Compiled Annual Performance Outcome Reports CCMHB Funded Programs, Contract Year 2020

(Updated January 5, 2021)

Compiled Annual Performance Outcome Reports (PORs)
CCMHB Funded Programs, Contract Year 2020
Table of Contents

Champaign Co. Children's Advocacy Center
Children's Advocacy Center Program
Performance Outcome Report PY20

Agency name: Champaign County Children's Advocacy Center
Program name: Champaign County Children's Advocacy Center
Submission date: 8/17/20

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 July 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.**
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 175 (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:

257 children (100%) who were referred for services received services. Of the 257 children 204 were opened as treatment plan clients and 53 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):

98%

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

100%

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

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):

95%

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

98% - Due to the COVID-19 pandemic there were 6 children from March/April who were determined to be non-emergency cases (MDT determined non-emergency cases to be children who were not in immediate danger AND the alleged perpetrator no longer had access) and were put on hold for 45 days until they engaged in services.

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:

5 months

Demographic Information

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

none

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

None collected specific to Champaign County for FY20

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.**
2. **Child attends counseling session based on trauma screening in order to initiate/facilitate the healing process.**
3. **Information gathered in a legally sounds manner.**
4. **Increased provision of medical exams when necessary.**
5. **Caregivers know why they were at the CAC.**

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

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

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

Outcome:	Assessment Tool Used:	Information Source:
1. Increased empowerment in advocacy clients	Measure of Victim Empowerment Related to Safety (MOVERS) survey	Client: 78.1% of clients strongly agreed that they felt safe while at the CAC. 15.6% of clients somewhat agreed that they felt. 6.3% of clients reported they didn't know if they felt safe while at the CAC.
2. Child attends counseling session based on screening results.	Attendance forms from counselors	64% of clients (65/101) who's screening indicated the need for a referral to a counselor engaged in counseling services.
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 FY19, 19% of victims received a medical exam (48/255). During FY20, 16% of victims received a medical exam (49/300).

		This goal was not met, there was not an increase in the number of clients who received a medical exam.
5. Caregivers know why they are at the CAC	OMS initial caregiver survey	97.1% of caregivers strongly agree they understood the reason for their visit to the CAC. 2.9% of caregivers somewhat agree.
Increased report of that the child's/parent's needs were met during the initial visit to the CAC	OMS initial caregiver survey	Non-offending caregiver: 91% Strongly agreed and 8.8% somewhat agreed that their needs were met while at the CAC.
Increase in the number of parents who were satisfied with the services received from the CAC	OMS initial caregiver survey	Non-offending caregiver: 94.1% of caregivers strongly agreed that they were satisfied with the services they received from the CAC. 5.9% somewhat agreed that they were satisfied.

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?

257 Champaign County participants

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

257 (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?

53 (21%)

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 given a copy of the initial visit caregiver survey. Caregivers were asked to place the survey in the survey box after completing the form before they exit the facility.

Results

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 FY19 and FY20 parent survey results:

	FY19-CAC	**FY20 CAC**	**Statewide results**
My child felt safe at the center	**97.4%**	**93.7%**	**95.2%**
The Center Staff made sure I understood the reason for our visit.	**100%**	**100%**	**94.9%**
My questions were answered to my satisfaction.	**98.8%**	**100%**	**91.8%**
The staff members at the CAC were friendly and pleasant	**100%**	**100%**	**97.3%**

The center staff provided me with resources to support my child in the days and weeks ahead	**100%**	**100%**	**91%**
I was given information about the services and programs provided by the Center	**98.7%**	**96.9%**	**94.5%**

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.

(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 forensic interview for a 13-year-old girl and her two brothers. The girl disclosed at school that her uncle, also her guardian, had been sexually abusing her over the course of 3 years. It was determined that the children could not return home to their uncle until the multidisciplinary team had determined if the children were safe. The DCFS investigator brought the children to the CAC and the young girl arrived at the CAC very nervous and very scared. After giving the children a tour and getting them settled in the waiting room, I asked the girl if she wanted to talk to me in private. She shared that she was terrified that her older brother was mad at her and blaming her for having to come to the CAC. I asked if she had talked to her brother or why she had these feelings. She said she hadn't talked to him but that he was glaring at her on the ride to the CAC and making faces at her in a way that made her feel anxious. I decided to sit with her in a separate room from her brothers until the start of her forensic interview and after the completion of her forensic interview to attempt to reassure her she was safe. I learned that she has carried a lot of stress and ownership in the abuse that she had endured from her Uncle and that she put up with it for years in an attempt to keep her brothers in her in an environment that was better than what they grew up in. She was able to calm down and even laugh a little when talking about things she liked to do and her friends. Even though there were many other work duties that needed my attention, nothing was more important that easing the mind of a scared girl while she was at the CAC. It was determined that the children would not be allowed to return to the Uncle's house and the sense of relief on the young girl's face was very rewarding.

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 all of the services available to them to either directly from the CAC or through referral.

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.

- There were no presentations completed in April due to the COVID-19 pandemic. However, the CAC joined with CASA and Crisis Nursery to display a Child Abuse Prevention billboard in April.

Service Contacts (SC):

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

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

Champaign Co. Christian Health Center
Mental Health Services at CCCHC Program
Performance Outcome Report PY20

Agency name: Champaign County Christian Health Center
Program name: Champaign County Christian Health Center
Submission date: 9/24/20

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) *CCCHC provides quality healthcare services for the uninsured and the underinsured.*
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 person calling for an appointment or walking in that are either self-reported uninsured or underinsured is eligible. Recently, a form was created with questions asked whether the patient was uninsured or underinsured.*
3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.) *Potential patients for CCCHC are reached through various outreach events (i.e. Healthcare Education events, healthcare fairs and workshops), referrals from other health care facilities (i.e. Carle Hospital, Christie Clinic, McKinley, OSF Hospital), word of mouth, flyers and online media (i.e. Facebook).*

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):

Anyone seen at the clinic will be assessed. 100%

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

This number is extremely difficult to assess as we take appointment calls at set times during the week and walk-ins until the available spots are taken. We do not have a waiting list. The number of people seeking assistance compared to those receiving assistance is difficult to garner. In statistics, specifically with probabilities, when you lack any further information to make a guess, the default is .5 or 50%.

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):

Varies based on when a person contacts the clinic for an appointment (Est 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):

A person is assessed the day they come to the clinic. Although follow up appointments may be necessary, services are provided that day. 2 days

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

Anyone seen at the clinic will be assessed. 100%

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

A person is assessed the day they come to the clinic. Although follow up appointments may be necessary, services are provided that day. 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):

They will be receiving care at the clinic the day they come. 100%

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

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

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

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

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

Varies greatly as some patients come in one time only while others may be a patient for 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)

In addition to demographics, we collect information from patients who may need mental health or nutritional counseling or have spiritual needs.

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

As mentioned above, we collect information from patients who may need mental health or nutritional counseling or have spiritual needs.

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*
3) *Increase in the number of dental patients served based on the needs of patient*

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) *Patient satisfaction surveys*
2) *Volunteer Database*

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? All

5. How many total participants did your program have?

150

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

All

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

We are currently developing a system to collect information during COVID-19.

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

Weekly or upon appointment completion

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 goal level of change involves the recruitment of mental health care practitioners which, consequently, increases the number of patients seen needing mental health care. We would like to recruit one psychiatrist, and a few more social workers who specializes in mental health. Additional funding will help us to expand care to 2 additional nights a month, seeing approximately 140 patients over the course of the year.

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

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

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

(Optional) Narrative Example(s):

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

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

Utilization Data Narrative –

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

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

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

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

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).

Champaign Co. Regional Planning Commission – Community Services
Homeless Service System Coordination Program
Performance Outcome Report PY20

Agency name: Champaign County Regional Planning Commission
Program name: Homeless Services System Coordination
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) **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 various agencies in the community to grow the CSPH's membership.

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 at all monthly CSPH meetings, facilitated trainings during the year, communicates with the CSPH membership and affiliates regularly through the CSPH e-mail list, and conducted one-on-one outreach with most CSPH members and affiliates throughout the year.

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):

Each member of the IL-503 Continuum will participate in at least 5 of 11 meetings each 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):
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 2019-June2020. Out of 30 MOU-members from July 2019 – June 2020, 66% of agencies attended 5 or more CSPH meetings.

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: 12
Private/Not for Profit Entity: 17
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**: IL-503 CSPH members will understand the mission of IL-503 CSPH and their role as a member.
   Specific Outcome Goals: 100 percent of members will be given the opportunity to complete an orientation. 80 percent of members who have completed an in-person orientation will endorse understanding the mission of IL-503 CSPH and their role.
   Description: An orientation presentation will be developed and used to orient all existing representative of member organizations and also future/ new members. In person orientations will be offered by the program coordinator and the orientation presentation will also be available via a website link.
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 program 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 regularly hosts webinars and regional calls addressing new policies, outcome data, new homeless initiatives, etc. The Supportive Housing Providers Association hosts a monthly call for homeless providers across the state. Annually, there is a HUD Peer to Peer conference. There are a variety of webinar trainings provided throughout the year. The program coordinator will attend teleconferences, webinars, and trainings addressing CSPH business and work, and during monthly IL-503 CSPH meetings, debrief the members regarding the knowledge gained and necessary action items.
3. **Outcome #3**: Members of the IL-503 CSPH will have opportunities for training that will support an improved and responsive homeless services system.
   Specific Outcome Goals: 100 percent of members will be given training opportunities each quarter.
   Description: The program coordinator will coordinate trainings to enhance the work of CSPH membership organizations and to meet CSPH mandates and other relevant trainings.

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 an Orientation in October 2019. A post-orientation survey was completed via SurveyMonkey to evaluate the Orientation, surveyee' s understanding of CSPH Mission, and areas of improvement for the survey.
Outcome #2 – The Coordinator periodically reports to the Executive the total number of webinars or calls attended in aggregate. The program coordinator attended HUD and other entity webinars and debriefed with appropriate community stakeholders, including sharing information with the CSPH Executive Committee & Full Board where appropriate.
Outcome #3 – Trainings conducted were discussed during full CSPH meetings and further specific details were shared during the CSPH Executive Committee.

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

Outcome:	Assessment Tool Used:	Information Source:
Outcome #1: IL-503 CSPH members will understand the mission of IL-503 CSPH and their role as a member.	**Outcome #1 – The HSSC Coordinator facilitated an orientation in October 2019. A post-orientation survey was completed via SurveyMonkey to evaluate the orientation, surveyee' s understanding of CSPH Mission, and areas of improvement for the survey.**	CSPH member who attended orientation (10/19 CSPH Mtg)
Outcome #2: The CSPH membership will be well informed of the local and national data and resources related to homelessness.	**Outcome #2 – The Coordinator periodically reports to the CSPH Executive Committee the total number of webinars**	Program Coordinator

	or calls attended in aggregate.	
Outcome #3: Members of the IL-503 CSPH will have opportunities for training that will support an improved and responsive homeless services system.	**Outcome #3 – Trainings conducted were discussed during full CSPH meetings and further specific details were shared during the CSPH Executive Committee.**	CSPH meeting minutes (Recorder: Tina Withers), CSPH Executive Committee meeting minutes (Recorder: Thomas Bates, Program Coordinator)

3. Was outcome information gathered from every participant who received service, or only some?
Surveys were offered to every person who completed the CSPH Orientation (Outcome 1), however not all attendees completed the survey.

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?
Approximately 30 MOU-member agencies for the majority of the program year; for Outcome 1, 29 individuals were present at the CSPH Orientation during the October 2019 meeting.

6. How many people did you *attempt* to collect outcome information from?
For Outcome 1, surveys were distributed to all CSPH members with the expectation that only those present for the CSPH Orientation would complete the survey (ie 29 individuals).

7. How many people did you *actually* collect outcome information from?
17 individuals completed the survey for Outcome 1.

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

Results

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

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

The nature of the Homeless System Service Coordination program is it is geared towards enabling and coordinating larger system change. In the program's first year, this has been reflected in an increase in engagement by members and overall an increase in agencies interested in pursuing grants to bring funds for homeless services into the community. At the start of the Program Year, the Program Coordinator conducted one-on-one (1:1) interviews with existing members, conducted an orientation to the full board, and met individually with many agencies after the orientation to debrief and answer questions. These meetings were crucial to rapport building with the individual member agencies and have made the Continuum broadly more approachable and readily engaged.

Notably, such collaborations helped to facilitate crisis response at the onset of the COVID-19 pandemic. Unlike some other communities in Illinois and nationwide, Champaign County did not experience a reduction in emergency shelter services. On the contrary, through cooperation between CU @ Home, Austin's Place, and the Regional Planning Commission, the CSPH was able to secure a grant of approximately $90,000 to expand shelter operations, provide non-congregate shelter options, and ultimately this helped lead to the early implementation of year-round emergency shelter for single individuals in the community. The Program Coordinator was central in the grant's initial drafting, coordinating services, and guiding agencies through report submission.

The coordination throughout the early stages of COVID also helped to propel more new grantees than any previous grant opportunity with the unprecedented ESG-CV grant opportunity which occurred at the very end of the Program Year. The education and engagement conducted by the Program Coordinator and facilitated throughout the CSPH was crucial in accomplishing this. Educating the public and participating agencies in these opportunities and providing mentorship in completing these complex grant opportunities was fruitful at the end of the Program Year and will continue to be reflected into the second Program Year.

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)

The Program Coordinator began the program year with a series of 1:1 meetings with CSPH members and has continued this model post-CSPH Orientation and with new members who are joining the CSPH. Typically, these 1:1s involve the Coordinator meeting with the agency staff or leadership who attends the CSPH full board meetings. The Coordinator generally explores the agency's history, mission, and programs to make connections with the broader CSPH mission and other member agencies that work on concert with it. If the agency is a long-time member, the Coordinator explores the person's feelings on the CSPH's strengths, weaknesses, and future opportunities, including what they believe would be helpful in promoting deeper member engagement. In cases where the person/agency is new to the CSPH, the Coordinator discusses some of the topics of the CSPH Orientation and discusses the history and mission of the CSPH, including how the person sees their agency/work fitting into that picture.

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)

One piece of feedback that was consistent across several of the 1:1 meetings at the beginning of the program year was that agencies were somewhat interested in pursuing grant opportunities related to the CSPH, but there was a deficit of knowledge of the vocabulary, definitions, and technical requirements. One member specifically noted a need for stronger mentorship on the complex grant opportunities such as the Emergency Solutions Grant (ESG). While not the primary purpose of the Program Coordinator, the Coordinator did engage in some mentorship of agencies – in concert with other experienced ESG-grantees – who applied to the FY21 ESG opportunity for the first time. The same is true for the ESG-CV opportunity at the very end of the first program year. Facilitating this sort of mentorship deepens the overall knowledgebase of the CSPH and results in more agencies able to seek grant funding, and more experienced grantees to continue that kind of mentorship with other new agencies in the future.

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.

   The program exceeded targets for the first operating year. The program facilitated this with targeted outreach which resulted in higher than expected turnout to the CSPH Orientation (treatment plan clients), higher than expected attendance to CSPH-organized training events (service contacts), and more executed Community Service Events (CSEs) than originally expected.

Treatment Plan Clients (TPC): **Treatment Plan Clients (TPC) will be representatives from the IL-503 Continuum of Service Providers to the Homeless (CSPH) organizations that complete an orientation regarding the mission of IL-503 Continuum of Service Providers to the Homeless, the work of the Continuum, and their role as a representative of a member organization.**

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): **Service Contacts/Screening Contacts will be the 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).

Champaign Co. Regional Planning Comm. – Community Services
Justice Diversion Program
Performance Outcome Report PY20

Agency name: Regional Planning Commission
Program name: Justice Diversion Program
Submission date: 8/25/2020

Consumer Access – *complete at end of year only*
Eligibility for service/program
1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application) **Individuals and families in Rantoul, Illinois who have had Crisis Intervention Team (CIT) or domestic offense police contact are eligible for Justice Diversion Program Services.**
2. How did you determine if a person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)? **The Rantoul Police Department contact logs and crisis intervention team (CIT) referrals forms are used to determine this criterion.**
3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.) **If the person met the criteria, then the Justice Diversion Program Coordinator will contact them via phone or home visit.**
4. a) *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application): **50%**

b) *Actual* percentage of individuals who sought assistance or were referred who received services: **51% percent of individuals received services. Out of 143 total individuals, 74 individuals 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): **Clients are screened with an ANSA approximately two weeks after referral.**
b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application): **100%**
c) *Actual* percentage of referred clients assessed for eligibility within that time frame: **100%**
6. a) *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application): **Individuals who are interested in services will be enrolled immediately. Clients who are responsive to staff services will engage in services within 1 to 3 weeks.**
b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application): **30%**
c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame: **25% 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 participation engagement in services is 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)
N/A

2. Please report here on all of the extra demographic information your program collected.
No other demographics were 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.**
3. **Increasing available services in Rantoul.**
4. **Reduce number of repeat calls to law enforcement for social emotional needs**

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

Outcome	Assessment Tool Used:	Information Source:
Needs Assessment	Adults Needs And Strengths Assessment	Client

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

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

Repeat Police Contacts were also recorded.

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?

143

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

43

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

43

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)

I learned how effective the program was by increase or decline in repeated calls for CIT incidents. The justice Diversion coordinator also learned that reaching out to clients is very successful when responding on scene with officers. I also learned that the pandemic has a large effect on the decrease of calls in April and May.

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?
No

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) will receive a referral from Rantoul Police Officers. The JDPC will reach out the participant to see if assistance is needed. If the participant needs further assistance, the participate will become a treatment plan client, in which the JDPC will work with them for roughly 3 months to provide services. The JDPC, along with the participant, will make referrals to other agencies that will be able to help the participant (i.e counseling, senior services, psychiatry, ect).
If the participant feels they don't need assistance from the JDPC 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 the 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.

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

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

Due to staff turnover, the program was in operation approximately 6-months rather than 12-months. Prorating the targets on a 6-month period, the actual number of achieved for TPC participants was 36% of the target. This was specifically impacted by the Shelter In Place order during the last quarter, limiting the in person engagement.

Non-treatment Plan Clients (NTPC):

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.

Due to staff turnover, the program was in operation approximately 6-months rather than 12-months. Prorating the targets on a 6-month period, the actual number of NTPC clients exceeds the initial target by 51%. After the new Coordinator was oriented to the program, the RPD provided a large number of CIT referrals for follow up from the time that the program was not in operation.

Community Service Events (CSE):

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

The annual target was met. Despite the turnover of the primary staff person for the program, the Community Services Director continued to coordinate and lead Rantoul Community Service Providers meetings.

Service Contacts (SC):

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 staff turnover, the program was in operation approximately 6-months rather than 12-months. Prorating the targets on a 6-month period, the actual number of Service Contacts exceeded the target by 14%. After the new Coordinator was oriented to the program, the RPD provided a large number of CIT referrals for follow up from the time that the program was not in operation.

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

Champaign Co. Regional Planning Commission – Community Services
Youth Assessment Center Program
Performance Outcome Report PY20

Agency name: Champaign County Regional Planning Commission
Program name: Youth Assessment Center
Submission date: 8/26/2020

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

police departments, etc. The YAC program is also listed on the Champaign County Regional Planning Commission website.

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

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

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

76% of individuals who sought assistance were referred and received services. Of those individuals, 24% who met the criteria, declined services.

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

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

81 % of youth assessed were eligible to engage in services.

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

Estimated length of time from referral date to engagement: 3 weeks

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

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

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

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

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

Within 90 days of assessment, 68% of youth eligible for services were engaged.

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

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

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

The average length of engagement time was 3.5 months.

Demographic Information

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

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

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

Demographic information for household income for participants in as follows: 45% were at the 30% MFI level, 12% at the 50% MFI level and 8% at the 80% MFI level. 34% of participants declined to provide MFI level information.

Consumer Outcomes – *complete at end of year only*

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

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

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

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

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

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

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

Outcome information is gathered for each participant who receives services.

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

5. How many total participants did your program have?

In FY20, the YAC had 164 unduplicated participants of which 84 were assessed at moderate/high with 35 of those matching the eligibility criteria of having two or more referrals.

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

The YAC attempted to collect outcome information from 164 participants.

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

The YAC collected outcome information from 164 participants.

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

Information was collected at client intake and exit.

Results

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

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

During FY 2020, the YAC saw a decrease in target participants with two or more law enforcement contacts assessed at a moderate to high level. However, the non-target participants assessed at a moderate to high level was single digits that of the targeted participant.

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

No

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

N/A

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

N/A

(Optional) Narrative Example(s):

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

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

Utilization Data Narrative –

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

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

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

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

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

Proposed: 63
Actual: 35

Explanation: RPC projected that 63 out of a total 259 participants, or 24.3%, would be re-referred youth who assessed at moderate to high risk. The actual number of TPCs for FY20 was 35 out of a total of 164 participants served, or 21.3%. Based off this data, RPC's projection was higher than the actual number of TPCs. Many youth referred to the YAC in FY20 were first time offenders, which would not be reflected in this data.

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

Proposed: 20
Actual: 1

Explanation: RPC projected only 20 out of a project total of 259 participants, or 7.7%, would be re-referred youth who assessed at no to low risk. This projection was higher than the actual rate of NTPCs in FY20, as the actual amount of NTPCs was 1 out of a total of 164 participants served, or .6%.

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

Proposed: 60
Actual: 29

Explanation: Community Service Events significantly decreased in quarters 3 and 4 due to COVID-19 preventing staff from participating in community events, resulting in only a 50% achievement rate for Community Service Events.

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

Proposed: 50
Actual: 31

Explanation: RPC anticipated a total of 259 participants for FY20. RPC proposed that 50/259 participants, or 18.9%, would not be contactable and/or not engage-Service Contacts. The data above shows that 31 out of a total of 164 actual participants, or 19.4%, were not contactable and/or did not engage. According to this data, the Service Contacts percentage target was achieved for FY20.
Other: Referrals made to the YAC by non-law enforcement/ juvenile justice entities. These will include referrals from schools, community, self/ family, etc. ***Proposed: 60*** ***Actual: 61*** ***Explanation: RPC projected that out of 259 participants served, 60 would be referrals from schools, community, or self/family, or 23%. For FY20, RPC received a total of 61/164 community, school, and/or self/family referrals, or 37%. The actual amount of "Other" referrals were higher in FY20 than originally projected.***
For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

Champaign Co. Regional Planning Commission – Head Start
Early Childhood Mental Health Services Program
Performance Outcome Report PY20

Agency name: Champaign County Regional Planning Commission Head Start/Early Head Start
Program name: Early Childhood Mental Health Services
Submission date: 9/11/2020

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 refer children to the Social-Emotional Development Specialist (SEDS) within one week after screening yields an ASQ-SE score indicating eligibility for services. The SEDS will determine eligibility and 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:

Savoy Site: 89% (out of 19 referrals 1 parent withdraw their child before services could be provided and 1 teacher withdrew the referral because they no longer needed assistance.)

Rantoul Site: 86% (out of 22 referrals by teachers, 3 parents chose not to sign consent forms for services)

Urbana site: 77% (36 referrals, only 28 needed assistance)

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

14 days

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

95%

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

All sites had 100% assessment rate.

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

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:

Savoy: 100%
Rantoul: 91% (2 children left the program before services could begin)
Urbana: 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:

Savoy: 5-6 months
Rantoul: 8 months
Urbana: 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:
436 families income below 100% FPG
87 families at 100-130% FPG
90 homeless families,
24 families in foster care
2 families public assistance
74 over income families

Language:
English-595
Spanish-51
Middle Eastern & South Asian-32
African-2
East Asian-5
European & Slavic-23
Unspecified- 5

Education level:
Less than HS Diploma-84
Completed HS-256
Associate degree or some college- 224
Advanced degree-59

Employment:
Employed-380
Unemployed- 87

Marital status:
Two parent home-156
Single parent home-471

Military status-0

Housing status:
Families that Acquired housing with our support this year- 16

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 of frequency and duration of challenging behavior	Behavior tally and DECA	Teacher and Parent
2. Improvement in Self-Regulation	DECA and Teaching Strategies Gold	Parent and Teachers
3. Improvement in Initiative	DECA and Teaching Strategies Gold	Parent and Teachers
4. Improvement in relationship building/ friendship skills	DECA and Teaching Strategies Gold	Parent and Teachers
5. Improvement in Emotional Literacy	DECA and Teaching Strategies Gold	Parent and Teachers
6. Improvement in Problem Solving	DECA and Teaching Strategies Gold	Parent and Teachers
7. Parent Perspective on Social skills	Parent Satisfaction Survey	Parents

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

No, we were unable to gather outcomes data at the end of the year as we would normally because of COVID. For the DECA we only have pre- service assessments. For Teaching Strategies GOLD we have two checkpoints documented but not the third.

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

It wasn't a choice, it was related to site closure and not having children in the classrooms.

10. How many total participants did your program have?

123 children received direct services or their teachers/parents received consultation. All teachers received support and consultation regarding classroom management which impacted all enrolled students.

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

We made the decision to not collect end of the year data because of the unprecedented circumstances of a pandemic and in consideration of teacher and parent stress.

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

We collected data from 124 Early Head Start students and 369 Head Start students.

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

Typically, it is collected 2-3 times throughout the year. This year we only got one data point from the DECA and two data points from Teaching Strategies GOLD.

Results

14. 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 year we saw measurable growth in our EHS and HS classrooms in the areas of Social Emotional Development. The chart below describes the percentage of students who fit into one of three categories within specific S-E outcomes, Below developmentally appropriate expectations for their age; Meeting; or Exceeding expectations. The chart shows outcomes over two data points, October and January. A third checkpoint usually takes place in April however we were not able to collect that information because of the pandemic.

Something to note, a new site of mostly EHS classrooms was opened between the fall check points and the winter checkpoints. Those new students baseline assessments are included in the winter numbers. As you

can see there was an increase in n between fall and winter. When documentation from that site is removed you see clear growth in Social-emotional development. Unfortunately, the software we use does not let us remove a site when aggregating data at the individual outcomes level. Looking at Social-Emotional development outcomes combined there was an increase in students meeting or exceeding developmental milestones from 91% in fall to 93% in winter.

Early Head Start S-E outcomes from Teaching Strategies GOLD

S-E Objective	***Fall n=73***	***Winter n=124***
1a. Manages Feelings	8.22% Below 86.3% Meeting 5.48% Exceeding	8.87% Below 87.9% Meeting 3.23% Exceeding
1b. Follows limits and expectations	6.85% Below 87.67% Meeting 5.48% Exceeding	8.94% Below 86.18% Meeting 4.88% Exceeding
1c Takes care of own needs appropriately	13.7% Below 83.56% Meeting 2.74% Exceeding	20.33% Below 76.42% Meeting 3.25% Exceeding
2a Forms relationships with adults	16.44% Below 79.45% Meeting 4.11% Exceeding	11.2% Below 88% Meeting 0.8% Exceeding
2b Responds to emotional cues	2.74% Below 89.04% Meeting 8.22% Exceeding	0% Below 92.68% Meeting 7.32% Exceeding
2c Interacts with peers	1.37% Below 84.93% Meeting 13.7% Exceeding	3.25% Below 81.3% Meeting 15.45% Exceeding
2d Makes Friends	0% Below 82.19% Meeting 17.81% Exceeding	.81% Below 83.74% Meeting 15.45% Exceeding
3a Balances needs and rights of self and others	8.22% Below 82.19% Meeting 9.59% Exceeding	10.57% Below 80.49% Meeting 8.94% Exceeding
3b Solves social problems	12.33% Below 84.93% Meeting 2.74% Exceeding	19.35% Below 75.81% Meeting 4.84% Exceeding

As evidenced in the chart below, we also so growth in Social Emotional Development in our Head Start classrooms between October and January.

