

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): **7**

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%

7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application):
10 weeks for BLAST; 36 weeks for Kid's Club

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

20 weeks- there were many youth who joined Kids Club throughout the year, plus there were quarantine periods, breaks, etc.

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 also collect income, family size, and family makeup.

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

We did not collect this information this year as all students who qualified for scholarships already had free/reduced lunch determinations from the district and didn't require further income verification.

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 ofyour 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. Improve engagement in school. MAYC strives to ensure that over 60% of kids are more engaged in school due to the after school program.
2. Improve attendance at school. We work to ensure that over 40% of parents expect better attendance from their children when the child is enrolled in BLAST.
3. Increase connectivity (new friends) with peer group. We expect over 70% of kids to make new friends as part of the BLAST program.
4. Increase interest in new areas. We expect over 70% of parents to feel that there is enough variety in the BLAST offerings to provide a broad spectrum of subject area content for exposure into new areas.

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

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

Outcome:	Assessment Tool Used:	Information Source:
E.g. 1. Increased empowerment in advocacy clients	Measure of Victim Empowerment Related to Safety (MOVERS) survey	Client
1. Improve engagement in school. MAYC strives to ensure that over 60% of kids are more engaged in school due to the after school program.	**Survey data - Improve engagement in school - BLAST coordinator at Mahomet Schools**	Client (Parent/guardian)
2. Improve attendance at school. We work to ensure that over 40% of parents expect better attendance from their children when the child is enrolled in BLAST.	**Survey data - Improve attendance at school - BLAST coordinator at Mahomet Schools**	Client (Parent/guardian)
3. Increase connectivity (new friends) with peer group. We	**Survey data - Increase connectivity with peer group -**	Client (Parent/guardian)

expect over 70% of kids to make new friends as part of the BLAST program.	**BLAST coordinator at Mahomet Schools**	
4. Increase interest in new areas. We expect over 70% of parents to feel that there is enough variety in the BLAST offerings to provide a broad spectrum of subject area content for exposure into new areas.	**Survey data - Broad exposure to different topics - BLAST coordinator at Mahomet Schools**	Client (Parent/guardian)

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

We did not collect any BLAST Survey data this year because BLAST didn't happen.

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

We did not collect any BLAST Survey data this year because BLAST didn't happen.

5. How many total participants did your program have?

13 in Kids Club

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

0

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

0

8. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc) Typically we do an annual parent survey after all BLAST classes are complete

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)

N/A

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

No

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

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

(Optional) Narrative Example(s):

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

The school district manages and operates both programs while MAYC provides funds for the families eligible for financial scholarships for their kids to participate, so we don't have a typical service delivery case to share. But, we can say that anecdotally, the families who received scholarships were very grateful for that as they struggle with adequate child care & employment through COVID.

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 are really glad we can provide this option so that families aren't turned way from the before/after school opportunities due to income. We've streamlined the process to allow the district to handle the registration for the programs as well as the scholarship process which has reduced the time and expenses for this program for MAYC allowing for more funds to go directly to low-income families.

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.

All of these data points were down significantly due to the cancellation of BLAST because of COVID. We do know that Kids Club was more in demand this year because of the altered school schedule and our funds went to help the families in need of the financial support to ensure their kids safety before & after school.

Treatment Plan Clients (TPC):

We will provide scholarships to youth that have economic needs that have IEPs, special classroom considerations, and other developmental requirements. We anticipate 4 TPCs as part of BLAST programming.

Non-treatment Plan Clients (NTPC):

We will provide scholarships to youth that have economic needs. We expect 70 students to take advantage of this program.

Community Service Events (CSE):

500 Community service events are based on registration, program check-in, and end of program survey

Service Contacts (SC):

1100 Service contacts are based on the number of courses and days met for BLAST and Kid's Club.

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: Mahomet Area Youth Club
Program name: MAYC Members Matter!
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) **All youth between the ages of 6 and 17 are eligible to participate in our out of school programming. Scholarships are available with on our income-based sliding scale fees. Youth over the age of 13 are ableto attend all programs for free. Participants must be a MAYC member which is an annual application and $20 per student fee.** **Our Jr. High after-school program is free to all participants. It is available to anyone attending the jr. high.**
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.)? Parents/guardians complete membership and registration forms to confirm the age of the youth, their home address and scholarship determinations are based off of submitted income documentation.
3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.) The Jr. High Program (including the remote learning program this year) was advertised by the school district on their website and through parent email updates. MAYC also alerts members of all programs via e-mail, newsletters and Facebook. The local press shares information on the club and programs regularly as well. Referrals from current or past members as well as school staff play a big role in information sharing about MAYC programs.

4. a) *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application): **100**

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

70%- we had to turn away many families/youth in the summer of 2020 & 2021 due to COVID guidelines for safe group sizes.

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): **2**

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%- we maintained our quick response time to referred families

6. a) *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application): **2**

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:
75%

7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application):
We like for students to remain involved in after school and out of school programming for at least three years.

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

On average, our students are engaged in services for 2-3 years. The limitations due to COVID on the number of people we were able to serve this past year definitely impacted this goal as many students were not able to be engaged in services. We believe that if COVID weren't a factor, we could confidently say 3 years continues to be the average length of participation by students.

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 also collect IEP/504 eligibility, household income, family size, and family makeup.

2. Please report here on all of the extra demographic information your program collected.
We ask for IEP/504 eligibility, household income and family makeup from all students through membership/registration forms completed by parents/guardians.

Of the youth we served this year:

- 16% have IEP/504
- 47% have household incomes less than $35,000/year
- 40% live in households led by single parents and/or 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.

Out of School Programs:

1. Increased enrollment numbers mirroring the increased need in the community for a safe and fun program.
2. Reduction of youth who will be home alone over the school breaks.
3. Improved relationships with peers and caring adults in the community.
4. Increased educational and recreational experiences for students of low income families.

Jr. High afterschool Program:

1. Ensure graduation occurs on-time. At least 90% of youth will move on to the next grade level on time.
2. Improve graduation rate. At least 80% of youth will have passing grades across Math, Science, and English.
3. Improve success in high school and leading into post secondary education. At least 60% of students will hold steady or improve grades across Reading, Math, and Science.
4. Improved engagement and attendance. At least 75% of students will miss less than 5 days of school during the school 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:
E.g. 1. Increased empowerment in advocacy clients	Measure of Victim Empowerment Related to Safety (MOVERS) survey	Client
OOSP 1. **Increased enrollment numbers mirroring the increased need in the community for a safe and fun program.**	**Member and registration data base**	Client (Parent/guardian)
OOSP 2. **Reduction of youth who will be home alone over the school breaks.**	**Parent survey/feedback**	Client (Parent/guardian)
OOSP 3. **Improved relationships with peers and caring adults in the community**	**Parent survey/feedback**	Client (Parent/guardian)
OOSP 4. **Increased educational and recreational experiences for students of low income families.**	**Parent survey/feedback**	Client (Parent/guardian)
Jr High P 1. **Ensure graduation occurs on-time. At least 90% of youth will move on to the next grade level on time**	**Report card data from Mahomet Schools through the Assistant Superintendent**	School district with parent/guardian permission
Jr High P 2. **Improve graduation rate. At least 80% of youth will have passing grades across Math, Science, and English.**	**Report card data from Mahomet Schools through the Assistant Superintendent**	School district with parent/guardian permission
Jr High P 3. **Improve success in high school and leading into post secondary education. At least 60% of students will hold steady or improve grades across Reading, Math, and Science.**	**Report card data from Mahomet Schools through the Assistant Superintendent**	School district with parent/guardian permission
Jr High P 4. **Improved engagement and attendance. At least 75% of students will miss less than 5**	**Attendance records by student through the Assistant Superintendent**	School district with parent/guardian permission

days of school during the school year.			

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

Outcome information from the out of school program participants is only received by some since it is an optional survey.

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

Participation in the parent survey is not required, so parents/guardians self-select to provide information

5. How many total participants did your program have?

159 total including the Jr. High program & out of school programs

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

159

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

65

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

Jr. High program data collection happens quarterly
Out of School program surveys happen annually
Membership/Registration required for everyone

Results

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

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

1. Out of School Programming: We aim to serve as many youth as possible made up of a mixed income population, with students of a variety of households and race/ethnic diversity (as compared to the community). Our program goals include improved opportunities for learning and recreation plus social & emotional development like relationships with peers. The data we collect helps us determine that these goals are being met. This year, we learned that despite our reputation as a place for low-income families, around half of our participants come from families with household incomes above the qualifying amount for low income. Although we can only guess as to why this is, we believe the pandemic impacted childcare options tremendously and MAYC became an option for many who hadn't considered it before. This will not change our mission, but we believe the mixture of demographics can only improve the experiences and outcomes of our students.

2. Jr. High Program: The grade and attendance reports are traditionally helpful in gauging how students are doing academically and in general, but the way the 20-21 school year went with the pandemic & virtual learning, we feel it wasn't a reliable gauge this year. We did use this data to guide our focus to students who were struggling with academics and connected with their parents/guardians of these students to ensure wrap around supports.

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

No

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

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

(Optional) Narrative Example(s):

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

There wasn't a whole lot of "typical" this year, so here's an interesting and unexpected situation that we had this year that speaks to the value of our programs (typical or not!).
This past school year, we offered a remote learning program for Jr. High students as the school district was doing a hybrid learning model. Students came to MAYC on days when they weren't at school. This program was advertised widely which gained us many new families and was well utilized among MAYC families. Because of this and the trust we've established with clients, we ended up with 2 high school freshman attending as well because they were really struggling with the remote learning and social isolation. Their parents contacted us to inquire if their students would be able to attend mid-way through the first semester. We made the exceptions for them to attend because we believed it was what was best for the students. Both students were able to get improved academic supports and socialization with other participantswhich was needed to help them succeed and survive their freshman year. Both of these students then became MAYC employees during our summer camp program continuing our mission of developing youth for lifelong success.

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 decline in academic achievement that these families were witnessing was all the evidence we needed to adjust our program age requirements to allow students in need to get the supports MAYC could offer.

Utilization Data Narrative –

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

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

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

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

   Our service contacts increased due to the Jr. High Remote Learning Program because we had more kids for more time throughout the school year.

Treatment Plan Clients (TPC):

The majority of MAYC members are primarily categorized as non-treatment plan clients. In working more closely with mental health providers, social workers, school administrators and in attempting to refer individuals to service providers, MAYC anticipates that the number of treatment plan clients may increase. We currently estimate 12 TPC participants for 2021.

Non-treatment Plan Clients (NTPC):

We provide services to youth that are socio-economically disadvantaged youth. Many of the youth attending our programming have multiple risk factors that can potentially limit success as they progress to and through adulthood. We provide services to 150 NTPC clients.

Community Service Events (CSE):

We anticipate 200 events a year based on 50 weeks of programming. We average 4 events a week with days off for holidays and days where school is not held. We have a week off between school and summer programming at the start and end of summer.

Service Contacts (SC): **2,200 contacts a year include at least three homework checks a week during the school year along with three checks with parents per each session as part of our out of school offerings.**
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, youmust report on the actual outcomes your program activities achieved in those three domains.

Agency name: NAMI Champaign County (IL)

Program name: NAMI Programs- NAMI Family-to-Family, NAMI Family Support Group, NAMI IOOV, NAMI Champaign County Warm Line, NAMI Family & Friends , NAMI Ending the Silence

Submission date: 08/2021

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) **NAMI Champaign programs are free and provide support to people whose lives areimpacted by mental health conditions.** **NAMI Champaign asks that participants in their group meetings be 18+. Members of thecommunity and providers are also encouraged to attend.**

For 'NAMI Ending the Silence'- Middle School and Highschool administrations arecontacted directly depending on availability to schedule presentations.

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.)?

Not applicable; NAMI is open to any person interested in learning more about mental health conditions, including family and friends of those with mental healthchallenges, along with those having lived experience with a diagnosis of mental illness.

For 'Ending the Silence'- Have to provide that they are a Middle School or HighSchool education program.

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

NAMI Champaign is often found by the community through the website www.NAMIChampaign.org, social media, provider referrals, referrals from other organizations, word-of-mouth, the 211, and various outreach events,

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

NAMI Champaign is an open-door organization.

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

Note: NAMI Champaign does not track references or follow-ups unlessnoted with client. NAMI Champaign does not track or keep record of non-members who seek assistance through our Warmline beyond trackingthe number of total calls monthly and their needs/resources provided.

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

Not Applicable.

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

(See response 2.)

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

Not Applicable (See response 2.)

6. a) *From your application,* estimated length of time from assessmentof eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application): **Not Applicable**
b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access,question #8 in the Program Plan application): **Not Applicable.**
c) *Actual* percentage of clients assessed as eligible who were engaged inservices within that time frame: **Not Applicable.**
7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the ProgramPlan application): **NAMI Champaign is an open-door organization. Our members participate anywhere from a few meetings, programs, to many years.**

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

Not Applicable (see above)

Demographic Information

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

NAMI Champaign will ask for Phone Number, Email address, and/or form ofcontact.

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

Phone Numbers, email addresses, and/or form of contact were requested on all sign-in sheets or attendance forms.

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.

   NOTE: Family & Friends and Ending the Silence were not offered during 2020-2021 due to coronavirus restrictions; we have no outcomes for thoseprograms.

   1) NAMI Champaign County's Friends & Family is structured to help people who are living with a mental health condition and their families understand better through a set of seminars how to best support one another.

   2) NAMI Champaign County's Ending the Silence presentations offered to students in middle and high school plus young adults in college is an engaging presentation that helps audience members learn about the warning signs of mental health conditions and what steps to take if you ora loved one are showing symptoms of mental illness.

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.)

