A Final Report on Building Evaluation Capacity for Programs Funded by the Champaign County Community Mental Health and Developmental Disabilities Boards (CCMHDDB) Year 7

Emily Blevins, M.S.
Hope Holland, M.S.
Nathan Todd, Ph.D.
Mark Aber, Ph.D.

Department of Psychology University of Illinois, Urbana-Champaign

September 9, 2022

A Final Report on Building Evaluation Capacity for Programs Funded by the Champaign County Community Mental Health and Developmental Disabilities Boards (CCMHDDB) Year 7

Statement of Purpose:

The aim of this effort was to continue to build evaluation capacity for programs funded by the Champaign County Mental Health Board (CCMHB) and the Champaign County Developmental Disabilities Board (CCDDB). In Year 7, we proposed to continue to implement the recommendations and specific plans identified via Year 1 assessment of current evaluation activities and priorities and to build upon our previous efforts over the last few years. Specifically, we proposed the following activities and deliverables.

1. **Continue to create a learning organization among funded agencies and the CCMHB and the CCDDB.**

    a. *Prepare new "targeted" agencies to share information at MHDDAC meetings once/year by end of summer, 2022 (as schedules allow). The actual presentation will occur in the August or September following the end of the fiscal year at the MHDDAC meeting.*

Together with the CCMHB and CCDDB staff, we targeted six programs for more intensive evaluation capacity building partnership. Six programs worked closely with evaluation consultants who were doctoral students supervised by Drs. Aber and Todd. These programs developed and engaged in targeted strategies for building evaluation capacity and received sustained individual support over the course of the year from their consultant throughout the process. The processes and outcomes from these partnerships are explained in detail in Sections II through VII of this report. Each section summarizes the effort engaged with each partner agency.

These relationships were created to foster a culture of learning, first within each program and then across CCMHDDB-funded agencies as a larger system. Consultants took an intensive approach that emphasized developing a learning organization, or one that is "skilled at creating, acquiring, and transferring knowledge, and at modifying its behavior to reflect new knowledge and insights" (pp. 79; Garvin, 1993). As one example, we hoped to position these target programs as 'peer experts' that could then report back and serve as resources to other CCMHB-funded programs. While the targeted programs are not at a point where they would be able to function as independent supports for other agencies building evaluation capacity, their experiences are valuable learning opportunities for their peers. During the Mental Health Agency Council (MHAC)

meetings from years two through six, representatives from each of the targeted programs presented to their peers about their experiences building evaluation capacity. Programs briefly shared about challenges they encountered and lessons learned, as well the general processes they engaged in. This feedback appeared to elicit some excitement among other programs, leading a few to express their desire to participate in this evaluation effort. Much of the research on learning organizations focuses on individual actors (e.g. employees) within an organization (e.g. a specific business). In addition to engaging at the individual and organizational levels, our process also engaged programs and agencies within a larger system (CCMHDDB). While ongoing effort will further advance these goals, the targeted partnerships begin the process of fostering a culture of i) valuing evaluation, ii) desiring evaluation to be meaningful, and iii) experimenting with evaluation.

2. **Continue to Support the Development of Theory of Change Logic Models.**
    a. *Offer 2 logic modeling workshops to support funded programs in model development in Fall 2021*
    b. *Schedule and announce logic model training dates with 30 days advance notice*
    c. *Provide follow-up support to targeted agencies who submit a model to the team for review (and to agencies who choose to develop the model using "hours" from the consultation bank)*

We held two (virtual) logic model workshops for funded programs. One workshop was offered in October of 2021 and was attended by four groups: Driven to Reach Excellence and Academic Achievement for Males (DREAAM), the Well Experience, First Followers, and Rape Advocacy, Counseling, and Education Services (RACES). The second workshop was offered in March 2022 and was attend by staff from the Refugee Center. During the workshops all programs engaged in hands-on theory of change logic model creation with the support of an Evaluation Capacity Building team member. All programs in attendance were provided with PowerPoint slides containing their logic models following the workshop.

3. **Choose three Programs for Targeted Evaluation Development in Consultation (up to two CCMHB and one CCDDB)**
    a. *Work in collaboration with up to three funded programs to develop evaluation plans and support them in the implementation of those plans (e.g., instrument development, data gathering, data reporting)*
    b. *The goal would be to guide an evaluation plan and process that can be implemented and sustained by the program in subsequent years*

We worked with three programs as new targeted partners for evaluation capacity building support in year 7, one funded by the CCDDB and two funded by the CCMHB. The new CCDDB program was the Champaign County Regional Planning Commission Decision Support Person-Centered Planning Program (CCRPC-DSPCP). The two new CCMHB

funded programs were the Well Experience and Women in Need Recovery (WIN Recovery). Individual meetings and customized efforts were provided to each of these three programs. Reports that elaborate on the specific activities engaged to build evaluation capacity and to create specific evaluation plans are provided in the following sections II, III and IV.

4. **Choose three Programs for Targeted Evaluation Data Usage in Consultation (up to two CCMHB and one CCDDB)**
    a. *Work in collaboration with up to three funded programs to support ongoing evaluation implementation (e.g., data collection, data usage, data translation).*
    b. *The goal would be to emphasize translating evaluation findings to inform program activities and facilitate usage of evaluation data to make informed programmatic decisions.*

We worked with three programs as continuing targeted partners, all funded by the CCMHB, for evaluation capacity building support targeted to data usage in year 7. Given the challenges associated with continuing to provide high quality services during the COVID-19 pandemic, no CCDDB funded programs were able to devote the necessary time and effort to participate in continuing partnerships in year 7. The continuing CCMHB programs included: Community Choices – Community Living program (CC-CL); Rape Advocacy, Counseling and Education Services – Sexual Violence Prevention Education program (RACES-SVPE); and Uniting Pride – Children, Youth, & Families program (UP-CYF). Individual meetings and customized efforts were provided to each of these four programs. Reports that elaborate on the specific activities engaged to build evaluation capacity and to create specific evaluation plans are provided in the following sections IV, V, VI, and VII.

5. **Invite follow-up with all previously targeted agencies via the Consultation Bank. This could include (depending on agency need):**
    a. *Reviewing evaluation implementation progress*
    b. *Revising and refining logic models*
    c. *Reviewing gathered data and developing processes to analyze and present data internally and externally*

We received two requests for consultation bank support from previously targeted agencies – DREAAM and the Community Service Center of Northern Champaign County (CSC-NCC). DREAAM interns met a couple of times with evaluation staff to clarify anticipated short-term outcomes and to operationalize program components. Progress was limited due to interns switching out for the semester as well as needing to clarify program scope with leadership more before creating a logic model. The new director of CSC-NCC sought consultation regarding the evaluation capacity building work done during previous fiscal years. We helped them build institutional knowledge about their evaluation strategy amid staff changes, and assisted them in using and updating an Excel spreadsheet we created for them

previously to analyze satisfaction data. To promote sustainability of these skills moving forward, we also provided resources on Excel from our data workshops which address the most common questions the staff were encountering.

6. **Continue the Evaluation Consultation Bank with Agencies Who Have not Had Targeted Partnerships**
    a. *Offer a bank of consultation hours for use by funded programs*
    b. *Funded programs would request hours based on specific tasks*
        i. *Developing an evaluation focus*
        ii. *Completing a logic model*
        iii. *Developing and sustaining evaluation activities (particularly in targeted agencies)*
        iv. *Reporting data*

This year we received no requests for consultation bank support from agencies who had not previously had a targeted partnership.

7. **Continue to Build a "Buffet" of Tools**
    a. *Maintain and expand a Google drive or other web-based repository for measures developed with and/or for funded programs*

The web-based repository of measures developed with and for funded programs continues to be maintained, however, this year all new measures that were developed were highly specific to the individual programs involved, and thus were not appropriate for use by other programs. Consequently, in year 7, no new measures were added to the repository of measures.

8. **Offer up to three workshops with CCMHB/CCDDB funded agencies regarding data usage fundamentals including, for example:**
    a. D*ata storage (setting up excel, confidential storage, identity keys)*
    b. *Basic analysis (shareware, means, standard deviations, change over time)*
    c. *Conceptualizing process and outcome evaluation questions based on the theory of change logic model*
    d. *Applying evaluation findings to inform programmatic decision-making*

In summer of 2022, we offered two data workshops to all CCMHB/CCDDB funded agencies. The workshops focused on the use of Excel for working with outcome data and were sequenced to build on each other, with the first workshop being more basic and the second more advanced. The first workshop, *Introduction to Excel for Outcomes Analysis – Part 1*, provided an basic introduction to Excel. It addressed the following topics: creating a workbook and adding new sheets; renaming, moving and deleting sheets; creating a current client worksheet; creating a workbook reference sheet; adding evaluation details to a reference sheet; creating response option dropdowns; tracking and organizing outcomes data; adding outcomes tracking content to a current client worksheet; creating a measure scoring worksheet; linking dropdown responses and

numerical values; using Xlookup to automate measure scoring; converting relative cell references to absolute cell references; producing a total measure score; and, generating counts using the "subtotals" dropdown. The second workshop, *Introduction to Excel for Outcomes Analysis – Part 2*, provided a practical demonstration of how to use Excel for PMO reporting. As was true for the year 7 logic modeling workshops, the data workshops were delivered online via zoom. Resources from the workshops (e.g., video examples of topics covered in the workshops as well as sample Excel workbooks) were stored for future access by present and future CCMHDDB funded programs in a Google Drive. The workshops were attended by staff from RACES, First Followers, the Refugee Center, DSC and GROW.

9. **Meet with CCMHB/CCDDB members as requested to provide information on, for example:**
    a. The varied uses of evaluation
    b. Logic modeling process
    c. CCMHB/CCDDB goals and priorities with regard to evaluation
    d. Instantiating evaluation practices for the CCMHB and the boards' funded programs

The evaluation capacity building team provided consultation to CCMHDDB staff regarding continued evaluation related supports that the board and staff might provide to funded agencies as the contract with the University of Illinois Department of Psychology Evaluation Capacity Building team was coming to an end due to the retirement of Dr. Aber and the relocation of Dr. Allen to Vanderbilt University.

Champaign County Regional Planning Commission – Decision Support Person-Centered Planning Program (CCRPC-DSPCP)

Program Overview

The Decision Support Person-Centered Planning Program at CCRPC is designed to support individuals living with intellectual and developmental disabilities (I/DD) in Champaign County who are not yet eligible for state-funded services. The Decision Support Program has three components: 1) support and provide transition planning for high school students with I/DD ages 14 and older, 2) provide person-centered planning case management services to adults, and 3) assist individuals in Champaign County with registering for the PUNS list and with organizing documentation required for state funding. From September 2021 to June 2022, one consultant from the University of Illinois worked with two staff members of CCRPC to build the program's capacity to evaluate and improve their program.

Goals for Targeted Partnership:

1. Update Preference Assessment survey to improve the richness of county-level needs assessment provided to DDB annually
2. Examine Preference Assessment results by various demographic variables to identify themes and opportunities to tailor services more closely to client needs
3. Update PMO consumer outcomes to align with program activities and long-term goals
4. Improve ability to analyze consumer outcome data efficiently, reproducibly, and more frequently

Executing Goals

1. Update Preference Assessment survey to improve the richness of county-level needs assessment provided to DDB annually

We began by reviewing the Preference Assessment, which is a needs survey administered to each person in the county when they update or initiate their PUNS list registration. Because every client seeking DDB-funded services must first be registered for the PUNS list and everyone on the PUNS list must meet with the case manager annually to update their registration, the Preference Assessment produces a rich dataset covering a large proportion of DDB-eligible citizens in Champaign County. These data are reported annually to the DDB and may at times be used to inform funding decisions and board priorities. For example, responses to the survey question "Where would you like to live?"

may be useful for planning where in the county there may be an increased need for services in the near future.

CCRPC staff noted previous attempts to use the Preference Assessment to answer important questions about county-wide needs but that the survey was missing critical questions that would allow them to answer these questions. We therefore worked together to add missing items as well as improve the existing items. Informant type (i.e., is the client filling out the assessment or a support person) and length of time on the PUNS list were added to enable parsing the data by these important variables. Further, we added demographic variables to allow CCRPC and DDB staff to look at differences in needs by client age, race and ethnicity, gender, income bracket, and zip code. The questions and response options were updated throughout, and additional items were added based on staff input (e.g., "On a scale from 1 to 10, how comfortable are you in navigating the DD system and/advocating for yourself or your loved one?"). The survey items were reviewed by CCRPC staff (including those who administer the Preference Assessment), the full Evaluation Capacity Building Team at the University of Illinois, and members of the DDB, and changes were implemented on a rolling basis. The final updated Preference Assessment was approved by DDB staff, and CCRPC began using the updated Preference Assessment in January 2022.

2. Examine Preference Assessment results by various demographic variables to identify themes and opportunities to tailor services more closely to client needs

After the revised Preference Assessment was implemented, we assisted CCRPC in conducting initial analyses of the data so they could begin to identify how to compare results for different types of participants. CCRPC staff worked to analyze the data in SurveyMonkey (where the survey is hosted), and we helped with reviewing and interpreting the results. For example, we alerted CCRPC staff to the result that over a quarter of respondents were for clients under 18. This highlighted the importance of breaking out all future analyses by age, given that children under 18 are not eligible for PUNS selection and also may have very different needs from adults with I/DD. These initial analyses were preliminary in nature but assisted the staff in practicing analyzing and interpreting survey results and in developing general guidelines for how to work with the updated survey.

3. Update PMO consumer outcomes to align with program activities and long-term goals

We assisted CCRPC in revisiting the consumer outcomes described in their FY23 DDB application and in their FY22 PMO and in updating these outcomes to better align with

the tasks they were currently completing as an organization. For example, due to the COVID-19 pandemic, the transition consultants have been working to reestablish in-person connections with schools and students. Thus, their previous consumer outcome relating to a targeted number of transition plans developed for students was not an accurate reflection of the outreach efforts that transition consultants were needing to engage in to increase referrals to their services.

Overall, we worked together to identify areas of the previous year's PMO and the most recent application where the evaluation strategy could be strengthened, and to implement those improvements in the upcoming FY23 PMO.

4. Improve ability to analyze consumer outcome data efficiently, reproducibly, and more frequently

Finally, CCRPC expressed they would like to be able to evaluate their consumer outcomes more easily. We therefore worked to improve their ability to analyze the consumer outcomes listed in their application on an ongoing basis. We used the upcoming FY23 PMO to anchor this activity and engaged CCRPC in analyzing their existing data to evaluate their updated consumer outcomes described in Goal #3 above. We worked to ensure that all analyses were thoroughly understood by CCRPC staff and were readily reproducible. Together, we developed a draft PMO report detailing CCRPC's progress with all consumer outcomes, including transition consultants' outreach efforts, satisfaction survey results, and comparing time from PUNS selection to state funding for individuals with and without a Decision Support Program case manager.