Head Start S-E Outcomes from Teaching Strategies GOLD

S-E Objectives	***Fall***	***Winter n=369***
1a. Manages Feelings	25.97% Below 69.25% Meeting 4.78% Exceeding	22.22% Below 72.63% Meeting 5.15% Exceeding
1b. Follows limits and expectations	23.28% Below 69.55% Meeting 7.16% Exceeding	22.37% Below 71.16% Meeting 6.47% Exceeding
1c Takes care of own needs appropriately	22.85% Below 69.14% Meeting 8.01% Exceeding	19.07% Below 76.57% Meeting 4.36% Exceeding
2a Forms relationships with adults	27.38% Below 64.88% Meeting 7.74% Exceeding	25.68% Below 66.22% Meeting 8.11% Exceeding
2b Responds to emotional cues	29.04% Below 60.78% Meeting 10.18% Exceeding	28.88% Below 62.67% Meeting 8.45% Exceeding
2c Interacts with peers	17.56% Below 68.45% Meeting 13.99% Exceeding	16.89% Below 70.3% Meeting 12.81% Exceeding
2d Makes Friends	27.46% Below 57.01% Meeting 15.52% Exceeding	27.79% Below 60.76% Meeting 11.44% Exceeding
3a Balances needs and rights of self and others	19.1% Below 68.96% Meeting 11.94% Exceeding	18.85% Below 70.22% Meeting 10.93% Exceeding
3b Solves social problems	37.72% Below 58.08% Meeting 4.19% Exceeding	29.78% Below 66.94% Meeting 3.28% Exceeding

We also collected feedback from parents regarding their perspective of their children's social-emotional skills development, relationship with teacher, and enjoyment of their classroom. All important contributing factors to long term educational success and positive mental health outcomes. Out of the 203 surveys returned to us over 92% of parents responded positively to the questions. See the chart below for details.

Parent Satisfaction Survey Results (2019-2020)

Social & Emotional Well-Being	203 surveys returned
My child is learning to interact, and problem solve.	**96% of children are learning to interact, and problem solve**
My child has a good connection with their teacher.	**99% of children have a good connection with their teacher**
My child feels comfortable and safe in the classroom.	**96% of children feel comfortable and safe in the classroom**
My child is learning self-control and calming skills.	**92% of children are learning self-control and calming skills**

We are not reporting DECA outcomes this year because we were not able to collect reliable post-intervention data due to the pandemic.

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

Yes

16. 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.

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

We met our goal with our youngest students, in January 93% of our early head start students were meeting or exceeding the S-E benchmark for their age group.

For the Head Start program we saw an increase in students meeting or exceeding their social-emotional benchmark from 63% in October to 67% in January.

(Optional) Narrative Example(s):

18. 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.

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

Something that stands out in the data is that around a quarter of our head start students aren't meeting developmentally anticipated milestones. In particular, we noticed the "solves social problems" and "makes friends" are two of the lower meeting percentages. This is striking to us in particular because of the use of gun violence in our community as a problem solving tool. We will increase our focus on the skills that support these outcomes during this next school year. We will also look at how we can involve caregivers in that effort.

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 sites shut down in March because of the governor's shelter in place order. We didn't reopen our sites until after the end of this fiscal year. Our goals for TPC was met, however we did not meet our expected number of NTPC because of lack of access to families and children during shutdown.

Treatment Plan Clients (TPC): Estimated 50/Actual 64

TPC are students between the ages of 6 weeks to 5 years old who are enrolled in our program options and who need enough support to warrant a behavior plan or whose teachers requested ongoing consultation and support.

NTPC and TPC clients are often shared and reported by both the ECMHA's and the SEDS, which is funded by the DD board.

Non-treatment Plan Clients (NTPC): Estimated 80/Actual 59

NTPC are students between the ages of 6 weeks to 5 years old who are enrolled in our program options and have had one off interactions with staff or whose teachers requested one off consultation.

NTPC and TPC clients are often shared and reported by both the ECMHA's and the SEDS, which is funded by the DD board.

Community Service Events (CSE): Estimated 5/Actual 11

Community Service Events: Attending and contributing to community meetings and training events.

Service Contacts (SC): Estimated 1,800/Actual 3,417

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

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

Champaign Co. Regional Planning Commission – Head Start
Social-Emotional Disabilities Service Program
Performance Outcome Report PY20

Agency name: Champaign County Regional Planning Commission Head Start/Early Head Start
Program name: Social-Emotional Development Svs
Submission date: 9/11/2020

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) determines eligibility through individual 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 an individual observation, functional behavioral assessment, and parent/teacher data collection. The findings are discussed with the parents and support staff and a determination is made on how to support the child**

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:

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):

14 days

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

95%

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

80 %

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):

90%

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):

The average length of services by the Social-Emotional Development Specialist is 9 months.

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

8 month

Demographic Information

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

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:
436 families income below 100% FPG
87 families at 100-130% FPG
90 homeless families,
24 families in foster care

2 families public assistance
74 over income families

Language:
English-595
Spanish-51
Middle Eastern & South Asian-32
African-2
East Asian-5
European & Slavic-23
Unspecified- 5

Education level:
Less than HS Diploma-84
Completed HS-256
Associate degree or some college- 224
Advanced degree-59

Employment:
Employed-380
Unemployed- 87

Marital status:
Two parent home-156
Single parent home-471

Military status-0

Housing status:
Families that Acquired housing with our support this year- 16

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 behavior goals or support plans will have a reduction in frequency and duration of challenging behavior.

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

2. 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 of frequency and duration of challenging behavior	Behavior tally and DECA	Teacher and Parent
2. Improvement in Self-Regulation	DECA and Teaching Strategies Gold	Parent and Teachers
3. Improvement in Initiative	DECA and Teaching Strategies Gold	Parent and Teachers
4. Improvement in relationship building/ friendship skills	DECA and Teaching Strategies Gold	Parent and Teachers
5. Improvement in Emotional Literacy	DECA and Teaching Strategies Gold	Parent and Teachers
6. Improvement in Problem Solving	DECA and Teaching Strategies Gold	Parent and Teachers

7. Parent Perspective on Social skills	Parent Satisfaction Survey	Parents

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

No, we were unable to gather outcomes data at the end of the year as we would normally because of COVID. For the DECA we only have pre- service assessments. For Teaching Strategies GOLD we have two checkpoints documented but not the third.

9. If only some participants, how did you choose who to collect outcome information from?
It wasn't a choice, it was related to site closure and not having children in the classrooms.

10. How many total participants did your program have?

56 children received direct services or their teachers/parents received consultation. All teachers, and site managers received support and consultation regarding classroom management and school climate which impacted all enrolled students.

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

We made the decision to not collect end of the year data because of the unprecedented circumstances of a pandemic and in consideration of teacher and parent stress.

12. How many people did you *actually* collect outcome information from?
We collected data from 124 Early Head Start students and 369 Head Start students.

13. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc)
Typically, it is collected 2-3 times throughout the year. This year we only got one data point from the DECA and two data points from Teaching Strategies GOLD.

Results

14. 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 year we saw measurable growth in our EHS and HS classrooms in the areas of Social Emotional Development. The chart below describes the percentage of students who fit into one of three categories within specific S-E outcomes, Below developmentally appropriate expectations for their age; Meeting; or Exceeding expectations. The chart shows outcomes over two data points, October and January. A third checkpoint usually takes place in April however we were not able to collect that information because of the pandemic.

Something to note, a new site of mostly EHS classrooms was opened between the fall check points and the winter checkpoints. Those new students baseline assessments are included in the winter numbers. As you can see there was an increase in n between fall and winter. When documentation from that site is removed you see clear growth in Social-emotional development. Unfortunately, the software we use does not let us remove a site when aggregating data at the individual outcomes level. Looking at Social-Emotional development outcomes combined there was an increase in students meeting or exceeding developmental milestones from 91% in fall to 93% in winter.

Early Head Start S-E outcomes from Teaching Strategies GOLD

S-E Objective	***Fall n=73***	***Winter n=124***
1a. Manages Feelings	8.22% Below 86.3% Meeting 5.48% Exceeding	8.87% Below 87.9% Meeting 3.23% Exceeding
1b. Follows limits and expectations	6.85% Below 87.67% Meeting 5.48% Exceeding	8.94% Below 86.18% Meeting 4.88% Exceeding
1c Takes care of own needs appropriately	13.7% Below 83.56% Meeting 2.74% Exceeding	20.33% Below 76.42% Meeting 3.25% Exceeding
2a Forms relationships with adults	16.44% Below 79.45% Meeting 4.11% Exceeding	11.2% Below 88% Meeting 0.8% Exceeding

2b Responds to emotional cues	2.74% Below 89.04% Meeting 8.22% Exceeding	0% Below 92.68% Meeting 7.32% Exceeding
2c Interacts with peers	1.37% Below 84.93% Meeting 13.7% Exceeding	3.25% Below 81.3% Meeting 15.45% Exceeding
2d Makes Friends	0% Below 82.19% Meeting 17.81% Exceeding	.81% Below 83.74% Meeting 15.45% Exceeding
3a Balances needs and rights of self and others	8.22% Below 82.19% Meeting 9.59% Exceeding	10.57% Below 80.49% Meeting 8.94% Exceeding
3b Solves social problems	12.33% Below 84.93% Meeting 2.74% Exceeding	19.35% Below 75.81% Meeting 4.84% Exceeding

As evidenced in the chart below, we also so growth in Social Emotional Development in our Head Start classrooms between October and January.

Head Start S-E Outcomes from Teaching Strategies GOLD

S-E Objectives	***Fall***	***Winter n=369***
1a. Manages Feelings	25.97% Below 69.25% Meeting 4.78% Exceeding	22.22% Below 72.63% Meeting 5.15% Exceeding
1b. Follows limits and expectations	23.28% Below 69.55% Meeting 7.16% Exceeding	22.37% Below 71.16% Meeting 6.47% Exceeding
1c Takes care of own needs appropriately	22.85% Below 69.14% Meeting 8.01% Exceeding	19.07% Below 76.57% Meeting 4.36% Exceeding
2a Forms relationships with adults	27.38% Below 64.88% Meeting 7.74% Exceeding	25.68% Below 66.22% Meeting 8.11% Exceeding
2b Responds to emotional cues	29.04% Below 60.78% Meeting 10.18% Exceeding	28.88% Below 62.67% Meeting 8.45% Exceeding
2c Interacts with peers	17.56% Below 68.45% Meeting 13.99% Exceeding	16.89% Below 70.3% Meeting 12.81% Exceeding
2d Makes Friends	27.46% Below 57.01% Meeting 15.52% Exceeding	27.79% Below 60.76% Meeting 11.44% Exceeding

3a Balances needs and rights of self and others	19.1% Below 68.96% Meeting 11.94% Exceeding	18.85% Below 70.22% Meeting 10.93% Exceeding
3b Solves social problems	37.72% Below 58.08% Meeting 4.19% Exceeding	29.78% Below 66.94% Meeting 3.28% Exceeding

We also collected feedback from parents regarding their perspective of their children's social-emotional skills development, relationship with teacher, and enjoyment of their classroom. All important contributing factors to long term educational success and positive mental health outcomes. Out of the 203 surveys returned to us over 92% of parents responded positively to the questions. See the chart below for details.

Parent Satisfaction Survey Results (2019-2020)

Social & Emotional Well-Being	203 surveys returned
My child is learning to interact, and problem solve.	**96% of children are learning to interact, and problem solve**
My child has a good connection with their teacher.	**99% of children have a good connection with their teacher**
My child feels comfortable and safe in the classroom.	**96% of children feel comfortable and safe in the classroom**
My child is learning self-control and calming skills.	**92% of children are learning self-control and calming skills**

We are not reporting DECA outcomes this year because we were not able to collect reliable post-intervention data due to the pandemic.

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

Yes

16. 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.

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

56We met our goal with our youngest students, in January 93% of our early head start students were meeting or exceeding the S-E benchmark for their age group.

For the Head Start program we saw an increase in students meeting or exceeding their social-emotional benchmark from 63% in October to 67% in January.

(Optional) Narrative Example(s):

18. 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.

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

Something that stands out in the data is that around a quarter of our head start students aren't meeting developmentally anticipated milestones. In particular, we noticed the "solves social problems" and "makes friends" are two of the lower meeting percentages. This is striking to us in particular because of the use of gun violence in our community as a problem solving tool. We will increase our focus on the

skills that support these outcomes during this next school year. We will also look at how we can involve caregivers in that effort.

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 sites shut down in March because of the governor's shelter in place order. We didn't reopen our sites until after the end of this fiscal year. We did not meet our estimated numbers because of lack of access to families and children during shutdown.

Treatment Plan Clients (TPC): Estimated 80/Actual 28

TPC are students between the ages of 6 weeks to 5 years old who are enrolled in our program options and who need enough support to warrant a behavior plan or whose teachers requested ongoing consultation and support.

NTPC and TPC clients are often shared and reported by both the ECMHA's and the SEDS, which is funded by the DD board.

Non-treatment Plan Clients (NTPC): Estimated 70/Actual 28

NTPC are students between the ages of 6 weeks to 5 years old who are enrolled in our program options and have had one off interactions with staff or whose teachers requested one off consultation.

NTPC and TPC clients are often shared and reported by both the ECMHA's and the SEDS, which is funded by the DD board.

Community Service Events (CSE): Estimated 20/Actual17 Community Service Events: Attending and contributing to community meetings and training events.
Service Contacts (SC): Estimated 700/Actual 638 **Service/Screening contacts: is defined as face to face services and supports given to NTP clients, TP Clients; consultation provided to teachers, and or parents related to NTPC/TPC; social-emotional skill building small groups in classrooms; large group guidance lessons in classrooms.**
For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

Community Service Center of Northern Champaign Co.
Resource Connection Program
Performance Outcome Report PY20

Agency name: Community Service Center of Northern Champaign County
Program name: The Resource Connection
Submission date: 8/26/2020

Consumer Access – *complete at end of year only*
Eligibility for service/program
1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application) Residents of the nine northernmost townships of Champaign County, with focus on low income households and people with disabilities. No restriction on clients seen by other programs using our offices.

2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)?
We verify residence thru an ID card and another current document such as a utility bill. Income information and other demographics are collected at time of intake.

3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.)
Word of mouth, referral from other agencies, outreach events, publicity in local paper.

4. a) *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application): Given the nature of our services it is not often that people are not served in one way or another, but we do not track that data. Based on our count of unmet needs from information and referral inquiries, only about 7.8% are classified as unmet needs, an increase of 1 percentage point 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

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

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

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

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

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

Demographic Information

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 during the holidays due to our activity levels increasing and the extra time it takes to conduct the assessment. Before we were ready to resume the process, the pandemic struck and we've had minimal contact with clients since then. We hope to resume this soon. The annual survey was completed, but the data had to be manually entered on a spreadsheet and we're just now working with the evaluation team to interpret the results.

2. For each outcome, what specific survey or assessment tool did you use to collect information on this outcome? (Please remember that the tool used should be evidence-based or empirically validated.)
We used a new evidence based consumer satisfaction survey developed by the U of I outcome evaluation staff. We also implemented a client needs assessment form every 6 months but that process was put on hold due to the pandemic.

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 close to 13% 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?
1309 households

7. How many people did you *attempt* to collect outcome information from?
Up to 170

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

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

Results

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

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

Considering the type of services we provide and that we use a satisfaction survey, what we can report is that all our satisfaction score was 4.8 on a scale of 1-5 with a standard deviation of 0.56. 70% of respondents used 2 or more services from our program or other programs available in our building. Our average cultural competence score was 4.3 on a scale of 1-5. We are still sifting through the results of the new survey document results to get more detailed information regarding client needs, their sense of well-being, and overall provision of services.

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

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

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

(Optional) Narrative Example(s)

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

A client comes in needing help with payment for utilities. In the interview process we find out they also need help with food and substance abuse counseling. Our intake staff provides information about the LIHEAP program, help set up an appointment and give information about Rosecrance services in Rantoul. Assistance with food is provided immediately and the client returns the following week for an appointment with a counselor. 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 incomplete due to the pandemic situation.

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 PY20. Both actual counts are even lower than expected, particularly the new NTPCs. We attribute this to the significant downturn in services from March thru June (and July) due to the pandemic.

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

N/A

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

Clients served directly by the program but without a specific treatment plan.
Community Service Events (CSE): Informational and educational events sponsored or hosted by the agency/program.
Service Contacts (SC): Phone call and walk in inquiries regarding human services and other needs.
For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

Courage Connection
Courage Connection Program
Performance Outcome Report PY20

Agency name: Courage Connection
Program name: Courage Connection
Submission date: 8/28/20

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. The definition that based this on comes from 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.

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:

88% 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 FY20: Chinese(3), Spanish (14), French(2)**
***Veterans for FY20: 7**
***Sexual Orientation for FY20: Heterosexual: 323, Homosexual: 9, Bisexual: 16, Queer: 15, Not Reported/Refused: 64**
***Pregnant Clients for FY20: 23**

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: 98%	Survey	Client

"I know more about community resources." **Answered Yes:** 95%	Survey	Client
"I feel safer from abuse by getting out of the abusive environment while in shelter." **Answered Yes: 100%**	Survey	Client
"I feel more hopeful about my future." **Answered Yes: 100%**	Survey	Client
"I have a better understanding of the effects of abuse on my life." **Answered Yes: 100%**	Survey	Client
"I have a better understanding of the effects of abuse on my children's lives." **Answered Yes: 100%**	Survey	Client

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?
551

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

8) How many people did you *actually* collect outcome information from?
177

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 try to survey them within their first week. For counseling/therapy and/or 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)

N/A

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 periodically.

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

Our outcome data exceeded our projections for FY20.

(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).

Crisis Nursery
Beyond Blue – Champaign Co. Program
Performance Outcome Report PY20

Agency name: Crisis Nursery
Program name: Beyond Blue
Submission date: 8/20/20

Consumer Access – *complete at end of year only*
Eligibility for service/program
1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application) *Beyond Blue* serves mothers who have or are at risk of developing perinatal depression (PD), targeting 33 mothers annually who demonstrate PD risk factors and have a child under age one. Mothers are

provided individual and group support and education to facilitate healthy parent-child engagement.

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

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

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

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

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

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

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

Crisis Nursery Family Specialists, working in the Beyond Blue program, made numerous connections with agencies and service providers in the rural and Champaign/Urbana communities during fiscal year 2020. Staff members spoke at several community and agency events about the Beyond Blue program and distributed brochures and program materials at social service agencies throughout the community. Presentations about the program were also made at WIC offices and to Carle and OSF's Labor and Delivery nurses, as well as nurses in the OBGYN Department of Christie Clinic. Additionally, presentations were made regarding Beyond Blue on behalf of the Home Visitor's Consortium to the Human Services Council, Early Intervention Providers, and the Birth to Three Coalition made up of all community home visiting agencies. Finally, Crisis Nursery shared about the Beyond Blue program at various public outreach events such as the Mental Health Awareness Panel, as well as formed new relationships with partnering agencies, such as Merci's Refuge and Hope Springs Counseling Center. 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. Presentations were made for the first time in 2020 to the Rantoul School's Social Work and Special Education program, in order to prepare social workers with appropriate education and information for parents with infants involved in the school system from early childhood through junior high.

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.

In an effort to reach more of those in need of Beyond Blue services, Crisis Nursery will begin coordinating with the newly opened Family Foundation program with Carle Hospital. This program ensures all mothers delivering at Carle receive at least one home visit from a nurse. 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.

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

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

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

In FY20, Family Specialists fully engaged a total of 30 new clients; 15 CU and 15 rural.

Crisis Nursery's Beyond Blue Program attempted new group and outreach forums within the Rantoul area in order to better reach mothers for group programming purposes. Though regular group days and times were held, in response to parent feedback surveys, there was still no attendance at the final attempted rural group. Family Specialists, however, continued to be present with the Community Services Center of Northern Champaign County, as well as within the Multi-Cultural Center, ultimately obtaining multiple referrals from surrounding rural areas, including Rantoul. Additional rural engagement also came by way of referrals directly from DCFS intact case managers. Though in person groups have not been successful, Crisis Nursery's Director of Programming and Child & Family Specialist began working on developing additional measurement tools in order to better gauge what barriers exist in preventing families from attending groups, mainly in rural areas. Since the need of response to COVID-19, families have been attending group support services virtually, providing support to those who may not have otherwise attended.

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

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 90% 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 adheres 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 has been a strength of the Beyond Blue program with ongoing enrollment happening virtually.

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

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

7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application): Families are able to engage in the program until their child turns 1 year.
b) *Actual* average length of participant engagement in services: The majority of families engage in some capacity until their child turns 1 year.

Demographic Information

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

N/A

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

N/A

Consumer Outcomes – *complete at end of year only*

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

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

Objectives identified included the following:

- Mothers will 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. Finally, a survey is being developed currently to better assess and collect data related to why mothers may not be interested in participating should a family choose not to engage. These tools are in the development stage with hopes of implementation beginning within FY21.

5. How many total participants did your program have?

30

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

30 (See parameters above)

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

EDPS: 29
ARCH: 25
ASQ: 24

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 FY20:

- 72% showed a decrease in their level of stress after using services,
- 92% felt there was an improvement in their parenting skills, and
- 92% believed that our services reduced the risk of harm to children.

Groups continue to be one of the most impactful ways we work with clients in the Beyond Blue program. Based on the evidenced-based intervention *Parents Interacting with Infants*, our Infant Parent-Child Interaction groups provide Family Specialists with the opportunity to model and support positive parenting interactions Throughout FY20 we held 13 successful Infant Parent-Child Interaction Groups. While marketed to our Beyond Blue clients, our Infant Parent-Child Interaction Groups are open to any community member with a child under the age of 1. We believe this strategy benefits Beyond Blue mothers, as they can witness non-depressive mothers model positive interactions with their infant.

We also offer a Beyond Blue Support Group, which provides the space for our Beyond Blue clients to connect with their peers, share their experiences, and expand their support network. In FY20, we offered 20 Beyond Blue support groups. Beyond Blue Support Groups were well attended by CU-based clients.

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

No

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

N/A

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

N/A

(Optional) Narrative Example(s):

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

Family Specialist Kelli Bertram shares about connecting with new mothers amidst the COVID-19 pandemic during FY2020:

Serena was new to our Beyond Blue program this year and was not shy about her hesitancy in asking for help. She shared with me, right away, her negative experiences with past therapists and counselors, and she told me she struggles to build connections with people. However, after our first phone call after enrollment, she opened up and shared a lot about herself with me, and at the end of the call she said she was surprised how quickly she connected and felt comfortable with me. I heard the concerns she had with past professionals and I am actively trying to not do those things. We both had an honest conversation with each other and were able to connect through one phone call and even thought we never saw each other in person.

Family Specialist Julia Gog shares about the silver linings of virtual visiting with mothers during FY2020:

Although there are definitely disadvantages to virtual visits, it seems that working with some families through this crisis and meeting them where they are has deepened our relationship. I've noticed some clients engage more than they did during in person visits. There could be many reasons for this: less pressure to clean the house, less invasive to speak on the phone or video call, etc. We are learning together ways to connect that works best for the family and going through a shared experience. It's also allowed more space for the parent to vent and express themselves during these uncertain times. I see a lot of strength in all my families I visit. The fact that most continue to engage shows the value and worth that our Beyond Blue program has in the lives of those we serve.

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

During FY20, Crisis Nursery underwent a project as a targeted partner in better developing a connection between our activities, services, goals and related measurement tools in order to better document the positive changes we so often hear about from the families served. As a result, Crisis Nursery will continue to use the aforementioned measurement tools, however will also plan to implement an environmental risk assessment, two surveys from the Mothers and Babies curriculum in order to gather direct parent feedback related to changes in mood, as well as the PICCOLO parent child-interaction assessment tool, pre and post, to gauge how the support of the Beyond Blue program impacts the mother or father's ability to interact with his or her child in a greater way.

Utilization Data Narrative –

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

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

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

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

   During FY20, there is a deficit within the service contacts with 522 projected and 472 actually taking place. The main culprit for change is evident in the difference between the numbers of EPDS's offered throughout FY20. During times when all services are offered in person, both Family Specialists administer these sensitive screenings in person. With the change to virtual visiting since April, screenings were not offered with as much frequency. Now that families have adjusted to connecting more virtually, screenings have begun to increase as time passes. 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.

   Beyond Blue Family Specialists have been able to remain on target with ongoing enrollment of parents even during the COVID-19 pandemic. Due to the pandemic, support groups and Parent Child Interaction groups were put on hold. Plans for virtual support and parenting groups are currently in place to begin in FY21 as the pandemic continues the need to respond virtually for an indefinite amount of time. Additionally, Family Specialists were unable to gain attendance to rural groups within the Rantoul area, prior to the pandemic, however many participants have expressed interest in virtual groups within the near future. Finally, a survey has been developed as a part of the aforementioned targeted partnership to better gauge the barriers preventing families from attending groups, in order to better understand this deficit as a program.

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

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

30 Treatment Plan Clients were served: 15 rural and 15 Champaign-Urbana mothers were deemed “at risk” of PD.

Non-treatment Plan Clients (NTPC):

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

90 Non-Treatment Plan Clients were served (47 rural and 43 Champaign-Urbana). Non-Treatment Plan Clients include the following: 31 infants and expected infants of the mothers participating in the program and other family members.

Community Service Events (CSE):

128 Community Service Events are projected. Community Service Events include: 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.

138 Community Service Events occurred. Community Service events include: 13 Parent-Child Interaction groups for the mother/baby dyads and 20 perinatal depression support group meetings. Other events include: 105 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 4,100 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.

472 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.

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

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

Cunningham Children's Home
ECHO Housing & Employment Supports Program
Performance Outcome Report PY20

Agency name: **Cunningham Children's Home**
Program name: **ECHO (Empowering Connections through Hope and Opportunities)**
Submission date: **08/28/20**

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.

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 FY20, we participated in 49 community service events regarding the ECHO program. An example of a few of these stakeholders/events included Rantoul Service Providers, Daily Bread, Mahomet Police Department, CU One Winter Night, Point in Time, 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:

26% (11 of 43) clients who were referred/sought assistance in FY20 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.

Note: The Mental Health Board asked that we monitor the number of clients served in the

ECHO program who were former Cunningham clients. In FY20, we served three clients who had been served in Cunningham programs previously (all three clients were enrolled in the program in FY19 and discharged in FY20).