Not applicable; Family & Friends and Ending the Silence were not offered during 2020-2021 due to coronavirus restrictions. Our intended assessment toolswere NAMI National's guidelines for assessing these Signature Programs.

NOTE: Two NAMI members completed training for Family & Friends, but thecourse was not offered due to coronavirus restrictions and accessibility.

Three NAMI members have completed training for Ending the Silence. Mock presentations were to be conducted for practice, but those were cancelled due to coronavirus.

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 surveymay 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 Relatedto Safety (MOVERS) survey	Client
N/A		
N/A		

N/A		
N/A		
N/A		
N/A		

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

Not Applicable

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

Not Applicable

5. How many total participants did your program have?

Not applicable

6. How many people did you *attempt* to collect outcome information from? **Not Applicable**
7. How many people did you *actually* collect outcome information from? **Not Applicable**
8. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc) **Not Applicable**
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; comparingrates 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

No.

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

Not Applicable

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

Not Applicable

(Optional) Narrative Example(s):

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

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

Utilization Data Narrative –

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

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

Here, you will report on the different types of service categories specified in your program plan application. Please remember that programs **do not** need to collectand 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 reportthe actual numbers of clients/contacts/community events for each reportedservice 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):

Not Applicable

Non-treatment Plan Clients (NTPC):

- **Not Applicable**

Community Service Events (CSE): 104

NAMI Champaign hosts virtual community education events to raise awareness, and bring light to resources in the community.

NAMI Champaign hosts Speakers to UIUC students going to U of I ,Parkland, and is open to others in the community.

NAMI Champaign has a picnic yearly to honor law enforcement in Champaign County, and CIT trained officers.

NAMI Champaign participates in various Anti-Stigma events throughout Champaign County, including Eberfest, 'Self-Help' and collaborates with local organizations.

NAMI Champaign is going to be hosting a fundraising event in 2021.

Note: Due to COVID19, NAMI Champaign did not host annual picnics honoringCIT officers or trivia nights.

Note: Target CSEs = 45

Actual CSEs = 104

- Q1: 21
- Q2: 26
- Q3: 36
- Q4: 21

Service Contacts (SC):

Not Applicable.

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: Promise Healthcare
Program name: Mental Health Services
Submission date: September 9, 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) Promise Healthcare's mental health services are available to anyone regardless of their ability to pay. Anyone is eligible for our 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.)? Not applicable.
3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.) Promise works on promotion several ways including working with collaborators and referring agencies and providers, marketing and social media. However, most patients learn about our mental health services through word of mouth from family and friends.
4. a) *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application): 100% of patients who sought assistance or were referred would receive a screening (to identify actual need or desire for counseling or psychiatry), Mental Health Assessment or Psychiatric Evaluation.

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

Actual percentage is 100%. No one is turned away who is seeking assistance or referred for counseling or psychiatry.

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

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):

100%

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

Counseling: 100% Everyone is assessed that is referred and keeps appointment
Psychiatry: 100% Everyone is assessed that is referred and keeps the appointment

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:

Counseling: 100%
Psychiatry: 100%

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

Average length of engagement in counseling services is 12-15 months. Average length of engagement in psychiatric services is ongoing.

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

Actual average length of engagement in counseling services is 12-15 months. Average length of engagement in psychiatric services is ongoing.

Demographic Information

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

In FY 2020, we continue to collect race/ethnicity, age, gender and zip code for both counseling and psychiatry services. Is language considered demographic information, what about sexual orientation and gender identity,

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

None.

Consumer Outcomes – *complete at end of year only*

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

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

We expect that clients in counseling and psychiatry will have
1. decrease in emotional distress or mental health symptoms, and
2. work to support patients to achieve their optimal health

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

1. Decrease in emotional distress or mental health symptoms will be measured using the Patient Stress Questionnaire (PSQ) in the electronic health record. The PSQ includes The Patient Health Questionnaire (PHQ-9) what about PHQ-2?, General Anxiety Disorder (GAD-7), and the AUDITscreening tool. The data will be patient reported to the behavioral health provider and entered into the electronic health record.
2. Work to support patients to achieve their optimal health can be measured by patients who are also medical patients through tracking clinical care gaps. Clinical care gaps are HRSA and CMS evidence-based standards of care. Patients of the mental health program can also anonymously report program experience through the annual patient experience survey.

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
Decrease in emotional distress or mental health symptoms	PHQ9, GAD-7, AUDIT	Client
Clinical care gaps	HEDIS standards, patient interviews from CCM	Electronic medical record, managed care plan reports, Client/CCM
Program experience through the annual patient experience survey.	Midwest Clinicians Network Survey	Client

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

No, only some

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

Patient Stress Questionnaire (PSQ) in the electronic health record with the Patient Health Questionnaire (PHQ-9), General Anxiety Disorder (GAD-7), and the AUDIT screening tool are to be collected for every patient engaged in therapy as part of the initial assessment and after six months of engagement and at discharge—when known. Counselors failed to collect outcome information for several reasons: patients did not continue with care, therapists failed to execute, and pandemic affected session content—whether on the phone or in person.

Psychiatry does not use a tool but instead subjective clinical judgement.

We tried to survey 20 patients per psychiatrist and 10 per therapist. Selection is based on the timing of when we were executing the surveys.

We try to screen all eligible medical patients for depression.

5. How many total participants did your program have?

362 counseling
1,889 psychiatry

Our number of unique patients compared to prior year was less due to the COVID pandemic. However, our number of visits per individual patient increased during this time frame.

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

PSQ/PHQ-9/GAD-7 outcome information collection is attempted from all counseling patients seen.

20 patients per psychiatrist and 10 per therapist for a goal of 80 surveys.

All eligible medical patients for depression screening

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

PSQ/PHQ-9/GAD-7 - 208 counseling patients from Champaign County.

We collected patient experience surveys from 66 patients.

We screened 3,767 for depression and prepared a follow-up plan of 4,380 eligible medical patients.

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

PSQ/PHQ-9/GAD-7 – should be collected as part of the initial assessment and after six months of engagement

We collect patient experience surveys once a year. Most patient surveys were collected in the fall of 2020 with some in early 2021.

Promise Healthcare screens medical patients for depression 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 ethnic and/or race; comparing characteristics of all clients engaged versus clients retained)

PSQ/PHQ-9/GAD-7 – PHQ-9/GAD-7 – Sixteen patients received outcome measurement tools, (PHQ-9/GAD-7) at time of assessment and at a six month follow up. Adjusting for two large outliers, PHQ-9 net scores dropped slightly by 5 and GAD-7 net scores improved by 3.

Most decreases at the six-month mark in both the PHQ-9 and GAD-7 scores occurred during the April of 2020 amid the large scale effects of the COVID-19 pandemic.

As COVID hit and stay at home orders from April through May volumes dropped, and no shows increased. While therapists checked in on patients via phone, providers did not capture assessments as they normally would. Staff are unsure how informative those tools are during a pandemic.

Patient Surveys – Promise Healthcare scored above the Midwest average on most measures.

Depression screening of medical patients – Promise screened and—when appropriate—provided follow-up care for 86% of eligible patients. 4,380 – eligible for depression screening and follow-up plan, 3,767 met measure (UDS year). In 2020 we were at 81% and 2019 was 55%. (for what?) When Promise initially started screening for depression for all patients 12 and older in 2017, we were not prepared for the additional number of patients who needed care for depression. However, our therapists worked with our quality improvement and risk management committees to adjust workflows and therapist scheduling guidelines to create access. All patients who screen positive for depression are able to schedule within 30 days, most within 13 days.

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?

PSQ/PHQ-9/GAD-7 – These are assessment tools that inform treatment decisions as such, no benchmarks exist. However, the target will continue to be a continued improvement as measured by these assessments. Relative stability of the scoring may also reflect overall functioning and stabilization of symptoms.

Patient Surveys – Promise Healthcare uses a survey tool from the Midwest Clinicians Network. This offers us the opportunity to not only compare our performance year over year but also as compared to other Midwest community health centers.

Depression screening of medical patients – The CDC has set a national target called Healthy People 2020. Their goal is 87%. Through UDS reporting to HRSA, we know how other community health centers are doing. The 2020 FQHC national average was 64%. The 2020 Illinois FQHC average was 70%.

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

PSQ/PHQ-9/GAD-7 – None available for these scores and benchmarking would likely not be informative due to COVID impacts in 2020.

Patient Surveys – Promise Healthcare scored above the Midwest average on 11 measures, equal on 2 and below peers on 32 measures.

Depression screening of medical patients – Promise screened and—when appropriate—provided follow-up for over 86% of eligible patients. This exceeds the 2020 Illinois and national rates.

(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):

Continuing treatment plan patients and new patients to counseling or seeing a psychiatrist (unduplicated) will be counted in TPCs as Treatment Plan Clients.

Non-treatment Plan Clients (NTPC):

Non Treatment Plan Clients will include patients who receive their behavioral health medications from their Promise Healthcare primary care provider due to the support provided by Dr. Chopra—usually tracked in psychiatry. We believe that we have built capacity for serving an additional 800 patients a year through PCPs. When a patient does not complete assessment or choses to not engage in therapy with one of our therapists, this is tracked in NTPC in counseling.

Community Service Events (CSE):

Community service events tracked as CSE includes our therapists promoting the mental health program or educating about mental health awareness outside the health center—typically a community event or health fair. For our psychiatrists, CSE is where we track the monthly noon meetings Dr. Chopra has with our other providers and nurses.

Service Contacts (SC):

Counseling encounters and medication management encounters by our psychiatrists will be tracked using SC to count each encounter or attended appointment.

Other:

Case management/consultation will include case management, enabling services, and visiting with prenatal patients provide by our counselors. For our psychiatrists this includes consultations with medical providers that assist in treating patients with mental health issues. Patients tracked here are not billable services. These are all tracked using Other.

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).

Psych	CSE	SC	NTPC	TPC	Other
Continuing	0	0	0	0	0
Q1	0	1,978	235	1261	0
Q2	0	1,984	236	146	0
Q3	0	1,853	219	128	0
Q4	0	1,763	234	118	0

Total	0	7,578	724	1,653	0
Target	4	7,500	850	1,600	0

The adult psychiatry program served less unique patients (TPC) with more visits (SC) for psychiatry.The program did not offer lunch and learns for medical providers in behavioral health and psychiatry due to the pandemic.

Counseling	CSE	SC	NTPC	TPC	Other
Continuing	0	0	0	90	0
Q1	0	317	0	46	0
Q2	0	432	0	60	0
Q3	0	434	0	150	0
Q4	0	492	0	74	0
Total	0	1,675	0	420	0
Target	0	2,750	0	500	0

The adult counseling program was executed as proposed.

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: Promise Healthcare
Program name: Wellness
Submission date: 9/8/21

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) Promise Healthcare coordinators assist anyone who is a Promise Healthcare patient of any program. Outreach and Enrollment assists all community members. Promise Healthcare's primary medical, behavioral health and dental services are available to anyone regardless of their ability to pay. Anyone is eligible for our 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.)? Any Promise patient is eligible.
3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.) Promise Healthcare's Wellness Program is primarily referred from our own staff and providers. Coordinators are paged to rooms and tasked in the electronic health record.
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:

98%. Nearly all requests are served. The most common need that we cannot assist with is applications for disability.

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):

3 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%, staff assist while patient is in the clinic or within 1 to 2 business days if tasked a request in the electronic health record.

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):

3 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% of those who have requests we can assist with receive assistance. Requesting help with disability applications is the most common(only) request we cannot assist.

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

Average length of engagement varies from one day to ongoing.

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

Average length of engagement varied dramatically from one day to the full grant year.
Some patients were helped twice at different times in the same day for two different issues.
We worked with some patients two different times eight months apart or more.
When a patient is getting assistance with medications, the engagement can be ongoing.

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)

Health coverage, veteran, migrant worker status, homelessness, and preferred language (gender anything? Are these all considered demographic information? By whose definition?

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

3,050 or 28.5% of all patients did not have health coverage.
138 or 1.29% of all patients identified as veterans.
88 or 0.88% of all patients identified as migrant workers.
1,359 or 12.70% of all patients were homeless.
1,486 or 13.89% are best served in another language.

Information from UDS report—which is a calendar year report for 2020.

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.

Promise Healthcare's Adult Wellness Program will work to
1. Help patients remove barriers to their treatment plan.
2. Assist patients with no health coverage in accessing mental health visits via our outreach and enrollment efforts of enrolling in coverage.

(all programs, includes non-Promise patients as well).
3. The program will work to support patients to achieve their optimal health.

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

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

Outcome:	Assessment Tool Used:	Information Source:
1. Treatment plan barriers are reduced.	"Promise Wellness Assist" Assessment of assistance needed, documented using dummy codes assigned to categories of assistance entered into EPM Charge Posting.	Adult wellness coordinator from patient communication or provider tasking need to be placed in the electronic medical record.
2. Maintain a percentage of mental health visits where patients do not have coverage to under 15% through outreach and enrollment efforts and help 2000 people enroll in coverage (all programs, includes non-Promise patients as well).	Financial reporting shows the percentage of patients seen by therapists and psychiatrists that were uninsured. This will be a ratio of visits and count of people enrolled in coverage.	Coverage verification through the State of Illinois Medicaid system (MEDI), Availity, Medicaid Managed Care plans and commercial insurance portals.

3. The program will work to support patients to achieve their optimal health.	Clinical care gaps are HRSA and CMS evidence-based standards of care.	The program will work to support patients to achieve their optimal health which can be measured by patients who are also medical patients through tracking clinical care gaps. Patients of the mental health program can also anonymously report program experience through the annual patient experience survey.

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

We collect information on those assisted for adult wellness. We have outcome information for all patients for clinical care gaps and health care coverage.

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

Outcome information is counted for every assist we provide. We do not track patient needs that we cannot help with.