These results were used to inform programming in real-time; for example, the time-to-funding metric was monitored weekly and used to identify areas' cases in need of attention. Ultimately, we completed the partnership with a strong start to the FY23 PMO and, more importantly, with the CCRPC staff understanding the rationale behind their evaluation procedures and feeling comfortable with how to measure their program's success at achieving their consumer outcome goals.

<u>Next Steps and Future Directions:</u>

1. Develop process for summarizing open-ended data on the Preference Assessment and on the Satisfaction Survey
2. Increase internal knowledge sharing to allow cross-pollination of learning between county- and state-funded person-centered-planning case managers

Appendix Items:

Section II A: Revised Preference Assessment
Section II B: Performance Outcome Report (DRAFT)

The Well Experience
New Targeted Partnership FY 22-23

Program Overview

The Well Experience "has created a conduit by which individuals that have been traditionally marginalized, underestimated and undervalued have an opportunity to receive trauma-informed care by means of evidence-based practices."

In service of their mission, The Well Experience (TWE) offers an expansive breadth of services (crisis management, age specific groups, family nights) dedicated to serving "Black/African American girls, women, teens, and families" in Champaign County. The organization advocates for a wraparound approach to service engagement, and the majority of clients are involved in multiple service programs. CCMHB funds support these services broadly, as opposed to being earmarked for a specific program.

Identifying Goals

The Well Experience (TWE) is both a new targeted partner and newly funded by the CCMHB. Early work involved discussion and informal modeling of the connections between program mission, activities, short-term and long-term goals, and underlying values. Discussion of these connections and organizational strengths and needs resulted in identifying multiple potential avenues for the partnership. After discussing the potential utility of each aim, the following three major goals were prioritized:

1) Develop an organizational theory of change logic model.
2) Develop an overarching and cohesive evaluation process.
3) Develop a structured intake tool to use across programs.

Executing Goals

1) Develop an organizational theory of change logic model.

As this agency's CCMHB funding is not allocated for one specific organizational program but instead may be used across organizational services, the early partnership focused on understanding the breadth of the services offered by TWE, including participant overlap between services, the influence of organizational values on program services, and general goals for improving evaluation.The breadth of interrelated potential services offered by TWE initially proved challenging for developing a parsimonious model. Additionally, TWE's work is highly informed by values of healing-centered engagement, community support, holistic care, and cultural identity; thus, understanding these values and frameworks was critical for accuately articulating the organization's theory of change. This level of values articulation may not be critical for every evaluation capacity building effort. However, given how influential these values are for both how

and why TWE operates, informal articulation of these values and concepts was critical for developing a culturally-reflective, empirically-useful evaluation process.

Ultimately, two models were developed through this partnership: one overarching agency model (Well Family Care model) and one programming-specific model (Girls2Life).

2) Develop a systematized, cohesive evaluation process

Because of the expansive nature of program activities and potential impacts, TWE's early articulations of evaluation goals were extensive and potential measurement strategies were vague. Challenges at this stage included identifying an evaluation strategy that both captured the breadth and interrelated nature of service activities and that was feasible and sustainable. Thus, a critical part of building organizational evaluation capacity involved bounding the shorter-term outcome domains to be prioritized during the rest of the partnership. This prioritization occurred through consultation of scholarly literature, consideration of current organizational data collection processes and potential measurement strategies, and concerns related to feasibility and sustainability. The outcome domains prioritized in the evaluation partnership are related to i) psychological health and ii) academic functioning.

Operationalizing the domains of psychological health and academic functioning helped to facilitate greater specificity in the agency's anticipated shorter-term outcomes, which were then used to identify specific measurement tools and relevant analytic strategy. Ultimately, the process of bounding and operationalizing anticipated shorter-term outcomes contributed to the development of an evaluation strategy that is both more specific and more feasible.

Validated and/or evidence-based measurement tools and analytic strategies were identified for the following shorter-term outcomes:

1) Participants will experience a reduction in symptoms of psychological impairment and distress.
    a) Youth
    b) Caregiver
2) (When applicable) Participants will experience a reduction in trauma symptoms and associated behaviors.
    a) Youth
    b) Caregiver
3) (When applicable) School-aged participants will maintain or improve their grades.
4) (When applicable) School-aged participants will maintain or improve their school attendance.

After specific measurement tools were identified, efforts moved towards developing a reproducible data analytic process. Challenges at this stage included identifying an analytic strategy that was both parsimonious and context-sensitive. For example, it was challenging to identify one analytic method that would satisfactorily capture attendance

related outcomes for youth with no or few absences and youth demonstrating significant truancy. We had similar discussions around capturing psychological functioning over time. Reporting the average across clients may disguise meaningful change occurring in, for example, clients experiencing particularly frequent absences, whereas this nuance may get "washed out" when averaged with clients who are infrequently absent. In response to these concerns, we hypothesized about any particularly significant potential clusters that may be relevant to the shorter-term outcomes indicated above. We then specified the criteria for each group (e.g., GPA of 3.0 or higher, GPA of 2.9 or lower). Finally, a data analysis workbook was created to directly reflect the measurement and analytic strategies identified during the partnership.

3) Develop a structured intake tool to use across programs

Early in the partnership, TWE described feeling both limited and overwhelmed by existing organizational data collection processes where forms and measurement tools were created and adapted as-needed, with completely different forms used for different programming. This practice is not uncommon among nonprofit organizations, though it is generally an inefficient use of agency time and an impediment to observing outcomes over time. Throughout the partnership, TWE expressed a desire for a cohesive intake tool that could be used to collect data from clients across programming areas.The agency also expresssed their desire for an evaluation process that was strengths-based, captured individualized outcomes, and was consistent across families, individual clients, and programs.

A cohesive intake assessment was developed to collect i) baseline outcome data from multiple informants, ii) demographic data, and iii) client context, presenting needs, and goals. We anticipate that integrating the collection of baseline outcome data directly into the intake process will simplify the process and result in this information being collected with greater consistency.

The cohesive intake assessment was developed to reflect agency preferences and is available for use as a "hardcopy" to be printed and filled out. After the intake appointment, data must be entered from the hardcopy into the electronic data analytic file. To streamline the process, the hardcopy includes specific scoring data that is also reflected in the data analytic file.

Next Steps and Future Directions

1) Implement and maintain the evaluation strategy for one quarter, and at that time assess consistency, barriers (including feasibility), etc.

2) Consider including qualitative data from individual family goals into the narrative section of the PMO end of year report.

3) Consider developing a structured progress report template for families based on individual progress.

Appendix Items:

Section III A: Well Family Care Logic Model

Section III B: Girls 2 Life Logic Model

Section III C: Overview of Data Workbook

Section III D: Cohesive Intake Assessment

Women in Need Recovery
New Targeted Partnership FY 22-23

Program Overview

WIN Recovery serves justice-involved women and the LGBTQ2+ community who struggle with substance misuse and have a history of trauma. They offer a continuum of services based on each client's individual recovery to help bridge the gap from incarceration to reentry. These comprehensive support services occur within the transitional living environment and includes programming designed to address and interrupt the source of trauma that leads to continuous cycles of incarceration.

Identifying Goals

Women in Need Recovery (WIN) is both a new targeted partner and newly funded by the CCMHB.

1) Develop an organizational theory of change logic model.
2) Increase capability to track and measure organizational effectiveness over time.
3) Develop a reproducible and feasible data analytic strategy that is relevant to agency vision and framework.

Executing Goals

1) Develop an organizational theory of change logic model.

WIN Recovery is emphatic that they do not simply provide a “recovery house.” Instead, they provide a range of scaffolded supports from peer-leaders that occur in the context of stable, safe housing. Given this holistic perspective, early partnership focused on understanding the nature of the services offered by WIN, including models or frameworks that inform program services, existing data collection and reporting practices, and general goals for evaluation and data processes.

Early stages of the partnership involved modeling the connection between program activities, anticipated shorter- and longer-term outcomes, and theoretical underpinning for the articulated connections. At this stage, a significant review of the literature was conducted to understand the frameworks articulated by WIN (e.g., gender-responsive, trauma-informed), their meaning in a substance use recovery context, and potentially-relevant evidence-based tools.

A second step involved linking current collected data to stages in the theory of change. As an example, the agency consistently collects information on 12 “benchmarks” that may be achieved by women while they are engaged in services with WIN. These

benchmarks were specifically included in the model because WIN treats them as very proximal short-term outcomes that are important to the foundation of sustainable recovery. These benchmarks have been really useful for WIN in understanding some of the concrete ways that they have been able to support participants (e.g., accessing identification documents) as well as identify the individual-level successes of women in the program (e.g., maintain sobriety for 3 months). However, the binary yes-no nature of these 12 benchmarks somewhat limits their utility as an outcome tool. WIN was motivated to identify other assessments that may capture organizational effectiveness in more complexity.

2) **Increase capability to track and measure organizational effectiveness over time.**

Once the organizational theory of change model was articulated, multiple potential avenues for measuring agency effectiveness were discussed. At this time, WIN expressed a desire for the capacity to measure i) individual-level outcomes that would ii) be directly relevant to programming and agency vision and iii) resonate with multiple types of stakeholders. With this in mind, we decided to pursue an evaluation plan that measured program impact on individual's trauma symptoms.

At this point, a targeted search of the scholarly literature was conducted to identify a high quality, accessible measure. After considering the sample appropriateness and feasibility of different measures, the Posttraumatic Check List- 5th Edition Civilian Version (PCL-5) was selected. In order to further improve applicability of the measure to WIN's participant context, the instructions of the PCL-5 were adapted to include examples of potentially-traumatic events that may be particular relevant to the context of women who have experienced incarceration and/or substance abuse.

3) **Develop a reproducible and feasible data analytic strategy that is relevant to agency vision and framework.**

In order to integrate future evaluation practices with existing agency routines, significant time was spent understanding the nature of and ways in which data is already collected and used. As a result, the current data strategy is significantly influenced by existing programming components and accessible resources, with the specific intention to streamline and systematize the data collection and analysis process. In particular, it was really important to the agency to develop a process that would be consistent across different caseworkers, locations, and time frames.

The analytic strategy was specified in an Excel workbook. However, it is important to note that WIN's existing data software was expected to be upgraded in August 2022. The agency anticipated building the developed analytic strategy (as outlined in the Excel workbook) into this upgraded software program.

Next Steps and Future Directions

1) Building the outlined analytic strategy into the software.

2) Train caseworkers on the process and implement the data collection practice.

3) After analysis, document observed group differences and make decisions about whether to analyze/report outcomes by group characteristics or overall.

Appendix Items:

Section IV A: WIN Recovery Theory of Change Logic Model

Section IV B: PCL-5 Measure

Section IV C: Overview of Analytic Strategy

Community Choices: Community Living Program

Program Overview

Community Choices is a human services cooperative and service provider for adults with developmental disabilities. They have three main philosophies: people need people, we are not afraid to try, and success is a shared responsibility. The Community Choices Community Living Program aims to help people build the lives they want to build by providing assistance to people in finding somewhere to live, taking care of their homes, getting from place to place, and having people to support them. By engaging in weekly meetings, they support people in moving out, in acquiring the skills and confidence to maintain their homes, in managing the support they need to make that happen, in building connections, and in achieving their self-determined goals. From September 2021 to July 2022, one consultant from the University of Illinois worked with two primary staff members of Community Choices to build the program's capacity to evaluate and improve their program.

Goals for Targeted Continuing Partnership:

1. Clarify objectives of the new iteration of Community Living Program, including how to assess progress in the context of ongoing needs for support
2. Develop an overarching strategy for data collection and evaluation across all facets of the Community Living Program, including streamlining the data collection timeline and various data sources
3. Develop tools to analyze and report data reproducibly and on an ongoing basis to support data-informed programming decisions

Executing Goals

1. Clarify objectives of the new iteration of Community Living Program, including how to assess progress in the context of ongoing needs for support

The Community Living Program was initially designed to be a transitional program in which Community Choices would help clients get housing and get connected to resources to maintain their housing, and then clients would transition out of the program. In our previous partnerships with Community Choices, we helped them to develop ways to evaluate this program, with a particular focus on clients' transition out of the program as a key metric of the program's success. Over the past few years, Community Choices has learned from their internal evaluations that clients were often experiencing unanticipated issues after obtaining housing (e.g., breaking a leg, losing a job, needing to move) that required reengagement with the Community Living Program. These insights led

Community Choices to reconsider whether a transitional program could adequately address the often cyclical nature of their clients' needs, and ultimately to restructuring the program to focus more on sustained progress in domains relating to independent living rather than targeting discontinuation of services.

To support Community Choices in implementing these data-informed changes to the Community Living Program, we worked to help them articulate clear and measurable objectives for the new iteration of their program. We began this work by discussing with Community Choices staff how they might define success in the context of ongoing engagement with a client. In other words, if transitioning out of the program is no longer the explicit goal, then what *are* the goals? We supplemented these partner discussions with a literature review on evaluating sustained progress in human services, particularly in agencies serving individuals with intellectual and developmental disabilities.

To help distill the learning from these discussions into clear and measurable objectives, we revisited the program's original logic model and identified short- and long-term outcomes that still applied to the newest iteration of the Community Living Program. We then transported those outcomes to a modified indicators worksheet where we asked Community Choices staff to identify what they would expect to see in their clients' lives if each outcome were being met. The purpose of this activity was twofold: 1) to transform staff's intuitive understanding of what success looked like into written objectives that could guide evaluation, and 2) to develop language for updated short-term outcomes which aligned with the long-term outcomes of the program. Through these activities, we developed the Outcomes Mapping Document, available in the appendices.

2. **Develop an overarching strategy for data collection and evaluation across all facets of the Community Living Program, including streamlining the data collection timeline and various data sources**

In addition to clarifying the objectives of the new iteration of the Community Living Program, Community Choices expressed a desire to simplify and consolidate their data collection processes. At the beginning of this year's partnership, Community Choices was largely relying on annual client surveys for their consumer outcomes data, and these surveys were being sent to everyone at the same time of the year even though clients could be in very different stages of the program. The staff were therefore eager to find ways to tie data collection to clients' timelines in the program so that, for example, an "annual" data collection could reflect clients' progress one year into the program. Additionally, Community Choices were finding it difficult to track their internal data collection needs while also tracking data required for their accreditors and local and state funders. We therefore aimed to help connect their data collection processes more closely

to their program operations, to reduce redundancy in data collection, and to maximize the usefulness of the data sources required for accreditors and funders.