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:

91% (10 of 11) clients were assessed for eligibility with 30 days of program enrollment.

Note: If we look at the totality of all ECHO clients (i.e., those enrolled in FY19 and FY20), the percentage is 92% (23 of 25).

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:

64% (7 of 11) TPC clients who enrolled/engaged in the program in FY20.

Note: If we look at the totality of all ECHO TPC clients (i.e., those enrolled in FY19 and FY20), the percentage remains the same (16 of 25).

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 10 discharges in FY20. The average length of stay for these participants was 309 days (10.2 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 FY20.

- **Eleven (11) of 25 ECHO clients received SSI/SSDI – some clients became eligible during program enrollment. Eight additional clients have applied for SSI/SSDI and/or are in the process of appealing their SSI/SSDI determination.**
- **Twenty (20) of 25 ECHO clients reported receiving Medicaid at the time of enrollment.**
- **Two (2) of 25 ECHO clients reported DOC or DJJ involvement at the time for enrollment.**
- **One (1) of 25 ECHO clients reported DCFS involvement**
- **Other reported social services and/or system involvement included: Regional Planning Commission (8), Rosecrance (3), Restoration Urban Ministries (1), ALLSUP (1), CCRC (1), Courage Connections (1), DHS (1), WIOA (1).**
- **Language was recorded for all 25 clients: all were English-speaking.**
- **Marital status was recorded for all 25 clients: 18 were single, 1 was married, 6 were divorced**
- **Religion was recorded for all 25 clients: 10 reported Protestant, 10 reported None and 5 reported Other (Non-denominational, Buddhist, Muslim)**
- **Grade level completed was reported for all 25 clients: 5 clients did not complete high school, 5 participants had earned a GED, 4 participants had obtained high school diplomas, 5 participants had completed some college, 3 participants had completed an associate or bachelor degree and 3 participants had completed graduate degrees.**

- **Disability information was collected at admission for all 25 clients: 4 reported no disability, 4 reported a physical disability, 13 reported a mental disability and 4 reported both mental and physical disabilities. This information is based on individual self-report of disabilities vs. disabilities that have been documented/determined by other more formal systems.**

Consumer Outcomes – *complete at end of year only*

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

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

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

1. **Length of Housing Stability: At least 80% of individuals will be housed within 90 days of assessment with at least 60% achieving housing stability for more than 90 days.**
2. **Length of Employment: At least 80% of individuals will be employed within 90 days of assessment with at least 60% achieving employment stability for more than 90 days. Individuals eligible for social security are excluded from this outcome although part time employment goals may still be relevant.**
3. **Life Skills Mastery: At least 90% of clients receiving both pre- and post- life skills assessment will show improvement in life skill mastery.**
4. **Participant Surveys: At least 60% of individuals will complete a participant satisfaction survey upon discharge. 95% of survey responses received will be agree or strongly agree with positive service quality statements.**

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

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

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

Outcome:	Assessment Tool Used:	Information Source:
E.g. 1. Increased empowerment in advocacy clients	Measure of Victim Empowerment Related to Safety (MOVERS) survey	Client
1. Length of Housing Stability	**Changes in housing status are tracked via Service Documentation System (SDS)**	**Staff observation as well as client and/or collateral reports**
2. Length of Employment	**Changes in employment status are tracked via SDS.**	**Staff observation as well as client and/or collateral reports**
3. Life Skills Mastery Improvement	**Life Skills Assessment tool is administered at intake and discharge**	**Case manager collaborates with client on completion**
4. Participant Satisfaction with Services	**Participant Satisfaction Survey (developed by Cunningham)**	**Client report**

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 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 losing contact with us.

Due to not having any satisfaction surveys completed in FY19, we adjusted our strategy for gathering this data to include an additional collection point. 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 January, 2020. 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 10 discharged clients. 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 Life Skills Assessment for 7 of 10 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 (January).

Results

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

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

1. Length of Housing Stability: At least 80% of individuals will be housed within 90 days of assessment with at least 60% achieving housing stability for more than 90 days.

Of the 25 clients served, 21 (84%) obtained permanent housing during program enrollment. Note: Two of these clients were not discharged to a permanent housing situation (one client left permanent housing to live with a friend and one lost their voucher due to leasing violations related to deteriorating mental health). The average length of time to secure permanent housing was 77 days (range of 1 to 261 days).

- **Fourteen (14) of the 21 (67%) obtained permanent housing within 90 days of program enrollment.**
- **Seventeen (17) of the 21 (81%) maintained permanent housing for 90+ days.**
- **Five (5) of 10 clients who were discharged in FY20 were in a permanent housing situation.**

At the close of FY20, one client was in a temporary housing situation (admitted in May, 2020).

Lessons learned/strategies:

During this past year, we have increasingly received referrals of homeless individuals who have significant mental health issues. A community program that is designed to provide case management services for this population has not been consistently available due to significant staff retention issues. As a result, we have enrolled many clients in ECHO who have significant mental health and treatment needs and are difficult to stabilize in housing.

We have seen an increase in the number of clients who are experiencing substance abuse issues (some of whom are self-medicating) and clients who are experiencing mental illness and are resistant to medication or other treatment. This population has been hard to stabilize in housing as a result of complaints from landlords and/or occupants of the apartment building around noise, drug use, guests, uncleanliness, etc.

Related to these challenges, we have made gains in the following areas:

- **We have developed a strong list of landlords that provide us with solid options for placing clients. These are landlords that are invested in the case of their properties, are interested in the needs of the homeless population and have become valuable options to place clients with SPC vouchers.**
- **We have established partnerships with other community providers (such as Salt & Light) that help us meet the immediate needs of our clients.**
- **We have become more closely connected to other community agencies and programs that serve homeless populations to provide a stronger safety net (with fewer gaps) for homeless individuals. We have been invited to the table to address community homelessness issues (e.g., the shelter to housing initiative for vouchers related to COVID-19, staffing needs at CU at Home, etc.).**

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

   Eleven (11) of 25 clients (44%) were eligible for/receiving SSI/SSDI during program enrollment. Seven (7) additional clients are either in the process of applying for SSI/SSDI or are appealing a denial of their application.

   Of the fourteen (14) clients for whom employment is tracked, 7 of 14 (50%) are or have been employed in FY20.

   - **Two (2) clients were employed at the time that they enrolled in the program and maintained employment with the same employer through discharge.**
   - **Three (3) additional clients obtained employment within 90 days of enrollment.**
   - **Two (2) clients obtained employment after 90 days and maintained employment for a brief period (less than 30 days). One of these clients started a new position in June, 2020.**
   - **Five (5) of those 7 (71%) maintained employment more than 90 days.**

   Lessons learned/strategies:

   The lessons learned are a continuation of what we addressed in last year's report and have also noted above.

   - **Several of our clients have very significant mental health issues that interfere with their ability to maintain any type of employment. Despite sometimes obvious mental health issues, clients are often denied SSI/SSDI. We have been consistent in helping clients to apply for these benefits and appeal denials, as applicable;**

- **Substance abuse issues are a significant barrier to a client's ability to maintain employment. We recognize that substance abuse is often the primary treatment need that must be met before the individual can successfully obtain housing and maintain a job.**

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

   All 25 clients have a pre-test measure for the Life Skills Assessment completed as part of intake paperwork. The range of scores on the pre-test was 135 to 186 (with 186 being the maximum score). The average pre-test score for all clients was 172 (92.5%).

   Seven (7) of 10 clients had completed at least two Life Skills Assessments at the time of discharge.

   - **Five (5) of 7 clients (71%) demonstrated an increase on the measure with an average increase of 7.5 points.**
   - **One (1) client had the maximum score of 186 at pre- and post-test so no change occurred.**
   - **One (1) client showed a decrease of 23 points between enrollment and discharge. This client was demonstrating a significant deterioration in his mental health at the time of discharge. He had previously completed a 6 month measure that was significantly higher than his admission score. It's unknown how much his mental health impacted each completion of the measure.**

   Lessons learned/strategies:

   As noted in last years' report, the Life Skills Assessment is likely most appropriate for younger populations who likely have less experience living on their own and yet the average age of our clients is mid-forties. The average pre-test score for clients served in FY20 (92.5%) is even higher than it was in FY19 (89.5%). We understand that a client's self-report that they know how to perform a given life skill is not the same as seeing them demonstrate performance of that task. We continue to grapple with how we can meaningfully capture a client's ability to successfully complete a given task.

   We also understand that there is more than knowledge of basic life skills that are preventing clients from being able to successfully manage housing and employment (e.g., trauma, mental health and/or substance issues, situational factors, etc.). During this next year, we will plan to connect with other providers to evaluate what assessments and tools they may be using to understand the skill and resource needs of their clients.

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

Six (6) of ten clients (60%) who were discharged from the ECHO program completed a participant satisfaction survey. 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 4.99.

In addition to the discharge summary, we added a point in time survey to obtain feedback from participants during program enrollment. The survey was offered to ECHO participants in January, 2020. Thirteen (13) participants were enrolled in the program at the time of administration. Nine (9) of 13 (69%) participants completed a survey. The overall item average on the survey was 4.79.

Survey comments indicated that the most helpful services include linkage to community resources and obtaining housing, furniture, food and medication. An opportunity for improvement is to continue growing the number of landlords and property managers we work with to better meet the challenges that some participants face.

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

No

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

N/A

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

N/A

(Optional) Narrative Example(s):

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

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

Utilization Data Narrative –

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

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

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

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

Treatment Plan Clients (TPC):

Defined as those individual actively accepting services and meeting with a case manager resulting in a service plan. It is estimated that this program will have 24 TPC over the course of the year.

Non-treatment Plan Clients (NTPC):

Defined as those individuals that are referred for services or are identified through street engagement efforts as eligible or likely eligible but have not yet actively accepted service engagement. Due to the unique engagement challenges of the target population, it is expected that substantial services may be provided through engagement efforts which may not result in a TPC. With a target of 80% engagement outcome, it is estimated that this program will have approximately 20 NTPC but likely will have cursory contact with a much higher number of NTPCs.

We only identified 5 clients in the NTPC category in FY20. In all cases, these were clients who entered the ECHO program and did not have an Individualized Care Plan completed at the close

of the quarter following their enrollment. Each of these clients did ultimately complete an ICP to become a TPC client.

We had 43 inquiry calls/screening contacts in FY20 – 11 of which resulted in enrollment in the ECHO program. Most individuals/providers were referred to Centralized Intake through the Regional Planning Commission.

With most ECHO clients coming through Centralized Intake, we would anticipate a relatively small number of NTPC clients to be enrolled in the ECHO program and not engage in developing an Individualized Care Plan. In developing our FY21 grant proposal we expanded the definition of NTPC to more clearly include those individuals who engage in contact with ECHO program staff via outreach and/or inquiry calls that do not enroll in the ECHO program. COVID-19 adversely impacted any street outreach efforts as our program made the decision to discontinue in-person contacts in mid-March, 2020.

Community Service Events (CSE):

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

Our program staff participated in 46 Community Service Events in FY20 which exceeded our projection. In part, the increased number of CSEs was due to opening a second program geared toward adolescents and young adults who are homeless (RHY). We participated in CSEs that provided information to several community agencies and partners that work with eligible populations. CSEs opportunities were restricted in the last quarter of FY20 due to COVID-19.

Service Contacts (SC):

Defined as the number of TPC (24) multiplied by using an assumption of an average estimated weekly service contacts for the first six months and monthly for the second six months which is an estimated 768 Service Contacts provided by the program to TPC at a minimum. Service Contacts include both direct service provision and collateral contacts (e.g., originating referral source, family member). The service contacts for NTPCs are tracked but not projected as part of the total number of Service Contacts.

While we did not average 24 TPC clients across the course of the year, we served a total of 25 clients during FY20 who were at different stages in the program across the course of the year. The average number of clients served on any given day was approximately 14 clients.
We exceeded the projected service contacts by documenting 936 services. It is important to note that the nature of services was impacted significantly by COVID-19. In mid-March, 2020, our agency made the decision to discontinue in-person contacts to maintain the safety of our clients, staff and community partners. Services documented in the last quarter of FY20 are much more often e-mails, text messages and phone calls between ECHO program staff and client or collaterals.

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

Cunningham Children's Home
Parenting Model Planning/Implementation Program
Performance Outcome Report PY20

Agency name: **Cunningham Children's Home**
Program name: **Families Stronger Together**
Submission date: **08/27/2020**

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 risk or involved in the juvenile justice system and their families to be further determined through Planning Phase.

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 the planning phase, we established the following eligibility criteria which are reflected in our FY21 grant submission:

- **Eligible youth: will live in Champaign County; will be aged 10 through 17; will have become involved, or are at risk of being involved, in the juvenile justice system; may be experiencing emotional/behavioral concerns, truancy, domestic violent, probation, pattern of chronic offenses and/or 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: substance use, IQ below 65, juvenile sex offenses, murder conviction, gang involvement and/or active psychosis**

As part of our program implementation efforts, we have developed a Referral Form to be completed by the referral agent which includes most of the information we need to evaluate client eligibility factors. In addition, the Families Stronger Together team has developed an additional list of questions to be asked of each client's family who is seeking services. Information from these sources will be provided to the Associate Director of Family Services who will make a disposition on the appropriateness/eligibility of the referral.

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

Our target population will learn about the program through referral sources, staff engagement efforts within the community, outreach events, community fliers and online through the agency's website. It is significant to note that COVID-19 has hampered community-based meetings and events throughout the past quarter of FY20.

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:

100% - 9 of 9 clients referred to Families Stronger Together received services. Three (3) NTPC clients received brief services (30 days or less). Six (6) TPC clients were enrolled in the full program. Note: All 6 TPC clients were enrolled as brief service (NTPC) clients before transitioning to the full 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:

100% - All 9 clients were assessed for eligibility with 30 days. The average time from referral to program enrollment was 10 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:

67% - Six of nine clients who enrolled in Families Stronger Together moved from brief services (NTPC) to the full program (TPC) at 30 days.

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

To be determined through the Planning Phase.

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

No TPC client was discharged from Families Stronger Together during FY20. The average length of program enrollment for the 6 clients admitted at the end of FY20 was 76 days.

Note: As part of the Planning Phase completed in FY20, we developed the following estimated average for program participation: 7 months average for Full Service (TPC) Cases

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.

Our goal is to collect data for clients in both brief (NTPC) and full service (TPC) program components.

Clients and their families have involvement with a variety of systems and/or social service agencies and programs:

- **All 9 clients were involved with (and referred by) the Youth Assessment Center;**
- **6 clients had past or pending DCFS involvement;**
- **5 clients received counseling and/or assessment services from various agencies (UIUC Psychological Services Center, Behavioral Wellness Center, Rosecrance, HopeSprings, ABC Counseling). One additional client was referred to psychiatric and counseling services, but did not have insurance to pay for services.**
- **3 clients had contact with SASS for pre-hospitalization screening (all were deflected);**
- **2 client's families received Medicaid;**
- **2 clients and/or client's family members were eligible for SSI;**
- **2 clients received services from Regional Planning Commission (one family reported enrollment with Emergency Shelter for Families program);**
- **1 client was enrolled in the READY program**
- **1 client was receiving services from CYFS**
- **1 client reported receiving services from the CU 1:1 Mentor program**

Grade level completed at the time of program enrollment was collected for all clients:

- **4th grade – 1 client**
- **7th grade – 2 clients**
- **8th grade – 2 clients**
- **9th grade – 3 clients**
- **12th grade – 1 client**

All clients are single. This demographic element was removed from the FY21 grant proposal due to the target population being children.

All clients spoke English as their primary language.

We captured very little information about the religious preferences/backgrounds of clients in FY20. While this data element is included on the referral form, it was consistently not completed by referral agents. One client reported his/her religion being Catholic. No religion was recorded for the remaining 8 clients. We will evaluate how (and/or when) to more consistently capture this information in FY21.

Disability information was not collected for clients FY20 and was removed from our FY21 grant proposal as it tends to be more closely associated with adult populations and SSI/SSDI eligibility.

Consumer Outcomes – *complete at end of year only*

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

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

We expect the impact of this project is to select a program that aims at decreasing emotional and behavioral problems and to show positive outcomes with children and families in the areas of trauma, mental illness, and delinquency. Specific outcomes will be determined based on selected model.

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

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

Outcome:	Assessment Tool Used:	Information Source:
N/A – no outcomes were identified for FY20 due to this being the Planning Phase of the program	**N/A – no specific assessment tools had been identified for FY20.**	**N/A – no information sources were identified for FY20.**

During the Planning Phase, we determined that the following outcomes will be measured in FY21:

1. **Presenting problems of the youth positively change over time.**
2. **Trauma-informed caregiving skills will be strengthened**
3. **Increase identification/utilization of family's natural supports**
4. **Improve protective factors for family**

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

Outcome information will only be collected for TPC (full program) clients. We do not yet have outcome information available for any clients due to having no TPC discharges in FY20.

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

We determined that we would not collect outcomes information from NTPC (brief services) clients due to the short-term nature of the program (30 days maximum).

5. How many total participants did your program have?

We served 6 Treatment Plan Clients (TPCs) in FY20. Three (3) additional Non-Treatment Plan Clients (NTPCs) were served only in the brief service component of the program. No TPC clients were discharged from Families Stronger Together in FY20.

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

Not applicable – no discharges

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

Not applicable – no discharges

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

While no outcome measures are yet available, the measures and timeframes were

determined as part of the planning phase. These include:

- **Strengths & Difficulties Questionnaire completed at intake and discharge**
- **ARC Tool completed quarterly and upon discharge**
- **Protective Factors Survey completed at intake and discharge**
- **Youth Connections Scale completed at intake and 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)

Strategies/Lessons Learned:

While this question is not applicable for FY20 as we did not have any discharges / client outcome information, we have noted the importance of our Families Stronger Together staff reaching out to engage family members prior to receiving the Referral Form. This active outreach/engagement has helped us build rapport and develop some trust even before they enroll in the program. This early engagement also helps demonstrate our commitment to working with both the child and their family.

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 Strengths and Difficulties Questionnaire has been normed and can provide some information about the youth served in the Families Stronger Together program.

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

Not applicable, no discharges in FY20.

(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):

From FY20 grant submission: To be determined based on model selected.

Note: During the Planning Phase, we developed the following description for Treatment Plan Clients: 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.

Non-treatment Plan Clients (NTPC):

From FY20 grant submission: To be determined based on model selected.

Note: During the Planning Phase, we developed the following description for Non-treatment Plan Clients: 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.

Community Service Events (CSE):

From FY20 grant submission: To be determined based on model selected.

Note: During the Planning Phase, we developed the following description for Community Service Events: 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.

Service Contacts (SC):

From FY20 grant submission: Definition and target to be determined during Planning Phase.

Note: During the Planning Phase, we developed the following definition/target for FY21: 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**

***Please note: Additional contacts with community partners will also be 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).

DREAAM House
DREAAM Program
Performance Outcome Report PY20

Agency name: DREAAM Opportunity Center
Program name: DREAAM
Submission date: September 11, 2020

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

1. Boys 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. Boys with an incarcerated parent and/or experiencing father deprivation.
3. Boys without access to physical activity and opportunities to improve health and wellness.
4. Parents/caregivers of boys ages 7-12 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.)?*

Priority eligibility includes: 1.) boys ages 7-13 with challenging behavior, history of suspensions or discipline referrals, or suspected ADHD indicators; 2.) boys ages 7-13 with an incarcerated parent or living in a single-family household; and 3.) Parents of DREAAM participants living with chronic stress and low emotional and social support. Other eligibility factors include low literacy skills and limited access to physical activity and positive role models.

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. Parent voice was and will always be essential to determining eligibility.

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

Parents learned about the program through outreach events, social media, 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 100% received services.

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

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

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

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

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

The actual percentage was 90%.

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

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

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

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

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

We achieved 100% engagement within that time frame.

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

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

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

Due to our pipeline model, program participants are engaged at least 10-11 months out of the year. Due to the pandemic, we had an extended break in services from mid-March to mid-April.

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.

Based on parent reports, a small percentage of DREAAMers are enrolled in special education services. A large percentage of the SDQ data indicated high levels of attention deficit behaviors. 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*	*Participant*
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 notes 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?

A total of 191 participants were in DREAAM.

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

N/A

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

Outcome data were collected from 191 participants.

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

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

Results

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

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

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. The violence prevention program was successful and youth made connections to their community.

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.
<u>Treatment Plan Clients (TPC):</u> *Participants who are continuing enrollment in program services, including summer, after-school, and social emotional programs.*
<u>Non-treatment Plan Clients (NTPC):</u> *Participants enrolled in kindergarten and will receive program services to develop healthy social emotional skills. Parents involved in the program and received family engagement services.*
<u>Community Service Events (CSE):</u> *This category includes the number of parent meetings/support groups, outreach events, and community presentations.*
<u>Service Contacts (SC):</u> *This category includes number of program activities, screenings, and family engagement events.*

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

Developmental Services Center
Family Development Program
Performance Outcome Report PY20

Agency name: **DSC**

Program name: **Family Development**

Submission date: **FY20**

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:

(a) are residents of Champaign County as shown by address;
(b) have evidence of a need for service based on an assessment;
(c) children, birth through age 5, with or at-risk for 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 under three years of age, have a 30% delay in one or more developmental areas and/or an identified qualifying disability. These same services and enhanced services for children up to age five are provided with CCDDB funds for children deemed "at-risk" but may be ineligible for state funding 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 Autism Walk, and the Buddy Walk. Additionally, Child and Family Connections makes referrals to the FD therapists.

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

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

5. a) *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application): **It is estimated that initial assessments are scheduled within seven days of initial contact.**
b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application): **100%**
c) *Actual* percentage of referred clients assessed for eligibility within that time frame: **100% of individuals referred were assessed within the given timeframe of 7 days.**
6. a) *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application): **It is estimated that children will be engaged in services within seven days of the eligibility assessment.**
b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application): **90% will engage in services within seven days.**
c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame: **100% of children were engaged in services within seven days.**
7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application): **Children may participate for one-time screening or for up to three years in the therapy program, depending on the age of child at entry.**
b) *Actual* average length of participant engagement in services: **For FY20, participants averaged 25 months of 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): **Other demographic data collected is 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, 84% of the families primarily spoke English in their homes; in 9% of the families, Spanish was the primary language and in 2% of the homes French was the primary language spoken. The remaining 5% consisted of Arabic, Mandarin, Korean, Russian, and unspecified.** • **The primary disability reported for those children receiving services was 51% for at risk of a developmental disability. Twenty-nine percent were referred because of speech delay and 12% for overall delay.** • **12% of the referrals came from parents; 5 % from daycares; 7% from physicians/clinics; and 5% from Child and Family Connections. Most of the remaining were referred by other local providers and agencies.**

Consumer Outcomes – *complete at end of year only*

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

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

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

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

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

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

Outcome:	Assessment Tool Used:	Information Source:
<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? **724 children received services in FY 20**

6. How many people did you *attempt* to collect outcome information from? **72 files were reviewed for both outcomes**

7. How many people did you *actually* collect outcome information from? **72 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 67/72 files reviewed for 93%. Parents noted improvement in children's skills in motor, communication, problem-solving, socialization, and confidence. Parents report appreciation for therapists' flexibility in scheduling, in-home therapy sessions, therapeutic techniques shared, communication, understanding, relationship-based styles, and patience. Additionally, parents' value the educational information provided that is tailored to their individual child.

Children made progress in goals identified by families on the IFSP in 68/72 reviewed for 94%.

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? The target/benchmark was met.
Outcome 1: Target of 90% was met with result of 93%.
Outcome 2: Target of 90% was met with result of 94%.

(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)

***Name changed for anonymity**

Matthew began receiving services in November 2019 after having qualified for Early Intervention a few months previously. Matthew's services included weekly developmental therapy from one of DSC's therapists and weekly speech therapy from a therapist at another agency. Matthew also received an occupational evaluation and qualified for services in December 2019. Once Matthew was making progress in his development, his mother decided to end developmental therapy but continue with the other therapies. Matthew's mother requested PLAY Project services after having concerns with his social development. Matthew and his family began PLAY Project in January 2020 provided by a therapist at DSC.

In May 2020, the IFSP team conducted annual assessments and held an annual meeting to review the results of the assessments and determine if any changes to the IFSP plan were needed. It was determined that continuing with services as outlined until Matthew reaches at least the age of three would be appropriate. Once he turns three in August 2020, the PLAY Project and speech therapy services will continue to be provided by therapists at DSC through this grant.

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)

Evaluations demonstrated that services are being helpful. This assists in making treatment decisions for each child.

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 is 655; 470 continuing children and 254 new openings = 724 children provided services in FY 20.

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. In addition, consultation to child-care centers and preschools for children enrolled in FD program services continues. FD staff participates in community groups including the Birth-to-Three Council, Infant Mental Health Learning Group, Home-Visiting Task Force, Local Inter-Agency Council (LIC), the Rantoul Community Providers, Local Area Network (LAN), and the Kindergarten Readiness group. Target is 300 and 374 events occurred.

Service Contacts (SC):

Screening contacts are the number of developmental screenings conducted by the screening coordinator. The screening coordinator continually builds new and maintains ongoing relationships with agencies serving underrepresented groups, including the Rantoul Multicultural Community Center, the Champaign Urbana Public Health District, DCFS, the Center for Youth and Family Solutions Intact Families program, Illinois State Board of Education Prevention Initiative Programs, and others. While the screening coordinator may screen children at a large resource event, the majority of developmental screenings are conducted in the child's home with the parent present.

Target is 200 and 146 were completed this year.

With the original DSC Screening Coordinator retiring, the replacement started towards the end of the first quarter. Screenings often took place at screening events and daycare facilities. Due to COVID, screenings were completed for most of third quarter and all of fourth quarter virtually.

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

Don Moyer Boys & Girls Club
C-U Change Program
Performance Outcome Report PY20

Agency name: Don Moyer Boys & Girls Club
Program name: C-U Change
Submission date: July 2020

Consumer Access – *complete at end of year only*

Eligibility for service/program

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

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

- Residents of Champaign County as shown by address;
- Have evidence of a need or service based upon an assessment;

- Have limited financial resources to meet the cost of their care.
- Youth referred will have 3 or more risk factors identified in the Target Population section.

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

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

With the program being based upon referrals, many of the programs referrals come from Champaign Youth Probation Services, the Youth Assessment Center, the READY Program, Champaign County School Representatives (i.e. administration, social workers, counselors, school resource officers, etc.) and other community organizations that may serve youth-at-risk from Mahomet, Rantoul, Urbana and Champaign. With the programs referral base coming from a variety of community based sources throughout Champaign County, CU Change is inclusive of all youth-at-risk serving systems and entities.

The program admissions process is as follows:

Step 1 - The Referral
Referral Forms will be distributed to agencies via program presentations, school meetings and community events. Referral based programs will complete the CU Change Referral Form for prospective youth and submit to the CU Change Coordinator.