5. How many total participants did your program have?

354 – Adult Wellness only, Champaign County only
4,380 – eligible for depression screening and follow-up plan, 3,767 met measure (UDS year)
651 – estimated enrolled in coverage in grant year

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

All patients

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

All patients that we were able to assist.

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

While providing assistance.

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 ethnicity and/or racial groups; comparing characteristics of all clients engaged versus clients retained)

We track outcomes for the Wellness program in three areas:

1. Patients assisted with barriers to care;
2. Health coverage, counting those enrolled in care and % of behavioral health visits for patients that are low income and uninsured; and
3. Clinical care gaps for all patients including depression screening.

1. Wellness program data for "Patients assisted with barriers to care" reported is for Champaign County only.

354 unique patients
22% less patients than last year (452 patients GY 20; 284 patients in GY19)
904 encounters/visits/contacts with adult wellness
Average 2.55 encounters/visits/contacts with adult wellness
32% less encounters that last year (904 contacts GY 20; 1120 contacts in GY19,
1108 issues addressed to reduce barriers to executing treatment plan
Average 3.13 issues per patient

01	- transportation	227
02	- food	52
03	- housing/utilities	55
04	- occupational/job resources	3
05	- medication/medical assistance	541
06	- internal forms/fee waivers	34
07	- coverage/insurance	36

08	- other	158
09	- justice involved	2
		1,108

The program grew in number of patients served and number of assists. By far at nearly 80% of assists, the area of greatest need was to help patients access medications due to financial barriers. Our second greatest patient need was transportation.

Numbers below are for all patients and not just Champaign County. Over 90% of Promise Healthcare patients live in Champaign County.

2. 651– estimated enrolled in insurance coverage in grant year. *Note many patients are enrolled in SFS program as well but those numbers are not included in this enrollment figure. 8.99% of behavioral health patients were low-income and uninsured at the time of service during the grant year. 23% of all Promise patients were low-income and uninsured at the time of service during the grant year.

3. Depression screening of medical patients – Promise screened and—when appropriate—provided follow-up care for 86% of eligible patients. 4,380 patients were eligible for depression screening and follow-up plan, 3,767 met measure (UDS year). In 2020 we were at 81% and 2019 was 55%. When Promise initially started screening for depression for all patients 12 and older in 2017, we were not prepared for the additional number of patients who needed care for depression. However, our therapists worked with our quality improvement and risk management committees to adjust workflows and therapist scheduling guidelines to create access. All patients who screen positive for depression are able to schedule within 30 days, most within 13 days.

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

1. No, other than year over year.
2. No, other than year over year.
3. Yes.

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

Promise Healthcare is able to compare our clinical quality against other FQHCs in Illinois and nationally.

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

1. Promise served 22% less patients than last year with 32% less encounters. The patient volumes and administrative resources were significantly impacted by the pandemic. Behavioral health program was significantly reduced to mitigate the spread of the virus. The CRC satellite location was permanently closed and patients were reassigned. Also some staff discontinued working for the organization during the pandemic.

2. Promise enrolled 651 people in coverage. This is less than GY20 with 1990 and GY 19 which was 2283 enrolled and less than our goal of helping 2,000 people enroll in coverage. The pandemic had significant impact on our ability to enroll patients in coverage as many patients deemed this contact as non emergent in nature. As such we realized a 33% reduction in enrollment from prior year.

3. The 2020 FQHC national average for depression screening and follow-up was 64%. The 2020 Illinois FQHC average was 70%. The CDC has set a national target called Healthy People 2020. Their goal is 87%. Promise was at 86%.

(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 complete 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 different from your actual numbers, you may give a narrative explanation for that discrepancy here.

Treatment Plan Clients (TPC):

Patients who are engaged with more than one contact or assisted through several barriers are considered case management (TPC).

Non-treatment Plan Clients (NTPC):

NTPC patients are ones who are just helped once in a program year. A service contact may be a referral from their primary care provider, mental health provider, or referring partner.

Community Service Events (CSE):

Promise Healthcare's Wellness Program will participate in at least twelve community service events during the grant year. Promise Healthcare will welcome referrals and seek out outreach events that will help target those involved in the criminal justice system. That could include area church programs, job fairs, and education programs.

The Wellness Program will execute fifteen appropriate collaborations with area agencies. These collaborations are all supported by our Adult Wellness Coordinator. Both events and collaborating agencies are tracked in CSE.

Service Contacts (SC):

Service contacts are encounters with patients assisted either through adult wellness or medication assistance program.

Other:

Other is where we record the number of people estimated to have been enrolled in health coverage including Medicaid and the Medicaid managed care organizations.

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).

Wellness	CSE	SC	NTPC	TPC	Other
Continuing	0	0	78	0	0
Q1	15	306	0	107	0
Q2	0	152	59	93	174
Q3	0	124	62	62	228

Q4	0	108	26	26	249
Total	15	690	225	288	651
Target	27	1500	460	175	2200

The program was significantly impacted due to the COVID 19 pandemic. The pandemic negatively reduced our patients, patient visits, and number of patients enrolled in healthcare coverage. We did adjust the way that services have been traditionally provided by embracing telehealth visits and delivering medications to patients at their homes.

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: Rape Advocacy, Counseling, & Education Services
Program name: Sexual Violence Prevention Education
Submission date: August 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)

RACES Prevention Education programming is offered for free to all schools and community organizations in Champaign County. Educators' schedules may fill quickly. With the staff we had available in FY19, some schools tried to schedule classes after our Educators' schedules were already full. Our request for increased funding would allow us to provide programming to schools that were unable to receive this service in FY19.

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

The nature of our education/prevention services are such that all people are eligible for services; there is a specific focus on the school-age population for the "prevention" aspect of our programming. All schools in Champaign County are contacted with an offer to provide these services, and those interested contact RACES to schedule times. School-age population (ages 5-18) represent the majority of these services provided.

Other groups are provided these services by request. Some are long-standing requests (e.g. groups within the University of Illinois, or the Juvenile Detention Center which asks us to help fulfill a requirement associated with the Prison Rape Elimination Act).

We also work with schools to ensure that they can provide an environment that ensures fidelity to quality programming. For instance, students cannot be seen in auditorium or assembly programming. Additionally, a minimum of three days is necessary to work with students. https://www.wcsap.org/prevention/concepts/9-principles-prevention

Unique to this year was the pandemic. RACES pivoted quickly to shifting content into online modalities, and most schools had the technological capability to accommodate this (as they similarly had to pivot for their jobs!). Ultimately, no school was denied service, and a few even received in-person services (albeit with several precautionary measures).

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

We utilized several approaches:

- **We sent a letter to every school principal (or other appropriate administrator) in Champaign County in mid-summer describing our free services and how to access them. This year, we included extensive additional information about our new online modalities.**
- **With established schools, we also followed up two weeks later with an email to the school principal and the school social worker or guidance counselor.**
- **There is a prevention education request tab on our website that can be utilized to request these services.**
- **At outreach events we hand out colorful cards describing prevention education and how to request the service.**
- **Due to long-standing relationships with teachers or school social workers, we are asked back to most of the schools in which we present.**
- **We also did an online presentation for parents this year to explain some of our content.**

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

80 (of *schools*, not persons in our case, who contact us)

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

100% of schools which contacted us or were referred received services.

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

4 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):

8 days (defined as time between a school's request, and a school's scheduling of the services for the year)

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):

80% (defined as eligible *schools*)

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

100% of schools were scheduled within the 8-day time frame. The nature of the asynchronous modality means that "scheduled" means "set up" (i.e. back-end student registration into online sites, etc.) happened within that timeframe; teachers and students were free to assign and complete the modules at a time that worked for them. This flexibility was much appreciated by the teachers (and not a few students!) given all the new challenges they had with remote learning and other pandemic-related concerns, and most competed the sessions very shortly after set-up.

Programming for the Juvenile Detention Center (JDC) was suspended by the Superintendent of Champaign County Juvenile Detention Services on March 13th, 2020, due to restrictions of visitors; we never were able to present during FY21, which was disappointing given the longstanding relationship we have had with the JDC and the increased vulnerability of their charges. However, our new Education staff are currently scheduled to resume in FY22.

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

Most programs consist of four sessions. Students usually receive four sessions. The program for adults is a single session.

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

Due to restructuring into online modalities, most cycles were condensed into three "sessions", although the asynchronous nature of the modalities meant students could complete them more or less at their own pace. The overall content amount stayed roughly the same.

Demographic Information

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

Our data collection is comprised of the zip code of the school or organization where the presentation takes place.

Due to the fact that this service is provided to large groups over multiple sessions, we can not collect data on race, ethnicity, age and gender.

Reviewing last year's note on this question, it is worth acknowledging here the (relative) anonymity of the asynchronous online modalities made for more "open" participation, perhaps because the dynamic of peer pressure and others knowing what you said was largely absent.

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

N/A

Consumer Outcomes – *complete at end of year only*

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

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

As with most education initiatives, the ultimate desired outcome is to change behaviors and attitudes for a lifetime; we seek to reduce the overall rates of sexual violence and to create more appropriate and sensitive societal response to sexual victimization.

Measuring such longitudinal change is outside the scope of a small, local agency. However, RACES uses age appropriate pre and post-tests to measure three key outcomes.
1. Knowledge gained
2. Attitude change related to risk factors
3. Attitude change related to protective factors

We are looking for increased knowledge (1), decreased acceptance of measures related to risk factors (2) and increased acceptance of measures related to protective factors (3).

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:
Increased knowledge related to (age-appropriate) risk factors of sexual violence	**Pre/Post tests created in coordination with the CCMHB Consultation Bank**	**Students**
Improve responses to survivors of sexual violence	**Pre/Post tests created in coordination with the CCMHB Consultation Bank**	**Students**

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

The asynchronous online nature of the service this year drastically impacted our ability to maximize the participation of students completing post-tests. While some teachers requested information on which students did not complete the modules (which we could provide), others did not, and we elected to not push teachers – already stretched thin by the pandemic and trying to track students remotely – into obtaining compliance. (We did inform teachers we could provide this information.) As a result, we saw comparatively large discrepancies between completed pre-tests and post-tests; overall 60% of the students who took pre-tests took a post-test. This still left a sizeable amount of students from which to complete data analysis. The overall improvement percentages are equivalent to previous years, bolstering that conclusion, but we must acknowledge that this overall dynamic may "self-select" for positive responses.

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

See above. Students self-selected to not complete a post-test; this could be for any number of reasons, including disinterest, exhaustion from the material, and simple misunderstanding of new technology.

5. How many total participants did your program have?

We provided services to at least 2,653 unduplicated students in Champaign County. Beyond this we also served several adults in various educational capacities (reflected in CSEs).

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

100% of participants. See above for challenges related to the pandemic and new online modalities.

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

Due to schools being closed to visitors, we were not able to collect data from our elementary school students. (This is typically post-test only, due to the age of the participants.) 870 post-tests were completed for grades 6-12.

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

Pre-tests were the first module in an online modality, and post-tests were the final module. For the few in-person classes we conducted, tests were conducted during the first session (pre-test) and the last session (post-test).

Results

9. What did you learn about your participants and/or program from this outcome information? Please be specific when discussing any change or outcome, and give appropriate quantitative or descriptive information when possible. For example, you could report the following:
    i. Means (and Standard Deviations if possible)
    ii. Change Over Time (if assessments occurred at multiple points)
    iii. Comparison of strategies (e.g., comparing different strategies related to recruitment; comparing rates of retention for clients of different ethnoracial groups; comparing characteristics of all clients engaged versus clients retained)

Due to the pandemic, and nature of online programming, we did not do evaluation surveys for our Second Step (K-2nd and 3rd-5th grade cohorts). For this curriculum, we only utilize a one-time testing model due to the age of the students and type of content. We also did not have enough data for 10th grade cohorts this year.

Further, the considerable variation in service provision across the year made a proper evaluation of (iii) above difficult to do accurately, as we have been able to do in previous years. Please see Question 12 below for long-term intentions. In looking in-depth at

individual questions, we did determine that we need to improve the content regarding the role of police in relation to reporting sexual assault.

The CCMHB Evaluation Bank was of immense support in analyzing our data, as they have always been. This is a critical component of ensuring the quality of the services provided.

- **Dating Matters (6th grade)**
  i. **PRE Mean 4.52/6; POST Mean 5.16/6. Std. 1.05**
  ii. **Increase of ~0.64 points (improvement). Statistically significant at a p-value of 5.97e-08. "Not sure" answers also dropped from 15.97% on the pre-test to 11.02% on the post-test.**
- **Safer Relationships (7th grade)**
  i. **PRE Mean 4.48/6; POST Mean 4.86/6. Std. 1.31**
  ii. **Increase of ~0.38 points (improvement). Statistically significant at a p-value of 0.001157. "Not sure" answers also dropped from 14.94% on the pre-test to 9.63% on the post-test.**
- **Safe Dates (8th grade)**
  i. **PRE Mean 4.01/7; POST Mean 5.63/7 Std. 1.30**
  ii. **Increase of ~1.62 points (improvement). Statistically significant at a p-value of 2.2e-16. "Not sure" answers also dropped from 19.52% on the pre-test to 4.98% on the post-test!**
- **I ♥ Consent (9th grade)**
  i. **PRE Mean 3.67/6; POST Mean 5.20/6. Std. 1.14**
  Increase of ~1.53 points (improvement). Statistically significant at a p-value of 2.2e-16. "Not sure" answers also dropped from 21.05% on the pre-test to 3.37% on the post-test!!

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?
The evaluation outcomes from our programming in FY19 and FY20 was our benchmark for outcomes in FY21. Given the radical shift in modalities due to the pandemic, this may not be a fully effective benchmark, but it was the best option available (previous data). Of particular note, the number of questions in most of the surveys were reduced, in part based off of previous years' data.