We used three main tools to consolidate and refine Community Choices' data collection processes. First, we took the Outcomes Mapping Document and added columns to identify the data source(s) for each objective (*"How would we know that was happening"*) and the time when data on each objective would be collected (e.g., at intake, quarterly, or during annual planning meeting). We worked to reduce any redundancies where multiple data sources were not needed for a particular outcome. We then developed a list of data sources that related to an outcome in the Outcomes Mapping Document and identified any gaps between the data they were collecting and the data they needed to evaluate their program objectives.

This practice allowed Community Choices to realize they wanted to evaluate outcomes related to clients' families (e.g., Families spending less time on care duties and enjoying more quality time with their loved one I/DD), but they were not actively collecting data from family members about these outcomes. We thus worked together to develop and implement the Family Feedback Form to administer to family members at intake and during the annual planning process.

We then transformed the list of data sources and their timings into a Data Collection and Evaluation Timeline that illustrated the data collection process from a client's intake to their annual planning meeting one year into the program (available in appendices). We used this timeline to refine the collection procedures, to inform the timings for data analysis, and to produce a visual aid to provide to staff responsible for collecting the data. The timeline also assisted with increasing the frequency with which progress on self-determined goals was being documented.

In reviewing the Data Collection and Evaluation Timeline, Community Choices staff realized that progress on self-reported goals was typically being updated only once a quarter, and without documenting goal progress more frequently, quarterly reports had become onerous tasks for staff. Staff were, however, already entering data weekly into the county and state claims spreadsheets which documented their contacts with each client. Thus, to make quarterly reports less onerous and facilitate more consistent updates on goal progress, we added columns to the claims spreadsheets for staff to enter brief contact notes and to denote which self-determined goal was being addressed in each client contact. Overall, this is one example of how the timeline tool helped Community Choices to see opportunities to consolidate existing evaluation processes to increase the efficiency and impact of their procedures.

3. Develop tools to analyze and report data reproducibly and on an ongoing basis to support data-informed programming decisions

Finally, we worked to translate the clarified program objectives into enumerated outcomes that could be evaluated quantitatively and reported to the CCDDB. We used the CCMHB/CCDDB Performance Outcomes Report (i.e., PMO) to anchor this activity, allowing Community Choices to practice evaluating and reporting their outcomes while we were available for support, and also giving them a head start on their annual reporting. These efforts resulted in the Performance Outcomes Report Instructions (Appendix D) which assigns a number to each outcome from the Outcomes Mapping Document and describes in detail how each outcome will be evaluated. These instructions include the data source for each outcome, which clients to include for each outcome, and how each outcome should be calculated.

To facilitate consistency in data analyses and reporting moving forward, Community Choices staff then largely worked amongst themselves to develop a spreadsheet to calculate all the enumerated outcomes in one place. We provided input on this document to maximize efficiency and minimize the potential for human error. This Data Tracking Spreadsheet is available in appendices.

Overall, we truly must commend the staff at Community Choices for their stellar progress during the partner year. They consistently worked between meetings to implement the ideas we discussed, and the tremendous gains they have made are a testament to their commitment to achieving high-quality services for the clients they serve.

Future Directions and Next Steps

1. Expand more frequent evaluation processes to other departments
2. Monitor data completion rates and how they compare to previous response rates for satisfaction surveys to identify potential areas for improvement
3. Monitor sustainability of new processes and responsively modify processes to improve long-term success
4. Share information about the evaluation process and why it exists with members of the organization co-op (comprising clients, their families, and community members) and improve engagement of co-op members in reciprocal feedback on programming and evaluation.

Appendix Items:

Section V A: Outcomes Mapping Document
Section V B: Family Feedback Form
Section V C: Data Collection and Evaluation Timeline
Section V D: Performance Outcomes Report Instructions
Section V E: Data Tracking Spreadsheet

Rape Advocacy, Counseling, & Education Services (RACES)

Program Overview:

RACES is an organization whose mission is to create a world that is free of sexual violence in our lifetime, starting with Champaign County. RACES offers a Child Assault Prevention Education Program that provides age-appropriate education to elementary-aged students and provides prevention education programs to public and private schools in Champaign County and beyond, focusing on topics including consent and fostering healthy relationships. They also provide confidential, compassionate, comprehensive support to those affected by sexual trauma through counseling, legal and medical advocacy, a 24-hour Crisis Line, and publication education and training. From September 2021 to July 2022, one consultant from the University of Illinois worked with staff members of RACES to build the program's capacity to evaluate and improve their program.

Identifying Goals:

1. Identify existing RACES education topics that map onto empirically established risk and protective factors for sexual violence and hone the evaluation of these topics.
2. Develop an efficient and reproducible process for analyzing in-person pre- and post-surveys to promote data-informed prevention education in K-12 schools.

Executing Goals:

1. **Identify existing RACES education topics that map onto empirically established risk and protective factors for sexual violence and hone the evaluation of these topics.**

At the onset of the partnership, RACES expressed a desire to evaluate the effectiveness of their prevention education at reducing sexual violence. They expressed satisfaction with their existing pre- and post-surveys at documenting increased knowledge among the students they serve, and they hoped to be able to move beyond increased knowledge to speak to whether the increased knowledge was resulting in lower rates of sexual violence. We discussed potential challenges with this goal, including considerations when evaluating brief interventions within larger systems (i.e., "how do you account for all of the variables that influence the desired outcome beyond the brief intervention?") and the complexity of evaluating prevention in general (i.e., "how do you measure something that doesn't happen?"). We then brainstormed ways that RACES could move toward their goal of measuring their programs' impact on rates of sexual violence in a methodologically feasible way.

We decided to identify the areas of RACES's education curricula that are empirically linked to known risk and protective factors for sexual violence, which would then help us determine if students were reporting shifts in attitudes or behaviors known to be

associated with sexual violence prevention or perpetration. We used the CDC's Center for Violence Prevention list of risk and protective factors for sexual violence perpetration to guide this activity (Appendix A).

RACES staff began reviewing their elementary, middle, and high school curricula for topics relating to these risk and protective factors. We then planned to hone the pre- and post-survey to adequately capture changes in the most relevant risk and protective factors for each curriculum. However, due to unforeseen circumstances (e.g., staff illness) and competing agency demands, RACES staff were not able to progress further in this process beyond the curriculum review.

2. **Develop an efficient and reproducible process for analyzing in-person pre- and post-surveys to promote data-informed prevention education in K-12 schools.**

Our next goal was to assist RACES with building capacity to analyze their pre- and post-surveys internally. During the previous partnership year, RACES had to switch to a virtual platform for their education efforts due to the COVID-19 pandemic. This brought challenges but also provided opportunities to collect data more efficiently through the online portal, which enabled more sophisticated data analyses. This year, however, RACES was able to return to in-person instruction, which was accompanied by a return to administering surveys by hand. With this return to hand-written surveys, RACES expressed a desire to maintain some of the benefits they saw with virtual data collection and analysis, including the ability to break out results easily by curriculum and by school and to create color-coded "hotspot" graphs that visually identified questions where students struggled most.

We therefore worked with RACES to develop an Excel workbook that would allow them to filter results easily by school and by grade. We also worked with RACES staff to build a calculations tab that recreated the color-coded "hotspot" graphs that they found helpful during the previous year. Given that this was a continuing partnership, we emphasized RACES's existing capacity in these areas and aimed to have RACES staff creating these resources themselves, with our team available to support them when needed. Ultimately, RACES was able to enter data from over 5,000 students into this workbook and to identify quickly areas of their programming that could be tweaked for next year. This workbook is available below under Appendix B.

RACES staff also attended both of the Data Workshops that our team offered in Spring 2022, and we were able to leverage the skills gained in these workshops during our one-on-one meetings with RACES staff following the workshops.

Finally, we worked with RACES staff to re-order the questions on the post-surveys to reduce test-retest effects and maximize the likelihood that improvements on the post-test reflected gained knowledge.

Next Steps and Future Directions:

1. Implement reordered post-survey questions and explore using automated scoring (e.g., Scantron) to make data collection more efficient and less prone to human error.
2. Review prevention education curricula for areas targeting evidence-based risk and protective factors and update survey items to ensure assessment of key drivers hypothesized to reduce sexual violence perpetration.

Appendix Items:

Section VI A: CDC List of Risk and Protective Factors for Sexual Violence Perpetration
Section VI B: RACES Data Workbook

References:

Center for Violence Prevention. *Risk and protective factors*. Centers for Disease Control and Prevention.
https://www.cdc.gov/violenceprevention/sexualviolence/riskprotectivefactors.html

Uniting Pride

Program Overview

Uniting Pride is an organization whose mission is to create a Champaign County where all who identify as gender and/or sexual minorities can live full, healthy, and vibrant lives. The Youth and Families Division of Uniting Pride is specifically focused on empowering LGBTQIA2S+ youth, their families, and adults who work with youth in professional settings to build community with and better support LGBTQIA2S+ youth. Uniting Pride hosts support groups for youth and parents, community social events, workshops for professional settings such as churches and schools, and connect others to LGBTQIA2S+ resources.

Identifying Goals

Uniting Pride (UP) is a continuing evaluation capacity building partner.

As an initial step to determine goals for FY22, UP's most recent logic model and FY21 evaluation capacity work was reviewed with the goal of identifying potential evaluation capacity goals. These discussions allowed multiple potential goals to emerge. Given UP's status as a continuing evaluation partner, efforts to move towards implementation and data usage were emphasized as particularly fruitful opportunities.

1) Streamline workshop evaluation content.

2) Develop a consistent and reproducible analytic plan.

Executing Goals

1) Streamline evaluation content.

As part of their long-term goal to make Champaign County a more inclusive and affirming place for LGBTQIA2S+ community member, over the years UP has developed and offered numerous cultural competence trainings to support community organizations' effective engagement with LGBTQIA2S+ community needs. Due in part to increasing community concerns (e.g., public testiomonials from LGBTQIA2S+ folks about mistreatment from local healthcare organizations) and changes in organizational capacity (e.g., staff hiring), UP intended to provide even more of these cultural competence workshops during FY22. Additionally, although UP was able to collect some evaluation data from previous workshops, the lack of consistency in both training and evaluation content limited the utility of data usage. Thus, streamlining and systematizing data collected from participants attending UP facilitated workshops was identified as a priority for the FY22 evaluation capacity building partnership.

A first step to streamlining the process involved taking stock of the multiple trainings and objectives previously offered by UP in order to identify opportunities for parsimony and shared objectives. After we brainstormed the types of workshop audiences together, UP staff and volunteers independently identified shared workshop objectives and streamlined workshop content accordingly. This led to a "core" workshop training. From here, we worked to develop clear and relevant "core" evaluation items based on workshop content. A series of potential supplemental workshop items was also developed for relevant situations.

2) Developing a consistent and reproducible analytic plan

At this stage, the uses and potential implications of the workshop evaluation data were discussed. A data analytic plan was developed based on the ways the agency hoped to use the data (e.g., to be able to see improvements in individual participants; to improve or update workshop content when needed; to share with stakeholders interested in booking a workshop). This data analytic workbook was developed with consideration of current agency resources and created in Excel.

Next Steps and Future Directions

1) Continue using the data workbook.

2) Very early work in the partnership considered cataloguing all current evaluation processes with the aims of a) reducing the reliance/burden on any one individual/position to maintain memory all of the organization's processes, and relatedly, b) to build and maintain institutional knowledge less susceptible to turnover. As UP systematizes individual evaluation processes (e.g., evaluation of cultural competence workshops; evaluation of PrideFest programming), they may benefit from documenting this information in one electronic document that is updated at regular, specific occurrences (e.g., The first two weeks of a new FY).

Appendix Items:

Section VII A: Core Workshop Items

Section VII B: Evaluated Outcomes

Section VII C: Overview of Data Workbook

A Final Report on Building Evaluation Capacity for Programs Funded by the Champaign County Community Mental Health and Developmental Disabilities Boards (CCMHDDB) Year 7

APPENDICES FOR SECTION II THRU SECTION VII

Emily Blevins, M.S.
Hope Holland, M.S.
Nathan Todd, Ph.D.
Mark Aber, Ph.D.

Department of Psychology University of Illinois, Urbana-Champaign

September 10, 2022

APPENDICES FOR SECTION II

Appendix Items:

Section II A: Revised Preference Assessment
Section II B: Performance Outcome Report (DRAFT)

ISC Preference Assessment

1. Please tell us who is completing this assessment.
   - Individual interested in receiving supports/services
   - Parent/guardian

2. Please provide Demographic Information of person on PUNS list

Gender	Race	Ethnicity	Age	Total Household Income:
☐ Male	☐ White	☐ Hispanic	☐ Under18	☐ ≤ $19,000/annually
☐ Female	☐ Black/African American	☐ Non-Hispanic	☐ 18-23	☐ $19,000-$30,000/annually
☐ Transgender	☐ Asian/Asian American	☐ Middle Eastern/North African	☐ 23-30	☐ $30,000-$60,000/annually
☐ Gender Non-Conforming	☐ Biracial/Multi-Racial	☐ Prefer not to answer	☐ 30-40	☐ ≥ $60,000/annually
☐ Prefer not to answer	☐ Other		☐ Over 40	☐ Prefer not to answer
	☐ Prefer not to answer			

3. How long have you been waiting on the PUNS list?
   - less than 1 year
   - 1 to 3 years
   - 3 to 5 years
   - Longer than 5 years

4. Which service category are you currently in on PUNS?
   - Seeking Services (Need services within one year)
   - Planning for Services (Do not need services for at least one year)

5. Where are you currently living?
   - In own home with no support
   - In own home with occasional support
   - At home with family
   - Supportive Living Facility

ISC Preference Assessment

6. What is your preferred living arrangement?
    - Live with family
    - Live alone
    - Live with roommates
    - 24-Hour Supervised Group Home (CILA)- Single Bedroom
    - 24-Hour Supervised Group Home (CILA) Shared Bedroom
    - Host Family CILA
    - Intermittent CILA
    - Intermediate Care Facility (ICF/DD)
    - Community Living Facility (CLF)
    - Supportive Living Facility (SLF)
    - State Operated Developmental Center