Step 2 - The Family Contact and Conference
Upon receiving referral, the CU Change Coordinator contacts the parent/guardian of the prospective youth to schedule a family conference. During the conference the CU Change coordinator discusses the dynamics of the referral to the program. Youth and the parent/guardian have the opportunity to describe challenges at home, school, peers and/or social issues. Throughout this process risk factors are identified and determined. The CU Change Coordinator then explains the program expectations and parameters which include the following:

- Youth must be a resident of Champaign County as shown by address
- Must show need for services by assessment, income and/or referral
- Have limited financial resources to meet the cost of their care.
- Youth must have 3 or more risk factors identified in the Target Population section.
- Youth must be between the ages of 11-18.
- Youth must engage and participate in required classes throughout the school day.

- Youth must be involved in required programs (i.e., counseling sessions, classes, groups, etc.)
- Youth must follow all respective school rules and the DMBGC Code of Conduct
- Parents/Guardians or Caring Adult Mentor are required to attend a quarterly student progress 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 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:
91%

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):

85%

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

49 of 56 87**%**

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:

49 of 56 87%

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:

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)

Household Income
Household Type
Head of Household

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?

1. 30 of 40 participants will demonstrate Improved Educational Achievement and Progress. Actual outcome 43 of 51 84%.
2. 30 of 40 participants will demonstrate Improved School Attendance and Behavior. Actual outcome 38 of 51 75%
3. 26 of 40 participants will demonstrate Improved Social-Emotional Skills. Actual Outcome 42 of 51 82%
4. 32 of 40 participants will demonstrate Improved Use of Free Time and Sense of Community. Actual Outcome 40 of 51 78%
5. 32 of 40 participants will demonstrate Improved Beliefs/Value System and Future Orientation (Goal-Setting). Actual Outcome 37 of 51 72%
6. 32 of 40 participants will demonstrate Reduced Aggression and Acts of Violence. Actual Outcome 39 of 51 76%
7. 32 of 40 participants will demonstrate Improved Decision Making and Self-Concept. Actual Outcome 45 of 51 88%
8. 25 of 40 participants will demonstrate Improved Leadership and Peer Relationships. Actual Outcome 38 of 51 75%
9. 22 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 45 of 51 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:
30 of 40 participants will demonstrate Improved Educational Achievement and Progress	YASI Assessment and Intensive Case Management	Case Manager/Client
30 of 40 participants will demonstrate Improved School Attendance and Behavior	YASI Assessment, Case Management, Progress Reports and Report Cards	Case Manager/Client
26 of 40 participants will demonstrate Improved Social-Emotional Skills	- YASI Assessment and Intensive Case Management	Case Manager/Client
32 of 40 participants will demonstrate Improved Use of Free Time and Sense of Community -	YASI Assessment and Intensive Case Management.	Report Cards/Parent-teacher Conference/IEP Meetings and Client
32 of 40 participants will demonstrate Improved Beliefs/Value System and Future Orientation (Goal-Setting) -	YASI Assessment and Intensive Case Management	Report Cards/Parent-teacher Conference/IEP Meetings
32 of 40 participants will demonstrate Reduced Aggression and Acts of Violence -	YASI Assessment, Case Management, School Districts and Champaign County Probation Services.	Case Manager/Client
32 of 40 participants will demonstrate Improved Decision Making and Self-Concept -	YASI Assessment and Intensive Case Management	Case Manager/Client
25 of 40 participants will demonstrate Improved	- YASI Assessment and Intensive Case Management	Case Manager/Client

Leadership and Peer Relationships		
22 of 40 participants of applicable youth will demonstrate Reduced involvement with the Juvenile Justice System	YASI Assessment, Case Management and Champaign County Probation Services.	Report Cards/Parent-teacher Conference/IEP Meetings
36 of 40 participants will demonstrate Increased Support System (via immediate family or caring adult)	YASI 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 56 Clients for the year.

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

56 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 51 out of 56 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:

Alongside adults, our CU Change youth were facing unique stress and fears associated with the Covid-19 pandemic and significant disruptions to their lives. This stress is compounded for our teens who are already affected by other forms of trauma such as exposure to violence, addiction, poverty and unsafe living conditions. Without question, these peril and uncertain times affected some of our program outcomes. For many of these teens, the impact of this pandemic exceeded their current capacity to cope, making it even more of a challenge for CU Change staff to respond with engagement strategies of compassion and understanding. Nevertheless, CU Change Program Managers were strategic and developed ways to maintain client/family relationships and engage them in programs and services such as daily virtual programming, home visits, phone calls and food distribution.

By comparison of FY 19 'Performance Outcome Report' to FY 20 'Performance Outcome Report' there are some significant differences that occurred:

1. Program Outcomes to promote and develop life skills education report Social-Emotional Skills increased from 65% in FY19 compared to 82% in FY20.

2. Program Outcomes to demonstrate School Attendance and Behavior decreased from 88% in FY19 compared to 75% in FY20.

3. Program Outcomes to improve Social-Emotional Skills increased from 68% in FY19 compared to 82% in FY20.

4. Program Outcomes to improve Beliefs/Value System and Future Orientation (Goal-Setting) decreased from 83% in FY19 to 78% in FY20.

5. Program Outcomes to demonstrate Reduced Aggression and Acts of Violence decreased from 82% in FY19 compared to 72% in FY20.

6. Program Outcomes to demonstrate Improved Decision Making and Self-Concept decreased from 81% in FY19 compared to 76% in FY20.

7. Program Outcomes to demonstrate Improved Leadership and Peer Relationships increased from 75% in FY19 compared to 88% in FY20.

8. Program Outcome to demonstrate Improved Leadership and Peer Relationships.

stayed consistent from 75% in FY19 to 75% in FY20.

9. Program Outcomes to demonstrate Reduced involvement with the Juvenile Justice System (If Applicable) from 81% in FY19 increased to 100% in FY20.
10. Program Outcomes to demonstrate Increased Support System (via immediate family or caring adult) increased from 75% in FY19 to 88% in FY20.

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

Yes.

12. 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.

13. 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):

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.

Treatment Plan Clients (TPC): Unduplicated Number of Youth Enrolled in Program.

- Estimated – 40
- Actual - 56

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 - 70

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 – 80

Community Service Events were limited due to the COVID-19 Pandemic however attempts to set up virtual presentations and in person meetings have been scheduled.

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 – 980

Due to the impact of COVID-19 Pandemic CU Change was able to create different methods to engage with each client and provide services/support during the 4th quarter. CU Change Program Managers used every source of connection such as: telephone, email, social media and Zoom platform to stay in connection with each CU Change Client for real-time interaction. CU Change Program Mangers provided one on one case management and programming virtually daily in support of each clients' goals and success plan. CU Change also partnered with The Tinervin Foundation to distribute 236 food boxes and Central Illinois Produce to distribute dry goods, fresh produce and dairy boxes to families that were in need. CU Change Program Managers provided transportation to and from the club for all active CU Change clients in order to attend Summer Camp at Don Moyer Boys and Girls Club where they were apart of positive youth development programming, community service, case management and an opportunity to prepare for a successful school year. CU Change Program Managers were able to provide 14 virtual program Zoom sessions to improve coping and risky behaviors by leading Positive Actions Groups twice weekly. CU Change clients were apart of Don Moyer Boys and Girls Club SMART Girls, Diplomas to Degrees, Passport to Manhood, Career Launch and Street Smart virtual and in person program sessions. Each of these programs provided skills in order to improve their educational performance, 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).

Don Moyer Boys & Girls Club
CU Neighborhood Champions Program
Performance Outcome Report PY20

Agency name: Don Moyers
Program name: CUNC
Submission date: 4 September 2020

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) Youth, young adults and families who live in areas affected by high rates of domestic violence and gun-related crimes and violence. These neighborhoods are Garden Hills, the Historic North End (First Street to Goodwin East and West), University and Bradley (North and South), and East Urbana. Fresh Start participants and their families and partners could also be served when needed.

(b) Community-level peer leaders and helpers. These are "natural helpers": parents, grandparents, individuals in the faith community, school volunteers, local business leaders, and others.

(c) Social service workers, social workers, youth service providers, educators, mental health professionals, behavioral health professionals, and others who provide services and support to individuals affected by traumatic stress and traumatic community experiences.

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

a & b: 'clients' demographic information is collected on intake and/or strength & needs forms.

c. Participants who attend trainings, educational events or community meetings complete sign in sheets which collects zip code, organization, and other relevant data.

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

Individuals and families receiving services from the CVRT were informed about our services from law enforcement, other families, CARLE hospital, community outreach workers, and via direct contact by the staff.

Individuals attending our trainings and education events were informed by social media, targeted distribution of flyers, direct outreach, referrals from providers, and other media events. During COVID we have amplified our social media and targeted engagement efforts on Facebook and have had 117% increase in engagement with our post/message or our Facebook group reaches over 700 people and we have a listserve that reaches 250 people.

Organizations were informed about our trauma informed care technical supports and trainings via word of month and at CCMHB activities.

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 anticipated 60% of those referred to the program would receive services by the program.

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

100% of those referred to our program for services received services. We were able to provide some measure of support to everyone who was referred to us.

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):

Estimated time from referral to eligibility determination = on average 36 hours at max.

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 60% would be deemed as eligible.

c) *Actual* percentage of referred clients assessed for eligibility within that time frame: 100% were accessed as eligible within that time frame. Every referral met our eligibility criteria.
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 were able to access those referred for eligibility within 48 hours because the referrals were much more specific, and we were much more efficient at reaching and engaging them. A partnership with Bend the Arc & MOM's Demand Action allowed us to bring 'comfort and care' packages at the 1st or 2nd meeting that that has improved our engagement with families/individuals. *COVID has allowed us to change our expectation of the first meeting from a face to face in person meeting to a virtual or phone meeting and that has definitely expedited our engagement process.
b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application): We estimated that only 50 % would be deemed as eligible during that
c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame: 90%
7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application): 12-15 weeks.
b) *Actual* average length of participant engagement in services: 22-52 weeks. (on average it takes individuals a much longer time to get settled and connected to resources than previously anticipated.) We have only been able to close 4 families/individual files this year. We provide some small measure of support to all of our families on an as needed basis.

Demographic Information

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

We do not have a formal process for collecting other information than basic demographic information. Our strength and needs discovery tells us about household size, schools,

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

We did not collect additional demographic data in an organized form.

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. Projected Referrals to the Program (100): Survivors of gun violence (past andfuture), primarily referred by law enforcement, hospital staff, schools, the family community and self- referral sources. We actually had 37 referrals (comprised of families and individuals) in part because had less capacity to provide supports that family needed of the times they need services/supports. (we anticipated that we would provide 12-15 weeks of support/instead we provided 22-52 weeks of support to families.

2. Projected Crisis Response Services (65): These cases require immediate response within two hours after an incident of violence. We anticipate that CUNC is called to incidents of significance, such as when there are children involved, when the survivor has complex needs, when the survivor is a minor or a senior, or when the survivor's needs require an immediate response. We actually received 37 referrals and all required crisis support.

3. Information, Linkage and Engagement Contacts (255): Every individual/family referred to the program usually needs some resource and/or a connection toa resource or support. We actually provided a lot more intensive support than expected. (537 contacts)

4. 12/37 enrolled individuals/ families participating in a comprehensive wraparound planning process.

We did not use the SPR. Instead we used the FAST (Family Assessment of Needs and Strengths) as suggested by the CCMHB board in FY20 decision making process. (see attachments for additional outcomes for clients, learning collaboratives and training participants.)

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:
E.g. 1. Increased empowerment in advocacy clients	Measure of Victim Empowerment Related to Safety (MOVERS) survey	Client
To increase understanding of family needs, strengths and necessary supports.	FAST (Family Assessment of Strengths an Needs	Clients, Natural Supports, and Social/Professional Supports
To understand improve understanding of trauma and the application of trauma informed/equitable practices	Training Surveys	Training participants
Improve organization's abilities to better understand the needs of individuals who have been impacted by	Trauma Informed Care Organizational Assessment based of Roger Fallot & Maxine Harris' Creating Cultures of Trauma	Organizations identify those who complete the survey.

trauma/adversity – to improve outcomes for participants and reduce staff stress.	Informed Care Tool	

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

We only collect for clients we have sustainable relationship (NTPC's) with because our program model is designed to be short term/noninvasive and crisis oriented and our clients have distrust of systems. We try to require as little as possible from them and only collect the data needed that are aligned with their needs.

For our NTPC are still figure out how best to collect data in a virtual environment that is aligned with privacy protects and availability technology.

5. How many total participants did your program have?

We had 93 TPC/NTPC Clients
Via our Community Events and Training – in person and virtually we reached over 1200 people
We did training in person pre-COVID for 153 people via our learning collaboratives and other activities.

6. How many people did you *attempt* to collect outcome information from?
15 (clients- individuals/families) – all the families
All training participants
We have not tried to collect data from participants in our virtual activities/events.

7. How many people did you *actually* collect outcome information from? We only collected FAST data for all enrolled clients.
We collected training evaluation data for 60% of participants (and we lost the data before we changed platforms.
When we moved to a virtual platform, we collected data from 42/60 participants.

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

FAST Data is collected at the intake and at discharge (or when needs change in the family/individual is still engaged)
Training evaluations are distributed at the end of each session.
Trauma informed organizational assessments are to be distributed before the training or consultations begun and re-administered annually.

Results

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

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

See Attached information about client, learning collaborative, and training outcomes. (p. 10-16)

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

There are no comparative benchmarks or targets

11. If yes, what is that benchmark/target and where does it come from?
For our direct service work all of the outcomes are personalized based on individualized goals and plans. No two people have the same needs/concerns.

For our learning collaborative – FY20 was year one and we are just establishing benchmarks with this first cohort.

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

NA

(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):

40) TPC: Individuals who are receiving support in a 'wraparound' support plan and who have completed a needs and strength assessment

Non-treatment Plan Clients (NTPC):

35) NTPC: Individuals who receive crisis only support but who are not formally enrolled in the effort

Community Service Events (CSE): (23) CSE: 2 (8 session Healing Solutions - 40 hour trainings)= 16 2 (2 session Mini Intensive 20 hour trainings)= 4 9 (monthly champions/responder support/continuing education events) 4 (community events - events for survivors, volunteers or the larger community) *COVID provided an opportunity for us to host more events and activities for the community at large (especially for communities impacted by violence/trauma & the providers that support them). Trauma Informed Care Implementation efforts - 63 training and technical assistance events. (6 organizations - 3 baseline training, plus 9 months of consultation support and other customized training. We only worked with 5 organizations because Rosecrance – one of the organizations in the carde was large and we did not feel like we had the capacity to support other organizations. *COVID and staffing changes interrupted the consultation process for our trauma informed care implementation at 2 organizations. We are excited to be able to continue their work in FY21.
Service Contacts (SC) (255) SC (linkage, engagement, referral, and support calls to those referred or receiving services or supports via this effort.)
For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

Don Moyer Boys & Girls Club
Community Coalition Summer Initiatives Program
Performance Outcome Report PY20

Performance Outcome Report

Summer 2019 (May 1 –September 30)

Don Moyer Boys and Girls Club served as Administrative Agent to support the efforts of the Champaign County Community Coalition to create a unified community effort to address youth and community violence by providing the following: youth unemployment, structured and adult led youth activities, and activities and training to assist community members in developing neighborhood support groups and dealing with trauma.

Twelve community organizations formed a partnership to provide a range of services and activities over a five month period. Outcomes from the variety of partner programs and activities include:

- 675 youth participated in partnership programming
- 24 High school youth provided with 8 weeks of employment and employment skills training
- 41 youth participated STEM focused "street college" learning activities and robotics development
- 200 plus teens participated in weekly midnight basketball and adult mentoring
- 160 youth participated in aquatics instruction and water safety programming provided by trained aquatics safety professionals.
- 45 youth participated in weekly fine arts and music related activities
- 16 Youth participated in "Girls Only" program focusing on social and emotional skill development and reading comprehension and fluency skills
- 32 Rantoul youth participated in leadership development daily recreation activities, field trips and youth development activities
- 85 youth participated in three weeks of performance arts training and participation taught by University of Illinois performing arts faculty and students.
- 29 Youth participated in career consultations, college tours and activates, academic enhancement activities, community volunteer experiences, health and wellness activities, cultural awareness activities, and life skill development activities.
- 111 youth participated in daily sports and mentoring activities through the First String program
- Trauma Training was provided to multiple coalition partners and community members
- "Link Up" community networking activities were conducted at three major community wide events, engaging more than 500 community members.
- Multiple youth and community members participated in weekly open programs and activities

Don Moyer Boys & Girls Club
Youth & Family Services Program
Performance Outcome Report PY20

Agency name: Don Moyer Boys & Girls Club
Program name: Youth & Family Services
Submission date: 8/28/20

Consumer Access – *complete at end of year only*

Eligibility for service/program
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 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. Criteria is met based upon self-disclosure that the child has a clinical diagnosis and/or expressed concern that their child's academic, socialization, or family/community relationships are being negatively impacted by the child's behavior.
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.)? Criteria is met based upon self-disclosure that the child has a clinical diagnosis and/or expressed concern that their child's academic, socialization, or family/community relationships are being negatively impacted by the child's behavior.
How did your target population learn about your services? (e.g., from outreach events, 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 signed

MOU's with: DREAAM Academy, Rattle the Stars, Cunningham/Hope Springs, and Regional Planning Commission - Youth Assessment Center. As an organization we are committed to collaborating and partnering with other organizations in Champaign County. We will continue to pursue MOU's with other family and child serving agencies in the area. We also received referrals from Rosecrance and GROW, however were not able to secure MOU's with the agency.

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

We estimated that 60% of persons who sought assistance or were referred would receive services.

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

73% of persons who sought assistance or were referred received services from our agency.

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):

Eligibility is determined during our first contact with a client after referral. We estimated 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 the Program Plan application):

We estimated that 70% of referred clients would be assessed for eligibility withing the 14-day time frame.

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

83.7% of referred clients were assessed for eligibility withing the 14-day time frame.

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 length of time from assessment of eligibility/need to engagement in services to be 14 days. For our agency, this would be the time from first contact to acceptance 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):

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 services within that time frame:

72% of eligible clients engaged in services within the 14-day timeframe.

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

We estimated average length of time of participant engagement in services to be 9-12 months.

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

At the end of this program year, the average length of participant engagement in services was 151.2 days (approximately 5 months). It is important to note that 92% of our participants were still engaged in services at the end of this program year. They will most likely reach the 9-12 month estimated length of time during the next program year.

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)

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:

- 15 referrals were received from the mental health system.
- 15 referrals were received from the child welfare system.
- 5 referrals were received from the education system.
- 2 referrals were received from the juvenile justice system.

We need to improve on better documenting secondary system involvement and diagnosis. We collected the information, but when we tried to pull the actual data we realized it needs to be documented in a different manner to get accurate results. This
is something we will focus on for the upcoming program year.

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 impact of 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

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.)

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 (if other program staff, who?_____)

Information regarding participant outcome(s) was provided by the participants themselves as well as the Parent Peer Support Partner.

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

Outcome information was not gathered from every participant who received service.

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

Outcome information was gathered from treatment plan clients only.

6. How many total participants did your program have?

Our program had a total of 33 participants (21 TPC and 12 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, but only 40% completed the 60 day follow up FAST. The 60% of participants we did not get all outcome data for didn't make it to the 60 day follow-up because they were closed out or because of not being able to get in contact with them after COVID.

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

Information was collected at client intake and throughout length of service. Each participant engaged in services differently (frequency of contacts, length of time, level of intensity) therefore assessment administration varied at the individual client level based on need and progress. Our goal was to collect information during our initial assessment at time of enrollment 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 impact of our program activities on consumers. Specifically, we expected the following outcomes:

- Types of Support: We were not able to compile accurate data on parents/caregivers reporting a greater breadth of types of supporters they have access to when facing the challenge of raising a youth with emotional behavioral needs. We realize that we need to improve on documenting this information during the next program year.
- Presence of Support: 20% of parents/caregivers receiving peer parent support reported greater consistency of support from important people in their life.
- Acceptance of Support: 40% of parents/caregivers will report greater acceptance from people in their lives with regards to their life choices and decisions.
- Systems self-efficacy: We were not able to compile accurate data on parents/caregivers reporting greater efficacy when interacting with systems when voicing ideas to professionals. We realize that we need to improve on documenting this information during the next program year.
- Coping with Stress: 40% of parents/caregivers will report greater coping with stress when they face challenges in their lives

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

Our comparative target or benchmark level for program services would be Information was collected at client intake and throughout length of service. Our goal was to collect information during our initial assessment at time of enrollment and then every 60 days following for those we were able to.

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

Last program year we did not collect benchmark data to compare this year's data with. This program year we collected data, but still realize there is a need for improvement, as only 40% of our participants completed the initial and 60-day follow-

up. We are attributing this mostly to the COVID-19 pandemic. However, for next program year, we will at least have some benchmark data to utilize and compare.

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

We do not have outcome data from last program year to compare to data from this program year.

(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)

The typical process for engaging families for YFPSA Peer Supporters, starts first with a referral. The referral can come from any child-serving community agency within Champaign County such as: Rosecrance, YAC, probation or DREAAM. There could possibly be a self-referral. Once a referral is received it is review by the Peer Support Supervisor and then assigned to a Parent Peer Supporter.

The referral is entered into YFPSA Apricot Database system. The PPSP that is assigned is now trying to make contact by phone, driving to home, or mail/email. Contact is tried up to 10 times until the referred peer is reached Typically, if there is a crisis during the time of referral, contact can be made with peer quickly. When contact is made the PPSP introducing themselves and begin to explain what YFPSA agencies is and what type of supports we offered. This is done by sharing information that is most relevant to the peer current situations, as that all PPSP have lived experience around navigating child-serving systems.

If the peer decides to accept supports from YFPSA and appointment is made for a face to face visit to complete necessary documents such as: YFPSA Release, Family Assessment Screening Tool (FAST) and possibly a Needs Assessment Tool. However, since we have a pandemic (COVID 19) we have made all documents into electronic forms. Based on the scoring and the current need due to the referral that was made we create a Treatment Plan that will help with setting goals or tasks that we need to complete to help guide the supports and to make sure that meetings are directed, intentional and purposeful.

The type of referrals that we received ranges from youth that are in crisis with mental health challenges, support for educational needs such as IEP meetings or behavioral concerns, supports around navigating systems such as: Child Welfare, Juvenile Justice, and Mental Health. Typically, we get a lot of referrals for school support and that will require us most of the time with helping set up a good plan for supports in school and possibly mirroring those supports in home as much as possible. Having some of the same routines around work habits and structure around discipline. When it comes to
navigating Mental Health we are supporting the peer in ways to educate themselves

around their child diagnosis, medications, what type of doctors or therapist will be most helpful, but mainly the PPSP is transferring skills and allowing the parent peer to direct supports. While working with the peer we are building a peer-based relationship to help the parent peer to relate with similar experiences. The PPSP continues to support the family as needed.

Sometimes when a family is in crisis or have a high need you will be able to meet with them frequently, but once that need is met it may be difficult to contact the family/peer. Unless the peer and the peer supporter have a good peer-based relationship, even then it could be difficult to meet until something else occurs.

We not only offer the peer support we also have other activities that could provide conditional supports such as: Parent Promoting Presence (P3) support groups for parents. We provide monthly training opportunities, we have monthly activities for youth: read aloud, crafts, movie night. Supports are typically continuing with referred peer for as long as they request it, or unless we cannot make any contact in over 30 days.

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

Through evaluation, we realize that we need to tighten up on our data collection measures and review our progress more frequently.

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.

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

Treatment Plan Clients (TPC):

Treatment Plan Clients are parents/caregivers who have completed our intake and enrollment process with the development of a treatment plan.

We served 21 treatment plan clients during this program year. Our goal was 30. We would have met this goal, but COVID-19 slowed down the frequency of referrals we got.

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 12 non-treatment plan clients during this program year. Our target was 70. 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. These types of in-person activities were ceased during the 3rd and 4th quarters of this program year.

Community Service Events (CSE):

Community Service events consist of public presentations, stakeholder meetings, agency meetings, etc.

We held 32 community service events this program year. Our target was 50. We would have met this goal, but COVID-19 slowed down the frequency of community service events that could be held during the 3rd and 4th quarters of this program year.

Service Contacts (SC):

Service contacts are the number of unduplicated face-to-face and phone contacts.

We had 552 service contacts this program year. We exceeded our target by 52 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).

East Central Illinois Refugee Mutual Assistance Center
Family Support & Strengthening Program
Performance Outcome Report PY20

Agency name: East Central Illinois Refugee Mutual Assistance Center
Program name: Family Support & Strengthening
Submission date: August 28, 2020

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 .005% 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 multi-lingual 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 FY20.

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.)

Surveying our clients is a very challenging proposition. Many of our clients do not read in any language. Therefore, any survey would not be anonymous, and would increase the staff time needed to care for each client. We are adding to our staff in FY21, which might help this process. Additionally, working remotely due to COVID -19 makes administering a survey next to impossible. We have found that interpreting over the phone is much more difficult than in person. This is especially true for our many Guatemalan clients that speak an indigenous Mayan language.

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 had 2,241 unduplicated individual clients in FY 20

6. How many people did you *actually* collect outcome information from? Heads of households completed intake, so approximately 450 households completed information for social services received and employment information.

7. 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

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

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.

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

No

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

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

(Optional) Narrative Example(s):

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

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, client 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 with 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 with accompanied clients to medical appointments and school related appointments as well, to serve as an interpreter and liaison.

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

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): 128.5
Service Contacts (SC): N/A
For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

Family Service of Champaign Co.
Counseling Program
Performance Outcome Report PY20

Agency name: Family Service of Champaign County
Program name: Counseling
Submission date: August 19, 2020

Consumer Access – *complete at end of year only*

Eligibility for service/program
1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application) **People over the age of 5 who live in Champaign County and who have a need for our services are eligible. A sliding fee scale provides low income and/or uninsured clients access to affordable mental health services. In general, there are no limits to the number of sessions available to a client. The fee is reduced or waived for Drug Court clients if requested by a representative of the assessment team or the presiding Judge. This allows access to service for a group of individuals who may not have insurance or income to pay for counseling.**
2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)? **Eligibility is determined during the intake interview. Information is requested at that time regarding county of residence and other eligibility factors. The potential client is also asked several questions about their presenting issue and mental health needs. The answers provided by the client will determine if our counselors are able to appropriately address the potential client's needs. If their needs are beyond our scope of services, we refer to other professionals.**
3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.) **Many individuals who seek our services are referred from outside sources, such as Drug Court. Information about our Counseling program has been distributed to school social workers, guidance counselors, and church pastors. An informational flyer is posted on the bulletin boards of community libraries and community centers in the rural Champaign County communities. The program director represents the Counseling program as a member of the Human Services Council that meets monthly. The Counseling program is represented at the Rantoul Providers Group and is also promoted on the Family Service website and Face Book page. Any outreach event that Family Service participates in also promotes the Counseling program. This includes the DisAbility Expo, Jettie Rhodes Community Day and health fair events held at Parkland College.**
4. a) *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application): **75%**

b) *Actual* percentage of individuals who sought assistance or were referred who received services:
77% of the individuals for which a phone intake was completed received services. 12% were left voicemails and never called back to schedule an appointment. 1% of the callers received appointments for services but no showed their appointments. 1% of the callers received appointments for services but cancelled their appointment. 8% were unreachable due to leaving incomplete contact information or their voicemail box was full or not set up. 1% were referred elsewhere.