12. If yes, how did your outcome data compare to the comparative target or benchmark?
Overall, the programming maintained its statistically significant demonstration of improvement in student learning. Comparison to previous years is difficult due to the numerous changes made in FY21 (both in evaluation tools and in modalities) die to the pandemic. Regardless, we can feel confident that the overall goal of educating students on the dynamics of sexual violence (including prevention) was effective.

Students also appeared, overall, to do better on the pre-test this year, suggesting that larger positive cultural shifts in understanding sexual violence + previous education from RACES and other bodies have contributed to a healthier generation.

While the same circumstances that make accurate comparison difficult mean that using FY21 as a baseline for FY22 is unwise (as we anticipate FY22 returning to a more traditional approach), we nevertheless will be exploring an in-depth analysis of the FY21 data with an eye towards our modalities (particularly in-person vs. online). We would like to continue the online modality in some format – it has the potential to increase our reach, and we had at least one anecdotal experience showed us massive improvements in student participation over the previous year – and while one modality will inevitably prove to be more effective than the other, this year showed us that both do indeed work to lessen the impact of sexual violence trauma on our community's children.

(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)

Please see above for intentions for use of FY21 data.

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. Prevention education attendees will not have treatment plans and will not be considered clients of the agency for these purposes.**

Non-treatment Plan Clients (NTPC): **N/A. Prevention education attendees are not considered clients of the agency for these purposes.**

Community Service Events (CSE): **Number of in-person educational presentations provided by RACES staff. Target of 200 presentations.**

Total live presentations was 36. As noted in the quarterly reports, we reported only synchronous presentations to keep in spirit of what was proposed in the application. Certainly, each asynchronous (i.e. recorded video) presentation was a presentation, but as these were used for multiple classes, fair and accurate reporting of the work is difficult to do.

Last year's total was 624 (and that was with losing several due to the pandemic hitting in the end of FY20), and was based on an estimation made from a nascent program; the application cycle presents difficulties in accurate predictions, particularly if using data from a growing program.

Service Contacts (SC): **Number of individuals who participate in one of our sexual violence prevention education cycles. We define a cycle as a series of three-four sequential sessions delivered to the same group of children or youth. Target of 1,500 unduplicated participants.**

Total was 2,653 unduplicated participants. (Due to the nature of the online modalities, we feel more confident in the relative accuracy of this number compared to previous years which always contained an appreciable undercount of actual students due to the multiple-session nature of the presentations and nature of collecting student information sans identifiers; online, students often had to register for individual accounts.) Last year was 4,242, with the same prediction challenges noted above for CSEs.

For "Other", we defined as sessions provided to the Juvenile Detention Center (JDC). Programming for the JDC was suspended by the Superintendent of Champaign County Juvenile Detention Services on March 13th, 2020 due to restrictions of visitors; we never were able to present during FY21, which was disappointing given the longstanding relationship we have had with the JDC and the increased vulnerability of their charges. However, our new Education staff are currently undergoing background checks to allow them to present at the JDC, so we are hopeful this will resume in FY22.

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: Rattle the Stars
Program name: Youth Suicide Prevention
Submission date: 9/10/2021

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)

Our program is available to youth living in or enrolled in a public or private middle or high school in Champaign County. The program is available to any adults who have contact with or interact with these youth. We require a minimum group size of 5 and a minimum of 8 hours to conduct the complete program. When shorter time periods are required, we will select the most relevant and useful sections of the program based on the participants' needs.

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

Self-report

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

Outreach events, direct contact with schools and agencies, social media advertising

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): 2 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: 98%
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): 50%
c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame: 80%
7. **a)** *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application): Youth: 2.25 hours in three sessions Adults: 4 hours in one session

b) *Actual* average length of participant engagement in services:
Youth: we did not conduct youth trainings during the pandemic
Adults: 4 hours in one session

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)

gender identity (cis- or trans-) and sexual orientation

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

3 of 67 Champaign County residents identifies as being transgender.
12 of 67 Champaign County residents identified as being LGBQ.

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. Increase understanding of suicide and decreased adherence to myths.

2. Increased knowledge of how to respond to suicide.

3. Increased confidence to respond to suicide.

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

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

Outcome:	Assessment Tool Used:	Information Source:
E.g. 1. Increased empowerment in advocacy clients	Measure of Victim Empowerment Related to Safety (MOVERS) survey	Client
1. Increase understanding of suicide and decreased adherence to myths.	our assessment tool developed with the evaluation team	Client
2. Increased knowledge of how to respond to suicide.	our assessment tool developed with the evaluation team	Client
3. Increased confidence to respond to suicide.	our assessment tool developed with the evaluation team	Client

3. Was outcome information gathered from every participant who received service, or only some? Only some.
4. If only some participants, how did you choose who to collect outcome information from? We initially only gathered outcome information from participants who attended trainings lasting at least 3 hours. In the 3rd Quarter, we began using a shortened post-test only evaluation to use after trainings lasting less than 3 hours. We did not collect outcome information from trainings and other presentations to general audiences in which we didn't control attendance, such as webinars arranged by others.
5. How many total participants did your program have? approximately 550
6. How many people did you *attempt* to collect outcome information from? approximately 250
7. How many people did you *actually* collect outcome information from? 140 (67 reported a zip code in Champaign County)
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 beginning and end of trainings lasting at least 3 hours -at the end of trainings lasting less than 3 hours
Results

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

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

Our evaluation tool (developed with the evaluation team) contained 6 graded questions assessing knowledge about suicide (including adherence to myths) and 9 graded questions assessing knowledge about what to say (communication skills). Knowledge of suicide response plans was assessed using self-report on a 4-point Likert-scale, and ratings of knowledge, skills, and comfort responding to suicide was assessed using self-report on a 4-point Likert-scale.

At pre-test, clients correctly answered an average of 4.04/6 questions on knowledge about suicide (SD=.89), and correctly answered an average of 7.87/9 questions on knowledge about what to say (SD=1.29), for a total of 11.91/15 (SD=1.70) correct answers (79.4% correct). Clients reported knowledge of suicide response plans (M=2.67, SD=.71), and rated their knowledge (M=2.57, SD=.67), skills (M=2.55, SD=.71), and comfort (M=2.58, SD=.71) to respond to suicide.

At post-test, clients correctly answered an average of 5.30/6 questions on knowledge about suicide (SD=.88), and correctly answered an average of 8.43/9 questions on knowledge about what to say (SD=1.12), for a total of 13.74/15 (SD=1.60) correct answers (91.6% correct). Clients reported knowledge of suicide response plans (M=3.62, SD=.49), and rated their knowledge (M=3.71, SD=.39), skills (M=3.61, SD=.48), and comfort (M=3.54, SD=.58) to respond to suicide.

The change in the average overall from pre-test to post-test was an increase of 1.26 correct questions on knowledge about suicide and .56 correct questions on knowledge about what to say for a total increase of 1.83 correct answers. The change in knowledge of suicide response plans was an increase of .95 points. The change in perceptions of knowledge was an increase of 1.14 points, skills was an increase of 1.06 points, and comfort was an increase of .96 points.

Clients that completed both pre-test and post-test had an average increase of 1.26 correct questions on knowledge about suicide and .78 correct questions on knowledge about what to say for a total increase of 2.04 correct answers. Clients had an average increase of .85 points in their knowledge of suicide response plans, and average increases of 1.13 points in their knowledge, 1.02 points in their skills, and .97 points in their comfort in responding to suicide.

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

No

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

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

(Optional) Narrative Example(s):

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

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

Utilization Data Narrative –

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

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

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

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

categories significantly differfrom your actual numbers, you may give a narrative explanation for that discrepancy here.
Treatment Plan Clients (TPC):
Non-treatment Plan Clients (NTPC):
Community Service Events (CSE): We will report our services as CSEs. We generally participate in school class presentations, workshop presentations, public presentations, planning meetings, media interviews, and information distribution events (speaking, tabling). Our projected target for PY21 is 200 CSEs. The majority of these will be school class and workshop presentations of our intervention education program. Our completed CSEs were lower than expected. We were not able to conduct youth trainings virtually due to concerns about our ability to ensure they learn the skills and our ability to assess their emotional state over zoom. Youth can become upset by our training and we have a responsibility to ensure they are safe, which becomes difficult in an online environment. We also had many cancelled events and were unable to participate in events for information distribution. We did not have the opportunity to have any programming at schools because they were closed much of the year.
Service Contacts (SC):
For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

Performance Outcome Report Template

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

Agency name: Rosecrance
Program name: Criminal Justice (FY 21)
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)

The Criminal Justice program serves individuals with mental health or co-occurring mental health and substance use disorders that have involvement in the Champaign County criminal justice system. This includes adults who are presently or within the past six months have been charged with a crime, are on some type of community supervision (probation, parole, conditional discharge, or court supervision), have been found unfit to stand trial, or are on conditional release because they were found not guilty by reason of insanity. Individuals may engage in services from a number of entry points, including the Jail, Drug Court, or the community.

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

Jail staff completes an initial screening using the Brief Jail Mental Screening Tool (BJMHS) and the Texas University Drug Screening tool (TCUDS) for all intakes into the jail. Positive screenings from the BJHMS and/or TCUDS prompt referrals from the jail staff to this program. Rosecrance staff completes a more thorough secondary screening interview to determine the need for mental health and/or substance abuse services. Once a client determines they want to participant in treatment they are scheduled for a full mental health or substance abuse assessment.

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

The following list indicates the various methods by which individuals are identified and referred to the program:

a) Jail staff

b) The mental health staff in the jail
c) Self-referrals within the jail
d) Names gained through the Illinois Jail Data Link program
e) Prior clients of Rosecrance who are incarcerated at the Champaign County Jail
f) Individuals that are sentenced to Problem Solving Court
g) Individuals that are referred by local law enforcement, courts, probation or parole
h) Self-referrals from the community

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

We estimate that 50% of the people who are referred or seeking assistance will receive the initial screenings

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

- 33 % of jail clients engaged or received services
- 100 % of clients referred were screened

5. **a)** *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application): 15 days or less

b) *From your application*, estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application): 70%

c) *Actual* percentage of referred clients assessed for eligibility within that time frame: Unable to determine due to incomplete data due to staff turnover in the last two quarters

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): 70%

c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame: Unable to determine due to incomplete data caused by staff turnover in the last two quarters

7. **a)** *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application): 5 months

b) *Actual* average length of participant engagement in services: Unable to accurately determine due to staff turnover in the last two quarters

Demographic Information

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

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

Consumer Outcomes – *complete at end of year only*

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

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

   1. Increase clients' access to resources. The UIUC evaluation team will take a lead role in data analysis of linkage to resources and services

   2. Increase clients' self-sufficiency in at least one of the four life domains being measured; Access to services, Mental Health, Substance Abuse, and Primary Health.

   3. Data on the length of stay in the jail for people with MI/COD; by collecting the date of booking into the jail and the date of release for each client who engages in the program from the jail, length of stay data for the MI/COD population could be compared with that of the general population in the jail. A collaborative effort between the jail data collector, the University of Illinois evaluation team, and Rosecrance would be needed to obtain this data. This could be an area of focus for enhanced data reporting in FY21.

2. For each outcome, what specific survey or assessment tool did you use to collect information on this outcome? (Please remember that the tool used should be evidence-based or empirically validated.)

1. Case managers enter linkage data into a spreadsheet that the U of I Evaluation team helped design. This data will be pulled by a Rosecrance employee.

2. The Self-Sufficiency Matrix will be used to collect the data. The scores will be entered by program staff into a spreadsheet. A Rosecrance employee will provide the data.

3. Length of stay data will be obtained by program staff as they have access to the jail data. Staff will enter booking and release data into the excel spreadsheet for analysis by a Rosecrance Employee.

3. Who provided the information about participant outcome(s)?
(Participant, participant guardian, clinician/service provider, other program staff (if other program staff, who? Program staff entered data into a spreadsheet for the Self-Program staff entered data into a spreadsheet for the Self-Sufficiency Matrix and one staff outside of this program (in our Performance Improvement Department), pulled the data on engagement, assessment timeframes, and length of service.

Was outcome information gathered from every participant who received service, or only some? Due to COVID restrictions and increased staff turnover, we were not able to collect data from every participant

4. If only some participants, how did you choose who to collect outcome information from? Typically outcome data was only taken from treatment plan clients

5. How many total participants did your program have? 22 New Treatment Plan Clients and 52 New Non-Treatment Plan Clients

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

- 22

7. How many people did you *actually* collect outcome information from?
Due to COVID restrictions and increased staff turnover, we were not able to collect enough data from the self-sufficiency matrix that would show any significance in outcomes

8. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc). Some data will be collected at year-end and other data will be collected throughout the client's participation in the program. This data will be pulled by a Rosecrance employee. June 30, 2021 was the last day linkage data was collected for FY21.

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., recruitment, retention, treatment, intervention)

Through assistance from the U of I Evaluation Team, we were able to collect and analyze a whole other set of data that based on our logic model, provided valuable information regarding the case management services. Here is the summary of this information:

- At the time of this report, an analysis was not completed due to the lingering Covid-19 restrictions throughout the year in the jail and community-wide, as well as turnover and training new staff in the third and fourth quarter. There was very little data within the self-sufficiency matrix; however this is an area for continued growth. This area will likely improve in the coming quarter and year thanks to the UI Evaluation Team completing the new, more efficient and accurate tracking spreadsheets

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

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

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

(Optional) Narrative Example(s)

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

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

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

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

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

Treatment Plan Clients (TPC):
TPCs will represent all clients engaged in case management services.

Non-treatment Plan Clients (NTPC):
Non-treatment Plan Clients (NTPC) will represent everyone who receives screening and referral information but chooses not to engage in case management services.