7. If you prefer to live in a setting with housemates, what is your preferred number of housemates? ____________________

8. Where do you want to live? (City, County, Geographic Region) (Select All that Apply):

    - Ludlow
    - Urbana
    - Bondville
    - Broadlands
    - Champaign
    - Dewey
    - Fisher
    - Foosland
    - Gifford
    - Homer
    - Ivesdale
    - Longview
    - Mahomet
    - Ogden
    - Penfield
    - Pesotum
    - Philo
    - Rantoul
    - Royal

ISC Preference Assessment

- Sadorus
- St. Joseph
- Savoy
- Seymour
- Sidney
- Thomasboro
- Tolono
- Champaign County
- Outside Champaign County
- Outside of Illinois
- No Preference

9. Are you interested in support to find competitive employment opportunities?
   - Yes
   - No

10. Are you interested in volunteer opportunities?
    - Yes
    - No

11. Do you currently work or volunteer anywhere in the community? If so, please specify____

12. What types of work/volunteer opportunities are you interested in pursuing?
    - Office
    - Retail
    - Restaurant/Food Services
    - Factory
    - Outdoors
    - Construction
    - Automotive
    - Service Industry
    - Recreation
    - Public Services
    - Education/Childcare
    - Agriculture
    - Working with Animals

ISC Preference Assessment

- The Arts
- Trade Work
- Technology Services
- Health Services
- Finances
- Writer
- Other
    - Please Specify______________________________

13. Are you currently participating in any community groups/organizations?
- Yes
- No
- Name of group or activity ____

14. What community groups/organizations would you like to participate in:
- Continuing Education
- Champaign Urbana Special Recreation (CUSR)
- Best Buddies
- Special Olympics
- Church
- Groups and/or Clubs
- Gardening
- Health & Wellness
- YMCA
- Other
    - Please Specify _______________________________

15. What leisure activities do you currently enjoy taking part in?
- Going to the Movies
- Theatre/Arts/Museums
- Shopping
- Zoo/Aquariums
- Parks
- Recreation/Sports
- Swimming
- Sporting Events
- Concerts
- Festivals

ISC Preference Assessment

- Eating Out
- Other
    - Please Specify ______________________________

16. Are there leisure activities that you would like to participate in but are not available to you? If yes, please specify:
    ____
    ____

17. What areas would you benefit from support in?
    - Independent/Daily Living
    - Medical
    - Financial
    - Transportation
    - Community Day Services
    - Competitive Employment Services
    - Assistive Technology
    - Socialization
    - Behavioral Therapy/Counseling
    - Physical Therapy/Occupational Therapy/Speech Therapy
    - Respite Services
    - None
    - Other
        - Please Specify _________________________________

18. Are you currently on the waiting list for any of the above services?
    - Yes
    - No

19. If yes, please specify below what agencies you are currently on a waitlist with, what services you are seeking, and length of time you have been on the waitlist?

Provider Agency:	Service/Support Seeking:	Length of Time on Wait List:
		☐ ≤ 1 year ☐ 1 to 3 years ☐ 3 to 5 years ☐ ≥ 5 years
		☐ ≤ 1 year ☐ 1 to 3 years

ISC Preference Assessment

		☐ 3 to 5 years ☐ ≥ 5 years
		☐ ≤ 1 year ☐ 1 to 3 years ☐ 3 to 5 years ☐ ≥ 5 years

20. Are you currently receiving case management services? If so, where from?
    - Not currently receiving services
    - CCDDB/CCRPC Independent Service Coordination
    - DSC
    - Rosecrance
    - PACE Center for Independent Living
    - Community Choices
    - Other
        - Please Specify______________________________

21. On a scale from 1 to 10, how comfortable are you in navigating the DD system and/advocating for yourself or your loved one?

1_______2_______3_______4_______5_______6_______7_______8_______9_______10

Not Comfortable	Somewhat Comfortable	Very Comfortable

Performance Outcome Report Template

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

Agency name:
Program name:
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)
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.)?
3. How did your target population learn about your services? (e.g., from outreach events, from referral from court, etc.) - **Are we asking this? We don't ask it on the preference assessment anywhere…** - **Maybe the transition consultants are asking this?** - **I know most people hear about us b/c schools are referring to us from PUNS or they get hooked up through a provider agency & have to get on PUNS to get their services, but I don't know that we have a specific question anywhere about this…**
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):

b) *Actual* percentage of individuals who sought assistance or were referred who received services: - **People on PUNS who then started receiving services through county-funded service** - **Does "services" include getting registered for PUNS?** **- Email folder with Angela & Mary to put intake referrals?** **5. a)** *From your application, estimated* length of time from referral/assistance seeking to assessment of eligibility/need (Consumer Access, question #5 in the Program Plan application):
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: - **Preference Assessment – waiting for our services** - **Mary would be able to speak to this**
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):
b) *From your application,* estimated percentage of eligible clients who would be engaged in services within that time frame (Consumer Access, question #8 in the Program Plan application):
c) *Actual* percentage of clients assessed as eligible who were engaged in services within that time frame: - **Do "services" mean with connecting with a county ISC? If so, no additional eligibility determination after PUNS registration..** - **Are "services" registration for PUNS? Do we report separate lengths of time for these different services?**

- **Is this length of time between someone being PUNS selected and when we get them funded?**
- **Mary would be able to speak to this**

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

b) *Actual* average length of participant engagement in services:
- Break up by service (ISC, Transition Consultant, Mary case mgmt)

Demographic Information

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

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

Consumer Outcomes – *complete at end of year only*

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

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

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

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

Additionally, in the chart below, please indicate who provided this information (e.g. participant, participant's guardian(s), clinician/service provider, other program staff (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
~~Individuals with I/DD will have greater choice of services and supports in Champaign County.*~~	~~Preference Assessment~~ *~~Person-Centered Plan—maybe not~~*	~~Client~~ *~~ISC~~*
Individuals with I/DD transitioning out of secondary education will have a goal plan in place developed collaboratively	# connections with schools (Outreach numbers in Transition Consultant spreadsheet)	Transition Consultants

Commented [EB1]: # of total services clients w/ & w/o ISC are receiving
Waitlist information: For # of total services receiving – include services on waitlist

with their Transition Consultant.		
~~Individuals selected from PUNS who were provided service through the Decision Support Person Centered Planning Program will be supported in service connection based on their personal preferences~~	~~Person-Centered Plan~~ ~~Preference Assessment~~	Client ISC
They will also meet eligibility criteria upon being selected from PUNS	DHS PAS	DHS
Have quicker access to Medicaid Waiver Services upon being selected from PUNS	Medicaid Waiver Service Award Letters	DHS
Individuals will report feeling supported/satisfied	Satisfaction Survey*	Client
Clients in crisis working with an ISC will be connected to crisis services more quickly ; crises will be recognized more quickly?	Crisis pass paperwork for Champaign County	BirdsEye (DHS)

Commented [EB2]: Change to build connections in school

Commented [EB3]: Deleting this outcome 06/15/2022

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

Just people on PUNS registering for first time or completing annual update.

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

5. How many total participants did your program have? **Combine all transition consultant #s, clients served with ISC, & Mary's clients** Transition Consultant #s: Clients with ISC: Mary's clients:
6. How many people did you *attempt* to collect outcome information from? Transition Consultant #s: Clients with ISC: Mary's clients:
7. How many people did you *actually* collect outcome information from? # completed preference assessments # person-centered plans
8. How often and when was this information collected? (e.g. 1x a year in the spring; at client intake and discharge, etc) Pref assessment: intake, renewed annually Person-centered plan: intake & annual
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)

~~Individuals with I/DD will have greater choice of services and supports in Champaign County.~~

- ~~Preference Assessment: # of total services clients w/ & w/o ISC are receiving – include services on waitlist~~

Transition Consultants will increase connections in community to increase referrals for students transitioning out of secondary education.

connections with schools (Outreach numbers in Transition Consultant spreadsheet)
Transition Consultants made # connections

Individuals selected from PUNS who were provided service through the Decision Support Person Centered Planning Program will be supported in service connection based on their personal preferences

Commented [EB4]: Connection to state-funded services?

- Last year's answer: 100% of persons eligible for DD services were given the opportunity to report their service preferences. This is standard practice during annual PUNS registration or PUNS update meetings. However, only 64% chose to participate in a preference assessment.
- #/% of persons connected with services (clients w/ ISC compared to clients w/o ISC); speed of connecting them? (in the narrative report rather than average waiting period to funding was 3 months for ISC-supported clients vs 4 months for non-ISC-supported clients)

Individuals selected from PUNS who were provided service through the Decision Support Person Centered Planning Program will meet eligibility criteria upon being selected from PUNS

- Last year's answer: Proposed Outcome: 95% of individuals selected from PUNS who were provided service through the Decision Support Program will be found eligible for Medicaid Waiver Services and 90% will begin receiving services within three months. Results: 21 individuals who received Decision Support Person Centered Planning services were selected from PUNS in FY21 (July 12, 2021). 100% of individuals selected from PUNS who were provided service through the Decision Support Person Centered Planning program were found eligible for Medicaid Waiver Services.

Individuals selected from PUNS who were provided service through the Decision Support Person Centered Planning Program will receive Medicaid Waiver Services award letter more quickly
10. Is there some comparative target or benchmark level for program services? Y/N
11. If yes, what is that benchmark/target and where does it come from?
12. If yes, how did your outcome data compare to the comparative target or benchmark?
(Optional) Narrative Example(s):
13. Describe a typical service delivery case to illustrate the work (this may be a "composite case" that combines information from multiple actual cases) (Your response is optional)
14. In what ways was the evaluation used to support changes in practice? What changes were made based on evaluation findings? (Your response is optional)

Utilization Data Narrative – *The utilization data chart is to be completed at the end of each quarter (including quarter 4) using the online reporting system.* *Comparative yearly totals (i.e. reporting estimates and actual numbers) and the narrative section described below are to be completed at end of year only.*
Here, you will report on the different types of service categories specified in your program plan application. Please remember that programs **do not** need to collect and report on every category- instead, you are to report only the ones that are most useful for understanding program impact.
1. Please copy and paste the definitions of service categories your program specified in your program plan application in the sections below**. You will report the actual numbers of clients/contacts/community events for each reported service category in the Part II Utilization/Production data form (located on the online system).** If your estimated number of clients/contacts/community events for reported service categories significantly differfrom your actual numbers, you may give a narrative explanation for that discrepancy here.
<u>Treatment Plan Clients (TPC):</u>
<u>Non-treatment Plan Clients (NTPC):</u>
<u>Community Service Events (CSE):</u>
<u>Service Contacts (SC):</u>
For more information on SCs, CSEs, TPCs, and NTPCs, see the Service Definitions at the end of the glossary (located at the end of the Performance Outcome Report Instructions).

APPENDICES FOR SECTION III

Appendix Items:

Section III A: Well Family Care Logic Model

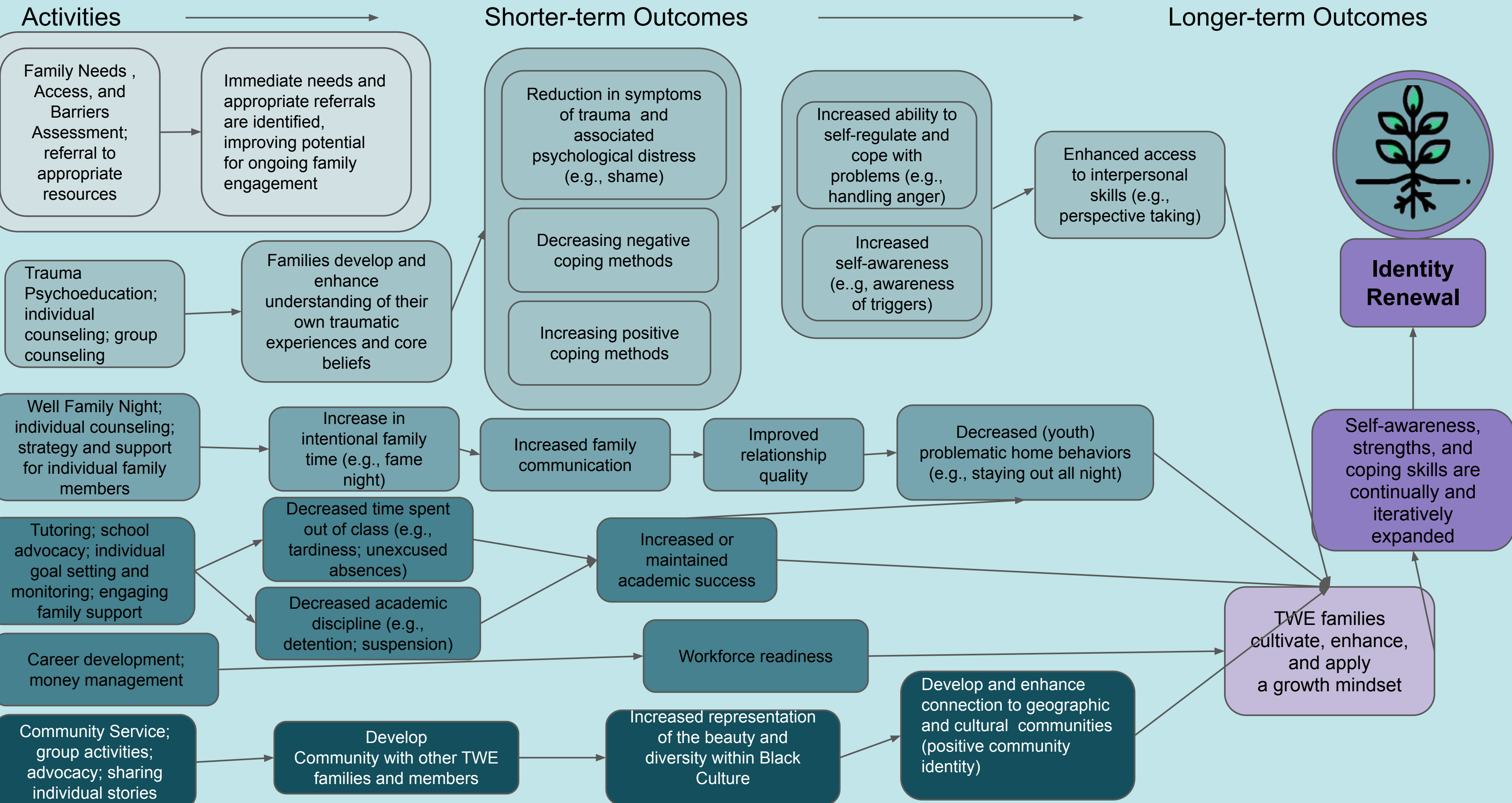
Section III B: Girls 2 Life Logic Model

Section III C: Overview of Data Workbook

Section III D: Cohesive Intake Assessment

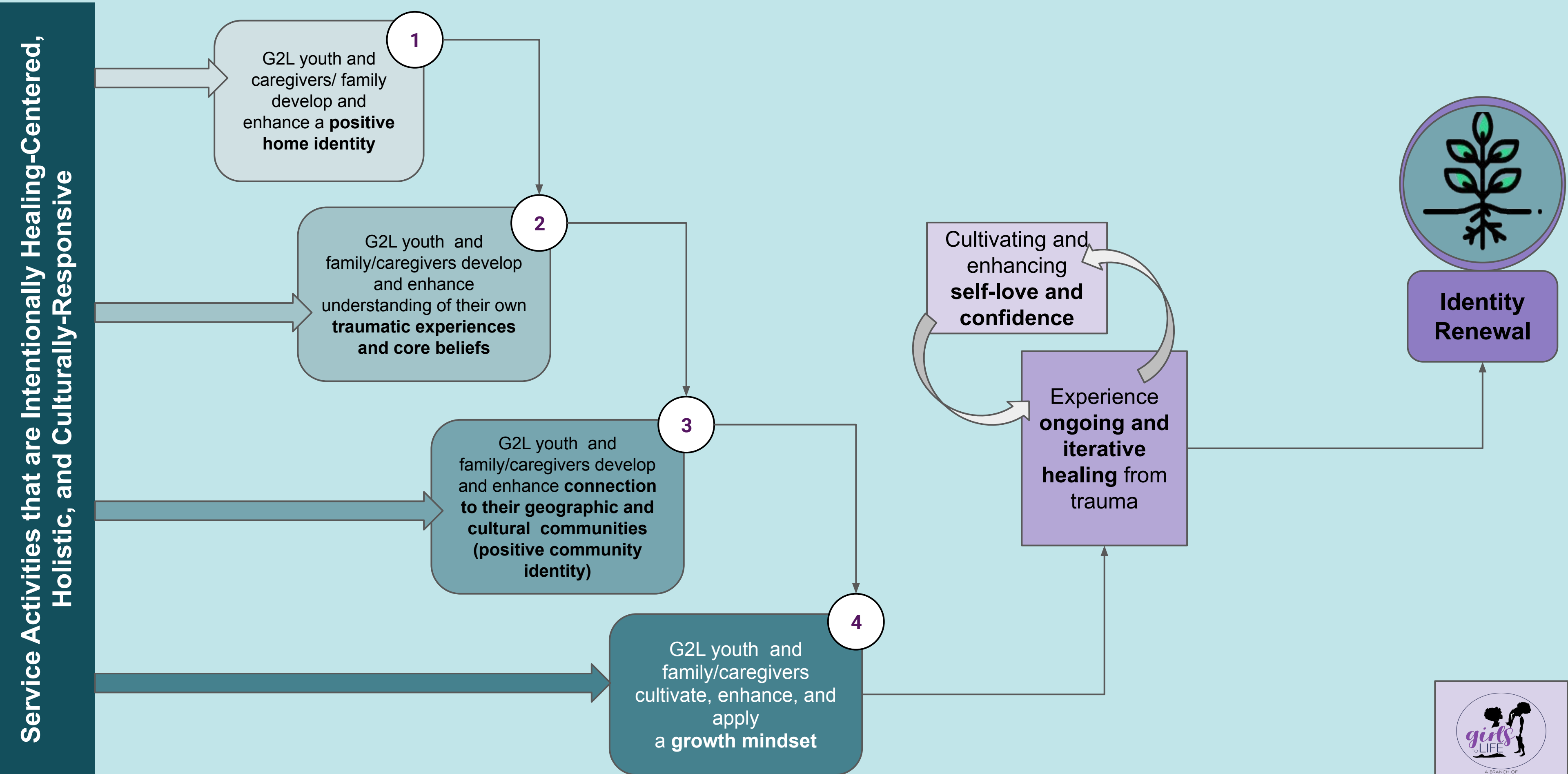
APPENDIX SECTION III A

Well Family Care



Girls to Life Youth Development Program (G2L)

APPENDIX SECTION III B



OVERVIEW OF DATA WORKBOOK

This document contains screenshots of the Excel data analytic workbook. When possible, the workbook has built in dropdown responses to streamline and improve reliability of data entry. The workbook also has built in analytic formulas to assess total scores and differences over time.

				Data Source(s)
Outcome Domains	Psychological Health Outcomes	Youth Psychological Health:	Broad Psychological Health Symptoms:	•Level 1 Cross-Cutting Symptom Measure for DSM-5 *(version: Age 11-17, Self-Report)*
				•Level 1 Cross-Cutting Symptom Measure for DSM-5 *(version: age 6-17, Caregiver Rater)*
			Trauma Symptoms:	•Child Rating of Trauma Symptoms Measure for DSM5 *(version:xyz Self-Report)*
				•Parent rated trauma symptom measure (*version: xyz, Caregiver Rater*)
		Caregiver Psychological Health:	Broad Psychological Health Symptoms:	•Level 1 Cross-Cutting Symptom Measure *(version: Adult, Self-Report)*
			Trauma Symptoms:	•PCL-5 *(version: Adult, Self-Report)*
	Academic Outcomes	Youth Academic Success:	Grades:	Grades as measured by (GPA) reported quarterly in mid-semester progress report and end of semester report cards,
			Attendance:	Reported by attendance records

Assessment Reporter
Self-Report
Informant Report (i.e., Parent or Guardian)
Note: Built-in redundancy to support use of correct sheet

Assessment Timepoint
Baseline (i.e., Intake)
Timepoint 2 (Approximately 3 mos after intake)
Timepoint 3 (Approx. 6 mos after intake)
Timepoint 4 (Approx. 9 months after intake)
Timepoint 5 (Approx. 12 mos after intake)
Note: Assessment Timepoint is relative to clients intake date and length of time in the program, with data collection schedule streamlined for ease (Sept., Dec., March, June)

YOUTH ASSESSMENTS

Broad Psychological Symptoms

Youth Self-Reported Broad Psychological Symptoms

Cross-Cutting Symptom Measure Level 1 ; Age 11-17	
Items 1-19	
Response Options	**Numerical Value**
None	0
Slight	1
Mild	2
Moderate	3
Severe	4
Items 20-25	
Response Options	**Numerical Value**
Yes	1
No	0

Cross-Cutting Symptom Measure Level 1; Youth Self Report (11-17 years)		
Domain Thresholds Indicating Further Assessment		
Domain:	**Item(s) Included in Domain:**	**Score Threshold Indicating Further Assessment:**
1. Somatic Symptoms	Items 1 and 2	Mild or greater (Rating of 2 or more)
2. Sleep Problems	Item 3	Mild or greater (Rating of 2 or more)
3. Inattention	Item 4	Slight or greater(Rating of 1 or more)
4. Depression	Items 5 and 6	Mild or greater (Rating of 2 or more)
5. Anger	Items 7 and 8	Mild or greater (Rating of 2 or more)
6. Irritability	Items 7 and 8	Mild or greater (Rating of 2 or more)
7. Mania	Items 9 and 10	Mild or greater (Rating of 2 or more)
8. Anxiety	Items 11, 12, and 13	Mild or greater (Rating of 2 or more)
9. Psychosis	Items 14 and 15	Slight or greater(Rating of 1 or more)
10. Repetitive Thoughts & Behaviors	Items 16, 17, 18, and 19	Mild or greater (Rating of 2 or more)
11. Substance Use	Items 20, 21, 22, and 23	Any "Yes"
12. Suicidal Ideation/Attempts	Items 24 and 25	**Any "Yes" -- Pause current assessments and begin safety protocol, etc.**

Caregiver Informant Broad Psychological Symptoms

Cross-Cutting Symptom Measure Level 1 ; Caregiver Informant	
Items 1-19	
Response Options	**Numerical Value**
None	0
Slight	1
Mild	2
Moderate	3
Severe	4
Items 20-25	
Response Options	**Numerical Value**
Yes	1
No	0
Don't Know	1

Cross-Cutting Symptom Measure Level 1; Caregiver Informant		
Domain Thresholds Indicating Further Assessment		
Domain:	**Item(s) Included in Domain:**	**Score Threshold Indicating Further Assessment:**
1. Somatic Symptoms	Items 1 and 2	Mild or greater (Rating of 2 or more)
2. Sleep Problems	Item 3	Mild or greater (Rating of 2 or more)
3. Inattention	Item 4	Slight or greater(Rating of 1 or more)
4. Depression	Items 5 and 6	Mild or greater (Rating of 2 or more)
5. Anger	Items 7 and 8	Mild or greater (Rating of 2 or more)
6. Irritability	Items 7 and 8	Mild or greater (Rating of 2 or more)
7. Mania	Items 9 and 10	Mild or greater (Rating of 2 or more)
8. Anxiety	Items 11, 12, and 13	Mild or greater (Rating of 2 or more)
9. Psychosis	Items 14 and 15	Slight or greater(Rating of 1 or more)
10. Repetitive Thoughts & Behaviors	Items 16, 17, 18, and 19	Mild or greater (Rating of 2 or more)
11. Substance Use	Items 20, 21, 22, and 23	Any "Yes" or "Not Sure"
12. Suicidal Ideation/Attempts	Items 24 and 25	**Any "Yes" -- If appropriate, Pause current assessments and discuss safety protocol, etc.**

s 2

Reference Sheet | Youth Broad Symptoms_Self Report | Youth Trauma Symptoms_Self Report | Youth Trauma Symptoms_Caregiver Report

The Well Experience Cohesive Intake Assessment

Included Components:

Part 1: Family Background and Individual Demographic Information

- **Demographic information**:
  - Family income range; zipcode, referral source
  - Referral source: School, DCFS, Community Youth Programs (DREAAM. B&G club), Youth Assessment Center, TWE, Other
  - TPC: Summer group is a TPC;
  - youth age(s), gender(s), race/ethnicity(s)
  - Caregiver relationship, gender, race/ethnicity
- **Family Context** (informed by Support Network and Psychosocial Stressors CFI supplementary modules and FAST 3.0 items)
  - Open-ended: What brought you to TWE? (Use this to assess current potential needs/stressors and hopes for their engagement in the program)
  - Salient Context/Family Stressors (this may inform Presenting Needs section):
    1. Current: list of options as well as open-ended (options include, for example: family arguments, not enough time with family, parental absence (death, incarceration, other), family member substance use, DCFS involvement, siblings fight, limited financial resources, not enough food, homelessness, health concerns, etc, stress engaging with child's school, community violence, etc.
    2. Past (only assessed during intake): e,g., family member was previously incarcerated; family was previously homeless
  - **Family Functioning: Family functioning domain items from Fast (family conflict, family role appropriateness**
  - **Family Supports:** E.g., Extended family; religious or spiritual organization (e.g., Church); family friends
  - **Family Strengths:** E.g., Communication, spirituality, tenacity, etc [items from FAST 3.0]
  - **Family Needs: (items from FAST about family safety, financial resources, residential stability)**
    - Literal resource needs (e.g., food, help signing up for insurance, identifying primary care, etc)
    - Abstract needs: e.g., caregiver-youth relationship needs

(Summary of Presenting Needs:

- From staff/interviewer perspective; to be included in case notes.)

Reason for Engaging with TWE:

- This may be related to presenting needs, salient stressors, etc, but not necessarily
- "What are you hoping to achieve by engaging with The Well?"

Part 2: Individual Baseline Assessments

Assessment of Youth		
Broad Assessment of Psychological Distress		
Informant	**Measure**	**Notes**
Self-Report	• Cross-Cutting Symptom Measure (Youth aged 11-17)	• *If total score 15 or more, administer Child Report of PTSD Symptoms (CROPS)*
Caregiver/ Parent Report	• Cross-Cutting Symptom Measure (Parent/Guardian version)	• *If total score 15 or more, administer Parent Report of PTSD Symptoms (PROPS)*
Assessment of Trauma Symptoms and Behaviors		
Self-Report	• Child Report of PTSD Symptoms (CROPS)	
Caregiver/ Parent Report	• Parent Report of PTSD Symptoms (PROPS)	

Assessment of Caregiver/Parent		
Broad Assessment of Psychological Distress		
Informant	**Measure**	**Notes**
Self-Report	• Cross-Cutting Symptom Measure (Adult version)	• *If indicated total score 15 or more, administer PTSD Checklist-5th Edition (PCL-5)*
Assessment of Trauma Symptoms and Behaviors		
Self-Report	• PTSD Checklist-5th Edition (PCL-5)	

Part 3: Academic-related Outcomes:

Measurement Timepoints**:** Baseline, September, December, March, June

- ☐ **Consent/permission to obtain reports of student's grades, attendance, and school-related disciplinary measures (e.g., detention; suspension)**

- **GPA 3.0 and above, 2.9 and below**
- **Attendance (total absences): Chronic absenteeism= 18 or more days missed**
- **Academic problems: — not reported as an evaluation outcome, but used for case management**