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):
90

c) *Actual* percentage of referred clients assessed for eligibility within that time frame:
100%
Referred clients are assessed for eligibility to receive services when the phone intake is competed with the therapist.

6. a) *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application):
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:
85% of clients were scheduled for appointments within the 5 day time frame. The remaining 15% were scheduled within 10 days of their initial phone intake. Clients make the decisions determining when they wanted their counseling appointments as it matched the availability of the counselors.

7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application):
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.
We collected gross family income only for those clients using the sliding fee schedule. 11% of our clients used the sliding fee schedule and the average gross income of that 11% was $19,812.50.

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.)

Outcome 1: We utilize the Outcome Rating Scale (ORS) developed by Miller & Duncan (2000). This self-report questionnaire is given to a client when their treatment plan is reviewed and/or revised. The ORS uses a gradient scale rating range of 0 (doing poorly) to 10 (doing very well) for each of the areas of functioning measured (individual, relational, social and overall functioning) for a maximum potential score of 40.

Outcome 2: Individual treatment plans are typically reviewed quarterly. Clients determine with the therapist success in meeting treatment objectives, outcomes and goals. The therapist uses the most recent treatment plan to evaluate the client's success with goal completion after a client's case is closed.

Outcome 3: The tool used is the Global Assessment of Functioning (GAF). A GAF score is determined by the therapist during the initial mental health assessment and re-determined whenever their plan is updated or the case is closed. A comparison of scores notes changes in a client's functioning. The scale ranges from 0 (inadequate information) to 100 (superior functioning).

Outcome 4: The assessment tool used is a relationship assessment developed by the Counseling program. It is completed with each Drug Court client before they can graduate. The Drug Court Judge receives a letter from the therapist noting completion of the assessment.

Additionally, in the chart below, please indicate who provided this information (e.g. participant, participant's guardian(s), clinician/service provider, other program staff (if

other program staff, indicate their role).) Please report all sources of information that apply for each assessment tool (e.g. the XYZ survey may be completed by both a youth client and their caregiver(s).

Outcome:	Assessment Tool Used:	Information Source:
E.g. 1. Increased empowerment in advocacy clients	Measure of Victim Empowerment Related to Safety (MOVERS) survey	Client
1. Individuals will report improvement in four areas of functioning (individual, relational, social and overall functioning)	**Outcome Rating Scale (ORS)**	**Client**
2. Individuals will meet the treatment goals that they established with their therapist.	**Treatment plan review**	**Client and therapist**
3. Individuals will have an improvement in their functioning over the course of treatment.	**Global Assessment of Functioning (GAF)**	**Therapist**
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? **62**

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

We attempted to collect outcome information from 62 clients.
However, some clients did not continue counseling past one or two sessions so they did not complete a treatment plan. Seven (7) non-Drug Court clients did not complete a treatment plan before discontinuing services.

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

Outcome information for outcomes 1 – 3 was collected from 38 of 38 treatment plan clients and outcome information for outcome 4 was collected from 17 of 17 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: 75% of the treatment plan clients who had both and initial and subsequent ORS score showed at least some improvement in their score during their treatment. Two clients reached the benchmark score of 35 – 40. Five 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 FY20, 4% of objectives we fully met, there was improvement on 92% of objectives but they were not fully met, and there was no progress or the clients were unable/unwilling to address 4% of objectives at the time the case was closed. For treatment plan clients whose case was still open as of 6/30/20 41% made progress on at least 83% of their objectives and goals. The remaining 59% of treatment plan clients whose case was still open as of 6/30/20 will have their first treatment plan review during the first quarter of FY21 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: 31% of clients increased their GAF score by 5 or more points. 8% of clients increased their GAF score by less than 5 points and 61% 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 72. Five 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. Eight Drug Court clients were encouraged to continue counseling after their assessment and 100% of those clients chose to do so.

(Optional) Narrative Example(s):

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

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

Utilization Data Narrative –

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

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

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

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

Treatment Plan Clients (TPC):

Treatment Plan Clients are those clients we see for at least three sessions and have the opportunity to develop a treatment plan.

In FY 20, our target was to serve 35 treatment plan clients.

We had 38 treatment plan clients in FY 20.

Non-treatment Plan Clients (NTPC):

Non-Treatment Plan Clients are primarily the Drug Court clients who we see for a one-time relationship assessment. Also included are clients who engage in service for several sessions but discontinue service before their treatment plan is complete.

In FY 20, our target was to serve 30 non-treatment plan clients.

We had 24 non-treatment plan clients in FY 20. Seventeen NTPC were Drug Court clients who completed a relationship assessment.

Community Service Events (CSE):

N/A

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).

Family Service of Champaign Co.
Self-Help Center Program
Performance Outcome Report PY20

Agency name: Family Service of Champaign County
Program name: Self-Help Center
Submission date: August 19, 2020

Consumer Access – *complete at end of year only*
Eligibility for service/program
1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application) **Those seeking the services of the Self-Help Center are not required to meet any eligibility criteria. The demographics for persons contacting the Self-Help Center are not available because information provided is confidential and anonymous. A log is kept to record the date of all phone calls and responses given. Consumers are also able to access information and services online through the Family Service webpage. All services are free except for a small registration fee to attend the biennial conference or the workshops.**
2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)? **Since there are no eligibility criteria there is no determination of eligibility.**
3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.) **Individuals learn about the Self-Help Center and its resources from extensive outreach efforts made by the coordinator and the program director. The Self-Help Center Coordinator is an active participant with several area coalitions and partnerships such as the Alliance for the Promotion of Acceptance, Inclusion and Respect, the Birth to Six**

Council and the Disability Expo Steering Committee. This involvement and leadership with creating, planning and participating in events assists the Self-Help Center to ensure that information relevant to the needs of diverse populations is delivered to those who can most benefit. A Support Group Directory is published every other year and is distributed to professionals, group leaders and members on an ongoing basis. The 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. The Self-Help Center posts information on bulletin boards in numerous human service agency lobbies, public libraries and counseling offices. The SHC mailing list includes the rural libraries and churches for distribution of the directory and other meeting notices.

4. a) *From your application,* estimated percentage of persons who sought assistance or were referred who would receive services (Consumer Access, question #4 in the Program Plan application):
95%

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

5. a) *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application):
The speed of consumer access is generally within 24 hours if a call or email occurs during business hours (in most instances response is sooner than 24 hours). Internet access is immediate. A log is kept to record the date of all phone calls and responses given.

b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application):
N/A: The Self-Help Center does not have any eligibility criteria.

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

6. a) *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application):
The Self-Help Center serves as an information clearinghouse. It links individuals to resources. There is no assessment for eligibility or time frame for engagement of services.

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

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

7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application):
When someone consults the Self-Help Center for assistance, the length of engagement varies depending on individual need. A person seeking to start a new group may require more technical assistance and support compared to an experienced group leader who is having issues of maintaining membership. The coordinator may spend a few minutes with an individual or could have several meetings that last an hour or more.

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

Demographic Information

1. *In your application* what, if any, demographic information did you indicate you would collect beyond those required (i.e. beyond race/ethnicity, age, gender, zip code)? (Demographic Information, question #1 in the Program Plan application)
Due to confidentiality and anonymity issues, limited information is collected on the information and referral calls except for the topic and if the person is a professional or a lay person. Data is collected from the conference registration form as it applies to gender, lay or professional registrant and zip code. This information lets us know how successful our outreach efforts are for participant needs.

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

Consumer Outcomes – *complete at end of year only*

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

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

Outcome 1: Through the Self-Help Center, individuals and families will be made aware of the existence of self-help groups and will be provided information and/or referral to a group(s) appropriate to address their needs (when one is available).
****Participation in public awareness activities, which include informational fairs, conferences, public education presentations, media events, and publications.**
****Continual update of the on-line version of the Support Group Directory, the Specialized Lists and the website.**
****Publication of the Self-Help Center phone number in the Sunday News-Gazette Community Calendar.**
****The rural libraries and churches in Champaign County will receive hard copies of the directory and other meeting notices.**

Outcome 2: Through the Self-Help Center, individuals wanting to start a group and group leaders experiencing difficulties will be able to effectively start and lead groups and group visibility will increase.
****Consultation services will be available to individuals wanting to start a group or to group leaders experiencing difficulties.**
****Training opportunities will be provided through the biennial Self-Help Conference and the workshops.**
****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; continual update of the on-line version of the Support Group Directory, the Specialized Lists and the website; publication of the Self-help Center phone number in the Sunday News-Gazette Community Calendar; and rural libraries and churches provided with a hard copy of the directory and other meeting notices.**	**Self-Help Center Coordinator**
2. Increased ability for individuals wanting to start a group and group leaders experiencing difficulties to find and receive training to be able to effectively start and lead groups for their group visibility to improve.	**Consultation services available; training opportunities provided through the biennial Self-Help Conference Support Group Needs survey**	**Self-Help Center Coordinator; Self-Help Center Advisory Council members**

3. **Through the Self-Help Center, professionals will be able to locate self-help groups to which they can refer their clients and will know how to work effectively with groups.**	**Distribution of the printed Support Group Directory, Specialized Lists, quarterly newsletter and website information to group leaders and professionals; Post-event evaluation of conference from attendees.**	**Self-Help Center Coordinator; Attendees at conference**
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 participants chose whether to complete a survey about the workshop. 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 FY2020, there were 4 consultations, 24 information and referral calls, 5,489 website views, 778 emails, 112 printed directories distributed, 2 health and/or information fairs at which the SHC staff participated, 7 presentations given by SHC staff, 2

newsletters distributed to the SHC mailing list, the fall Self-Help Center workshop with 16 attendees (with 3.5 CE credits available), and 16 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 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 updated and distributed.

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

- **16 participants who attended the fall workshop (workshop evaluation form)**
- **200 support group leaders (Support Group Needs survey)**

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

- **16 participants from the fall workshop but not all responded to every survey question (Conference evaluation form)**
- **16 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 2020 Self-Help Center workshop attendees. Support group data was collected in a survey conducted by the Self-Help Center in October 2020 via SurveyMonkey.

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 16 respondents:

a) Eight of the respondents were group leaders/facilitators.

b) Twelve of the respondents had been group members for more than 5 years.

c) The topic most commonly addressed within their groups (with a rate of over 60%) was mental health. Following closely were issues related to addiction and disability.

d) The majority of the reporting groups had an average attendance of up to ten members per meeting, closely followed by meetings with an average attendance 20 or more members per meeting.

e) The Self Help Center services used by the Support Groups were the Support Group Directory (67%), Self-Help Center Workshops (53%), Self-Help Center Biennial Conference (53%), and the Newsletter (40%).

f) Most of the respondents groups have been in existence for 11 years or more (81%).

g) Of the reporting group facilitators, the most frequently provided services besides the face to face meetings were a lending library (69%) and phone support (63%).

h) The top five ways in which people found out about a group according to the reporting facilitators were: 1) by a family/friend (75%) 2) by other group members (68.75%), 3) by a professional referral (62.5%), 4) information gleaned from the internet (50%) and 5) Referral from State or National Chapter and Referral from the Self-Help Center (tied at 37.5%).

i) Of the reporting facilitators, the majority of their groups utilized professionals in capacities such as facilitators (57%) and as guest speakers (43%).

j) As identified by the reporting facilitators, the top five issues presenting challenges to the group as a whole and affecting the group's ability to function smoothly were:
Attracting new members: 50%
Difficulty arranging transportation to the meeting for members: 44%
Getting members involved in sharing the work of the group: 25%
Communication among group members: 25%

Overworked facilitators or group members: 25%

The title of the fall workshop was "Laying the Groundwork for Collaboration" with Dr. Peter Patton and Kimberly Simpson.

a) 94% of the participants found the content applicable.

b) 90% of the participants said the information provided will improve the quality of their care/services.

c) 97% of the participants said the presenters provided the content clearly.

10. Is there some comparative target or benchmark level for program services? Y/N
Yes, for our workshops and conference.

11. If yes, what is that benchmark/target and where does it come from?
We set a benchmark in 2005 to obtain a good or excellent rating from all attendees of the workshops or conference regarding acquisition of skills, knowledge, satisfaction, networking opportunities and implementation of information presented by the speaker(s). This means we need to achieve 100% to meet that benchmark.

12. If yes, how did your outcome data compare to the comparative target or benchmark?
From the fall workshop, we obtained the following results from the 16 respondents:

- **100% of the participants stated the workshop met or exceeded their expectations.**
- **100% of the attendees liked the venue of University of Illinois Extension Office in Champaign, Illinois.**

(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): **N/A**

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

Community Service Events (CSE): **271 Community Service Events were completed by the Self-Help Center in FY2020.**

At the end of the FY20, COVID-19 made it impossible to meet in person and participate in fairs and presentations. However, we were able to exceed our goal of 270 CSEs as a result of meeting the needs of many people searching for groups and making active use of the webpage for seeking information. Conference attendees provided great ideas for the workshop that will be held in the fall and the biennial conference in spring 2021. The Self-Help Advisory Council is exploring virtual options to the biennial conference scheduled for spring 2021.
Service Contacts (SC): **N/A**
For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

Family Service of Champaign Co.
Senior Counseling & Advocacy Program
Performance Outcome Report PY20

Agency name: Family Service of Champaign County
Program name: Senior Counseling & Advocacy (2020)
Submission date: August 25, 2020

Consumer Access – *complete at end of year only*
Eligibility for service/program
1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application) Senior Counseling and Advocacy (C&A) services are available to any Champaign County resident age 60 or older living in a domestic setting. Many services are available to adults with disabilities. Services are also available to family or friends providing direct care to seniors in their homes. All clients must have one or more of the needs addressed by the program: anxiety, depression, isolation, grief, or other mental health issues; family concerns; neglect, abuse, or

exploitation; and/or the need to access financial or material services or benefits. There are no fees charged for the services so that income does not become a barrier to receive services.

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

Eligibility is determined by interview (address, birth date, statement of presenting need) at the time service is requested. Assessment for particular benefits or programs may be supplemented by standardized assessment as needed.

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

Staff do concerted outreach in the rural areas of the county and in residential areas of the county that have a large concentration of lower income seniors. They also participate in community events that allow us to highlight our services and to provide on-the-spot information and referral.

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

All people eligible for services receive services.

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

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 waiting list who does not qualify for service. Those who are not eligible (out of county,

not a senior or an adult with a disability) can still receive referral to other possible service agencies that may be able to help them.

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

All potential clients will be assessed for eligibility during the initial call or contact.

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

All potential clients were assessed for eligibility during initial contact.

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

New treatment plan clients are generally opened within a week with assessments completed within 2-3 weeks.

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

60 percent of clients will receive service in 15 working days or less and that 20 percent will receive service in 5 working days or less

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

49% of clients received services in 15 working days.

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

Non-treatment plan clients are those receiving and completing service within 2-3 contacts. Treatment plan and Other (caregiver clients) can remain active clients for several years if necessary.

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

Non-Treatment Plan Clients engaged in services for an average of 29 days.
Treatment Plan Clients engaged in service an average of 85 days for APS participants and an average of 2.6 years for counseling clients.

Demographic Information

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

Percentage of clients served who are low income, rural, and minority compared to census data for Champaign County seniors.

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

4% of our clients are rural
43% are minorities
83% are Low Income

Consumer Outcomes – *complete at end of year only*

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

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

Outcome 1: People will be referred to needed services for anxiety, depression, and/or social isolation.

Outcome 2: People will have reduced anxiety, depression, and social isolation scores.

Outcome 3: Seniors and adults with disabilities receiving protective services will have reduced risk scores.

Outcome 4:. The clients served by the program will reflect the demographics of senior residents in Champaign County.

Outcome 5: People will have information about benefits and services available.

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

Outcome 1: People will be referred to needed services for anxiety, depression, and/or social isolation.
*Geriatric Anxiety Scale, Geriatric Depression Scale, Geriatric Perceived Social Isolation Scale,

PEARLS PHQ-9.

Outcome 2: People will have reduced anxiety, depression, and social isolation scores.
*Geriatric Anxiety Scale, Geriatric Depression Scale, Geriatric Perceived Social Isolation Scale, PEARLS PHQ-9.

Outcome 3: Seniors and adults with disabilities receiving protective services will have reduced risk scores.
*State risk assessment tool.

Outcome 4:. The clients served by the program will reflect the demographics of senior residents in Champaign County.
*Census data and zip codes of clients.
*Percentage of clients served who are low income, rural, and minority compared to census data for Champaign County seniors.

Outcome 5: People will have information about benefits and services available.
*Information and referral logs, client satisfaction surveys.

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

Outcome:	Assessment Tool Used:	Information Source:
People will be referred to needed services for anxiety, depression, and/or social isolation.	*Geriatric Anxiety Scale, Geriatric Depression Scale, Geriatric Perceived Social Isolation Scale, PEARLS PHQ-9.	Client
People will have reduced anxiety, depression, and social isolation scores.	*Geriatric Anxiety Scale, Geriatric Depression Scale, Geriatric Perceived Social Isolation Scale, PEARLS PHQ-9.	Client
Seniors and adults with disabilities receiving	*State risk assessment tool.	Client

protective services will have reduced risk scores.		
The clients served by the program will reflect the demographics of senior residents in Champaign County.	*Census data and zip codes of clients.	Client
People will have information about benefits and services available.	*Information and referral logs, client satisfaction surveys.	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 535 Non-Treatment Plan Clients and 418 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 and depression scales were collected from most 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 14.4, indicating moderate depression. At the end of our sessions we had an average score of 10.8, indicating mild depression.

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?

N/A

(Optional) Narrative Example(s):

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

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

Utilization Data Narrative –

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

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

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

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

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

Clients counted in this category are those who require help with long term and/or complex needs including mental health issues. Their case record includes a comprehensive assessment, other assessments for depression, anxiety, social isolation, cognitive functioning and/or unmet needs. Each client has a treatment plan addressing assessed needs.

Non-treatment Plan Clients (NTPC): Clients counted in this category are those who require interventions to address needs that can be resolved in no more than two or three contacts. Their case record includes a comprehensive assessment, but no formal treatment plan is developed.
Community Service Events (CSE):
Service Contacts (SC): Activities counted in this category include information, referral and assistance provided by telephone or computer to seniors, those with disabilities, their families, service providers and the community regarding resources and services that are pertinent to aging.
For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

First Followers
Peer Mentoring for Re-Entry Program
Performance Outcome Report PY20

Agency name: FirstFollowers
Program name:Peer Mentoring
Submission date: September 2020

Consumer Access – *complete at end of year only*
Eligibility for service/program
1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application) All those impacted by incarceration but especially people with felony convictions and people returning home from prison or jail and their loved ones.

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 and check with IDOC, County or Federal Bureau of Prisons records.
3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.) Word of mouth and social media, especially Facebook.
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:60% **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): This varies widely, plus the number this year were greatly reduced due to COVID-19. We get people who have come home from prison in the previous week along with those who have been out of prison for years but are still having challenges due to their background
b) *From your application,* estimated percentage of referred clients who would be assessed for eligibility within that time frame (Consumer Access, question #6 in the Program Plan application):60%
c) *Actual* percentage of referred clients assessed for eligibility within that time frame: We don't do eligibility like that since we don't administer benefits. We provide referrals and personal support.

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): Immediately

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: N/A

7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application): 1 day to three years.

b) *Actual* average length of participant engagement in services: 1 day to three years.

Demographic Information

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 (optional)**

1. Please report here on all of the extra demographic information your program collected. We had one disabled person who participated, one transgender person, 40% of our clients were housing insecure and 50% had no employment.

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. Access to employment, education and housing (80%)
2. Access to services (80%)
3. Provide enhanced self-esteem (90%)
4. For workforce development: acquisition of basic building skills, public speaking, critical thinking, basic math (80%)

2. 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)

1. Data collection and follow up survey by volunteers or students
2. Data collection and follow up survey by volunteers
3. Focus group interviews by professional consultant
4. Focus group interviews by professional consultant; assessment tests

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:
E.g. 1. Increased empowerment in advocacy clients	Observation	Client

Access employment	Follow up interview	Client
Access housing	Follow up interview	Client
Enhanced self-esteem	Follow up interview	Peer mentor assessment
Workforce development skills	Observation by facilitator Focus group interview by consultant	Facilitator Consultant

4. Was outcome information gathered from every participant who received service, or only some? No, only some. Many are not reachable.

5. If only some participants, how did you choose who to collect outcome information from? Those we were able to contact.

6. How many total participants did your program have?

105

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

35

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

15

9. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc) Ideally every other month but the COVID-19 pandemic shut down our efforts in the second half of the year.

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 ethnoracial groups; comparing characteristics of all clients engaged versus clients retained)

We learned that the instability in people's lives in terms of housing, employment, and social/emotional factors made it difficult for them to consistently take part in our programs. However, we were able to overcome some of this by providing lots of support (e.g. transport, food) and following what experts are now labelling "relentless engagement"-i.e. staying with the people in our program through thick and thin, demonstrating that we are consistent and caring

11. Is there some comparative target or benchmark level for program services? Y/N Recidivism, employment, housing security are used though there are no real benchmarks in this work. .

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):

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) A person has spent more than four decades in prison. We have been corresponding with him during his last year in prison. We meet him at the bus station on the day of his arrival. We arranged funding for him to spend five days in a hotel and help him get his ID and medical card. He moves to the shelter while we look for a housing opportunity for him and sign him up for rental assistance and general assistance. He acquires those and we help him move into a room in a house, while procuring him some furniture. We provide him with some part-time work doing follow up interviews for us so he can pay a few bills, then he gets further employment with a part-time job with the county. We facilitate a three month-rent payment for him, gather some furniture donations for him, and help him move into his new apartment. This lays the foundation for him to put his life together in the absence of any family or other supportive individuals in the community. His case illustrates that people can be put on the right track but it takes a team of organizers, an organization of people who can empathize and point him to resources in order to put him on the pathway to success.

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) We modified our intake form and digitized the system in order to be able to gather data more effectively

Utilization Data Narrative –

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

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

Here, you will report on the different types of service categories specified in your program plan application. Please remember that programs **do not** need to collect and report on every category- instead, you are to report only the ones that are most useful for understanding program impact.
1. Please copy and paste the definitions of service categories your program specified in your program plan application in the sections below**. You will report the actual numbers of clients/contacts/community events for each reported service category in the Part II Utilization/Production data form (located on the online system).** If your estimated number of clients/contacts/community events for reported service categories significantly differ from your actual numbers, you may give a narrative explanation for that discrepancy here.
Treatment Plan Clients (TPC): Individuals who take part in support groups
Non-treatment Plan Clients (NTPC): Those who make use of our drop-in center and reentry services.
Community Service Events (CSE): Public events that we organize and focus group interviews
Service Contacts (SC):Number of meetings with employers and other sources of support
For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

GROW in Illinois
Peer-Support Program
Performance Outcome Report PY20

Agency name: GROW In Illinois
Program name: Growth to Maturity
Submission date: August 2020

Consumer Access – *complete at end of year only*

Eligibility for service/program

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

We serve anyone 18 years or older, while participation by anyone under 18 years old would need a parent's approval. There is no other criteria needed to attend GROW's Program of Growth to Maturity.

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

Phone call and discussion with parent for those under 18 years of age.

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

From the recent survey taken July 2020, we found that 12.5% of participants heard about GROW through orientations, 37.5% through family and friends, and 50% through other means (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):

In the application for this year, we did not estimate the percentage of people seeking assistance who received services.

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

100%

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

In the application for this year, we did not estimate the length of time from referral/assistance seeking to assessment of eligibility/need. 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):

In the application for this year, we did not estimate the length of time from assessment of eligibility to engagement in services.

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

In the application for this year, we did not estimate the percentage of eligible participants engaged in services within a specified time frame.

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

GROW does not currently collect this data; however, we are looking into collecting this data in the future.

7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application):
In the last application, we did not estimate an average length of participant engagement.

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 July 2020, 43.8% of participants had attended GROW for less than 1 month, 6.3% attended for 1 to 3 months, 6.3% attended between 6 months to 1 year, 12.5% attended between 1-2 years, 18.8% attended between 2-5 years, and 12.5% attended for 5 years or longer. Some of the participants were inmates of the jail and may reside there for 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, and zip code.

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

We found that 5.9% of participants identified as agnostic, 11.8% as spiritual, 76.5% as religious, 5.9% 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. increased social resources

4. increased personal growth
5. increased wellbeing
6. number of participants in leadership roles

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

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

Outcome:	Assessment Tool Used:	Information Source:
1.decreased hospitalization frequency	GROW survey	GROWERs
2.decreased medication use	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	internal (using guidelines from GROW book	Fieldworker, 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?

Outcomes 1-3 and 5-7 were collected from only those who consented to the GROW survey and were present at a survey collection session. Outcome 4 was collected from everyone.

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

The GROW survey was administered only to GROWERs who were present at the meeting in which surveys were collected and who gave their consent.

5. How many total participants did your program have?

Our program had 73 participants in FY20. We started with 21 continuing GROWers, and had 52 newcomers to groups.

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

In FY20, we attempted to collect data for outcome 4 from all 73 participants, while we attempted to collect data from outcomes 1-3 and 5-7 from 17 participants (9 baseline and 8 follow-up) who were present at the survey administration meetings or were able to complete survey on-line and who consented to the GROW survey.

7. How many people did you *actually* collect outcome information from? Outcome 4 was collected from all 73 participants, while outcomes 1-3 and 5-6 were collected from 17 participants (9 baseline and 8 follow-up) who were present at the survey administration meetings who consented to the GROW survey.

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

The survey is being administered at the end of the fiscal year [usually in 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 on-line [in addition to the written survey]. We had originally hoped to reach more individuals who were unable to attend the meeting 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. We will continue to administer the survey yearly both in group [written] and available on-line.

Results

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

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

1. decreased hospitalization frequency

On average, GROWERs 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.

2. decreased medication use

89% of GROWERs who filled out the baseline survey reported currently taking 0 medications and 25% reported taking 2 medications, with 0% taking 1, 3, 4, or 5 medications.

25% of GROWERs who filled out the follow-up survey reported currently taking 0 medications, 25% reported taking 1 medication, 25% reported taking 2 medications, 12.5% reported taking 3 medications, 12.5% reported taking 4 medications, and 0% reported taking 5 or more medications.

3. increased social resources

For GROWERS who filled out a baseline survey, the mean score for emotional support received on scale of 1 to 5 was 3.22 (with a standard deviation of 1.09), and the mean score for emotional support provided on a scale of 1 to 5 was 3.93 (with a standard deviation of 1.05).
For GROWERS who filled out a follow-up survey, the mean score for emotional support received on scale of 1 to 5 was 3.91 (with a standard deviation of 1.42), and the mean score for emotional support provided on a scale of 1 to 5 was 4.35 (with a standard deviation of 0.59).
Emotional support provided is of particular interest, because past research has indicated that this may be a key mechanism of change in mutual help groups like GROW. For example, one paper found that providing support and help to others improved psychosocial adjustment for GROW members (Roberts, Salem, Rappaport, Toro, Luke, & Seidman, 1999).