Community Service Events (CSE): n/a

Service Contacts (SC):
One service provided at the jail is collecting request slips that are reviewed by a jail case manager. Requests slips are for the inmates to communicate to our case manager for referrals, assistance, messages, and questions regarding mental health and substance abuse services. Our case manager at the jail receives these request slips and will communicate to coordinate services within Rosecrance or outside entities, and linkages to community resources. Collectively 201 requests slips were made for FY21

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: Crisis, Access, & Benefits
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) Any individuals seeking and in need of behavioral health services are eligible for services.
2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)? Through direct referrals, first responder requests, phone referrals, and walk-ins, individuals will be screened and assessed by a clinician to determine current behavioral health needs and to provide linkage to appropriate services and needed levels of care.
3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.) The Crisis Line Coordinator and Director of Mental Health Services will provide information through local outreach events, brochures, cards, word of mouth, agency websites, and communications with our collaborations with other community agencies.
4. **a)** *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application): It is estimated that 100% of those seeking information, screening, or referral will receive those services.
b) *Actual* percentage of individuals who sought assistance or were referred who received services: Actual percentage of individuals seeking information, screening, or referral services who received this service was 100%.

5. **a)** *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application):
It is estimated that clients seeking services will be screened the same day they are referred, call, or walk-in.

b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application):
It is estimated that 100% of referred clients will be assessed for eligibility.

c) *Actual* percentage of referred clients assessed for eligibility within that time frame:
Actual percentage of clients assessed for eligibility same day they were referred, called, or walked-in was 100%.

6. **a)** *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application):
If it is determined the individual is in crisis, services are provided same day. For all other services, such as psychiatric, case management, counseling/therapy, capacity/waitlist will dictate the length of time from assessment to engagement.

b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application):
It is estimated that 100% of eligible clients experiencing a crisis situation will be engaged in services same day.

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

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

For Crisis, Crisis Line, or Access, average length of engagement is 1-3 days with most individuals being served same day.

b) *Actual* average length of participant engagement in services:
Actual average length of participant engagement in Crisis services is 1.29 days.
Actual average length of participant engagement in Crisis Line is not able to be tracked based on the electronic health record tracking.
Actual average length of participant engagement in Benefits Case Management is not able to be tracked as these clients are grouped in with all Community Support clients in the electronic health record.

Demographic Information

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

Demographic information, including residency zip code, race, ethnicity, gender, and date of birth, is tracked in the electronic health record for all Rosecrance services, and will be reported quarterly to CCMHB. Additionally, Rosecrance also collects income level, education level, living arrangement, and #of dependents, contact information, primary language, religion, veteran status, marital status, employment status, and legal status.

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

When clinically appropriate and client provides demographic information Rosecrance was able to collect income level, education level, living arrangement, # of dependents, contact information, primary language, religion, veteran status, marital status, employment status, and legal status.

Consumer Outcomes – *complete at end of year only*

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

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

1. It is estimated that 100% of those seeking information, screening, or referral will receive those services.
2. It is estimated that clients seeking services will be screened the same day they are referred, call, or walk-in.
3. It is estimated that 100% of referred clients will be assessed for eligibility.
4. If it is determined the individual is in crisis, services are provided same day. For all other services, such as psychiatric, case management, counseling/therapy, capacity will dictate the length of time from assessment to engagement.
5. It is estimated that 100% of eligible clients experiencing a crisis situation will be engaged in services same day. For internal referrals, the estimated percentage of eligible clients who will be engaged in services within that time frame is estimated to be less than 50%. This estimate comes from the knowledge that for those referred for full mental health assessments, typically only 50% follow

through. For all referrals outside the organization, this information is not available.
6. For Crisis, Crisis Line, or Access, the average length of engagement is 1-3 days with most individuals being served same day. The exception to this is Benefits Case Management engagement which could take several months for benefits determination and/or acquisition.

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.)

Outcomes 1 -6 are measured in our records. The goal is to stabilize and restore functioning, and minimize disruption within the family and community. In addition, these clinicians complete intake screenings for people who present during walk-in times and are available to consult with police regarding incidents in the community. Crisis clinicians use a proprietary crisis assessment, founded in best practices and developed based on the Suicide Assessment Five-Step Evaluation and Triage (SAFE-T). The SAFE-T assists clinicians in conducting suicide assessments, using a 5-step evaluation and triage plan to identify both risk factors and protective factors, suicide inquiries, determining risk levels and potential interventions, and documenting treatment plans.

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

Outcome:	Assessment Tool Used:	Information Source:
1. Determine level of care	Suicide Assessment Five-Step Evaluations and Triage (SAFE-T)	Client, Collaterals

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

Yes, For every client assessed in crisis, a disposition regarding level of care was determined in part based on the SAFE-T.

4. If only some participants, how did you choose who to collect outcome information from?
Not Applicable

5. How many total participants did your program have?
We assessed 853 clients in crisis.

6. How many people did you *attempt* to collect outcome information from?
100% of clients assessed clinicians attempted to collect outcome information.

7. How many people did you *actually* collect outcome information from?
Collected outcome information from 100% of clients assessed in crisis.

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

Results

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

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

Not Applicable

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

11. If yes, what is that benchmark/target and where does it come from?
Not Applicable

12. If yes, how did your outcome data compare to the comparative target or benchmark?
Not Applicable

(Optional) Narrative Example(s):

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

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

Utilization Data Narrative –

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

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

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

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

Treatment Plan Clients (TPC):
Not applicable

Non-treatment Plan Clients (NTPC):
Non-TPC's (NTPC's) will represent the number of Crisis assessments for adult and youth for those who are Champaign County residents and who are seeking Rosecrance services.

Community Service Events (CSE):
Community Service Events (CSE's) will continue to reflect the number of educational presentations, community events or requests for consultations attended by the Crisis Line liaison and/or Supervisor of Crisis/Crisis Residential.

Service Contacts (SC):

Service Contacts (SC's) will continue to represent the number of Crisis Line calls.
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: CU Fresh Start
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) The Eligibility criteria are that participants must be 18 Y/O or older; be currently on probation or parole; have a prior felony arrest; have a prior gun arrest or a violent crime conviction; law enforcement must have credible information of recent involvement in violent crime, and have **No** current unresolved case(s).
2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)? Law Enforcement, family members, community figures identify and submits the names of "impact players" who may not yet be convicted of a crime or "influential" who impact players respects, of individuals who meet the 6 criteria. A meeting called a "Custom Notification" is held between a small subset of representatives of Law enforcement, two (2) Community members, the CU Fresh Start Outreach Liaison and a representative from the City of Champaign. Custom Notifications are small individualized non-threatening approaches to the CU Fresh Start Program. If potential participants of the CU Fresh Start program agrees to "put their guns down" resources in the form of linkages with other Social Service Agencies (e.g., housing vocational trainings, intensive case management, support and advocacy) are available to those whose desire is to become contributing citizens of Champaign County.

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

The target population learns about the program through their probation/parole officer, family members, community members or they can self-refer. Parole/probation officers submit the names of potential CU Fresh Start participant to the Law Enforcement sub-Committee for approval. If approved for participation, potential participants are notified by their Parole/Probation Officer of a meeting date, time and location with the Custom Notification team. The Custom Notification Team is a subset of Law Enforcement, community members, Liaison of the CU Fresh Start Program and a representative of the city of Champaign. During the Custom Notification meeting, it is the Teams' effort s to send a message of "Victory over Violence" and of all the services that are available if they put their "guns" down for the opportunity to rid themselves of lifelong involvement with law enforcement and the brighter future that awaits them.

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

The estimated % of individuals referred who received services for FY21: 50%

b) *Actual* percentage of individuals who sought assistance or were referred who received services: 100% of participants who were referred received services this would include an "Information Packet" on community resources and services given at the Custom Notification to all attendees even those who eventually choose not to sign up for the program.

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

The estimated length of time from referral to assessment for FY21 is 14 days/2 weeks. This is based on FY20 results of 3- week average from the Custom Notification to ANSA administration. COVID-19 pandemic during the last 4 months of the FY20 impacted length of time.

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):

50% of referred clients who will be assessed within 2 weeks.

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

8 out of 8 participants were assessed for eligibility within 2 weeks. FY21 Actual: 100%

6. **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 time engaged in services is 9 months.

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

Actual average length of stay for FY21 is 11 months.

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

8 out of 8 participants engaged in services within 2 weeks. FY 21 Actual: 100%

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

The estimated average length of participant engagement in services for FY21 is 9 months. This estimate is based on FY20 results: Total for all engaged participants: participants= 5 months average. As long as offenders remain actively engaged in the program, are approved by the Law Enforcement Committee, and are working towards individual goals, they may continue to participate in the program. Therefore, the projected length of involvement in the program will vary by individual.

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

FY21 Target: 9 months

FY21 Actual: 11 months

FY21: 91 months/8 clients=11 months

Demographic Information

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

Other demographic information collected (from ANSA): Crisis/Safety Issues; Living Situation; Family Makeup; Basic Needs/Financial; Mental Health history; Alcohol or Other Drug Abuse; Social and Recreational; Education/Vocational; Legal; Medical/Dental; and Independent Living Skills. Other demographic information collected (from ANSA): Crisis/Safety Issues; Living Situation; Family Makeup; Basic Needs/Financial; Mental Health history; Alcohol or Other Drug Abuse; Social and Recreational; Education/Vocational; Legal; Medical/Dental; and Independent Living Skills.

2. Please report here on all of the extra demographic information your program collected.
   Data collected from the Adult Needs and Strengths Assessment (ANSA): Number of clients with identified needs un each area:
   2 Crisis/Safety Issues; 6 Living Situation; 3 Family Makeup; 4 Basic Needs/Financial; 2 Mental Health history; 4 Alcohol or Other Drug Abuse; 3 Social and Recreational; 5 Education/Vocational; 6 Legal; 3 Medical/Dental; and 0 Independent Living Skills.

Consumer Outcomes – *complete at end of year only*

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

1. From your application, what impact on consumers did you expect your program activities to have? That is, what outcome(s) did you want your program to have on the people it is serving? (Consumer Outcomes, question #1 in the Program Plan application). Please number each outcome.
   a) Estimated percentages for 3 target areas listed below with benchmark data reported for FY21: a) of those who agree to engage in the program will receive case management services from the Community Outreach Liaison. FY 21 Target: 100%; FY21 Actual: 100%; FY21 Target: 100%; FY21 Actual: 100%.
   b) % of the participants successfully linked to at lease one identified community service (especially substance use disorder and mental health treatment services), housing, employment, education, benefits enrollment, or vocational support and/or resources.

FY Target: 100%; FY21 Actual: 100%
FY Target: 100%; FY21 Actual: 100%

c) 100% of the participants successfully linked to at least one identified community service (especially substance use disorder and mental health treatment services), housing employment education, benefits, enrollment, or vocational support and/or resources. FY 21 Target: 100%; FY21 Actual: 100%. FY20 Target: 100%; FY20 Actual: 100%.

2. For each outcome please indicate the specific survey 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 of participants.	Measure of Victim Empowerment Related to Safety (MOVERS) survey	Participant
Decrease in Gun violence	Tracked and calculated by area police departments in Champaign County.	Mary Catherine Roberson, city of Champaign
Participants receive case management services	Adults Needs and Strengths Assessments (ANSA)	Community Outreach Liaison and Participants.
Participants are referred/linked to Community Service Resource	N/A/ (Tracked by Case Manager in Excel Spreadsheet (Documented in electronic health record as a Progress Note)	Community Outreach Liaison and participants (through participation in Monthly meetings of the Resource sub-Committee.

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

4. If only some participants, how did you choose who to collect outcome information from? Client Satisfaction Surveys were sent to all participants via mail. Despite efforts by the case manager only 3 were returned.

5. How many total participants did your program have?

There were 11 treatment plan clients carried over from FY 20 and 8 new treatment plan clients in FY21 for a total of 19 participants for FY21.

6. **How many people did you *attempt* to collect outcome information from?**
   10

7. How many people did you *actually* collect outcome information from?
   Three. Surveys were mailed out to participants but most weren't returned. Despite this, participants shared their opinions about the program one-on-one with the Community Liaison and in some cases with their assigned Champaign County Probation Officer.

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

   The Rosecrance Client Satisfaction Survey is administered twice a year. The Community Liaison collects informal feedback from clients throughout the fiscal year during face-to-face or telephone contacts with participants. Participants also provide feedback to the Mary Catherine Roberson, Community Relations Specialist with the City of Champaign's Office of Equity, Community & Human Rights who staffs clients with the Community Liaison weekly.

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 participants of different ethno-racial groups; comparing characteristics of all participants engaged versus participants retained)

Based on feedback from participants conversation with the Community Outreach Liaison and probation staff that indicated their discomfort with the Call-in format being "public" and feeling they were being subjected to "public shaming" the MDT conducted research into other methods of engagement in different cities and decided to implement a Custom Notification and Referral process. Based on participant feedback, the Call-in format was discontinued for FY21.

The substantial increase in gun violence in the community includes shots fired verified by gun shell casings/property damage due to gun violence; verified shootings resulting in injury; and verified shootings resulting in death. The Street Crimes Task Force, States Attorney Office, City officials and Community Services Organizations are actively working together to address the uptick in gun violence.

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

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).