APPENDICES FOR SECTION IV

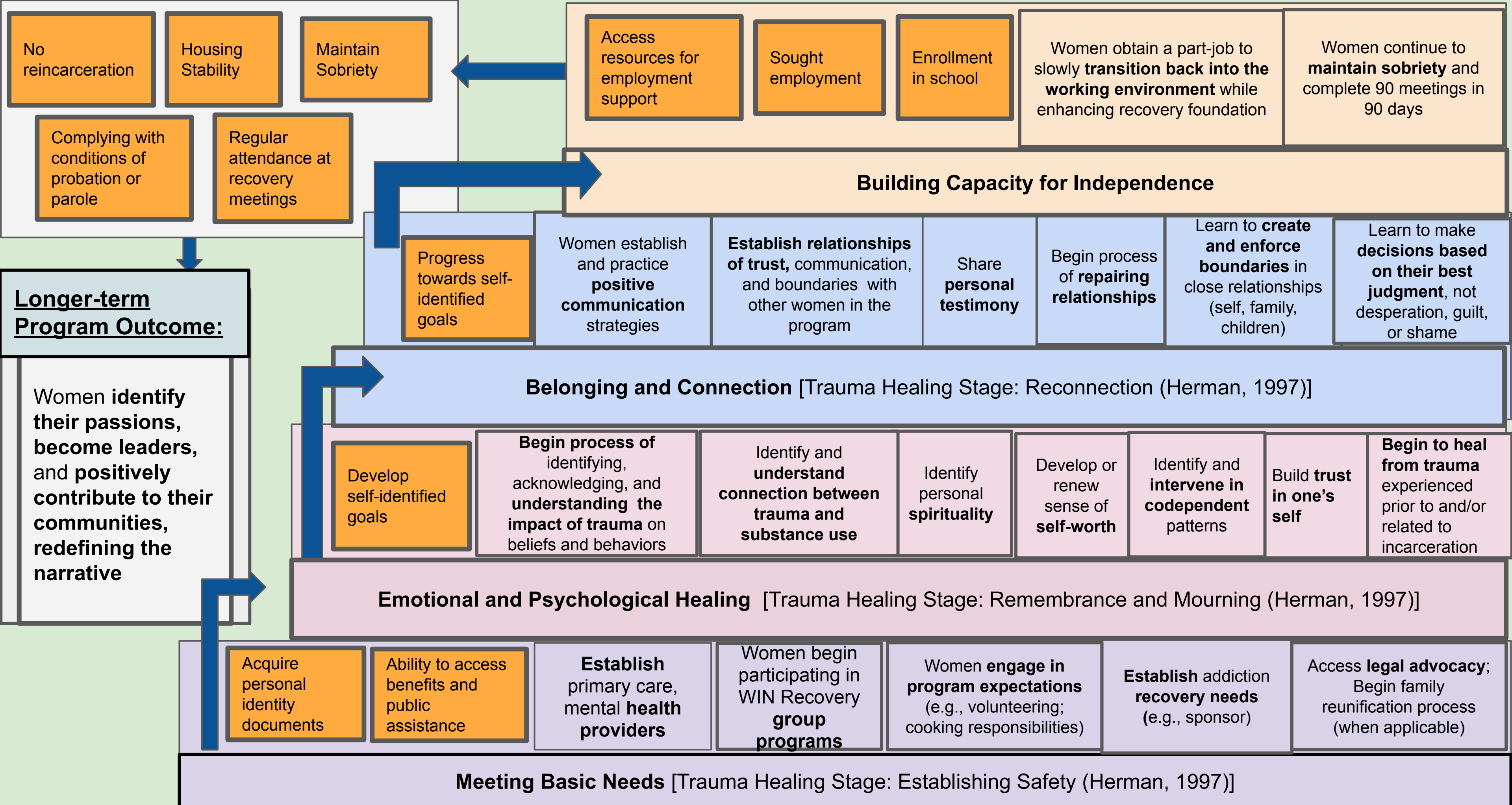
Appendix Items:

Section IV A: WIN Recovery Theory of Change Logic Model

Section IV B: PCL-5 Measure

Section IV C: Overview of Analytic Strategy

APPENDIX SECTION IV A



WIN Recovery Provides a Holistic Foundation for Healing and Recovery from Substance Abuse and Trauma

PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

Overview of Analytic Strategy

This document contains screenshots of the Excel data analytic workbook. When possible, the workbook has built in dropdown responses to streamline and improve reliability of data entry. The workbook also has built in analytic formulas to assess total scores and differences over time.

Outcome Language:
On average, women report an X point reduction in PTSD symptoms at Timepoint 2 (Transition to WIN Independent House) as compared to Baseline.
On average, women report an X point reduction in PTSD symptoms at Timepoint 3 (Transitioning to Independent Living compared to baseline.
On average, women report an X point reduction in PTSD symptoms at Timepoint 4 (6 months after transitioning to living indepenently) compared to baseline.
Overall, [X] number of women demonstrated reliable change in PTSD scores as compared to baseline assessment.
Overall, [X] number of women demonstrated statistically-significant change ib PTSD scores as compared to baseline assessment.

Analytic Strategy
Analysis will start with one aggregate group; if high symptom trajectory results are getting "washed out" with low symptom trajectory results, then could consider having two analysis groups:: one with baseline high trauma symptom trajectories and one with baseline low trauma symptom trajectories.

Please note that all client reported data and associated outcome numbers included in this document are fake and for testing and example purposes only.

Templates and Descriptions		
1) Template for PCL-5 Data Entry	2) Template for Client Sheet	3) Template for Visual Charts

Manually Enter	Use Dropdown to Select	Manually Enter	Use Dropdown to Select	Domain B: Intrusion Symptoms					ain C: Avoidance Symp		Domain D: Negative Alterations in Cognition and/or Mood							Domain E: (	
ClientID	Program Enrollment	Date of Measure	Data Timepoint	PCL_1	PCL_2	PCL_3	PCL-4	PCL_5	PC_6	PCL_7	PCL-8	PCL-9	PCL_10	PCL_11	PCL_12	PCL_13	PCL_14	PCL_15	PCL_16

AVERAGEIF(WorkshopType, 'Reference Sheet'!U5, 'Data_Aggregated Item Responses '!AH:AH)

All Programs, PCL Score Average by Timepoint					
Average Total_PCL	Average Total	Average Total_Timep	AverageTotal Timepoint3	Average Total_Timep	AverageTotalTimepoint5
36	49	33	28	41	27

All Programs Average Change:			
T1-T2	1-T3	T1-T4	T1-T5
16	21	8	23

Re-Entry Program, PCL Score Average by Timepoint					
Average Total_PCL	Average Total	Average Total_Timep	AverageTotal Timepoint3	Average Total_Timep	AverageTotalTimepoint5
37	53	31	23	48	40

Re-Entry Program Average Change:			
T1-T2	1-T3	T1-T4	T1-T5
22	30	5	13

Decarceration Program, PCL Score Average by Timepoint					
Average Total_PCL	Average Total	Average Total_Timep	AverageTotal Timepoint3	Average Total_Timep	AverageTotalTimepoint5
33	42	38	38	34	13

Decarceration Timepoint Average Change:			
T1-T2	1-T3	T1-T4	T1-T5
4	4	8	29

Program Enrollment
Response Options
WIN Re-Entry
Decarceration

PCL-5 Measure Data Collection Timepoints	Variable Name	Description of Timepoint
WIN Recovery Phase 1	PCLTotal_Baseline	Baseline/Intake
WIN Recovery Phase 2	PCLTotal_Timepoint2	Transition to WIN independent house
WIN Recovery Phase 3	PCLTotal_Timepoint3	Transition to living independently (e.g., housing voucher)
	PCLTotal_Timepoint4	6 months after transition to living independently

List of Response Options for Data Validation Dropdowns:

Program Enrollment	WIN Re-Entry
	Decarceration

		Value for Excel Calculations
Item Response Options:	Not at all	0
	A little bit	1
	Moderately	2
	Quite a bit	3
	Extremely	4
	(Missing response)	"No data"

		Time point numerical value
Data Collection Timepoints:	Baseline	1
	Transition to WIN Independent House	2
	Transition to Living Independently	3
	6 months after Living Independently	4
	Program Graduation	5

APPENDICES FOR SECTION V

Appendix Items:

Section V A: Outcomes Mapping Document

Section V B: Family Feedback Form

Section V C: Data Collection and Evaluation Timeline

Section V D: Performance Outcomes Report Instructions

Section V E: Data Tracking Spreadsheet

Goals for Next Iteration of Community Living Program Evaluation/Program Goals	**Outcomes** What would you expect to see to know goal is being met? Participant outcomes	**Data Sources/Indicators** How is this being measured/tracked? How do you know participant are doing this? What is the checkbox?	**Timing**
People have rich and fulfilling lives (self-defined)	/Housing figured out /~~Job they like~~ and/or financially secure /Have friends/connection to broader world /Have stuff they like to do /Know how to navigate challenges/barriers (could include having a system or supports)	/Participants say "I like where I live" - Independent living skills checklist response transferred to narrative report /Sustained housing over time - Where were they at start of fiscal year, did they move (narrative report; filled out by case worker) / "Do you have enough money to meet your basic needs?" "have money to do the things you want to do" from POM /money left over after paying all bills (witnessed by case worker helping with budget – maybe in narrative report) /contact notes? (prob not practical source longterm) /Planning interview – how much can you afford to pay, SSI, monthly income, section on finances (sources of income, who manages money)	Annual plan update, tracked across time in narrative report Narrative report updated quarterly Annually in POM update Narrative report updated quarterly ?? At intake
People maintain housing over a sustained period	/Nobody is homeless /People aren't switching locations; staying in the same place for a period	/Participants say "I like where I live" - Independent living skills	Annual plan update, tracked across time in narrative report

	of months without emergency situations or crises (e.g., unsure if they'll be able to pay rent) /People don't have to move to higher level of support (e.g., group home)	checklist response transferred to narrative report /Sustained housing over time - Where were they at start of fiscal year, did they move (narrative report; filled out by case worker) /Leaving the program (moving to a group home would eliminate the funding for community living program). Narrative report "Annual Plans" tab	Narrative report updated quarterly Quarterly update to narrative report
Participants have a long-term plan for sustainable community living	/Having a plan written -- e.g., In the next five years, moving out…" & participants say plan feels doable/realistic /Report from person that they feel good/confident in being in the world /If ask participants "What will happen after your parents can't help you," they say "I'm okay. I know that CC can help me, or I know how to do that myself, or I know who can help me" /Participants have strategy for navigating challenges - Recognizing barriers people may have and how we'll mitigate those and troubleshoot them to be successful - Participants know when to ask for help - Could include power of	/3rd part of Planning Interview (long-term planning). Question for family: "Do you feel like you can make some of these changes (e.g., stepping back in some areas; contacting lawyer)?" /Self-efficacy questions in Living Skills Checklist - Maybe one learned helplessness statement (e.g., I need help from people when I have problems.) and another on self-advocacy (e.g., "I know how to solve problems on my own") /Family questions in annual planning: "You said you were going to work on xyz, have	/Intake /Annual planning process /Annual planning process /Annual planning

	attorney/crisis planning /Participants and parents understand local resources for attaining long-term plan (e.g., where to get an attorney, get help with a trust, guardianship)	you made progress? Were the resources we provided helpful/used?" /Feedback form after planning interview ("Are your next steps manageable and clear?")	/Intake
Parents feel able to step back in support areas	/Parents have more free time (e.g., able to go on vacation, go out for dinner) /Higher quality of time spent with child (able to do more nice things rather than spending time on supports) /Parents report having more time to self and being able to step back	/Planning interview (where are we now, what do we want this to be) /Initial feedback form ("how much free time do you have in your life" "how much quality time – not providing support – do you spend with your child?") /Annual family evaluation form ("how much free time do you have in your life" "how much quality time – not providing support – do you spend with your child?" "Do you think these changes are because your person is more independent?")	/Intake /Post-intake /Annual planning process
People have the skills to self-direct their ongoing supports and problem solve	/Participants experience a sense of agency or ownership over their goals. People feel in charge of their lives. /Self-directing supports: - e.g., I know who I can call if I need help with SNAP benefits; I know Carly can help me reach my PSW. I know how to call my PSW to ask them to pick me up from	/POM interview ("I define my goals," "I realize my goals") /Self-efficacy scale in Living Skills Checklist - E.g., "I sometimes have to tell people what I need" vs "Other people know best what I need"	/Annual planning process /Annual planning process

	work. - Participants are deciding what they need rather than agencies deciding for them (e.g., "I want to live here; I don't want to live there.") - Participants define their goals and are involved in the process of how to make them happen /Problem-solving: - People tell us about it. They call Ryan and say they had this problem, they did this. & They ask "was this okay" - If we don't hear about it, that often means it's worked out /People have learned the skills they said they wanted to learn & are implementing those, maintaining them, & able to generalize those skills to other settings /Increased sense of self-agency	/Self-efficacy scale of Living Skills Checklist - E.g., "I know that things will work out because I have the ability to find solutions" vs "I never know how to fix my problems" /POM interview ("I realize my goals") /Narrative summary (goals met yes/no – counts/percentages; supports	/Annual planning process /Annual planning process /Annual planning process
Natural supports maximized to the greatest extent possible	/Participants can identify their natural supports (e.g., I could call Jasmine about the bus because she's good at taking the bus) /Participants have skills/plan for	/Asked in POM interview (not part of scoring) - If they have a goal for that, then use of natural resources would be tracked in notes, narrative report etc ***Do we want to ask about this in the family annual eval form or add a question to the ILSC for the participant? – maybe not high on the list* /If they had a goal, then	/Annual planning process, regular meetings/quarterly reports /possibly quarterly reports, annual planning process

	incorporating friends, other resources/people/acquaintances into their plan of how they get around the world & get things done on a regular basis *Difficult to know*	tracked	
People are satisfied with their housing and have the skills, resources, and connections to sustain it.	/People stay in housing /People say they like their housing /Able to pay bills to stay in place they like /Can use resources available to help them pay bills (e.g., voucher, IHEAP) /House is clean enough, relatively healthy and safe /Housing allows them to be connected to community they like (e.g., close enough to friends, places they enjoy)	/ILSC – eval questions section /same as above /Quarterly Narrative(done annually) /ILSC /ILSC /ILSC – eval questions (though not direct)	/Annual Planning Process
People's natural supports increase trust in individual's growing agency	/Parents can back away (I know it's okay for me to go out of town) /Parents' idea of long-term changes a little bit (e.g., from "they're never going to be able to live on their own" to "maybe this could keep going if I move away or die") – shift in imagination of what's possible /Maybe they don't need to x,y,z; letting the person take over certain tasks on their own – giving them more freedom & control over their own lives (e.g., debit card)	/Parent Eval (annual) /Parent Eval (possibly) /Cumulative goal data in narrative reports, parent eval	/Annual Planning process /Quarterly (but over time)
People increase their sense of agency		ILSC	Annual

People meet goals for identified skills		Narrative Report	Quarterly
People meet resource goals		Narrative Report	Quarterly
People move out		Narrative Report	Quarterly

APPENDIX SECTION V B

Planning Interview - Family Evaluation

To be completed following the completion of the Planning Interview

* Required

1. Did you recently complete your INITIAL planning interview, or an ANNUAL planning interview? *

Mark only one oval.

- Initial (just getting started with services) *Skip to question 2*
- Annual (reviewing progress after 1+ years working with us) *Skip to question 5*

Routine, Time, and Family Role - INITIAL

2. How many hours a week of FREE TIME (time to pursue pleasurable activities and interests) do you have each week?

____

3. How much time per week do you spend providing support, instruction, prompting for your adult family member with a disability?

____

4. Did going through this planning process with us help you build a new image of what your parent role could be in your family member’s community-based life?

Mark only one oval.

- Not at all *Skip to question 10*
- Somewhat *Skip to question 10*
- Yes *Skip to question 10*

Routine, Time, and Family Role - ANNUAL

5. How many hours a week of FREE TIME (time to pursue pleasurable activities and interests) do you have each week?

____

6. How much time per week do you spend providing support, instruction, prompting for your adult family member with a disability?