4. increased personal growth

It has been observed at the GROW Satellite Jail group (men's) that the 'mature' inmates are more likely to actively participate in the program and seem to encourage the younger inmates to participate in the program [and their own recovery]. We were only able to hold

a few Women's group at the Satellite Jail before shut down by the pandemic quarantine. We recently resumed active group meetings and have observed participation and growth for these women participants.
The GROW Rantoul Group organizer has been promoted to part-time Fieldworker Trainee. She has been active with the GROWers throughout Champaign County, helping to organize socials, involved in presentations, as well as keeping the groups stocked with literature and making sure the groups are run according to our group method. One GROWer has resumed communication with his family and maybe visiting them soon. (This is a big deal). This GROWer has also taken the step and has spoken with his doctor to decrease his medicine to a once a month shot as he was having a hard time remembering to take his prescriptions as prescribed. Another GROWer that was always hopping from one living arrangement to the next has taken charge and applied and was excepted at the EDEN Supportive Living Center. She will also be taking one college class at a time as to not overwhelm herself as is the past. All GROWer's continue to work through problems as they arise with the tools and the friends that GROW supplies them with.

5. increased wellbeing

The 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 59.11 on a scale of 0 to 100 (with a standard deviation of 32.19).

6. number of participants in leadership roles

22.2% (2 of 9) of participants who filled out a baseline survey had leadership role in GROW.
62.5% (5 of 8) of participants who filled out a baseline survey had leadership role in GROW.

7. satisfaction with GROW

On a scale of 1 to 5, participants rated their satisfaction with GROW at 4.7 on average.

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

1. Yes
2. Yes
3. No
4. No
5. Yes
6. Yes
7. No

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

1. We set a 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. No benchmark.
5. As we described in our FY20 application, the normative range for adults in Western nations [whole population] is between 70 and 80 points (International Wellbeing Group, 2013). Our benchmark is for GROWers to score within 10 points of the average wellbeing score collected on data from the International Wellbeing Group, with an aim for a score of 70. While the International Wellbeing Group surveyed adults at random, 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.
6. As described in our FY20 application, we aimed to add at least 1 leadership role per group to FY2019's leadership roles, which were held by 3 out of 12 members who took the survey.
7. No benchmark.

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

1. The average number of hospitalizations in the past year was 0.44 for baseline and 0 at follow-up, which meets our target.
2. We met our benchmark, as no participants were taking 5 or more medications.
3. no benchmark.
4. no benchmark
5. GROWERs scored 56.3 on average for baseline and 59.11 for follow-up compared to 75 on the International Wellbeing Group's survey. While these scores are outside of the 10 point range of normative data, about half of participants were in jail and there is a worldwide pandemic, which may account for lower wellbeing scores than expected.
6. In FY20, 2 out of 9 first time survey takers reported having a leadership role, and 5 of 8 follow-up survey takers also reported having a leadership role. Consequently, more than 1 leadership role was added per group, which met our benchmark.
7. no 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)

See response to #4 above.

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):</u>
N/A

<u>Non-treatment Plan Clients (NTPC):</u>
All clients in GROW are non-TPC. Although all GROWers receive services, they do not receive individualized treatment plans to treat a specific diagnosed condition.

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

1. Orientations at Church of the Living God monthly clinics since fall 2019 until March 2020 COVID-19 quarantine.

2. Orientations at Community Resource Center, OSF, Christian Health Clinic, this is to be a monthly clinic. Only met twice before quarantine.
3. Presentation on February 18 at Family Services, Champaign, IL.
4. Presentation on February 27 for the Wellness on the Farm, Champaign County Farm Bureau and Carle.
5. Virtual Presentation for the Champaign-Urbana Public Health District, Behavioral Health Interest Group May 21, 2020.

Service Contacts (SC): clients who have called and been assessed for eligibility
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).

Mahomet Area Youth Club
BLAST Program
Performance Outcome Report PY20

Agency name: Mahomet Area Youth Club
Program name: BLAST (Bulldogs Learning & Succeeding Together)
Submission date: 8/28/2020

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. Scholarship criteria is based on free and reduced lunch eligibility. The school compares each youth against their internal documentation.

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 criteria is based on free and reduced lunch eligibility. The school compares each youth against their internal documentation.

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

The school district shares information about BLAST with ALL district families through school email and social media and MAYC also shares the information with families we serve through both email and social media. Teachers, social workers and administrators also directly encourage participation with students and parents from the target population.

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 those referred will be assessed
95% of those assessed will engage in services

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

95% of those referred and assessed were able to be engaged in 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):

Within 7 days of referral participants will be assessed and within 7 days of the assessment, participants will be engaged in services.

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

100% of those referred will be assessed
95% of those assessed will engage in services

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

100% of referred clients were assessed for eligibility

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):

Within 7 days of referral participants will be assessed and within 7 days of the assessment, participants will be engaged 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):

100% of those referred will be assessed
95% of those assessed will engage in services

c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame:
95% of clients assessed as eligible were engaged in services in the 7 days time frame

7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application):
20 weeks for BLAST and 36 weeks for Kid's Club

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

12 weeks for BLAST and 26 weeks for Kid's Club (less due to school closings from March-May due to COVID-19)

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)

Income, family size and family makeup

2. Please report here on all of the extra demographic information your program collected.
Income & family size is gathered to determine eligibility

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. Improve engagement in school. MAYC strives to ensure that over 60% of kids are more engaged in school due to the afterschool program.
2. Improve attendance at school. We work to ensure that over 40% of parents expect better attendance from their children while 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.

5. 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. Improve engagement in school. MAYC strives to ensure that over 60% of kids are more engaged in school due to the afterschool program.	Parent survey	Parents, clients & BLAST coordinator
2. Improve attendance at school. We work to ensure that over 40% of parents expect better attendance from their children while enrolled in BLAST	Parent Survey	Parents, clients & BLAST coordinator
3. Increase connectivity (new friends) with peer group. We expect over 70% of kids to make new friends as part of the BLAST program.	Parent Survey	Parents, clients & BLAST coordinator
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.	Parent survey	Parents, clients & BLAST coordinator

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

No, we weren't able to do the end of year survey due to COVID-19 and the cancellation of school & BLAST in the final months of the year

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

7. How many total participants did your program have?

261

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

0- Survey wasn't possible

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

0- Survey wasn't possible

10. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc) **Should have been annually at the end of the spring semester**

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)

N/A

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)

A typical service delivery case for BLAST & Kids Club starts when a family inquires about either program and scholarship eligibility through the school district. The district enrolls students and collects required information to determine income eligibility (usually free/reduced lunch or CCAP info). Once students are enrolled and receiving scholarships for services, the district shares information with MAYC and bills us at the end of each semester for the scholarship amounts. MAYC has little to no interaction with families in an effort to not complicate the process for families.

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.

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>

Scholarships to youth with economic needs, IEP's, special classroom considerations and other developmental requirements.

Goal was 4, Actual was 33. We saw an increase in TPC's because of increased numbers in the 1st & 3rd quarters indicating new students were able to access services. This can be linked to improved and increased awareness at the district level through both district staff promoting it and parents hearing about it.
Non-treatment Plan Clients (NTPC): **Scholarships to you with economic needs** **Goal was 116, Actual was 125.**
Community Service Events (CSE): **Based on registration, program check-in, and end of program survey.** **1,000 was the goal and 1040 was actual**
Service Contacts (SC): **Based on the number of courses and days met for BLAST and Kid's Club** **2500 was the goal and 2176 was the actual due to the missing 4th quarter because of COVID.**
For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

Mahomet Area Youth Club
MYC Members Matter! Program
Performance Outcome Report PY20

Agency name: Mahomet Area Youth Club
Program name: MAYC Members Matter
Submission date: 8/28/2020

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 based on our sliding scale fees. Youth over the age of 13 are able to attend for free. Our Jr. High after-school program is free to all participants. It is available to anyone attending the Jr. high. Parents must fill out registration forms to confirm the age of the youth, and scholarship determinations are based off of submitted income documentation. The Jr. High Program is advertised on the school website and through parent updates in Skyward, the school communication platform. The club also alerts parents before each out of school session via e-mail and Facebook. Additionally, we ensure that parents are aware of the MAYC out of school program by placing flyers at Candlewood, Lake of the Woods Apartments, and Kid's Club checkout. We also let parents know about the Jr. High Program via email before it starts each semester.**
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 Mahomet-Seymour students are eligible to participate in our out-of-school programs and anyone who attends the Jr. High is eligible for the Jr. High program. This is self-reported. Sliding scale fees are determined with proof of income- either tax returns, recent pay stubs or free/reduced lunch eligibility documentation or TANF documentation.**
3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.) **Mahomet-Seymour families learn about our services through electronic announcements through the school district, social media and email blasts from MAYC.**
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): **Within 2 days from referral, 100% of those referred will be assessed. Within 2 days of assessment, 75% of those assessed will engage in services.**
b) *Actual* percentage of individuals who sought assistance or were referred who received services: **100% of those referred were assessed and 80% were then engaged in 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):

Within 2 days from referral, 100% of those referred will be assessed. Within 2 days of assessment, 75% of those assessed will engage in services.

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

Within 2 days from referral, 100% of those referred will be assessed.

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):

Within 2 days of assessment, 75% of those assessed will engage 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):

Within 2 days of assessment, 75% of those assessed will engage in services

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):
People will engage in services, on average, for 3 years.

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

3 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)

Income, family size & Family makeup

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

Income, family size, family makeup, disability, medical condistions

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. 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 90% 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.)

1. Report card data from Mahomet Schools through the Assistant Superintendent (Ensure graduation occurs on time)

2. Report card data from Mahomet Schools through the Assistant Superintendent (Improve graduation rates)
3. Report card data from Mahomet Schools through the Assistant Superintendent (Improve success in high school and post secondary education).
4. Attendance records by student through the Assistant Superintendent (Improved engagement and attendance).

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. Ensure graduation occurs on-time. At least 90% of youth will move on to the next grade level on time.	Report card data	District administration
2. Improve graduation rate. At least 90% of youth will have passing grades across Math, Science, and English.	Report card data	District administration
3. Improve success in high school and leading into post secondary education. At least 60% of	Report card data	District administration

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.	Attendance records	District administration

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

This outcome information was gathered from only some participants- only those who participated in the Jr. High afterschool program

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

We choose only to collect academic related outcome data from those that we served during the school year- the Jr. High students who participated in the afterschool program.

5. How many total participants did your program have?

163

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

33

7. How many people did you *actually* collect outcome information from?
33

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

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)

Of the 33 students in the Jr. High afterschool program:
General program participant info:
3 students live in Seymour
2 are homeless
10 have IEP's/504's
3 students identify as a race other than white

Grades/Academic achievement:

Ensure graduation occurs on-time. At least 90% of youth will move on to the next grade level on time.

100% of the 33 students moved on to the next grade

Improve graduation rate. At least 90% of youth will have passing grades across Math, Science, and English.

30 students, or 91% of students had passing grades in Math, Science and English

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.

Within the 19-20 school year, 30 students or 91% held steady or improved their grades from 1st semester to 2nd semester.

5. Attendance: Improved engagement and attendance. At least 75% of students will miss less than 5 days of school during the school year.

22 students or 66% missed 0-5 days of school
9 students or 27% missed 5.5-10 days of school
2 students or 6% missed 10.5 or more days of school

Another outcome measurement that we track for MAYC Members Matter! is income level and scholarship eligibility for out of school programs like summer camp. This helps us ensure that we are serving families in need. The summer of 2019 had high numbers in general for program participants and this past summer program was much smaller in total numbers due to COVID and the required safety & health precautions, but both programs still had more than 50% of participants who were low-income families and eligible for scholarships for our daily program fees.

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

N0

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

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

(Optional) Narrative Example(s):

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

There are two different types of "typical cases"- the first is a family learning about our out-of-school programs like summer day camp, inquiring about the program and then registering. In the registration process, we are able to learn more about the families and begin building a relationship with them. Based on this, we are able to connect families to services they may need through information sharing like social media, flyers, direct connects and referrals. We

also know that we are providing an essential service for families allowing parents to work and students to not be left home unsupervised.

The other type of "typical case" is a Jr. High student attending our afterschool program. These students are enrolled by their parents, but are often referred by teachers, social workers or other school staff. The students are enrolled into our program and then we are able to monitor missing assignments, provide tutoring and homework help, social & emotional development and opportunities for recreation and fun. Students engagement in school is improved because of this and relationships with other students and caring adults outside of home & school are developed which are critical for positive youth development.

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

Grade and attendance monitoring for the Jr. High program helps us improve our programs by being able to individualize supports.

Income & family data helps us understand our clients needs and improve offerings like meals.

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): **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.** **5 was the goal, 10 Total was served. This can be attributed to a larger group of 6th graders who were new to the Jr. High program and were in need of referrals to other service providers.**
Non-treatment Plan Clients (NTPC): **Socio-economically disadvantaged youth. Many of the youth attending our programming may have multiple risk factors that can potentially limit success as they progress to and through adulthood.** **130 was the goal, 163 was actually served. This was larger because of the growth of the Jr. High program, the addition of new out-of-school day programs and the larger amount of students served in the summer 2019 program.**
Community Service Events (CSE): **Events per 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.** **200 was the goal, 146 actual number. This was lower due to the closing of schools and the club from mid-March to early June because of COVID.**
Service Contacts (SC): **Includes at least 3 homework checks a week during the school year along with 3 checks with parents per each session as part of our out of school offerings.** **2000 was the goal and 1737 was the actual number, again lower because of the closing of schools and the club from mid-March to early June because of COVID.**
For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

Agency name: **NAMI Champaign County Illinois**
Program name: **NAMI Champaign Grant App. (2020)**
Submission date**: September 11, 2020**

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) While the programs of NAMI Champaign County's focus on helping people with mental health conditions and their families, we do not have any membership or other requirements for anyone who wishes to participate in our meetings. NAMI Champaign asks that participants in their group meetings be 18+. Members of the community and providers are also encouraged to attend.
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 health challenges, along with those having lived experience with a diagnosis of mental illness.

7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application):
NAMI Champaign is an open-door organization. Our members participate anywhere from a few meetings 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 County will ask for a phone number and email address.

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

   Phone numbers and email addresses were requested on all sign-in sheets.

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 PY 2020 due to coronavirus restrictions; we have no outcomes for those programs.

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 or a loved one are showing symptoms of mental illness.

The focus is to help people impacted by mental health problems and the public to have a deeper understanding of mental illness and to end the stigma that surrounds it. Ultimately, NAMI Champaign County wants to let those who need support to understand they are not alone.

NAMI Champaign County will create or use a rubric already in use by other affiliates to assess the impact of new programs. NAMI Champaign County wishes to realize a positive change for participants of Family & Friends with at least 60% of participants benefiting.

NAMI Champaign County wishes to realize a positive change for participants of Ending the Silence using rubrics created for this 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.)

Not applicable; Family & Friends and Ending the Silence were not offered during PY 2020 due to coronavirus restrictions. Our intended assessment tools were NAMI National's guidelines for assessing these Signature Programs.

NOTE: Two NAMI members completed training for Family & Friends, but the course was not offered in PY 2020 due to coronavirus restrictions. Six NAMI members began training for Ending the Silence. Mock presentations were to be conducted for practice, but those were cancelled due to coronavirus. Our student presenters left campus due to UIUC orders in response 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 survey may be completed by both a youth client and their caregiver(s).

Not applicable.

Outcome:	Assessment Tool Used:	Information Source:
E.g. 1. Increased empowerment in advocacy clients	Measure of Victim Empowerment Related to 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; comparing rates of retention for clients of different ethnoracial groups; comparing characteristics of all clients engaged versus clients retained)

Not applicable.

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

11. If yes, what is that benchmark/target and where does it come from?
Not applicable.

12. If yes, how did your outcome data compare to the comparative target or benchmark?
Not applicable.

(Optional) Narrative Example(s):

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

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

Utilization Data Narrative –

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

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

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

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

NAMI Champaign hosts community education nights to raise awareness and end the stigma of mental illness.

NAMI Champaign has a picnic yearly to honor the law enforcement of Champaign County.

NAMI Champaign participates in Ebertfest encouraging members to exhibit their creations.

NAMI Champaign holds trivia nights and gives speeches to students going to the U of I.

NAMI Champaign is going to host a fundraising event in 2020.

Note: Of the above CSEs, four were cancelled or postponed due to coronavirus restrictions: annual picnic honoring CIT officers, trivia nights, EbertFest, and a fundraising event (planned for May with NAMI Campus Club UIUC for Mental Health Awareness Month).

Note: Target CSEs = 45
Actual CSEs = 54
- **Q1 = 10**
- **Q2 = 20**
- **Q3 = 18**
- **Q4 = 6**

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).

Promise Healthcare
Mental Health Services with Promise Program
Performance Outcome Report PY20

Agency name: Promise Healthcare
Program name: Mental Health Services
Submission date: August 28, 2020

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.

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), General Anxiety Disorder (GAD-7), and the AUDIT screening 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 are, 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?

365 counseling
2561 psychiatry

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 - 263 counseling patients over 280 encounters from Champaign County.

We collected patient experience surveys from 71 patients.

We screened 4,038 for depression and prepared a follow-up plan of 4,945 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 2019 with some in early 2020.

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 thefollowing:

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)

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 11 measures, equal on 2 and below peers on 32 measures. For psychiatry, Promise saw patient satisfaction in decrease slightly and remain the same for counseling as compared to prior years.

Depression screening of medical patients – Promise screened and—when appropriate—provided follow-up care for 81% of eligible patients. 4,945 – eligible for depression screening and follow-up plan, 4,038 met measure (UDS year). In 2018 we were at 55% and 2017 was 36%. 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 2019 FQHC national average was 72%. The 2019 Illinois FQHC average was 78%.

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 81% of eligible patients. This exceeds the 2019 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	1	2403	466	1388	0
Q2	1	2224	354	253	0
Q3	1	2025	168	108	0
Q4	1	2262	109	80	0

Total	4	8914	1097	1829	0
Target	10	7500	850	1600	0

The adult psychiatry program served more patients (TPC) with more visits (SC) for psychiatry. The program offered fewer lunch and learns for medical providers in behavioral health and psychiatry. Primary care providers felt they needed less training and were able to support more patients with behavioral health medication (NTPC).

Counseling	CSE	SC	NTPC	TPC	Other
Continuing	0	0	0	108	0
Q1	0	501	0	79	0
Q2	0	500	0	78	0
Q3	0	496	0	33	0
Q4	0	317	0	36	0
Total	0	1814	0	334	0
Target	0	2000	0	370	0

The adult counseling program was executed as proposed.

Ped Psych	CSE	SC	NTPC	TPC	Other
Continuing	0	0	0	0	0
Q1	0	65	0	39	0
Q2	0	25	0	0	0
Q3	0	26	0	0	0
Q4	0	6	0	0	0
Total	0	122	0	39	0
Target	0	2000	0	0	0

Our contracted pediatric psychiatrist left after September 30, 2019. Promise nursing and providers continued to provide support for pediatric psychiatry patients. Most were maintained by their primary care provider. Some continued care with pediatric psychiatry at Carle and a couple moved to Promise adult psychiatry. CCMHB funding was for nursing support for these patients which was maintained through the grant year.

Agency name: Promise Healthcare
Program name: Wellness
Submission date: 8/28/20

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 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

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

3,634 or 29.01% of all patients did not have health coverage.
170 or 1.36% of all patients identified as veterans.
122 or 0.97% of all patients identified as migrant workers.
1,526 or 12.18% of all patients were homeless.
1,865 or 14.89% are best served in another language.

Information from UDS report—which is a calendar year report for 2019.

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. Maintain a percentage of mental health visits where patients do not have coverage to under 15% through outreach and enrollment efforts and help 2000 people enroll in coverage

(all programs, includes non-Promise patients as well).
3. The program will work to support patients to achieve their optimal health.

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

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

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

452 – Adult Wellness only, Champaign County only
4,945 – eligible for depression screening and follow-up plan, 4,038 met measure (UDS year)
1,990 – 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 thefollowing:

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 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 visitsfor 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.

452 unique patients
59% more patients than last year (284 patients in GY19, 269 patients in GY18)
1337 encounters/visits/contacts with adult wellness
Average 2.96 encounters/visits/contacts with adult wellness
19% more encounters that last year (1120 contacts in GY19, 250 contacts in GY18)
1372 issues addressed to reduce barriers to executing treatment plan
Average 3.04 issues per patient

01	- transportation	126
02	- food	34
03	- housing/utilities	70
04	- occupational/job resources	3
05	- medication/medical assistance	1093
06	- internal forms/fee waivers	15
07	- coverage/insurance	7

08	- other	23
09	- justice involved	1
		1372

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. 1,990 – estimated enrolled in coverage in grant year
8.99% of behavioral health patients were low-income and uninsured at the time of service during the grant year. 25.27% 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 81% of eligible patients. 4,945 patients were eligible for depression screening and follow-up plan, 4,038 met measure (UDS year). In 2018 we were at 55% and 2017 was 36%. 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 67% more patients than last year with 17% more encounters.
2. Promise enrolled 1,990 people in coverage. This is less than GY19 with 2283 enrolled and less than our goal of helping 2,000 people enroll in coverage. While slightly down all year, the program enrolled 44% fewer people in Q4 during the pandemic than the same quarter

the year prior largely due to the reduction in in-person visits. 438 patients assisted for coverage for COVID-19 testing are not reflected in the total—as it is a different kind of coverage. We did maintain a rate of uninsured patient visits for behavioral health services under 15% at 8.99% of visits for behavioral health services uninsured at the time of service. 3. The 2019 FQHC national average for depression screening and follow-up was 72%. The 2019 Illinois FQHC average was 78%. The CDC has set a national target called Healthy People 2020. Their goal is 87%. Promise was at 81%.

(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	175	48	0
Q1	15	353	43	19	534
Q2	4	322	32	14	473
Q3	2	341	0	57	543

Q4	0	321	0	64	440
Total	21	1337	250	202	1990
Target	27	600	150	150	2000

The program was executed as proposed. Wellness did serve more patients than GY19 and more than projected. This was largely due to improved fidelity in documentation and reporting.

Rape Advocacy, Counseling & Education Services
Sexual Violence Prevention Education Program
Performance Outcome Report PY20

Agency name: Rape Advocacy, Counseling, & Education Services (R.A.C.E.S.)
Program name: Sexual Violence Prevention Education
Submission date: August 2020

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

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.
- 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 are also seeing that (1) as social workers or teachers move to different schools, they continue to request our services; and (2) social workers are referring us to their SW friends at other schools. We have added schools via both methods!

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 were scheduled for services.

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

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):

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. However, a few schools never received services for FY20 due to COVID-19. There were four schools where we were unable to provide any programming for their students this year, as the initially scheduled dates fell during the shelter-in-place for Illinois. There were four schools where we were unable to fully complete programming for their students (a total of 1,007 students). And there were four schools that we were unable to see their students for the spring semester/4th quarter (estimated total of 508 students). Finally, 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, which has caused us to miss 16 sessions at the end of FY20.

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:

Not counting the exceptions detailed above related to COVID-19, all schools engaged in either 3 or 4 days of programming. The ideal length if 4 days, although we did and will continue to accept 3 days of programming if that is the best a school can offer, as there is still a measurable positive impact on the students with 3 days.

In FY20, it was an even split among 3- or 4-day programming (67 each out of 134 cycles), but there was appreciable difference between grade levels.

- 27/33 Elementary were 4 days
- 11/22 6th grade were 4 days
- 9/24 7th grade were 4 days
- 15/25 8th grade were 4 days
- 5/30 High school were 4 days (I ♥ Consent)

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)

From our 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.

It is worth acknowledging here that another reason to not collect demographic information is because we are discussing very sensitive and potentially triggering topics with minors. There are already significant barriers for minors to receive services, or to disclose abuse, and we did not want to add more by asking potentially identifying information of students. Our main philosophy with prevention programming is to create an empowerment-focused, trauma-informed space where students can ask questions and be the experts in the room. By asking identifying information, there is already a dynamic created in the space where the facilitators are authority, and therefore could potentially lead to a decrease in participation (and therefore learning).

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?

Some students – for example, if a student was absent on the final day/first day of the sessions – did not have a post-test/pre-test completed. This does not impact data analysis, as data in analyzed on a classroom level and not an individual level.

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

Many cycles we were unable to collect information from since we were unable to return due to COVID. However, we collected data from all students who completed all sessions of scheduled

programming.

5. How many total participants did your program have?

We provided services to at least 4,242 unduplicated students.

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

100% of participants

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

Due to COVID-19, we were not able to collect data on many of our elementary school students that we could not complete our cycle with, since their programming is spread out across four quarters; this was 933 students.

We collected data from EVERY school/student that we completed a cycle with during FY20.

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

Tests were conducted during the first session (pre-test) and the last session (post-test).

Results

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

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

All data was collected and analyzed with the assistance of the CCMHB Consultation Bank

- Second Step (Kindergarten-2nd grade)
  i. Mean 3.79/4, Std 0.55
  ii. N/A- this curriculum only utilizes a one-time testing model due to the age of the students and type of content.

iii. We found that there was a statistically significant increase in outcomes for schools that utilized our four-day programming (the fourth of which is a review day), versus 3 days.

We also found that there was a statistically significant increase in outcomes for schools that separated our content over the school year, versus schools that had us deliver services in a shorter time frame.

- Second Step (3rd-5th grade)

  i. Mean 4.75/5, Std 0.62

  ii. N/A- this curriculum only utilizes a one-time testing model due to the age of the students and type of content.

  iii. We found that there were significant differences for schools who utilized our 3 versus 4-day programming, as well as schools that had us deliver programming in a row versus separated across the school year. However, these results were only significant for certain outcomes (2 questions), which may be from a recency effect.

- Dating Matters (6th grade)
  i. PRE Mean 5.97/9; POST Mean 6.72/9 Std. 1.92
  ii. Increase of ~0.75 points (improvement). We found that majority (82%) of our knowledge-related questions had statistically significant differences between pre and post testing (2 were marginally significant). The two questions that were not statistically significant may be due to a ceiling effect, as pre-test numbers were high to begin with (.891 and .895 respectively).
  Additionally, we found that there was a statistically significant decrease of students marking "Not Sure" as an answer between pre and post-test.
  iii. We found that outcomes were not impacted by anomalies in delivering data (anything that might impact fidelity), by utilizing 3 or 4 days of programming, or by delivering services in a row or separated over time.
  Overall, we found that all students improved at about the same rate regardless of school.