An "At-risk offender" name is submitted and referred to the Law Enforcement Committee then passed on to a sub-set of the Law Enforcement to the Custom Notification Team. Participants are referred by law enforcement due to high profile case/re-entering community/suspected involvement in illegal community activity involving guns} or Referral {participant can be referred by family member, community service organization or a self-referral}. After initial referral CN /R process is the same as after a Call-in. Having the additional methods of entry into the program has improved program participation numbers compared to previous years. The Custom Notification Team is composed of five members (e.g., law enforcement, community members, CU Fresh Start Liaison and a representative from the city of Champaign). The participant is encouraged but not required to attend or participate in the Custom Notification meeting. It is after meeting with the Custom Notification Team and listening to the opportunities afforded by participating in the CU Fresh Start program. The participant sets an appointment date and time within two weeks to meet with the Community Outreach Liaison at Rosecrance for an Intake. The Community Outreach Liaison completes the Adults Needs and Strengths Assessment (ANSA) and a service plan with the client at intake. The assessment determines what areas of life the participant needs assistance in. Typical areas include: finding full-time employment, securing housing, obtaining medical coverage through the Affordable Care Act (ACA), and providing transportation for court and probation meetings. The Community Outreach Liaison has telephone and/or face-to-face contact with the participant several times per week to assist them in following through with referrals and service linkage. With the support of intensive case management services, the participant is able to make improvements in their daily living skills, employment, housing, education, and health with the goal of deterring them from activities that may result in gun violence. Participant may be in the program anywhere from 2 months to 15 months depending on their needs, motivation, and legal outcomes. Participants can be involved in the program as long as needed. The Custom Notification methods of entry into the program has improved program participation numbers compared to previous years.

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)

Call-ins have been discontinued based on public and participant feedback. All participants who join the program will either come through Custom Notification, referral or self-referral. Based on feedback from participants conversation with the Community Liaison and probation staff that indicated their discomfort with the Call-in format being "public" and feeling they were being subjected to "public shaming" the MDT conducted research into other methods of engagement in different cities and decided to implement a Custom Notification and Referral process.

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

Due to the evaluation used to support changes in practices, Custom Notifications were instituted in July 2019. Custom Notifications proved to be a more effective method to deal with those re-entering our community after being incarcerated.

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.

Treatment Plan Clients (TPC): TPC: Number of unduplicated persons identified by the Fresh Start Steering Committee who engage in the program and develop a strengths-based individualized services plan with the Community Liaison.
FY20 Estimated TPC: 35
FY20 Actual: 32
FY21 Target: 15
FY21 Actual: 8

Non-treatment Plan Clients (NTPC): Number of persons identified by the Fresh Start Steering Committee who choose not to engage in the program.
FY20 Estimated NTPC: 10
FY20 Actual: 24
FY21 Target: 10
FY21 Actual: 11

Community Service Events (CSE): Number of MDT (formerly Steering) Committee and other service coordination/planning meetings attended by Community Outreach Liaison, Supervisor, and/or Administrator. For example, Rosecrance RCI Administrator currently participates in the Specialty Court Steering Committee, Champaign County Re-entry Council, and Crisis Response Planning Committee. The collaboration which results from participation on all of these committees/councils results in more coordinated care for individuals served by Rosecrance RCI Killarney and other organizations.

FY20 Target: 120
FY20 Actual: 261
FY21 Target: 80
FY21 Actual: 161 (telehealth meetings due to COVID-19 substantially increased this outcome as well as increased program and community meetings due to increase in shots fired and community violence)

Service Contacts (SC): SC: Number of Screenings completed.
FY20 Target: 20
FY20 Actual: 19
FY21 Target: 10
FY21 Actual: 8

Other: Number of linkages (to transportation, employment, housing, education, healthcare, and behavioral health treatment) which the Case Manager helps develop while working with Fresh Start participants who engage in the program and develop a strengths-based individualized services plan with the Case Manager.
FY20 Target Other: 50
FY20 Actual: 71
FY21 Target: 30
FY21 Actual: 118 (COVID-19 related needs substantially increased this outcome as well as increased needs due to increase in shots fired and community violence)

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: Prevention Program
Submission date: 8/26/21

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)

Youth at schools throughout the county are eligible to participate. Afterschool sessions are based on the request of the school/youth-based organization making the request and may include sessions on life skills, substance abuse education, and violence prevention. Parents and communities in Champaign County interested in Prevention services or resources may also request special presentations.

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.)?

Prevention services are available to any student, parent, or community in Champaign County wishing to partner with the Rosecrance Prevention Department.

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

Outreach to schools, youth-serving organizations, parents, and communities are ongoing. Outreach activities include face-to-face interactions, correspondence, community events, and communication campaigns. Our Prevention Team continues to increase involvement in our community to help our program reach more students, parents, and community members.

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):

Unless there is a scheduling conflict, all persons seeking resources from our Prevention Department will receive prevention services. This is a collaborative effort in which the Prevention staff work directly with schools, youth-serving organizations, parents, and communities to provide the requested services. Every effort is made to find an available Prevention Team member to cover requests for presentations and other services.

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

100% of individuals seeking resources from the Prevention Department received prevention services.

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

The length of time from request for services to the services being performed is variable and dependent upon the type of request, as some services require more preparation than others.

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

Unless there is a scheduling conflict, all schools and community partners wishing to receive prevention services will receive the requested services as jointly planned.

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

100% of individuals seeking resources from the Prevention Department received prevention services.

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

The length of time from request for services to the services being performed is variable and dependent upon the type of request, as some services require more preparation than others.

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

Unless there is a scheduling conflict, all schools, youth and community partners wishing to receive prevention services will receive the requested services as jointly planned.

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

100% of individuals seeking resources from the Prevention Department received prevention services.

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

The 10-session Too Good for Drugs curriculum is presented weekly on a quarterly basis. The Too Good for Violence curriculum is a 7-session series also presented weekly during a quarter. After school programming is also coordinated on a quarterly basis. Community events and other presentations are generally a one-time engagement.

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

The participants in the 10-session Too Good for Drugs curriculum attended, on average, weekly on a quarterly basis. The participants Too Good for Violence curriculum attended the 7-session series also, on average, weekly during a quarter. After school program participants also, on average, attended weekly on a quarterly basis. Community events and other presentations are generally a one-time engagement.

Demographic Information

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

N/A

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

   N/A

Consumer Outcomes – *complete at end of year only*

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

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

   It is the intent of the Prevention services offered to youth, parents, and communities to improve Champaign County youth knowledge and attitudes about alcohol, drugs and/or violence.

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

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

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

Improve Champaign County youth knowledge and attitudes about alcohol, drugs and/or violence	**Too Good for Drugs and Too Good for Violence pre and post-tests**	**Youth (Students)**

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

All Too Good for Drugs participants were able to take the pre and post-tests evaluations either in person or online.

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

Data on the youth knowledge and attitudes about alcohol, drugs and/or violence is only compiled from eligible students at participating schools.

5. How many total participants did your program have?

3873

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

All students participating in Too Good for Drugs.

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

3873

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

Too Good For Drugs pre-test is given at the first day of the program at the beginning of each quarter, and the post-test is give on the last day of the program at the end of each quarter.

Results

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

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

From our pre/post test results we can see an average of about 11 % increase in knowledge from the beginning of the program to the end of the program for all grades. There is also a 9% increase in knowledge between 6th and 7th grade pre-test scores, and a 7% increase in knowledge from 7th grade to 8th grade pre-test scores. This shows that there is an initial improvement in knowledge during a single school year, and retained knowledge through the grade levels.

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

There is no national or state benchmark for the Too Good For Drugs/Too Good For Violence pre/post-test results. The intent of the program is to provide an improvement from pre-test to post-test. These improvements are tracked and measured.

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

N/A

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

N/A

(Optional) Narrative Example(s):

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

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

Utilization Data Narrative –

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

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

Here, you will report on the different types of service categories specified in your program plan application. Please remember that programs **do not** need to collect and report on every

category- instead, you are to report only the ones that are most useful for understanding program impact.
1. Please copy and paste the definitions of service categories your program specified in your program plan application in the sections below**. You will report the actual numbers of clients/contacts/community events for each reported service category in the Part II Utilization/Production data form (located on the online system).** If your estimated number of clients/contacts/community events for reported service categories significantly differfrom your actual numbers, you may give a narrative explanation for that discrepancy here.
Treatment Plan Clients (TPC):
Non-treatment Plan Clients (NTPC):
Community Service Events (CSE): **Community Service Events (CSE's) include the number of prevention presentations performed throughout the county. Presentations may be in such places as classrooms, afterschool programs, community-based organizations, and the like. Past year (FY21) projected total for Community Service Events (CSEs) was 975. The actual # of CSEs completed was 1218, which was 125% completion rate.**
Service Contacts (SC):
For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

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
Program name: RECOVERY HOME
Submission date: 8/22/2021

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)

A licensed recovery home is an alcohol and drug free housing component whose rules, peer-led groups, staff activities and other structured operations are directed toward maintenance of sobriety for persons who exhibit treatment resistance, relapse potential and/or lack of suitable recovery living environments or who recently have completed substance abuse treatment services or who may be receiving such treatment services at another licensed facility.

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

Persons interested in participating in Recovery Home services must complete an application for services. They must meet the American Society for Addiction Medicine (ASAM) criteria for Level II (intensive outpatient) or Level I (outpatient) care, and exhibit treatment resistance, relapse potential and/or lack of suitable recovery living environment.

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

Clients most often learn about our services from either treatment, completion of residential, court referral, Drug Court, AA and NA or other support group meetings

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

The estimated percentage of persons who seek Recovery Home services who receive the services will depend upon program eligibility and bed availability. It is estimated that 30% of those referred will receive a bed.

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

38%

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):

3 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):

Rosecrance coordinates access to Recovery Home services with the residential treatment provider, to offer a seamless transition at time of discharge from residential to admission to the Recovery Home. If a bed is available at time of referral, access to services will be within 1-2 days

b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application):
70%

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

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 stay will be 3 months.

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

Demographic Information

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

Demographic information, including residency zip code, race, ethnicity, gender, and date of birth, is tracked in the electronic health record for all Rosecrance services, and will be reported quarterly to CCMHB. Additionally, Rosecrance also collects income level, education level, living arrangement, # of dependents, contact information, primary language, religion, veteran status, marital status, employment status, and legal status.

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

Unable to run a report out of our EHR to report on all the information collected

Consumer Outcomes – *complete at end of year only*

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

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

One of the foundational principles of lasting recovery is a strong support network and longer engagement in treatment. Recovery home settings provide on-going learning to help decrease the likelihood of relapse and a chance for residents to practice living their new lifestyle in a supportive environment.

Measurable outcomes include:
1) Successful linkage to items in individualized plan: affordable housing, vocational/educational resources, medical, dental, psychiatric/counseling services; engagement in 12-step support groups;
2) Step down to less intensive services
3) Secured housing
4) Secured employment or engagement in education program

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

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

Outcome:	Assessment Tool Used:	Information Source:
E.g. 1. Increased empowerment in advocacy clients	Measure of Victim Empowerment Related to Safety (MOVERS) survey	Client
Successful linkage to items in individualized plan: affordable housing, vocational/educational resources, medical, dental, psychiatric/counseling services	EHR	EHR

Engagement in 12-step support groups	Client meeting sheet	Client
Step down to less intensive services	Counselor report	Counselor
Secured housing	Lease	Client
Secured employment or engagement in education program	Pay Stub	Client

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

Only some

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

Only persons who were Champaign County residents at time of admission to program

5. How many total participants did your program have?

20 Champaign County Residents

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

20

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

20

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

Throughout services

Results

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

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

We look at the change from admission to discharge, by reviewing their service plan with them, behaviors in the recovery home, engagement in 12 steps, and employment. The clients who are engaged in 12 step and employment have done better than those who have not.

Of note: COVID-19 hampered participation and engagement in support groups, as meeting virtually is not the same level of accountability and support as meeting in person for many clients. Staff continued to encourage client participation in virtual support group meetings until meetings took place in person. 12-Step Support engagement increased once meetings started to take place in person.

As the program continues to develop (this is 2nd full year of the program), there has been an increase in percentage of clients completing the program with employment/education, stepping down to a lower level of care/completing substance use disorders treatment, and support group engagement.

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

No

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

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

(Optional) Narrative Example(s):

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

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

Utilization Data Narrative –

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

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

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

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

Treatment Plan Clients (TPC): **20**

Non-treatment Plan Clients (NTPC): **0**

Community Service Events (CSE): **0**

Service Contacts (SC):**52**

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: Specialty Courts
Submission date: August 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)

Eligibility criteria includes the participant being a convicted felon, not classified as high risk dangerous, not be convicted of a non-probationable offense under 20 ILCS 301/40-5; not have a mental illness or developmental disability which would interfere with completing requirements to graduate from Drug Court; complete a Drug Court Assessment; be willing to engage in and comply with the treatment and supervision requirements of drug court; and be residents of Champaign County at time of assessment and time of offense.

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

Participants must be assessed as MEDIUM-HIGH RISK/HIGH NEEDS on a Validated Risk and Needs Assessment approved by the Champaign County Drug Court. Assessment must show the participant has a drug or alcohol addiction or dependency.

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

Potential participants are identified by defense counsel, state's attorney, law enforcement, family, and friends. Defendants can request to be assessed for drug court through their attorney/counsel.

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

receive services for FY21 is 62%. In 2019, 61 % of the individuals that requested an assessment for drug court were found eligible and accepted into the program. In 2020, 53% of the individuals that requested an assessment for drug court were found eligible and accepted into the program.

b) *Actual* percentage of individuals who sought assistance or were referred who received services: For FY 21 53% of those who applied to drug court were found eligible AND accepted to the program. 80% assessed were accepted into the program. 33% of all that applied in FY20 were deemed ineligible to be assessed.