____

7. Have you noticed improvement in the amount of free time or quality time with your family member since becoming involved in the Inclusive Community Support program?

Mark only one oval.

- ◯ Not at all
- ◯ Somewhat
- ◯ Yes, there has been improvement

8. If you answered "Somewhat" or "Yes," what do you think has driven this change?

____
____
____
____
____

9. Has your parent role changed in the ways you'd hoped/in positive ways since engaging with the Inclusive Community Support Program?

Mark only one oval.

- Not at all *Skip to question 12*
- Somewhat *Skip to question 12*
- Yes *Skip to question 12*

Plan Development - INITIAL

10. Based on your participation in the CC Planning Interview, please rate the following:

Mark only one oval per row.

	1 (Not at all)	2 (Very little)	3 (Somewhat)	4 (A fair amount)	5 (A great deal)
I have clear idea of what I would like a community-based living situation to look like for my family member with I/DD					
I know the immediate next steps necessary to make community-based living possible for my family member with I/DD					
I feel confident that my family member can continue to live in the community without me.					
I was provided with resources I am eager to use in my next steps.					

11. What resources provided in your planning interview are you most eager to use in your next steps?

____

Skip to question 17

Resources - ANNUAL

At your Planning Interview we discussed long-term planning steps for your family.

For example:
-Setting up guardianship or successor guardianship
-Creating an ABLE account
-Developing a system to report wages to SSA
-Set up a Special Needs Trust
-Discussing long term plans with extended families and/or siblings

12. What progress have you made on these long-term planning steps?

____
____
____
____
____

13. Were the resources provided useful in making progress?

Mark only one oval.

- ◯ Not at all
- ◯ Sometimes
- ◯ Yes

14. What else would have been helpful for you to move forward?

Skip to question 15

Impact - ANNUAL

15. Do you feel that the Inclusive Community Support program has been helpful to your family member in the following areas:

Mark only one oval per row.

	1 (Not at all)	2	3	4	5 (Very much)
learning new skills					
finding or sustaining preferred community-based housing					
connections and social networks					
accessing support other than from yourself					

16. Overall, what more could the program be doing to support your family member to live a full, community-based life?

Pilot Questions - INITIAL

17. What was most helpful to you from this Planning Interview Process?

18. What would you have changed in this Planning Interview Process?

19. Did you have a clear sense of what the purpose of the Planning Interview was when starting?

20. Did you have a clear sense of what to expect next from CC at the end of the Planning Interview Meeting?

21. What type of additional resources or materials would have made this process more helpful?

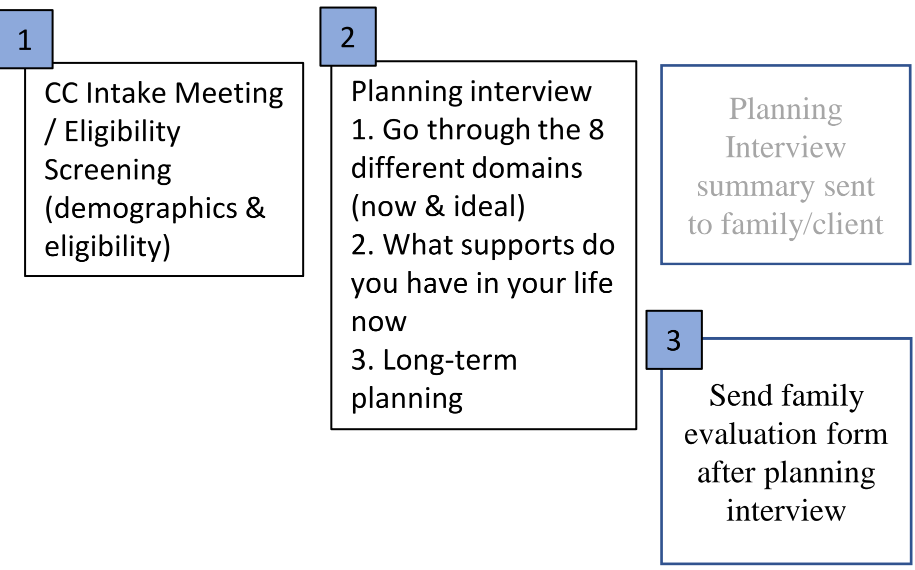
22. Is there anything the facilitators could have changed to make the meeting more productive? If so, what would you have changed?

This content is neither created nor endorsed by Google.

Google Forms

APPENDIX V C

Intake



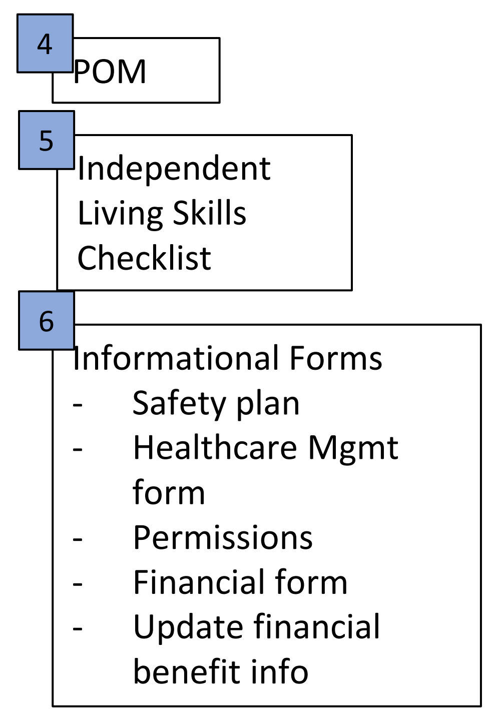
July 1, 2022

July 20, 2022 – Aug 5, 2022

Gray font: No explicit data collection

Participants have a long-term plan for sustainable community living 2, 3
Parents feel able to step back in support areas 3
Natural supports maximized to the greatest extent possible 2
People's natural supports increase trust in individual's growing agency 3

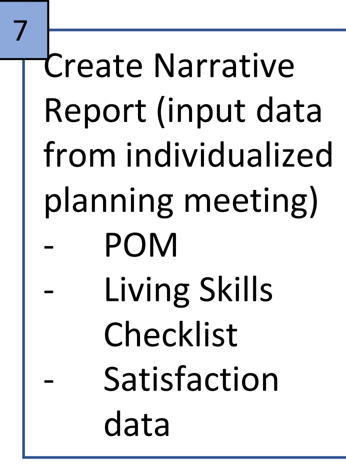
Initial Individualized Planning Meeting(s)



Aug 12-26, 2022

People have rich and fulfilling lives (self-defined) 4, 5
People maintain housing over a sustained period 5
People have the skills to self-direct their ongoing supports and problem solve 4, 5, 6
Natural supports maximized to the greatest extent possible 4, 5, 6
People are satisfied with their housing and have the skills, resources, and connections to

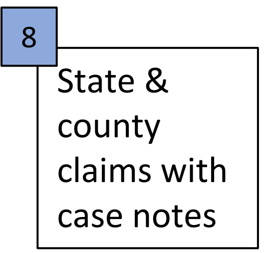
Action Plan



Sep 1, 2022

People have rich and fulfilling lives (self-defined) 7
People maintain housing over a sustained period 7
Natural supports maximized to the greatest extent possible 7

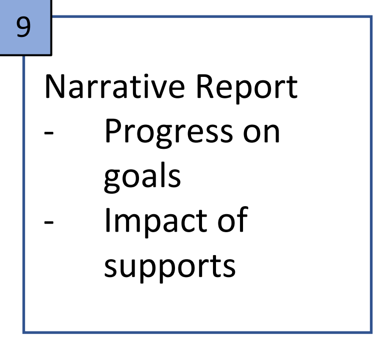
Routine Services



Ongoing

People meet goals for identified skills 8
People meet resource goals 8
People move out 8

Quarterly Report



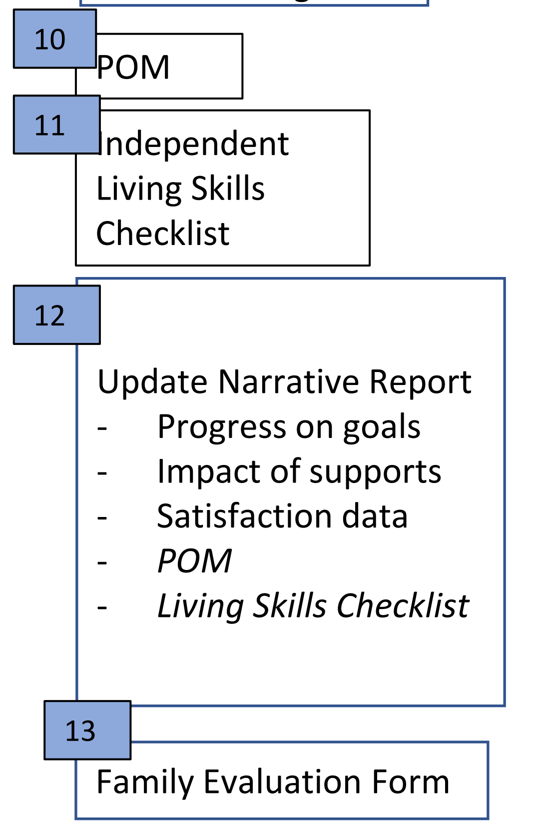
October 15, 2022

January 15, 2023

April 15, 2023

People maintain housing over a sustained period 9
Participants have a long-term plan for sustainable community living 9
People have the skills to self-direct their ongoing supports and problem solve 9
People are satisfied with their housing and have the skills, resources, and connections to sustain it. 9 (officially just 1x per year)
People's natural supports

Annual Planning Meetings



13
Family Evaluation Form

Sep 1, 2023

People have rich and fulfilling lives (self-defined) 10, 11, 12
People maintain housing over a sustained period 11, 12
Participants have a long-term plan for sustainable community living 13, 11,
Parents feel able to step back in support areas 13
People have the skills to self-direct their ongoing supports and problem solve 10, 11, 12, 13

Consumer Outcomes -- FY23

==

What impact will this program have on the people it serves? Provide Numbered Outcomes. (300 word limit)

1. FAMILY SUPPORT AND PLANNING: Whole Families have access to the supports that are important for them to fulfill their Community Living Plan.
    a. Families feel that they have an achievable long-term plan for sustainable community living.
        - 1a: Initial Family Eval Form
            - X = the total number of families who have participated in a Planning Interview during the FY.
                - We use the "New" client list and indicate who has involved families. This is the number of people we attempt to contact. Actual X is the number of people who respond with a timestamp within the fiscal year.
                - Success is indicated when the person has chosen the "Somewhat" - "Extremely" options. Lack of Success is indicated by "not at all" and "A little" options.
    b. Families indicate a decrease in time spent providing daily living support.
        - 1b: Annual Family Eval Form
            - X = All "Continuing" participants if they have involved families (we have contact with).
                - We use our "continuing client" list. Of these, we choose who has involved families. This is the number of people we attempt to contact. Actual X will be the number of families who actually respond with a timestamp within the fiscal year.
                - Calculate the difference between the initial response or the previous year's response and the most recent annual eval. We could report the average change, or the mode (most frequent) change.
    c. Families indicate an increase in their quality of life.
        - 1c: Annual Family Eval Form
            - X = All "Continuing" participants if they have involved families (we have contact with).
                - We use our "continuing client" list. Of these, we choose who has involved families. This is the number of people we attempt to contact. Actual X will be the number of families who actually respond with a timestamp within the fiscal year.
                - Success is indicated when they choose "Somewhat" Or "Yes". Lack of success is indicated when they choose "No"
    d. Family members indicate that ICS has supported their person to achieve desired housing, and build natural supports, skills, and connections.
        - 1d: Annual Family Eval Form
            - X = All "Continuing" participants if they have involved families (we have contact with).

- We use our “continuing client” list. Of these, we choose who has involved families. This is the number of people we attempt to contact. Actual X will be the number of families who actually respond.
- Success is indicated when the person has chosen the “Somewhat” - “Extremely” options. Lack of Success is indicated by “not at all” and “A little” options.

2. HOUSING, LEARNING, CONNECTING: Participants build lives in the community.
    a. HOUSING
        i. Participants maintain stable housing over time
            - 2ai: Quarterly Check-In/Narrative Reports
                - *X = All “Continuing” participants, including those in consultation*
                - *Does NOT Include NEW people. We would NOT include data from the initial ILSC, only the annual (2nd, 3rd, etc).*
                - *POSSIBLE OUTCOME TO report: Do people with stable housing show greater progress/success on goals?*
        ii. Participants indicate they are satisfied with their housing
            - 2aii: ILSC
                - *X = All “Continuing” participants, including those in consultation*
                - *Does NOT Include NEW people. We would NOT include data from the initial ILSC, only the annual (2nd, 3rd, etc).*
        iii. Participants indicate ICS has been helpful in finding or sustaining preferred housing.
            - 2aiii: ILSC
                - *X = All “Continuing” participants, including those in consultation*
                - *Does NOT Include NEW people. We would NOT include data from the initial ILSC, only the annual (2nd, 3rd, etc).*
    b. LEARNING
        i. Participants develop the skills they identified as critical for community living
            - 2bi: Action Plan & Quarterly Check-in/Narrative Report
            - ***Of X number of participants, xx% made progress on at least 1 goal.***
                - *X= The total participants actively working in the department during the FY.*
                    - *Go to client list by quarter document & make list of who should be included:*
                        - *Engaged in the program for at least 2 quarters (2 quarterly report entries)*
                        - *Participants in Consultation should NOT be counted*
                - *Calculating xx% = Review each person’s goals. If they made progress on at least 1 goal during 1 quarter of the fiscal year, then that is counted as “success”. Then calculate this percentage.*
                    - *Progress can include “taking steps on own” or “taking steps with guidance”.*
                - *We could break this down even more and say:*
                    - *XXX% made progress on multiple goals*
                    - *XXXX% made began making progress independently (w/o our Support)*