- Safer Relationships (7th grade)
  i. PRE Mean 4.22/6; POST Mean 4.87/6. Std. 1.29
  ii. Increase of ~0.65 points (improvement). We found that the majority (70%) of our knowledge-related questions has statistically significant differences between pre and post testing. The three questions that were not statistically significant may be due to a ceiling effect, as pre-test numbers were high to begin with (.84, .88, and .83 respectively).
  iii. We found that outcomes were not impacted by anomalies in delivering data (anything that might impact fidelity).
  We did find that there was a marginally significant increase in outcomes for schools that utilized four days of programming versus three.
  Overall, we found that all students improved at about the same rate regardless of school.

- Safe Dates (8th grade)
    i. PRE Mean 4.55/8; POST Mean 6.05/8 Std. 165
    ii. Increase of ~ 1.5 points (improvement). We found that most of our knowledge-related questions (92%) had statistically significant differences between pre and post testing. The one question that was not statistically significant may be due to a ceiling effect, as pre-test numbers were high to begin with (0.84).
    iii. We found that outcomes were not impacted by anomalies in delivering data (anything that might impact fidelity), or by utilizing 3 or 4 days of programming. We did find a statistically significant difference between schools that delivered services in a row (1.87 points of growth) versus schools that had services delivered over time (1.39 points of growth).
    Overall, we found that all students improved at about the same rate regardless of school.

- I ♥ Consent (9th grade)
    i. PRE Mean 5.01/8; POST Mean 6.49/8. Std. 1.85
    ii. Increase of ~1.48 points (improvement). We found that many of our knowledge-related questions (83%) had statistically significant differences between pre and post testing. The two questions that were not statistically significant may be due to a ceiling effect, as pre-test numbers were high to begin with (.88 and .94 respectively).
    iii. We found that outcomes were not impacted by anomalies in delivering data (anything that might impact fidelity).
    We found a marginally significant difference in outcomes by school, with the largest differences between public schools and magnet/charter schools.
    We found a significant increase in outcomes for schools that utilized 3 days of programming (1.37 points of growth) versus 4 days of programming (2.47 points of growth). These outcomes may be correlated with school differences mentioned above.

- One Love (10th grade)
    i. PRE Mean 3.56/6; POST Mean 5.13/6
    ii. Increase of ~1.57 points (improvement). We found that most of our knowledge-related questions (75%) had statistically significant differences between pre and post testing. One of the two questions that was not statistically significant may be due to a ceiling effect, as pre-test numbers were high to begin with (.98).
    iii. We found a statistically significant difference in outcomes by school; however, this program was only delivered in two schools for FY19.

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 for FY19 is our benchmark for outcomes in FY20.

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

- Second Step (Kindergarten-2nd grade)
    i. In FY 19, the mean was 3.58/4, so there has been an increase in outcomes (3.79/4 for FY20).
    ii. We continue to see that all students improved at about the same rate, including across schools. There was one question where there was marginally significant difference, but there was no statistically significant difference overall.

- Second Step (3rd-5th grade)
    i. In FY 19, the mean was 4.67/5, so there has been an increase in outcomes (4.75/5).
    ii. We continue to see that all students improved at about the same rate, including across schools. There was one question that was statistically significant between schools, but there was no statistically significant difference overall.

- Dating Matters (6th grade)
    i. We did not have data to report for FY19 on this program, as it was not delivered within Champaign County. However, if we look at outcomes for schools outside of Champaign County, we can see a maintenance of outcomes (9% increase in FY19 and FY20).
    ii. We continue to see that all students improved at about the same rate, including across schools.

- Safer Relationships (7th grade)
    i. We did not have data to report for FY19 on this program, as it was not delivered within Champaign County. However, if we look at outcomes for schools outside of Champaign County, we can see an increase in outcomes (2.5% for FY19 versus 11.2% in FY20).
    ii. We continue to see that all students improved at about the same rate, including across schools.

- Safe Dates (8th grade)
    i. In FY19, we saw a ~0.87-point increase between pre and post-test, so there has been as increase in outcomes (~1.5 for FY20).
    ii. In FY19 we saw that outcomes were impacted by a school that we did not see for FY20. As stated in FY19, we believe that school was unique in its classroom management challenges, and those issues have since changed. We are glad to see that the data supports this reasoning.

- I ♥ Consent (9th grade)
    i. In FY19, we saw a ~1.3-point increase between pre and post-test, so there has been an increase in outcomes (~1.48 for FY20).
    ii. In FY20 we saw marginally significant differences in outcomes across schools that we did not see in FY19. This difference may be due to new schools that were added to our programming in FY20. We will continue to look at this outcome for FY21.

- One Love (10th grade)
    i. This is a new program for FY20, so we do not have any FY19 data to benchmark with. The evaluations that were utilized for FY20 will create our benchmark for future programming.

(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)

A large change that was made between FY19 and FY20 is how we discuss the cause of sexual violence. In FY19, we saw that many participants of our 9th grade program were unable to identify this cause, even after receiving our services (35% pre and 44% post). For FY20 we changed the way we discuss the myths around this concept: that sexual assault happens because people are drunk, that sexual assault happens because someone gets 'turned on' and can't control themselves, or that sexual assault is just someone lying. Our educators put a lot of work into re-framing this section of our programming based off of trial and error over the year, observing what delivery style and content was better received by the audience.

These changes had a HUGE impact. In FY20, we saw that 77% of students could correctly identify that sexual assault occurs because one person decides that they are entitled to sex without consent. Additionally, we saw that there was a 45% increase in students being able to correctly identify that people do not lie about sexual assault.

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 presentations was 624. This was due to making an estimation based off of a rapidly changing (and growing) programs.

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 4,242 unduplicated participants. (Actual total of participants seen is higher due to the nature of counting students without identifying information. This represents a conservative count so as to ensure no duplication.) This was due to making an estimation based off a rapidly changing (and growing) program.

For “Other”, we defined as sessions provided to the Juvenile Detention Center. Our target was 40, and we completed 24. COVID-19 resulted in the cancellation of 16 sessions. The nature of this particular service allows for a much more reliable prediction of available participants and scheduling.
For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

Rattle the Stars
Youth Suicide Prevention Education Program
Performance Outcome Report PY20

Agency name: Rattle the Stars
Program name: Suicide Prevention Education
Submission date: 8/28/2020

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 45 minutes to conduct the training.

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

Eligibility was determined by self-report. All youth attending a school in Champaign County were considered eligible. All adults who had contact with youth in Champaign County (parent, educator, service provider, coach, mentor, etc.) were eligible.

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

We had information tables at events in the community, including the Taste of CU and CU Pride Festival. We discussed our services in media promotions, posted them on our social media accounts, and distributed information in our newsletter. We established relationships with key contacts at local schools and agencies that serve youth through direct email and networking.

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):

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):

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:

92%

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: 3 hours in one session

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

Youth: 1.5 hours in varying sessions
Adults: 3.75 hours in varying sessions

Demographic Information

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

gender identity (cis- or trans-) and sexual orientation

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

21% (12/58) of Champaign County participants identified as LGBQ, and 5% (3/58) of Champaign County participants identified as Transgender.

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. Increased capacity to respond to suicidal ideation in others due to greater knowledge and understanding of suicide and increased confidence and competence to intervene.
2. Reduced stigma and negative perceptions of mental illness and suicide due to greater knowledge and understanding of the causes and risk factors for suicide.
3. Increased perceived social support and feelings of acceptance and understanding.
4. Increased use of resources and supports.
5. Fewer reports of thoughts of suicide and suicide attempts.

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 capacity to respond to suicidal ideation in others due to greater knowledge and understanding of suicide and increased confidence and competence to intervene.	Pre/post-test evaluation	Participants who attend in-person or online trainings of at least 3 hours

2. Reduced stigma and negative perceptions of mental illness and suicide due to greater knowledge and understanding of the causes and risk factors for suicide.	Pre/post-test evaluation	Participants who attend in-person or online trainings of at least 3 hours
3. Increased perceived social support and feelings of acceptance and understanding.	Pre/post-test evaluation	Participants who attend in-person or online trainings of at least 3 hours
4. Increased use of resources and supports.	Pre/post-test evaluation	Participants who attend in-person or online trainings of at least 3 hours
5. Fewer reports of thoughts of suicide and suicide attempts.	Student questionnaire or school data	Students or school 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?

Outcome information was only gathered from participants who attended in-person or online trainings lasting at least 3 hours.

5. How many total participants did your program have?

675

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

146

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

134 (58 reported zip codes 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)

Information was collected at the beginning and end of each training lasting at least 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 4.48/6 questions on knowledge about suicide (SD=1.16), and correctly answered an average of 7.68/9 questions on knowledge about what to say (SD=1.70), for a total of 12.16/15 (SD=2.24) correct answers (81.08% correct). Clients reported knowledge of suicide response plans (M=3.15, SD=.73), and rated their knowledge (M=2.97, SD=.77), skills (M=2.96, SD=.76), and comfort (M=2.93, SD=.79) to respond to suicide.

At post-test, clients correctly answered an average of 5.14/6 questions on knowledge about suicide (SD=.98), and correctly answered an average of 8.67/9 questions on knowledge about what to say (SD=.83), for a total of 13.81/15 (SD=1.21) correct answers (92.1% correct). Clients reported knowledge of suicide response plans (M=3.51, SD=.45), and rated their knowledge (M=3.74, SD=.45), skills (M=3.68, SD=.47), and comfort (M=3.51, SD=.43) to respond to suicide.

Clients that completed both pre-test and post-test had an average increase of .53 correct questions on knowledge about suicide and .95 questions on knowledge about what to say for a total increase of 1.47 correct answers. Clients had an average increase of .47 points in their knowledge of suicide response plans, and average increases of .81 points in their knowledge, .73 points in their skills, and .58 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)

Based on feedback from clients reported on the evaluation we increased the amount of time spent during adult trainings from 3 hours to 7 hours. This allowed for additional topics to be added and more time for explanation and practice of skills. Evaluations of clients completing the longer training reflect the positive change.

We are also exploring ways to help increase client's feelings of comfort in responding to suicide. While clients reported an increase in comfort, the increase was less than the increases in knowledge and skills. While knowledge and skills are important, clients may not use the skills if they do not feel comfortable doing so.

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. Our projected target for FY20 is 150 CSEs. The majority of these will be school class and workshop presentations of our intervention education program.

Our completed CSEs was significantly lower than expected. We have encountered difficulties scheduling trainings in schools (e.g. classroom time constraints, lack of staff time, lack of response capacity) and have had to spend additional time "selling" our program to schools and organizations. The reported CSEs do not reflect the time we spent on response plan consultation and building relationships with organizations. We also had many cancelled events and trainings in the 3rd and 4th quarters due to the Covid-19 pandemic.

Service Contacts (SC):

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

Rosecrance Central Illinois
Criminal Justice PSC Program
Performance Outcome Report PY20

Agency name: Rosecrance
Program name: Criminal Justice (FY 20)
Submission date: September 4, 2020

Consumer Access – *complete at end of year only*

Eligibility for service/program

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.

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

Justice involvement within the past six months and completed screening/assessment(s) indicating a mental health and/or substance use needs are the criteria for eligibility to the Criminal Justice program.

3. How did your target population learn about yourservices? (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:

- Jail staff
- The mental health staff in the jail
- Self-referrals within the jail
- Names gained through the Illinois Jail Data Link program
- Prior clients of Rosecrance who are incarcerated at the Champaign County Jail

- Individuals that are sentenced to Problem Solving Court
- Individuals that are referred by local law enforcement, courts, probation or parole
- Self-referrals from the community

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:

- 49% of jail clients engaged or received services
- 100 % of clients referred were screened

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:
18% were assessed within 5 days

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:
82%

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:
106 days

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

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)

- Increase clients' access to resources. The UIUC evaluation team will take a lead role in data analysis of linkage to resources and services
- 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.
- 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.)

- 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. June 30, 2020 is the last day linkage data will be collected for FY19.
- 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.

- 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-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?

Outcomes are reported on treatment plan clients only.

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

We chose treatment plan clients because they would be the population to receive more than just a screening.

6. How many total participants did your program have?

29 New Treatment Plan Clients and 126 New Non-Treatment Plan Clients

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

For the Self-Sufficiency Matrix we looked at the 52 people who had been discharged from the program in the fiscal year.

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

Due to the Emergency Stay in Place Order, we were not able to collect enough data from the self-sufficiency matrix that would show any significance in outcomes.

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, 2020 is the last day linkage data will be collected for FY19.

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)

At the time of this report, an analysis was not completed due to the Emergency Stay in Place Order and other Covid-19 restrictions during the third and fourth quarters, as well as turnover and training new staff in the first quarter. There was very little data within the self-sufficiency matrix; however this is an area for continued growth. This area will need further assistance from the UI Evaluation Team, where appointments will be set up together.

However, within the data gathered from the jail, a combined total was calculated for this past fiscal year. It was shown that for FY19 Substance Abuse (63.04%) and Housing (65.22%) were the highest identified needs, and the highest two areas for linked to services provided were MRT (63.64%) and Anger Management (60.42%). Thus, individuals had more identified needs for housing and substance abuse, but those who were engaged in the Anger Management and MRT groups had a greater chance of being linked to services due to those groups being offered within the jail. The reports also showed that self-referrals (44.93%) were significantly greater than any other type of referral within the jail, and majority of those were currently involved with probation(26.81%) supervision or not involved (63.04%) with any formal criminal justice supervision (i.e. parole, probation, court supervision, NGRI conditional release). Based upon these findings within the jail, we learned that when services are available within the jail, more individuals needs are met and more services they are linked to.

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?

Based upon the data collected in 2018 by the University of Illinois Evaluation Team, the highest percentage of linkages made were participants involved in MRT with 84.6% of linkages to identified needs. In addition to linkages made to MRT, at least 30% of linkages were successful. Thus, participants in MRT were more likely have their needs met compared to those who were not linked to MRT. It was also shown in the data collected that 23.5% of participants with stable housing were more likely to have linkages met than those (18.2%) do not have stable housing. At this time there is no updated data to test with the Self-Sufficiency Matrix, but will continue to collect data in FY21. Our target for next fiscal year is increasing our number of linkages with participants in MRT to 87% to an identified need. In addition to MRT, we will anticipate increasing our successful linkages to 35%.

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

Level of change is identified in response above.

(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)

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

As the second half of this fiscal year was disrupted by Covid-19 and several restrictions were put in place, the criminal justice system was shut down to the public and to our team. Working hard to communicate with the jail, probation, and drug court, albeit restricted, we were able to continue our services through virtual telehealth communication (i.e. video chat, email, and phone). Thus, these unprecedented times created difficulty in assessing and determining if any changes needed to be made due to having several disruptions through the last two quarters on top of having a great turn over within the team in the beginning of this fiscal year. As stated in number ten above, this is an area for continued growth and we will continue to utilize UI evaluation team for a closer look into the data gathered to help improve our program, as well as using the self-sufficiency matrix.

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.

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 543 requests slips were made for FY19.
For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

Rosecrance Central Illinois
Crisis, Access, & Benefits Program
Performance Outcome Report PY20

Agency name: Rosecrance Central Illinois
Program name: Crisis, Access, & Benefits
Submission date: 9/4/2020

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. There is also local advertisement through radio ads, news articles and billboards. Through community events, counselors, hospitals, doctors, and police. Rosecrance also has membership on Continuum of Care, the I-Plan committee, Mental Health Agency Council, and the Community Coalition, etc.

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

It is estimated that 100% of those seeking information, screening, or referral will receive those services.

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

Actual percentage of individuals seeking information, screening, or referral services who received this service was 100%.

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

It is estimated that clients seeking services will be screened the same day they are referred, call, or walk-in.

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

It is estimated that 100% of referred clients will be assessed for eligibility.

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

Actual percentage of clients assessed for eligibility same day they were referred, called, or walked-in was 100%.

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

If it is determined the individual is in crisis, services are provided same day. For all other services, such as psychiatric, case management, counseling/therapy, capacity/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 1,129 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 ethnoracial groups; comparing characteristics of all clients engaged versus clients retained)

Not Applicable

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

No

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

Not Applicable

12. If yes, how did your outcome data compare to the comparative target or benchmark?
Not Applicable

(Optional) Narrative Example(s):

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

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

Utilization Data Narrative –

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

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

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

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

Treatment Plan Clients (TPC):

Non-treatment Plan Clients (NTPC):

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

Rosecrance Central Illinois
Fresh Start Program
Performance Outcome Report PY20

Agency name: Rosecrance Central Illinois
Program name: C-U Fresh Start
Submission date: 08/28/2020

Consumer Access – *complete at end of year only*

Eligibility for service/program

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

The Eligibility criteria are that participants be 18 or older; be currently on probation or parole; have a prior felony arrest; have a prior gun arrest or a violent crime conviction; law enforcement must have credible information of recent involvement in violent crime; have No current unresolved case(s).

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

Law Enforcement submits a list of individuals who meet the 6 criteria. A meeting is held between Law enforcement and a subset of MDT members to review packets of information on each potential participant. Once the packets are reviewed and questions asked the 3 MDT members select the individuals that will be invited to the call-in. Law enforcement officials notify probation/parole officers of the selections.

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

The target population learns about the program through their probation/parole officer. The C-U Fresh Start community liaison coordinate with the selected individuals' probation/parole officer to schedule a meeting to do introductions, give a description of the C-U Fresh Start program, explain what the call-in is, call-in expectations, and issue an invitation.

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

The estimated % of individuals referred who received services for FY20 is 50%. FY20: There was one Call-in: 4/19; there were 3/5 Custom Notifications and 3/4 Referral Clients for a total of (36%) who received services.

b) *Actual* percentage of individuals who sought assistance or were referred who received services:
100% of participants who were referred received services this would include information on community resources and services given at the post call in to all attendees even those who eventually chose not to sign up for the program.

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

The estimated length of time from referral to assessment for FY20 is 2 weeks. This is based on FY19 results of 3 week average from call-in 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): The estimated 50% of referred clients who will be assessed within 2 weeks.

c) *Actual* percentage of referred clients assessed for eligibility within that time frame:
10 out of 10 participants were assessed for eligibility within 2 weeks. FY20 Actual: 100%

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

The estimated length of time from assessment (ANSA) to engagement in services for FY20 is 2 weeks.

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

The estimated % of call in, custom notification, and/or referral participants who sign up for services engaging within 2 weeks is 50% FY20.

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

10 out of 10 participants engaged in services within 2 weeks. FY 20 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 FY20 is 19months. This estimate is based on FY19 results: Total for all engaged participants: 119 months/24 participants= 5 months average. As long as offenders remain actively engaged in the program, are approved by the Steering Committee, and are working towards individual goals, they may continue to participate in the program. Therefore, the projected length of involvement in the program will vary by individual.

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

FY20 Target: 9 months

FY20 Actual: 15 months

FY 20 Actual: 241 months total/16 participants=15 months average

Demographic Information

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

Other demographic information collected (from ANSA): Crisis/Safety Issues; Living Situation; Family Makeup; Basic Needs/Financial; Mental Health history; Alcohol or Other Drug Abuse; Social and Recreational; Education/Vocational; Legal; Medical/Dental; and Independent Living Skills.

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

Data collected from the Adult Needs and Strengths Assessment (ANSA):

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) Decrease gun violence and violent crimes by assisting those who decide to move away from a life of crime and violence to make a fresh start via referrals/linkages to services.
   i. According to a report submitted by Champaign Chief of Police Anthony Cobb there for FY19, there were 84 shooting incidents in the city of Champaign and for FY20 there were 140 in the city of Champaign. This would mean there was a 66.67% increase between the years for Champaign.
   ii. For UPD – FY19 had 32 shooting incidents and FY20 had 42. This would mean there was a 31.25% increase for the city of Urbana.

b) Estimated percentages for 3 target areas listed below with benchmark data reported for FY19: a) % of those who agree to engage in the program will receive case management services from the Case Manager. FY19 Target: 100%; FY19 Actual: 100%; FY20 Target: 100%; FY20 Actual: 100%

c) % 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.
FY19 Target: 100%; FY19 Actual: 100%
FY20 Target: 100%; FY20 Actual: 100%

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

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

Outcome:	Assessment Tool Used:	Information Source:

Decrease gun violence	Tracked & Calculated by Champaign and Urbana police departments	Champaign Chief of Police Anthony Cobb and Mary Catherine Roberson (City of Champaign)
Participants receive case management services	Adults Needs and Strengths Assessment (ANSA)	Participants and Case Manager
Participants referred/linked to community service resource	N/A (Tracked by Case Manager in Excel Spreadsheet) (Documented in electronic health record as a progress note)	Participants Case Manager Community Resource (through participation in resource subcommittee monthly meeting)

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

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

5. How many total participants did your program have? 16

6. How many people did you *attempt* to collect outcome information from? 13

7. How many people did you *actually* collect outcome information from? 0. Surveys were mailed out to participants but none were 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. The feedback was discussed at length in the MDT committee meetings. The feedback that was received was utilized to make changes resulting in two additional, more neutral ways for participants to enter the program in addition to the Call-in.

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 clients of different ethno-racial groups; comparing characteristics of all clients engaged versus clients retained)

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 in addition to the traditional Call-in. Changes may also be made to the Call-in format for FY21 based on participant feedback as well.

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, Assistant States Attorney Office, City officials and Community Service Organizations are actively working together to address the uptick in gun violence. Despite the uptick, only one Fresh Start participant has been verified to be involved in a gun violence incident in which he was the victim. This participant is now paralyzed, but continues to meet regularly with the Community Liaison while hospitalized (rehab services).

No C-U Fresh Start victims have been charged or convicted of gun violence during FY20. Those who were re-arrested were involved in domestic violence, traffic violations, child-support default, or outstanding warrants from prior incidents outside the county. There have been individuals involved in gun violence incidents who were referred to C-U Fresh Start that had declined to participate in the program.

10. Is there some comparative target or benchmark level for program services? Y/N
Rosecrance benchmarks against previously reported client survey data year by year for quality of services provided, client satisfaction, and client report of outcomes. Additional client demographic is collected and entered into the electronic health record on each

individual client, ability to aggregate data for total clients would take a considerable amount of time, however this information is available in the electronic health record and can be reviewed during the annual site visit conducted by CCMHB staff.

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

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

(Optional) Narrative Example(s):

13. Describe a typical service delivery case to illustrate the work (this may be a "composite case" that combines information from multiple actual cases) (Your response is optional)
At-risk offender is referred to the C-U Fresh Start call-in. The participant is required to attend the call-in but not required to sign up for the program. The participant is signed up for the program during the post call-in meeting on the same night as the call-in or within 2 weeks. The case manager completes the Adults Needs and Strengths Assessment (ANSA) and a service plan with the client at intake. The assessment determines what areas of life the participant needs assistance in. Typical areas include: finding full-time employment, securing housing, obtaining medical coverage through the Affordable Care Act (ACA), and providing transportation for court and probation meetings. The case manager has telephone and/or face-to-face contact with the participant several times per week to assist them in following through with referrals and service linkage. With the support of intensive case management services the participant is able to make improvements in their daily living skills, employment, housing, education, and health with the goal of deterring them from activities that may result in gun violence. Participant may be in the program anywhere from 2 months to 15 months depending on their needs, motivation, and legal outcomes. Participants can be involved in the program as long as needed. In addition to the call-in participants can also now come in to the program through Custom Notification (CN) {participant 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.

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)

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 in addition to the traditional Call-in. Changes may also be made to the Call-in format for FY21 based on participant feedback as well.

Utilization Data Narrative –

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

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

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

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

Treatment Plan Clients (TPC): Number of unduplicated persons identified by the Fresh Start Steering Committee who engage in the program and develop a strengths-based individualized services plan with the Case Manager.
FY19 Estimated TPC: 20
FY19 Actual: 6
FY20 Target: 23
FY19 Actual: 16

Non-treatment Plan Clients (NTPC): Number of persons identified by the Fresh Start Steering Committee who choose not to engage in the program.
FY19 Estimated NTPC: 10
FY19 Actual: 16
FY20 Target: 10
FY20 Actual: 14

Community Service Events (CSE): Number of MDT (formerly Steering) Committee and other service coordination/planning meetings attended by Case Manager, Supervisor, and/or Administrator. For example, Rosecrance RCI Administrator currently participates in the Specialty Court Steering Committee, Champaign County Re-entry Council, and Crisis Response Planning Committee. The collaboration which results from participation on all of these committees/councils results in more coordinated care for individuals served by Rosecrance RCI Killarney and other organizations.
FY19 Target: 130
FY19 Actual: 190

FY20 Target: 120 FY20 Actual: 261 (telehealth meetings due to COVID-19 substantially increased this outcome)
Service Contacts (SC): SC: Number of Screenings completed. FY19 Target: 20 FY19 Actual: 3 FY20 Target: 10 FY20 Actual: 10
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. FY19 Target Other: 30 FY19 Actual: 29 FY20 Target: 40 FY20 Actual: 39
For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

Rosecrance Central Illinois
Prevention Services Program
Performance Outcome Report PY20

Agency name: Rosecrance Central Illinois
Program name: Prevention Program
Submission date: 8/27/2020

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? **Typically, all Too Good for Drugs participants take the pre and post-tests evaluations. However, due to COVID-19 school closures, our team was not able to administer pre- and post-tests to students who completed the virtual Too Good for Drugs lessons.**

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? **3946**

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

All students participating in Too Good for Drugs in Q1, Q2 and Q3. Due to COVID-19 school closures, students were unable to complete pre- and post-testing in Q4. For FY21, the Prevention Team will conduct pre- and post-testing virtually when students are working remotely.

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

2346

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

Typically, 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. However, with the uncertainty of COVID-19 closures in Q4, we were unable to collect this information from students who received virtual lessons.

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 13 % 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 6% increase in knowledge from 7th grade to 8th grade pre-test scores. This shows that there is an initial improvement in knowledge during a single school year, and retained knowledge through the grade levels.

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

There is no national or state benchmark for the Too Good For Drugs/Too Good For Violence pre/post-test results. The intent of the program is to provide an improvement from pre-test to post-test. These improvements are tracked and measured.

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

N/A

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

N/A

(Optional) Narrative Example(s):

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

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 (FY19) projected total for Community Service Events (CSEs) was 950. The actual # of CSEs completed was 1141, which was 120% completion rate.**
Service Contacts (SC):
For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

Rosecrance Central Illinois
Recovery Home Program
Performance Outcome Report PY20

Agency name: ROSECRANCE
Program name: RECOVERY HOME
Submission date: 8/24/2020
Consumer Access – *complete at end of year only*
Eligibility for service/program

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

A licensed recovery home is an alcohol and drug free housing component whose rules, peer- led groups, staff activities and other structured operations are directed toward maintenance of sobriety for persons who exhibit treatment resistance, relapse potential and/or lack of suitable recovery living environments or who recently have completed substance abuse treatment services or who may be receiving such treatment services at another licensed facility.

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

Persons interested in participating in Recovery Home services must complete an application for services. They must meet the American Society for Addiction Medicine (ASAM) criteria for Level II (intensive outpatient) or Level I (outpatient) care, and exhibit treatment resistance, relapse potential and/or lack of suitable recovery living environment.

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

Clients learn about our services from either treatment, completion of residential, court referral, Drug Court, AA and NA meetings

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

The estimated percentage of persons who seek Recovery Home services who receive the services will depend upon program eligibility and bed availability. It is estimated that 80% of those referred will receive a bed.