5. **a)** *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application): Consumers who received assessment within three business days of sentencing to Drug Court.
FY21 Target: 100% FY21 Actual: 100% Due to Champaign County Drug Court changing program policy to require substance abuse assessments for referred clients be completed prior to sentencing to drug court, all admitted drug court clients are assessed. And meet this criteria.

b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application): Consumers who received assessment within three business days of sentencing to Drug Court.
FY21 Target: 100% FY21 Actual: 100% Due to Champaign County Drug Court changing program policy to require substance abuse assessments for referred clients be completed prior to sentencing to drug court all admitted drug court clients are assessed. And meet this criteria.

c) *Actual* percentage of referred clients assessed for eligibility within that time frame: This measurement is no longer valid due to changes in the drug court program. All individuals requesting drug court are now assessed prior to being considered. A substance abuse assessment is completed at the jail while the individual is still incarcerated and awaiting a court date. Once the individual is assessed then the drug court team will staff the applicant to determine eligibility. If accepted then the individual is scheduled for intake at residential or intensive outpatient services.

6. **a)** *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application): Clients who began treatment within three business days of assessment.
This measurement is no longer valid due to changes in the drug court program. All individuals requesting drug court are now assessed prior to being considered. A substance abuse assessment is completed at the jail while the individual is still incarcerated and awaiting a court date. Once the individual is assessed then the drug court team will staff the applicant to determine eligibility. If accepted then the individual is scheduled for intake at residential or intensive outpatient services.
(100% of clients engaging in outpatient services began treatment within three business days. 100% of clients who did not begin treatment within three business days were court-ordered to remain incarcerated until residential services were available.)

b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application): Clients who began treatment within three business days of assessment.
This measurement is no longer valid due to changes in the drug court program. All individuals requesting drug court are now assessed prior to being considered. A substance abuse assessment is completed at the jail while the individual is still incarcerated and awaiting a court date. Once the individual is assessed

then the drug court team will staff the applicant to determine eligibility. If accepted then the individual is scheduled for intake at residential or intensive outpatient services. (100% of clients engaging in outpatient services began treatment within three business days. 100% of clients who did not begin treatment within three business days were court-ordered to remain incarcerated until residential services were available.)

c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame: FY21 Actual: %100

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

Estimated average length of participant engagement in services is a minimum 1 year of sobriety, however most participants are in the program for 1.5 years.

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

Average length of participant engagement in services is a minimum 1 year of sobriety, however most participants are in the program for 1.5 years. This has not changed from previous fiscal year reports due to the drug court program being set up for participants to progress through phases towards graduation from the program.

Demographic Information

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

In addition to the required demographic information Rosecrance also collects income level, education level, living arrangement, the number of dependents, contact information, primary language, religion, veteran status, marital status, employment status, and legal status.

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

Additional client demographic is collected and entered into the electronic health record on each individual client, ability to aggregate data for total clients would take a considerable amount of time, however this information is available in the electronic health record and can be reviewed during the annual site visit conducted by CCMHB staff.

Consumer Outcomes – *complete at end of year only*

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

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

a) Drug court aims to eliminate substance abuse among the participants, decrease recidivism, help participants to achieve and maintain sobriety, and decrease the costs of crimes associated with substance abuse.
   - Of our graduates with 5 or more years post-graduation, 22 of the counted charges are for driving on revoked or suspended licenses. If you were to remove these Class A Traffic Misdemeanors we would have a 73% success rate over 5 years.

b) The Drug Court Coordinator tracks the recidivism rate of the drug court graduates. Recidivism refers to graduates who are convicted of a new charge (excluding minor traffic offenses or ordinance violations) or are returned to court on a revocation of probation. Client charts also are used to track progress in treatment, including admission and discharge data required for SAMHSA National Outcome Measures (NOMs).

   - There are 309 clients who have graduated more than 1 year ago. Of these 309 graduates 23 recidivated in the first year. There are 267 Graduates who have at least two years post-graduation who did not recidivate in year 1. Of these 267 eligible graduates, 33 recidivated in year two.

   - There are 216 graduates who have at least three years post-graduation and did not recidivate in years 1 or 2. Of these 216 graduates 20 recidivated in year 3.

   - There are 177 graduates who have at least 4 years post-graduation and did not recidivate in years 1-3. Of these 177 graduates, 17 recidivated in year 4.

   - There are 150 graduates who have at least 5 years post-graduation and did not recidivate in years 1-4. Of these 150 graduates, 12 recidivated in year 5.

   - Overall, 105 of the 309 graduates with at least 12 months post-graduation, have recidivated with equals a recidivism rate of 33.9%, or a success rate of 66%.

c) The Champaign County Drug Court Coordinator provides the data for the recidivism rate of the drug court graduates. Clinical staff enter admission and discharge data required for SAMHSA NOMs in the client chart at intake and at time of discharge. Positive changes in substance use, employment/education, and 12-step group involvement are anticipated for those who engage in the program.
   - 7% Recidivism rate in year 1 post-graduation.

- 12% Recidivism rate in year 2 post-graduation.
- 9% Recidivism rate in year 3 post-graduation.
- 9% Recidivism rate in year 4 post-graduation.
- 8% Recidivism rate in year 5 post-graduation.

d) The Champaign County Drug Court Coordinator provides the data the recidivism rate of the drug court graduates. Clinical staff enter admission and discharge data required for SAMHSA NOMs in the client chart at intake and at time of discharge. Positive changes in substance use, employment, education, and 12-step group involvement are anticipated for those who engage in the program.

5) Rosecrance benchmarks against previously reported data year by year for quality of services provided and NOMs outcomes.

6) a) No. of Graduates: FY21 Target: 20; FY21 Actual: 20; FY22 Target: 20; b) % of Graduates who do not experience recidivism: FY21 Target: 65%; FY21Actual: 66%; FY22 Target: 65%;
b) Individuals with potential barriers who received Case Management services. FY21 Target: 100%; FY21 Actual: 100%; FY22 Target: 100%

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

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

Outcome:	Assessment Tool Used:	Information Source:
See #9 below	Rosecrance Client Satisfaction Survey	Clients
6) a) No. of Graduates: 20	Not applicable	Rosecrance Staff /Champaign County Drug Court Staff Report
6) b) Individuals with potential barriers who received Case Management services: 100%	Not applicable	Progress Notes in electronic health record Avatar

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

Only some, the client satisfaction survey is provided to all clients twice a year, but it is completely voluntary with clients having the option to not participate.

4. If only some participants, how did you choose who to collect outcome information from? Clients chose whether or not to complete the survey.

5. How many total participants did your program have?

For fiscal year 2021, Rosecrance served 53 (40 continuing/13 new) unduplicated Drug Court consumers.

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

23

7. How many people did you *actually* collect outcome information from? 10

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

Results

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

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

Sample of some of the Client Satisfaction Survey questions/answers:

1) I am aware of my progress toward the goals of my treatment plan.
   a. Strongly Disagree 0 0%
   b. Disagree 0 0%
   c. Neutral 1 10%
   d. Agree 1 10%
   e. Strongly Agree 80%
   f. Total Responses: 10
2) I am satisfied with the services I receive from Rosecrance.
   a. Strongly Disagree 1 10%
   b. Disagree 0 0%

c. Neutral 0 0%
d. Agree 2 20%
e. Strongly Agree 7 70%
f. Total Responses: 10

3) I feel prepared to continue my recovery and wellness outside of Rosecrance.
   a. Strongly Disagree 0 0%
   b. Disagree 0 0%
   c. Neutral 0 0%
   d. Agree 1 10%
   e. Strongly Agree 8 80%
   f. Total Responses: 9 One respondent left this question blank
4) I am satisfied with the services I have received overall.
   a. Strongly Disagree 1 10%
   b. Disagree 0 0%
   c. Neutral 0 0%
   d. Agree 0 0%
   e. Strongly Agree 9 90%
   f. Total Responses: 10
5) I feel better as a result of my experience at Rosecrance.
   a. Strongly Disagree 1 10%
   b. Disagree 0 0%
   c. Neutral 0 0%
   d. Agree 2 20%
   e. Strongly Agree 7 70%
   f. Total Responses: 10
6) Treatment at Rosecrance helped me deal with my problem/addiction.
   a. Strongly Disagree 1 10%
   b. Disagree 0 0%
   c. Neutral 0 0%
   d. Agree 3 30%
   e. Strongly Agree 6 60%
   f. Total Responses: 10
7) Rosecrance provides high quality care and services.
   a. Strongly Disagree 1 10%
   b. Disagree 0 0%
   c. Neutral 0 0%
   d. Agree 2 20%
   e. Strongly Agree 7 70%
   f. Total Responses: 10

10. Is there some comparative target or benchmark level for program services? Y/N
Rosecrance benchmarks against previously reported data year by year for quality of services provided and NOMs outcomes, however this is the first full year as Rosecrance so there is no data to benchmark against/no comparison data.

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

N/A

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

N/A

(Optional) Narrative Example(s):

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

A typical drug court client is referred to Champaign county drug court by their defense attorney in hopes of deferring a jail/prison sentence in exchange for participation in the drug court treatment program. The client is assessed typically in jail while awaiting court, then the assessment is reviewed and if accepted the client is referred to drug court. The client is admitted into either residential or outpatient treatment services based on the results of the substance abuse assessment. The client will spend 28-30 days at residential and then be transferred to intensive outpatient treatment services and eventually stepped down to continuing care treatment services as they work through the drug court phases. The client typically is followed from admission to graduation by the same addiction counselor. The client will receive case management (transportation and referral services), individual and group sessions, as well as toxicology testing. Upon completion of all treatment program requirements and drug court phases the client will participate in a graduation ceremony. Also, the client is required to have a sponsor, participate in AA/NA support groups, have a job and return once a month to sit in on a treatment group for the first 6 months following graduation.

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

Utilization Data Narrative –

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

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

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

1. Please copy and paste the definitions of service categories your program specified in your program plan application in the sections below**. You will report the actual**

numbers of clients/contacts/community events for each reported service category in the Part II Utilization/Production data form (located on the online system). If your estimated number of clients/contacts/community events for reported service categories significantly differ from your actual numbers, you may give a narrative explanation for that discrepancy here.

In addition to consumers' court ordered to remain incarcerated, there were also changes to the drug court referral procedure on the court side. Potential participants are now assessed prior to being considered for drug court, therefore most referral to assessment and assessment to treatment times are longer than 3 days due to those two factors. Clients whose assessments recommend residential treatment are court ordered to remain in jail until a residential bed opens up or to complete jail time prior to entering residential, thus impacting treatment start dates.

Actual number of new drug court participants was impacted by a reduced number of referrals due to the Champaign County Courthouse temporarily ceasing court hearings and other COVID-19 mitigation efforts during the past fiscal year.

There was also staff turnover at RCI in FY21: Addictions Counselor Jason Abrams resigned effective 10/23/20. He was eventually replaced by Jeremy Bell (start date 12/7/2020); Outreach Worker Mark Dotson resigned 8/21/20. He was replaced by Ivy Evans-Tetter on 8/28/20.

Treatment Plan Clients (TPC):
Number of Drug Court clients with a strengths-based, individualized Treatment Plan.
FY20 Target: 90 (50 Continuing, 40 New)
FY20 Actual: 51 (27 Continuing, 24 New)
FY21 Target: 60 (30 Continuing, 30 New)
FY21 Actual: 53 (40 Continuing, 13 New)
FY22 Target: 50 (25 Continuing, 25 New)

Non-treatment Plan Clients (NTPC): Not applicable for this program

Community Service Events (CSE): M = Number of times media reports on Champaign County Drug Court
G = Number of Drug Court Graduation Events
FY20 Target: 5 total (3 M,2 G)
FY20 Actual: 3 total (2 M, 1 G) These numbers were impacted by the COVID-19 pandemic (no graduations held).
FY21 Target: 4 total (2 M, 2 G)
FY21 Actual: 4 total (2 M, 2 G)
FY22 Target: 4 total (2 M, 2 G)

Service Contacts (SC):
Number of weekly Drug Court reports completed and submitted to Champaign County Drug Court. FY 17 criteria were different therefore not included in this application.
FY20 Target: 1500
FY20 Actual: 1467
FY21 Target: 1500
FY21 Actual: 1037 These numbers impacted by lower number of participants due to FY21 COVID-19 court closure.
FY22 Target: 1400

OTHER (CM.SH)
CM = Number of Hours of Case Management provided for Drug Court clients by RCI outpatient treatment staff
SH = Number of Service Hours for individual and/or group treatment services provided to Drug Court clients by RCI outpatient treatment staff.
FY 21 Target: 6000
FY21 Actual: 4368
FY22 Target: 5,000

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: Uniting Pride of Champaign County
Program name: Uniting Pride FY21
Submission date:

Consumer Access – *complete at end of year only*
Eligibility for service/program
1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application) **The program is available to all LGBTQ+ youth, families, and caregivers living in Champaign County. There are no fees associated and Uniting Pride does not seek to bill any insurance payment providers.**
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.)? **During intake, participants provide demographic information and confirm that they are part of the LGBTQ+ community and families in Champaign County.**
3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.) **Participants report hearing about our Youth Programming from a variety of sources including the Uniting Pride website, Facebook, instagram, service professions (e.g. counselor) and community programming (e.g. annual Pride Festival and Parade). Uniting Pride staff visit and/or maintain contact with high school and middle school GSAs in Champaign County and partner with religious education groups, after-school programs, and youth service providers to provide education and promote our programming. Flyers are also posted in public gathering places around the 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):

100%

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

90%
No one who is eligible is turned away. Most services provided in this program are opt in. Once a person receives the needed information, it is their choice to receive services or participate in program opportunities.

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):

6 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:

90%
The time frame is based on the schedule of the individual/family's schedule and their interaction with Uniting Pride staff.

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):

0 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:

Once a person receives the needed information about service, they are able to participate in program activities immediately. Services in this program are opt-in, so people have the opportunity to participate right away.

Due to the structure of this program, there's limited data available for this question. People are continually given opportunities to engage in programs through targeted communication.

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

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

Due to the structure of this program, there's limited data available for this question. People tend to participate in our various support programs as they are going through difficult transitions, and individual participation in support programs ebbs and flows.

Demographic Information

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

No other demographic information

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

Consumer Outcomes – *complete at end of year only*

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

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

1. Youth Empowerment: Increased belongingness, Increased self-efficacy, Increased self-worth, Increased social support
2. Improved interpersonal communication skills
3. Access for youth to affirming and knowledgeable resources: caregivers, educators, spiritual leaders, medical professionals
4. Increased knowledge and practical skills for professionals in supporting LGBTQ+ youth
5. Increased caregiver support

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. Youth Empowerment: Increased belongingness, Increased self-efficacy, Increased self-worth, Increased social support	Uniting Pride Youth Survey	Participants
2. Improved interpersonal communication skills	Uniting Pride Youth Survey	Participants
3. Access for youth to affirming and knowledgeable resources: caregivers, educators, spiritual leaders, medical professionals	Uniting Pride Youth Survey	Participants

4. Increased knowledge and practical skills for professionals in supporting LGBTQ+ youth and families	Uniting Pride training workshop practical skills	Observation
5. Increased caregiver support	Uniting Pride UParent and PlayGroup survey	Participants

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?

Participants were asked to respond to the survey but may have chosen not to.

5. How many total participants did your program have?

72

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

72, 100%

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

28, 39%

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

1x per year at the end of Q4

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)

Youth (Talk it UP and Queries) Survey Responses

We received 11 responses to the survey for youth participants in Uniting Pride programs. *Awareness of and intent to use resources:* Of those who responded, 73% (n=8) confirmed that they were planning to use additional LGBTQ-related resources when they age out of the youth programs.

Affirming adults: 100% (n=11) were able to identify at least one affirming or supportive adult in their lives, either in their immediate family (n=9), extended family (n=6), or school (n=9).

Connectedness: 73% (n=8) indicated they felt very attached to the local LGBT community and 91% (n=10) said they identified strongly with the local LGBT community.

Social support: All participants confirmed that if they were stressed about questioning their gender identity, they had a friend or peer who they could reach out to directly to talk about it. 91% (n=10) said they had a friend they could talk about if they were stressed due to issues at home related to their gender or sexuality, and the same proportion indicated this was true about issues at school related to gender or sexuality. 73% (n=8) indicated they had made a new friend because of their involvement in Uniting Pride youth programs.

Self-esteem: We measured self-esteem using the Rosenberg Self-Esteem Scale consisting of 10 survey items which are summed to make a composite measure of self-esteem. Scores can range from 0 to 30 with scores under 15 indicating low self-esteem. Of the 11 youth participants who completed the survey, 64% (n=7) had scores indicating low self-esteem. Because the survey was administered once at the end of the year, it is unclear whether this is a change from the start of the youth participants' involvement with Uniting Pride.

Comments from youth participants include:

"[H]aving the option to be there and have support means the absolute universe to me. I'm glad

I was introduced to this place and found more people like me who are likeminded and accepting and supportive.”

"I enjoy the community and people because they were my family when I had nobody."

Caregiver (UParent and Play Group) Survey Responses

We received a total of 17 responses to surveys for adult caregivers/family members of LGBTQ+ children/youth.

Connectedness and Support: 82% (n=14) indicated that attending a caregiver group helped them to connect with other LGBT caregivers/parents, and 65% (n=11) indicated that attending a caregiver group allowed them to feel more connected to the local LGBTQ community. Additionally, 83% (n=10, 5 did not answer) of clients indicated that group was a safe and affirming space for their children (if applicable).

Knowledge/Awareness: 76% (n=13) indicated that attending a group increased their awareness of LGBTQ+ topics, and 71% (n=5) of UParent respondents indicated that the group allowed them to become a better ally/supporter to their child.

One participant commented: "We have really appreciated and enjoyed the Saturdays on Zoom and are really looking forward to checking out an in-person playgroup!" Another participant commented: "It's been really useful to talk with other parents of trans kids."

Uniting Pride Training Practical Skills

Uniting Pride training workshops for professionals offer 4 practical skills for immediate use to support LGBTQ+ youth and families. We are expanding our evaluation efforts to document the impact of these workshops.

Pronoun competence: Our training workshops allow for LGBTQ+ youth and caregiver serving professionals to develop skills using pronouns and neopronouns.

LGBTQ+ Terminology: Our training workshops cover basic LGBTQ+ terminology and allow for LGBTQ+ youth and caregiver serving professionals to develop general knowledge of terms and definitions.

Resource Utilization: Our training workshops include an overview of local resources for LGBTQ+ youth and caregivers, and the ways in which professionals can help their clients access these services.

Gender Competence: Our training workshops allow for LGBTQ+ youth and caregiver serving professionals to develop skills working with gender diverse and trans clients.

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

No

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

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)

People who participate in Uniting Pride programming have full freedom to opt in to the support groups, programs, and opportunities we provide. As written above, our goals are to help the LGBTQ+ community in Champaign County have access to affirming and knowledgeable resources, and have increased support and feelings of empowerment.
We have seen people who choose to be involved and connect with resources build meaningful connections and a close community. Below are two examples. One is an example of services, supports, and potential outcomes for someone who is highly involved inour programming, and the other is someone with more limited involvement.

<u>Highly Involved Participant</u>
Teenager A recently disclosed to their parents and teacher at school that they are queer. Teenager A's teacher connected them with the school GSA, who's sponsor communicates regularly with Uniting Pride staff. The GSA referred Teenager A to the Uniting Pride staff, who in turn connected Teenager A with Uniting Pride's Talk It UP facilitator. After talking with the group facilitator, Teenager A begins to attend Talk It UP and connects with LGBTQ+ teens from all over Champaign County. As Teenager A's self-esteem and empowerment grows, they attend Uniting Pride's Queer Prom, workshops, and the annual Pride Festival and Parade. Teenager A's parents are not sure how to be supportive of their queer child. Sothey ask to be referred to Uniting Pride's UParent group. At UParent, they connect with other parents who are learning how to best support their LGBTQ+ children at school, at home, and in the community. Because Teenager A and their parents are plugged into UnitingPride, they learn about which healthcare professionals in Champaign County provide inclusive care, as well as community and state action that affects them.

<u>Limited Involved Participant</u>
Teenager B hasn't disclosed to their family or friends at school that they are questioning their gender identity. They came across Uniting Pride's Facebook page and sent a private

message asking what kind of help was available for them. Uniting Pride staff responded with an offer to answer any questions, and provided information about the Talk It UP program. Teenager B talked to the group facilitator a few times and after a couple months, decided to attend the group. Teenager B has come once a month to group for the past 9 months, and engages with the other teens at group. They aren't ready to disclose anything to anyone outside of the group but feel like they have a safe place to ask questions and be themselves each month.

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.

<u>Treatment Plan Clients (TPC): 0</u>

Treatment Plan Clients (TPC) will be reported as LGBTQ+ adolescents and families in need of case management services. TPCs will provide demographic information as well as a survey asking about their present needs to develop a treatment plan. Case management includes

one-to-one meetings between the Program Coordinator and the participant to create a plan for managing distress and connecting the adolescent to appropriate community resources. New TPCs are any individual starting case management services for the first time in FY21. Returning TPCs are individuals continuing case management services from FY20 to FY21.

This program did not have any treatment plan clients in FY21. The program does not plan to have treatment plan clients in the future.

Non-treatment Plan Clients (NTPC):

Non-Treatment Plan Clients (NTPC) will be reported as LGBTQ children adolescents and families attending a support group. NTPCs will be asked to complete a form asking for the same demographic information as TPCs, as well as performance metrics. New NTPCs include individuals attending the youth and families support groups for the first time in FY21. Returning NTPCs include individuals who attended the youth or family support group in FY20 and returned for FY21.

Goal: 65

Uniting Pride had 72 unique LGBTQ+ children, adolescents, and family members attend our support groups in FY21.

Community Service Events (CSE):

Community Service Events (CSEs) will be reported as events held in the community with the goal of increasing sensitivity and tolerance toward LGBTQ individuals. They will also include school, church, and GSA visits with the intention of both assessing community needs for LGBTQ+ education and services, and promoting support group programs. CSEs can include the annual Pride Festival, Queer Prom, education events, fundraising events, social gatheringsand more.

Goal: 50

Uniting Pride participated in 72 community service events in FY21. Some examples of those community service events include: My Black Mental Health Matters series, Trans Musician Showcase, speaking with GSAs, Trans Day of Visibility, Drag Queen Story Hour, Queer Clothing Swap, and many workshops and trainings for various community organizations.

Service Contacts (SC):

Service Contacts will be reported as those individuals who contact Uniting Pride by email or social media inquiring about youth or family services, or seeking referrals. Service Contacts will be tracked in a spreadsheet and recorded only by their reason for contacting Uniting Pride.

Goal: 80

Uniting Pride recorded 319 service contacts in FY21.

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: Urbana Neighborhood Connections Center
Program name: Community Study Center
Submission date: 10/29/2021

Consumer Access – *complete at end of year only*
Eligibility for service/program
8. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application) T**he eligibility criteria for participation in UNCC's Afterschool Study Center include:** **1, Be a resident of Champaign County (specific outreach to Urbana residents),** **2. Be enrolled in local school districts (K12);** **3, Be willing to participate in a continuum of structured and supervised out of school time academic, social emotional and recreational activities.**
9. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)? Whether or not a person meets enrollment criteria for UNCC's Afterschool Study Center is determined by: 1. Review of the 3-4 page registration document and 2. Face to face meeting with parent(if child is in elementary) and child/youth
10. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.) Members of the targeted population learn about UNCC's Community Study Center via the following avenues: School personnel, family to family, informational fliers.

11. a) *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application):
98%

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

100%

12. a) *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application):
1

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%**

13. a) *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application): 2

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%

14. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application):
One year with up to 8 years in consecutive services. Many return for college and career program in junior and senior year of high school.

b) *Actual* average length of participant engagement in services:
1-8 years

Demographic Information

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

4. Please report here on all of the extra demographic information your program collected.
Parents completed free and/or reduced lunch eligibility and SNAP eligibility for each youth enrolled during the registration process. These status along with others are verified through collaboration with the local school district and maintained on file.

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

3. *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.

Urbana Neighborhood Connections Center's 2019-2020 desired program measurement outcomes for the Community Study Center Program are:

1. Engage targeted youth in structured out of school time educational, social emotional development and recreational activities.
2. Reduced and/or minimal criminal activities by engaged youth
3. Expose targeted high school students to various college and career related activities
4. Implementation and accomplishment of 2 of the Cultural Competency Plan goals and objectives.

Expected Results
1. Maintain and/or increase the number of hours spent investing in academic and social-emotional skill development.
2. Exposure to new and/or increased amount of involvement in physical fitness and cultural arts activities
designed to promote acceptable behaviors, attitudes and confidence needed to maintain positive and healthy lifestyles at home, school and on community.
3. Exposure to juvenile delinquent indicators and prevention services to reduce and/or minimal criminal activities by engaged youth
4. Increased knowledge, awareness and skill performance related to Cultural Competency planning and implementation.

In addition to outcomes related to the overall operation of the Community Study Center, special efforts will continue to be made to incorporate essentials of Illinois State Social Emotional Learning Standards that (1) develop self-awareness and self management skills necessary to achieve school and life success; (2) use self-awareness and interpersonal skills to establish and maintain positive relationships; and (3) demonstrate decision-making skills and responsible behaviors in personal, school, and community context. By incorporating these Social and Emotional Learning (SEL) skills during non-school hours, youth will be able to recognize and model healthy social emotional and academic functioning in multiple environments.

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

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

Outcome:	Assessment Tool Used:	Information Source:
E.g. 1. Increased empowerment in advocacy clients	Measure of Victim Empowerment Related to Safety (MOVERS) survey	Client
1. Engage targeted youth in structured out of school time educational, social emotional development and recreational activities.	**Daily Attendance and Activity Participation Records**	UNCC Administrator
2. Reduced and/or minimal criminal activities by engaged youth	**Consultation with parents and school personnel.**	Youth, parent/family, school
3. Expose targeted high school students to various college and career related activities	Participation/attendance records	Program coordinator
4. Implementation and accomplishment of 2 of the Cultural Competency Plan goals and objectives.	Record of completion	UNCC Admministrator

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

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

7. How many total participants did your program have? 125

8. How many people did you *attempt* to collect outcome information from? 125

9. How many people did you *actually* collect outcome information from? 125

10. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc) 1X per year- At the time of enrollment.

Results

11. 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)

As in years past and during difficult cirumstances such as those presented by COVID-19, the most critical learning point during this reporting period is that by providing as out of school time supplemental academic, social and emotional, and physical development activities consistently is very beneficial to children and youth. Progress in the previous mentioned developmental areas looks different for each youth and should be measured from stances. Parent/family support along with collaboration with school personnel are necessary components in engaging children and youth in out of the home activities.

12. Is there some comparative target or benchmark level for program services? Y/N No
13. If yes, what is that benchmark/target and where does it come from?
14. If yes, how did your outcome data compare to the comparative target or benchmark?
(Optional) Narrative Example(s):
15. 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)
16. 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.

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

Treatment Plan Clients (TPC):

0

Non-treatment Plan Clients (NTPC):

UNCC Community Study Center program offers community based academic support, tutoring, Reading/literacy/Math instruction, social/emotional development, prevention, intervention, and career opportunities for Non Treatment Plan Clients (NTPC).

UNCC will be counting multiple programs and/or activities within one category called the Community Study Center (CSC).

UNCC will only be reporting the number of Unduplicated NTPC's receiving multiple programs within the Community Study Center

125 unduplicated youth served

Community Service Events (CSE):

0
Service Contacts (SC): 0
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).