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

54% Due to bed availability and a higher-than-anticipated amount of applications, the percentage of clients who were engaged in services was below anticipated amount.

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

100% of those referred will be assessed prior to/at time of referral

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

100%

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

6. a) *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application):
Rosecrance coordinates access to Recovery Home services with the residential treatment provider, to offer a seamless transition at time of discharge from residential to admission to the Recovery Home. If a bed is available at time of referral, access to services will be within 1-2 days

b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application):
70%

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 stay will be 3 months.

b) *Actual* average length of participant engagement in services:
3.67 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 Champaign County residents

5. How many total participants did your program have?
23 Champaign County Residents

6. How many people did you *attempt* to collect outcome information from? **23**

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

23

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 take place in person.

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): **23**
Non-treatment Plan Clients (NTPC): **0**
Community Service Events (CSE): **0**
Service Contacts (SC):**84**

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

Rosecrance Central Illinois
Specialty Courts Program
Performance Outcome Report PY20

Agency name: Rosecrance
Program name: Specialty Courts
Submission date: August 28, 2020

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 FY20 is 62%. In 2018, 33.8% of the individuals that requested an assessment for drug court were found eligible and accepted into the program. In 2019, 61 % 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 20 53% of those who applied to drug court were found eligible AND accepted to the program. 80% assessed were accepted into the program. 33.8% of all that applied in FY20 were deemed ineligible to be assessed.
62 requests/referrals in total-
21 Denials
41 Assessed in Total
8 Assessed denied
33 Assessed Accepted

53% Assessed Acceptable and admitted.
80% of those who were assessed were accepted.
33.8% of those who applied were deemed ineligible 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): Consumers who received assessment within three business days of sentencing to Drug Court.
FY20 Target: 100% FY20 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.
FY20 Target: 100% FY20 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.)
FY20 Target: 100% FY20 Actual:100%

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

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

Estimated average length of participant engagement in services is a minimum 1 year of sobriety, however most participants are in the program for 1.5 years.

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

Average length of participant engagement in services is a minimum 1 year of sobriety, however most participants are in the program for 1.5 years. This has not changed from previous fiscal year reports due to the drug court program being set up for participants to progress through phases towards graduation from the program.

Demographic Information

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

In addition to the required demographic information Rosecrance also collects income level, education level, living arrangement, the number of dependents, contact information, primary language, religion, veteran status, marital status, employment status, and legal status.

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

Additional client demographic is collected and entered into the electronic health record on each individual client, ability to aggregate data for total clients would take a considerable amount of time,

however this information is available in the electronic health record and can be reviewed during the annual site visit conducted by CCMHB staff.

Consumer Outcomes – *complete at end of year only*

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

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

1) Drug court aims to eliminate substance abuse among the participants, decrease recidivism, help participants to achieve and maintain sobriety, and decrease the costs of crimes associated with substance abuse.

2) The Drug Court Coordinator tracks the recidivism rate of the drug court graduates. Recidivism refers to graduates who are convicted of a new charge (excluding minor traffic offenses or ordinance violations) or are returned to court on a revocation of probation. Client charts also are used to track progress in treatment, including admission and discharge data required for SAMHSA National Outcome Measures (NOMs).

3) The Champaign County Drug Court Coordinator provides the data 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.

4) The Champaign County Drug Court Coordinator provides the data the recidivism rate of the drug court graduates. Clinical staff enter admission and discharge data required for SAMHSA NOMs in the client chart at intake and at time of discharge. Positive changes in substance use, employment, education, and 12-step group involvement are anticipated for those who engage in the program.

5) Rosecrance benchmarks against previously reported data year by year for quality of services provided and NOMs outcomes.

6) a) No. of Graduates: FY19 Target: 20; FY19 Actual: 11; FY20 Target: FY20 Actual: 5 (Due to COVID-19 no graduations have been held during the 3rd or 4th quarter of FY20); b) 66% of Graduates who do not experience recidivism: FY19 Target: 65%; FY19Actual: 64%; FY20 Target: 65%; FY 20 Actual: 66%
b) Individuals with potential barriers who received Case Management services.
FY19 Target: 100%; FY19 Actual: 100%; FY20 Target: 100%FY20 Actual: 100%
(Case Management is one of the requirements that has to be met to be accepted into and continue in the drug court 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.)

All data below tracked by the Champaign County Drug Court Coordinator

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%.

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.

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.

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

Outcome:	Assessment Tool Used:	Information Source:
See #9 below	Rosecrance Client Satisfaction Survey	Clients
6) a) No. of Graduates: 18	Not applicable	Rosecrance Staff /Champaign County Drug Court Staff Report
6) b) Individuals with potential barriers who received Case Management services: 100%	Not applicable	Progress Notes in electronic health record Avatar

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

No outcome data was collected during the 2nd half of the fiscal year. Outcome data is based on previous client satisfaction survey last year. Due to COVID-19 pandemic surveys were mailed out to clients. According to the survey coordinator no surveys were returned by Specialty Courts clients.

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 2020, Rosecrance served 51 (27 continuing/24 new) unduplicated Drug Court consumers.

6. How many people did you *attempt* to collect outcome information from? 30

7. How many people did you *actually* collect outcome information from? No surveys were received back from clients?

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 from previous survey:

1) I am aware of my progress toward the goals of my treatment plan.
   a. Strongly Disagree 0 0%
   b. Disagree 0 0%
   c. Neutral 1 12%
   d. Agree 3 38%
   e. Strongly Agree 4 50%
   f. Total Responses: 8 Mean: 4.38 Standard Deviation: 0.74
2) I am satisfied with the services I receive from Rosecrance.
   a. Strongly Disagree 0 0%
   b. Disagree 0 0%
   c. Neutral 1 12%

d. Agree 4 50%
e. Strongly Agree 3 38%
f. Total Responses: 8 Mean: 4.25 Standard Deviation: 0.71

3) I feel prepared to continue my recovery and wellness outside of Rosecrance.
   a. Strongly Disagree 0 0%
   b. Disagree 0 0%
   c. Neutral 1 12%
   d. Agree 2 25%
   e. Strongly Agree 5 62%
   f. Total Responses: 8 Mean: 4.50 Standard Deviation: 0.76
4) I am satisfied with the services I have received overall.
   a. Strongly Disagree 0 0%
   b. Disagree 0 0%
   c. Neutral 1 12%
   d. Agree 4 50%
   e. Strongly Agree 3 38%
   f. Total Responses: 8 Mean: 4.25 Standard Deviation: 0.71
5) I feel better as a result of my experience at Rosecrance.
   a. Strongly Disagree 0 0%
   b. Disagree 0 0%
   c. Neutral 1 12%
   d. Agree 3 38%
   e. Strongly Agree 4 50%
   f. Total Responses: 8 Mean: 4.38 Standard Deviation: 0.74
6) Treatment at Rosecrance helped me deal with my problem/addiction.
   a. Strongly Disagree 0 0%
   b. Disagree 0 0%
   c. Neutral 1 12%
   d. Agree 3 38%
   e. Strongly Agree 4 50%
   f. Total Responses: 8 Mean: 4.38 Standard Deviation: 0.74
7) Rosecrance provides high quality care and services.
   a. Strongly Disagree 0 0%
   b. Disagree 0 0%
   c. Neutral 1 12%
   d. Agree 4 50%
   e. Strongly Agree 3 38%
   f. Total Responses: 8 Mean: 4.25 Standard Deviation: 0.71

10. Is there some comparative target or benchmark level for program services? Y/N
Rosecrance benchmarks against previously reported data year by year for quality of services provided and NOMs outcomes, however this is the first full year as Rosecrance so there is no data to benchmark against/no comparison data.

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

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

N/A

(Optional) Narrative Example(s):

13. Describe a typical service delivery case to illustrate the work (this may be a "composite case" that combines information from multiple actual cases) (Your response is optional)
A typical drug court client is referred to Champaign county drug court by their defense attorney in hopes of deferring a jail/prison sentence in exchange for participation in the drug court treatment program. The client is assessed typically in jail while awaiting court, then the assessment is reviewed and if accepted the client is referred to drug court. The client is admitted into either residential or outpatient treatment services based on the results of the substance abuse assessment. The client will spend 28 days at residential and then be transferred to intensive outpatient treatment services and eventually stepped down to continuing care treatment services as they work through the drug court phases. The client typically is followed from admission to graduation by the same addiction counselor. The client will receive case management (transportation and referral services), individual and group sessions, as well as toxicology testing. Upon completion of all treatment program requirements and drug court phases the client will participate in a graduation ceremony. Also, the client is required to have a sponsor, participate in AA/NA support groups, have a job and return once a month to sit in on a treatment group for the first 6 months following graduation.

14. In what ways was the evaluation used to support changes in practice? What changes were made based on evaluation findings? (Your response is optional) Since no surveys were received back from drug court clients, staff will be asked to collect surveys from clients directly once in-person services are resumed.

Utilization Data Narrative –

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

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

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

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

   In addition to consumers' court ordered to remain incarcerated, there were also changes to the drug court referral procedure on the court side. Potential participants are now assessed prior to being considered for drug court, therefore most referral to assessment and assessment to treatment times are longer than 3 days due to those two factors. Clients whose assessments recommend residential treatment

are court ordered to remain in jail until a residential bed opens up or to complete jail time prior to entering residential, thus impacting treatment start dates. There was also staff turnover at RCI in FY20: Addictions Counselor Natalie Hall transferred to the mental health department as of September 2019 and was eventually replaced by Caren Cohen-Heath whose start date was October 21, 2019. In addition the drug court program has been impacted by COVID-19. Three of the drug court team members were directly affected by COVID-19 with two being hospitalized and out on leave for several weeks. The third individual was out for 1 week. TPC numbers were impacted due to the Champaign County Court shutting down and putting all court hearings on hold during the Emergency Shelter in Place issued by the Governor. No graduations have been held during the last two quarters for safety reasons and limits put in place for crowd size and indoor social distancing requirements. SC (Court Reports) numbers weren't impacted by the COVID-19 pandemic due to the Judge requiring clinical staff to continue to submit reports on client progress him despite clients not being called in to court during the shutdown of the courthouse. Clinical Services were transitioned to tele-health services for both individual, group and case management services. At the end of the FY20 Rosecrance implemented a gradual return to on-site services with safety measures in place by offering hybrid group services (some clients in person and some via tele-health).

Treatment Plan Clients (TPC):

Number of Drug Court clients with a strengths-based, individualized Treatment Plan.
FY19 Target: 90 (50 Continuing, 40 New)
FY19 Actual: 48 (24 Continuing, 24 New)
FY20 Target: 90 (50 Continuing, 40 New)
FY20 Actual: 51 (27 Continuing, 24 New)
FY21 Estimate: 60 (30 Continuing, 30 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
FY19 Target: 5 total (3 M,2 G)
FY19 Actual: 9 total (7 M, 2 G)
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)

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.
FY19 Target: 1700
FY19 Actual: 1478
FY20 Target: 1500
FY20 Actual: 1467
FY21 Target: 1500

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 20 Target: 1500 (This number was based on lower drug court participant numbers in FY19 at the time of the FY20 application submission, client participation numbers have gone up slightly during FY20.)
FY20 Actual: 5,698
FY21 Target: 6,000 total (600 CM, 5,400 SH)

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

The UP Center of Champaign County
Children, Youth & Families Program
Performance Outcome Report PY20

Agency name: The UP Center of Champaign County
Program name: Children, Youth, and Families Program
Submission date: 8/25/2020

Consumer Access – *complete at end of year only*
Eligibility for service/program
1. *From your* application, what are the eligibility criteria for your services? (I.e., who is eligible for your services?) (Consumer Access, question #1 in the Program Plan application) The Program is available to all LGBTQ youth (13-18 years old) and families with LGBTQ youth living in Champaign County. There are no fees assessed and the UP Center does not seek to bill any insurance company or other 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.)? Youth and families self-select into the program based on their identities, which as self-reported. We collect zip codes along with demographic information to ensure that they are residents of Champaign County.
3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.) Youth primarily were referred to the program through GSA visits made by the Youth Program Coordinator prior to the COVID-19 pandemic. In the current situation, clients find services through google or facebook searches.
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): 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: 50% (due to fluctuations of frequency of events due to Covid-19)
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
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: 0% (This seems to be an error in our application as written; assessment to engagement cannot happen in zero days. Our assessment process is definitely rapid, due to the self-selected nature of our clientele, but it still takes on average 2-4 days to complete the email interactions required to get to know a querent and connect them to the correct program.
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: 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)

The survey is administered to all youth programming participants quarterly. The survey includes demographic questions, the Depression, Anxiety, and Stress Scale (DASS-21), the Personal Feelings Questionnaire (PFQ2), the Adolescent Alcohol and Drug Involvement Scale (AADIS) and self report of perceived social support.

At baseline, the needs of families participating in the families support group are assessed through open-ended questions. Following quarter one, families report perceived benefit from participating in the group, and areas of improvement for the group, through a series of open-ended questions.

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

Our work with the Program Evaluation Team revealed that the survey above was no longer meeting the assessment needs of our program, and we ceased administering it due to the discomfort our participants experienced in taking it. While creating the new assessment tools, we continued to evaluate the program through open-ended question. The new survey will be administered beginning in Q1 of 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.

Youth Programming:

1. Improved psychological & behavioral well-being for the individual clients.
2. Improved social well-being for the individual clients.
3. Increased positive visibility of LGBTQ+ individuals in Champaign County.
4. Increased support for LGBTQ+ and individuals in Champaign County.

Family Programming:

1. Improved support for parents of LGBTQ youth.
2. Improved knowledge of LGBTQ identities and issues for parents of LGBTQ youth.

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.)

Youth Programming:
1. DASS-21, PFQ-2, AAIDS.
2. Self-report of perceived social support.
3. Surveys distributed post-community events through our listservs and social media (e.g., Facebook) asking for positive and negative feedback on community.
4. Increase the number of inter-agency partnerships under memorandums ofunderstanding; and provide training to partnering agencies; maintain partnership with city of Champaign police.

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).

Due to the transition between the goals listed in our application and those developed with the Program Assessment team, data appropriate to the list above was not gathered.

Through this transition, all reported assessment comes from participants in the program and is self-reported.

Outcome:	Assessment Tool Used:	Information Source:
E.g. 1. Increased empowerment in advocacy clients	Measure of Victim Empowerment Related to Safety (MOVERS) survey	Client
Demographic Data	Intake survey	Client (parent if client is under 10)

3. Was outcome information gathered from every participant who received service, or only some? Demographic data was taken from all new clients.
4. If only some participants, how did you choose who to collect outcome information from? Self-assessment was voluntary through this transitional year.
5. How many total participants did your program have? 47
6. How many people did you *attempt* to collect outcome information from? All
7. How many people did you *actually* collect outcome information from? All
8. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc) At client's first participation.
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)

Visits to GSAs, especially in rural districts, is the best way to recruit students from outside of CU.
Demand for pre-teen groups remains high, though attendance to virtual program is low.
Direct relationships with organizations providing services to at-risk youth is essential to increasing our capacity to serve LGBTQ+ people in racial and economic minority groups and should be a goal for the coming year.
In Talk it UP, retention is tied to the strength of new friendships between youth, whereas UParent participants are more interested in topic-specific programming.

Administering the youth survey and continuing to develop broader assessment strategies should be a priority in FY21.

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

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

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

(Optional) Narrative Example(s):

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

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

Utilization Data Narrative –

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

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

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

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

While our averages came out close to our estimates, we experienced a sharp increase in NTPCs and SCs in Q2 and Q3 with the addition of our new Program Administrator, who enlivened our social media, and with the addition of support group programming for pre-teens and play groups for younger children. These then dropped off in Q4 during the pandemic, leading to our annual averages being close to target rather than exceeding them.

Treatment Plan Clients (TPC):

Treatment Plan Clients (TPC) will be reported as LGBTQ+ adolescents and families in need of case management services. TPCs will provide demographic information, as well as a survey asking about their present needs to develop a treatment plan. Case management includes one-on-one meetings between the Program Coordinator and the consumer 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 FY20. Returning TPCs are individuals continuing case management services from FY19 to FY20. We anticipate 3 new TPCs in FY20.

Non-treatment Plan Clients (NTPC):

Non-Treatment Plan Clients (NTPC) will be reported as LGBTQ adolescents and families attending support groups. NTPCs will be asked to complete a form asking for the same demographic information as TPCs, as well as performance metrics. New NTPCs includes individuals attending the youth or families support groups for the first time in FY20; returning NTPCs includes individuals who attended the youth or families support group in FY19 and returned for FY20. We anticipate a total of 20 new NTPCs for FY20.

Community Service Events (CSE): Community Service Events (CSES) will be reported as events held in the community with the goal of increasing sensitivity and tolerance toward LGBTQ individuals. Community Service Events can include the annual Pride Festival, Queer Prom, educational events, fundraising events, social gatherings, etc. We currently anticipate 40 CSEs during FY20.
Service Contacts (SC): Service Contacts will be reported as those individuals who contact The UP Center by email, social media, or phone inquiring about youth or family services. Service Contacts will be tracked only by their reason for contacting The UP Center in a spreadsheet. We currently anticipate 60 service contacts during FY20.
For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

Urbana Neighborhood Connections Center
Community Study Center Program
Performance Outcome Report PY20

Agency name: Urbana Neighborhood Connections Center
Program name: Community Study Center
Submission date: August 28, 2020

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 for participation in UNCC's Afterschool Study Center include: Be a resident of Champaign County (specific outreach to Urbana residents), Be enrolled in local school districts (K12); Be willing to participate in a continuum of structured and supervised out of school time academic, social emotional and recreational activities.
2. How did you determine if a particular person met those criteria (e.g., specific score on an assessment, self-report from potential participants, proof of income, etc.)? Eligibility determination for each program participant is verified by: Review of the 3-4-page registration document and Face to face meeting with parent (if child is in elementary) and child/youth
3. 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
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): **98%**
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): **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): **100%**
c) *Actual* percentage of referred clients assessed for eligibility within that time frame:

100%

6. a) *From your application,* estimated length of time from assessment of eligibility/need to engagement in services (Consumer Access, question #7 in the Program Plan application): **2 days**

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

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

7. a) *From your application*, estimated average length of participant engagement in services (Consumer Access, question #9 in the Program Plan application):
1 year with the option to continue throughout high school graduation

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

1 year with the option to continue throughout high school graduation

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)

Income level via free and/or reduced lunch or SNAP

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

Household income, free and/or reduced lunch, special education needs

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.

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. Reduced and/or minimal criminal activities by engaged youth
4. Implementation and accomplishment of 2 of the Cultural Competency Plan goals and objectives.

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
Engage targeted youth in structured out of school time educational, social emotional development and recreational activities.	**Daily Attendance Records**	**Daily Attendance Records**

Reduced and/or minimal criminal activities by engaged youth	**Consultation with parents and/or local police department**	**Parents and/or police department**
Implementation and accomplishment of 2 of the Cultural Competency Plan goals and objectives.	**Documentation per CC Plan**	**Cultural Competency Plan**

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

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

5. How many total participants did your program have?
158

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

7. How many people did you *actually* collect outcome information from?
158

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 start of program

Results

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

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

The most critical learning point during this reporting period is that by providing 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.

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

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

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

(Optional) Narrative Example(s):

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

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

Utilization Data Narrative –

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

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

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

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

Treatment Plan Clients (TPC):

Non-treatment Plan Clients (NTPC):

NCC 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).

158 unduplicated NTPC served

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).

Champaign Co. Health Care Consumers
CHW Outreach & Benefit Enrollment Program
Performance Outcome Report
PY20

Agency name: Champaign County Health Care Consumers (CCHCC)
Program name: CHW Outreach and Benefit Enrollment (2020)
Submission date: December 21, 2020 – past due

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 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:

94%

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):

90 %

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

93% - the pandemic situation which has had us working remotely led to a few delays because of having to relay messages internally and then "playing phone tag" with a few of our 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:
93% - 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.

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

This was our first year funded by CCMHB, and therefore tracking length of participant engagement in services. The average length of participant engagement in services 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 300 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	CCHCC's Intake Form, which identifies the client's needs, and our actions to assist them; applications	In most cases, client provides their own information. In some instances, a family

(Medicaid, SNAP, Rx Fund, etc.)	for Medicaid, SNAP, Rx Fund assistance	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 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 142 total participants – 48 NTPC, 103 TPC, and 8 Other.

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

We attempted to collect outcome information from 111 participants.

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

We collected outcome information from 111 participants. These were the TPC and Other 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 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 2.8 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)

Mr. A is referred to CCHCC by Carle Social Work. He is in need of help filling prescriptions, signing up for health insurance (Medicaid) and SNAP, and other social services. Carle Social Work has tried to help Mr. A, but Mr. A is anxious, slightly delusional, manic, and vacillates about getting the help that he needs from Carle, so he is referred to CCHCC. Mr. A misses multiple appointments at CCHCC, but then presents to CCHCC as a walk-in (pre-pandemic). He is not homeless, but his hygiene is very poor, and his odor is disruptive to the office. CCHCC staff member, Adani Sanchez, agrees to see him, knowing that we have been trying to work with him for a few weeks and he is in need. When he shows up at CCHCC, he is very manic, scattered, cannot focus, and asks many theoretical questions, rather than focusing on the practical matters at hand. Over the course of three months and multiple appointments/walk-ins from Mr. A, Adani is able to get his prescriptions filled, and then, as his (psych) prescriptions begin to take effect, he becomes more focused and easier to work with. Adani signs him up for Medicaid and SNAP and Carle Financial Assistance. He returns to the CCHCC office every time he gets a piece of mail from DHS, HFS, and Carle. Adani then helps Mr. A choose a Medicaid Managed Care plan that will work with the providers of his choice, and that will cover the prescriptions that he needs. This process takes multiple visits, but is finally complete. Mr. A contacts Adani multiple times throughout the year in order to get help understanding his mail, including SNAP redetermination, etc., or simply just to stop in and tell Adani a story that he thinks she will find interesting. Adani corresponds with Carle Social Work to notify them of progress with Mr. A, and to update his health insurance information at Carle. Later in the year, Mr. A is helped with LIHEAP and various other services/benefits. Mr. A is stabilized and he is more functional, though he remains manic and a bit scattered. Over time his hygiene improves as well. We remain in contact with Mr. A to make sure he is getting and taking his medications, and to let him know about expanded SNAP benefits during the pandemic, and we answer any of his questions whenever he calls or contacts CCHCC.

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 will be 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 estimate 250 to 300 TPC clients.

We recorded 103 TPC clients. We believe that this is an underestimate of the actual total number of TPC clients we served. This was our first year as an MHB funded program, and it took us some time to ramp up and design our client-tracking system for this program. So, we believe that the total number of TPC clients is actually higher, but early on, in our system, we may not have identified some MHB clients. Then, later in the fiscal year, the pandemic hit and it was 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 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 48 NTPC clients. 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 38 – far 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.

Service Contacts (SC):

We anticipate approximately 650 service contacts as a result of serving approximately 300 clients in FY2020 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 596 SCs, and we believe that this is an underestimate for the reasons stated in the TPC section. 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.

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

Champaign Co. Health Care Consumers
Justice Involved CHW Services & Benefits Program
Performance Outcome Report
PY20

Agency name: Champaign County Health Care Consumers (CCHCC)
Program name: Justice Involved CHW Services & Benefits
Submission date: December 22, 2020 (past due)

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 and involvement with the criminal justice system. Clients are also eligible by virtue of referrals by Rosecrance and the County Jail 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.**
3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.) **Our target population learned about our services through 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. Some also learned 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 learned 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 received a phone call from the Rosecrance reentry caseworker, and many received information about our services from this caseworker.

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:

91%

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):

90

c) *Actual* percentage of referred clients assessed for eligibility within that time frame:
95%

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

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:

80% - there were some delays in engagement in services for some clients who were first assessed for eligibility while they were in the County Jail. Some clients were released from the jail before Chris Garcia was able to meet with them to begin engagement in services. Often, these clients contacted Chris after they had been released from the jail.

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.

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

This was our first year funded by CCMHB, and therefore tracking 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.

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.
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 72 total participants – 11 NTPC, 58 TPC, and 3 Other.

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

We attempted to collect outcome information from 61 clients.

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

We collected outcome information from 61 participants. These were the TPC and Other 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 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 2.3 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)

Mr. G is referred to Chris Garcia by Rosecrance jail-based caseworker, Courtney Bean, because Mr. G needs health insurance. Chris meets with Mr. G in person at the Satellite Jail (pre-pandemic) and informs Mr. G that he is eligible for Medicaid and that Chris can begin the enrollment process. Mr. G does not have all of the documentation needed in order to complete the enrollment, but he informs Chris that a family member can provide the documentation, and he gives Chris permission to contact the family member. Chris also informs Mr. G that he is eligible for SNAP (food stamps) and asks him if he would like to also apply for SNAP. Mr. G says that he would like to apply for SNAP, as well as Medicaid. Upon further discussion about Mr. G's health needs and where he will go to get the health care that he needs, Chris learns that Mr. G has medical bills at Carle that he cannot afford. Chris informs Mr. G that Chris can help him apply for financial assistance at Carle, and that based on Mr. G's eligibility for Medicaid, he will get automatic approval for a 100% discount on his medical bills at Carle.

Chris follows up with Mr. G's family member in order to secure the documents needed to complete the Medicaid and SNAP applications for Mr. G. Mr. G is then released from the county jail and follows up with Chris a few days later. While in the county jail, Mr. G saw a psychiatrist who prescribed a medication for him. Mr. G needs to fill a prescription for that medication, but he has no money and his Medicaid approval is still pending, so Chris enrolls Mr. G into the CCHCC Rx Fund. Mr. G's prescription is submitted to the OSF outpatient

pharmacy because this is the pharmacy with whom CCHCC partners for the Rx Fund program. Mr. G's prescription is filled, and CCHCC pays for the cost of the prescription.

Chris continues to check the Medi system to check on the status of Mr. G's Medicaid and SNAP. He sees that Mr. G has been approved. Chris calls Mr. G to let him know to expect mail that will inform him of his approval for these programs. Chris informs Mr. G that he will need to pick a Medicaid Managed Care plan when he is prompted to do so by a letter that he will receive in the mail.

Once Mr. G receives his mail, he contacts Chris. Chris then works with Mr. G to select a Medicaid Managed Care plan that will cover him at the providers of his choice, and that will cover his prescriptions.

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 will be 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 estimate approximately 110 TPC clients.

We recorded 58 TPC clients. 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. Then, later in the fiscal year, the pandemic hit and it was 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 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 20 such clients.

We recorded 11 NTPC clients. 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 20 – 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.

Service Contacts (SC):

We anticipate approximately 350 service contacts as a result of serving approximately 100 clients in FY2020 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 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 20 SCs, and we believe that this is an underestimate for the reasons stated in the TPC section. 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. Because this was our first year of direct MHB funding, it took us some time to ramp up our process to track these types of contacts from our clients, and we believe that we simply failed to record many of these recurring 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).