- **** the base number of people would always remain the same. X always = the number of total active people in the department (as above). The %s always are based on that.*

ii. Participants indicate that Inclusive Community Supports have been helpful in skill building.
   - 2bii: ILSC
      - *X = All "Continuing" participants, including those in consultation*
      - *Does NOT Include NEW people. We would NOT include data from the initial ILSC, only the annual (2nd, 3rd, etc).*

c. CONNECTING

i. Participants identifying a desire to build connections, find belonging with people, places, or groups in their community.
   - 2ci: Action Plan & Quarterly Check-in/Narrative Report
   - ***Of X number of participants that had goals related to CONNECTING, xx% made progress on at least 1 of their connection goals.***
      - *Count the number of participants who had Connection-related goals from the Narrative Report. This is X - New participants will be counted if they have been engaged in the program for at least 2 quarters (2 quarterly report entries).*
      - *Of these participants, count the number that made progress in at least 1 Q of the past fiscal year. Then calculate the % of these successful cases.*
         - *Progress can include "taking steps on own" or "taking steps with guidance".*
      - *Could breakdown further…*
         - *xxx% is making progress independently at their goal.. etc.*

ii. Participants indicate ISC has been helpful to their building community connections.
   - 2cii: ILSC
      - *X = All "Continuing" participants, including those in consultation*
      - *Does NOT Include NEW people. We would NOT include data from the initial ILSC, only the annual (2nd, 3rd, etc).*

iii. Participants have people and places where they are comfortable
   - 2ciii: ILSC
      - *X = All "Continuing" participants, including those in consultation*
      - *Does NOT Include NEW people. We would NOT include data from the initial ILSC, only the annual (2nd, 3rd, etc).*
      - *POSSIBLE OUTCOME TO REPORT: Are people with social connections (people and places) more likely to have stable housing?*

3. PERSONAL OUTCOME MEASURES

a. Participants increase their POM scores in targeted outcomes over time
   - 3a: POM

b. Participants increase their POM Supports present for targeted outcomes over time
   - 3b: POM

4. PERSONAL DEVELOPMENT CLASSES: Individuals with I/DD build distinct independent living skills
    a. 100% of participants [15] will indicate growth or skill development based on the course assessments.
        - 4a: Class Pre/Post Evaluation

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)

Assessment Tools/Data Collection Used:

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

OUTCOME NUMBER:			2ai	2aii	2aiii	2bi	BONUS	2bii
DATA SOURCE:			ILSC/Q Report	ILSC/Q Report	ILSC/Q Report	Q Report	Q Report	ILSC/Q Report
WHO TO INCLUDE:			All Continuing + Closed Clients (if known), even if in consultation	All Continuing + Closed Clients (if known), even if in consultation	All Continuing + Closed Clients (if known), even if in consultation - NO New People	Continuing clients who are NOT in consultation New Participants w/ 2 Q Report entries	Continuing clients who are NOT in consultation New Participants w/ 2 Q Report entries	All Continuing Clients, including those in consultation
LIST ALL PROGRAM PARTICIPANTS - delete any closed clients from the "continuing list"	**Program Status**	**CONSULTATION for more than 1/2 the year? (consultation = the person doesn't have any specific goals to work on, and any support is informal and not "life-critical")**	**Did the person maintain stable housing from one year to the next?**	**Did the person indicate that they are satisfied with their housing?**	**Did the person indicate that ICS has been helpful in their finding or sustaining perfered housing?**	**Did the particpant make progress on at least 1 goal for 1 Q? (progress = taking steps on own or with guidance**	**Did they made progress on multiple goals?**	**Did the person indicate that ICS had been helpful in Skill Building?**
Client A	Continuing	YES	YES	YES	NO	N/A	N/A	NO
Client B	New Q4	No	YES	YES	N/A - Initial year	YES	N/A	N/A - Initial Year

2ci	2ci	2cii	2ciii	3a	3a	3a		3b
Q Report	Q Report	ILSC/Q Report	ILSC/Q Report	POM/Q Report	POM/Q Report	POM/Q Report		POM/Q Report
Review All	All participants w/ Connection Goals (must have 1 Q Report Entries) -- can sort for "Yes" in Column J	All Continuing + Closed Clients (if known), even if in consultation - NO New People	All Continuing + Closed Clients (if known), even if in consultation - NO New People	All Continuing Clients who are NOT in Consultation, include closed clients if data is present	All Continuing Clients who are NOT in Consultation, include closed clients if data is present	All Continuing Clients who are NOT in Consultation, include closed clients if data is present		All Continuing Clients who are NOT in Consultation, include closed clients if data is present
Did the person have a goal related to Connections?	**Did the person make progress on their Connection Goal (taking steps on own or with guidance)?**	**Did the person indicate that ICS had been helpful in building community connections?**	**Does the person indicated that they have people and places they feel connected to?**	**Number of Targeted POM Outcomes Present THIS YEAR:**	**Number of Targeted POM Outcomes Present in inital POM? (if known)**	**Number of Targeted POM Outcomes present last year?**		**Number of Targeted POM Supports Present THIS YEAR:**
NO	N/A	NO	YES	N/A	N/A	N/A		N/A
NO	N/A	N/A	YES	5	5	N/A		1

3b	3b		3a+b	4a	4a	4a	4a	4a
POM/Q Report	POM/Q Report		POM/Q Report	Classes Narrative Report	Classes Narrative Report	Classes Narrative Report	Classes Narrative Report	Classes Narrative Report
All Continuing Clients who are NOT in Consultation, include closed clients if data is present	All Continuing Clients who are NOT in Consultation, include closed clients if data is present		All Continuing Clients who are NOT in Consultation, include closed clients if data is present	Class 1	Class 1	Class 2	Class 2	Class 3
Number of Targeted POM Support Present in inital POM? (if known)	**Number of Targeted POM Supports present last year?**		**Number of years in program?**	**How many participants?**	**How many participants indicated growth**	**How many participants?**	**How many participants indicated growth**	**How many participants?**
N/A	N/A		5					
1	N/A		0					

4a	4a	4a	4a	4a
Classes Narrative Report	Classes Narrative Report	Classes Narrative Report	Classes Narrative Report	Classes Narrative Report
Class 3	Class 4	Class 4	Class 5	Class 5
How many participants indicated growth	**How many participants?**	**How many participants indicated growth**	**How many participants?**	**How many participants indicated growth**

APPENDICES FOR SECTION VI

Appendix Items:

Section VI A: CDC List of Risk and Protective Factors for Sexual Violence Perpetration

Section VI B: RACES Data Workbook

CDC Centers for Disease Control and Prevention

APPENDIX SECTION VI A

Violence Prevention

Risk and Protective Factors

Risk factors are linked to a greater likelihood of sexual violence (SV) perpetration. They are contributing factors and might not be direct causes. Not everyone who is identified as at risk becomes a perpetrator of violence. A combination of individual, relational, community, and societal factors contribute to the risk of becoming a perpetrator of SV. Understanding these factors can help identify various opportunities for prevention.

CDC focuses on preventing the first-time perpetration of SV. Watch Moving Forward to learn more about how increasing what protects people from violence and reducing what puts people at risk for it benefits everyone.

Risk Factors for Perpetration

Individual Risk Factors

- Alcohol and drug use
- Delinquency
- Lack of concern for others
- Aggressive behaviors and acceptance of violent behaviors
- Early sexual initiation
- Coercive sexual fantasies
- Preference for impersonal sex and sexual-risk taking
- Exposure to sexually explicit media
- Hostility towards women
- Adherence to traditional gender role norms
- Hyper-masculinity
- Suicidal behavior
- Prior sexual victimization or perpetration

Relationship Factors

- Family history of conflict and violence
- Childhood history of physical, sexual, or emotional abuse
- Emotionally unsupportive family environment
- Poor parent-child relationships, particularly with fathers
- Association with sexually aggressive, hypermasculine, and delinquent peers
- Involvement in a violent or abusive intimate relationship

Community Factors

- Poverty
- Lack of employment opportunities
- Lack of institutional support from police and judicial system
- General tolerance of sexual violence within the community
- Weak community sanctions against sexual violence perpetrators

Societal Factors

- Societal norms that support sexual violence
- Societal norms that support male superiority and sexual entitlement
- Societal norms that maintain women's inferiority and sexual submissiveness
- Weak laws and policies related to sexual violence and gender equity
- High levels of crime and other forms of violence

Protective Factors for Perpetration

Protective factors may lessen the likelihood of sexual violence victimization or perpetration. These factors can exist at individual, relational, community, and societal levels.

- Families where caregivers work through conflicts peacefully
- Emotional health and connectedness
- Academic achievement
- Empathy and concern for how one's actions affect others

References

1. Tharp, A. T., DeGue, S., Valle, L. A., Brookmeyer, K. A., Massetti, G. M., & Matjasko, J. L. (2013). A systematic qualitative review of risk and protective factors for sexual violence perpetration. Trauma, Violence, & Abuse, 14(2), 133-167. https://doi.org/10.1177/1524838012470031

Page last reviewed: February 5, 2022

AutoSave Off Appendix_B_RACES_Data_Workbook Search (Alt+Q)

File Home Insert Page Layout Formulas Data Review View Help Acrobat

C3 fx

	A	B	C	D	E	F
1	Formula for "Counts for all Schools" tab:	=SUMIF('K2 All Schools'!B3:B4136 ,"Incorrect",'K2 All Schools'!C3:C4124)	Circle the box that shows what to do if someone asks to see or touch your body parts. **Correct: B; Key Outcome 1**	Circle the box that shows someone using the Always Ask First skill.	Circle the box that says how to refuse an unsafe touch.	Circle the box that shows what your private body parts are.
2	School	Accuracy	Q1_pre	Q2_pre	Q3_pre	Q4_pre
3	St Joe	Correct				
4	St Joe	Incorrect				
5	Booker T	Correct				
6	Booker T	Incorrect				
7	Broadmeadow	Correct				
8	Broadmeadow	Incorrect				
9	Carrie Busey	Correct				
10	Carrie Busey	Incorrect				
11						

AutoSave Off Appendix_B_RACES_Data_Workbook Search (Alt+Q)

File Home Insert Page Layout Formulas Data Review View Help Acrobat

H11 fx

	A	B	C	D	E	F	G	H
1			K2 Grade Pre-Test (N = 500)					
2			Pre Q1	Pre Q2	Pre Q3	Pre Q4		**The formulas on this sheet use the "SUMIF" function in Excel to only count the numbers who answered each quetsion "Correct" and "Incorrect" (searches Column B for "correct" or "incorrect" and sums the number of students in Column C, D, E, etc)**
3		Correct	0	0	0	0		
4		Incorrect	0	0	0			
5								
6								
7			K2 Grade Post-Test (N = 300)					
8			Post Q1	Post Q2	Post Q3	Post Q4		
9		Correct						
10		Incorrect						
11								
12								
13								
14								
15								
16			3-5 Grade Pre-Test (N = 400)					
17			Pre Q1	Pre Q2	Pre Q3	Pre Q4		=SUMIF('K2 All Schools'!B3:B4136,"Incorrect",'K2 All Schools'!C3:C4124)
18		Correct	0					
19		Incorrect	0					
20								
21								
22			3-5 Grade Post-Test (N = 400)					
23			Post Q1	Post Q2	Post Q3	Post Q4		
24		Correct						
25		Incorrect						
26								

... 3-5 All Schools | 6-8 All Schools | 9-12 All Schools | **Counts for all Schools** | +

APPENDICES FOR SECTION VII

Appendix Items:

Section VII A: Core Workshop Items

Section VII B: Evaluated Outcomes

Section VII C: Overview of Data Workbook

Core Workshop Items

Core Assessment Item Language:	
Item Prompt: "PRIOR TO participating in the training, how would you rate yourself?"	
Pre_1	*"My knowledge about LGBTQ+ issues in general"*
Pre_2	*"My knowledge about trans experiences"*
Pre_3	*"My confidence to share my pronouns"*
Pre_4	*"My confidence to correct someone who uses the wrong pronouns for another person"*
Pre_5	*"My confidence to correct someone who uses the wrong name for another person"*
Pre_6	*"My awareness of the impact of correct language use for the LGBTQ+ community"*
Pre_7	*"My intent to improve experiences for LGBTQ+ people"*

Core Assessment Item Response Options and Assigned Values	
Response Option	Numeric Value
Not at all	0
A little	1
Moderately	2
Quite a bit	3
A lot/ Extremely	4
No response	*"Missing response"*

Item Prompt: "AFTER participating in the training, how would you rate yourself?"	
Post_1	*"My knowledge about LGBTQ+ issues in general"*
Post_2	*"My knowledge about trans experiences"*
Post_3	*"My confidence to share my pronouns"*
Post_4	*"My confidence to correct someone who uses the wrong pronouns for another person"*
Post_5	*"My confidence to correct someone who uses the wrong name for another person"*
Post_6	*"My awareness of the impact of correct language use for the LGBTQ+ community"*
Post_7	*"My intent to improve experiences for LGBTQ+ people"*

Core Assessment Item Response Options and Assigned Values	
Response Option	Numeric Value
Not at all	0
A little	1
Moderately	2
Quite a bit	3
A lot/ Extremely	4
No response	*"Missing response"*

Evaluated Workshop Outcomes

Outcome Language:
X% of participants reported an increase on at least 1 assessment item.
X% of participants experienced an 4 or more assessment items.
X% of participants experienced an increase on all 7 assessment items.
Overall, workshop participants demonstrated statistically significant change on [X] number of assessment items.
Overall, participants rated the relevance of the training as *[qualitative descriptor here; example* :very high], with an average rating of X.X out of 10 (with 1 being low and 10 being very high).
Overall, participants rated the knowledge level of the workshop presenter as *[insert qualitative descriptor (e.g., very high/high),* with an average rating of X.X out of 10 (with 1 being low and 10 being very high).
Overall, workshop participants indicated that they would be *[insert qualitative descriptor (e.g., very likely/likely/unlikely)]* to recommend the training to others, with an average response of [X.X] out of 10 (with 1 being low and 10 being very high).

Number of workshop respondents indicating improvements on		Percentage of Total Sample
...at least one assessment item		0%
...4 or more assessment items		0%
...all 7 assessment items		0%

Excel Analysis Workbook Overview

Reference Sheet:

Includes:

- **Description of Data Fields, Survey Item Language, Response Options, and Assigned Values Used Within this Workbook**
- **Reported Outcome Language, Description of Data Source(s), and Formula(s) Used in Analysis**
- **Overview of Collected Demographic Information, Item Language, and Response Options**

Procedure:

-When making any changes to definitions, group categories, etc, be sure to save a copy of the workbook with the previous data in case anything goes wrong.
-Be sure to update categories, definitions, etc on the reference sheet of the Workbook.
-Note that sometimes adding categories can create problems in existing formulas, so try not to do this often.

Data Field:	Description:	Data Entry Method and Format:
Workshop Date	Date the workshop was held, not necessarily the same date the survey was completed	Manually entered; Column is formatted as "Short Date"
Workshop Type	Describes the nature of the workshop in terms of a) whether the content was significantly customized for the setting, and if not then b) the length of the workshop (standard/extended)	Dropdown selection; see response options in a following table ("Workshop Type")
Workshop Context	Describes the workshop setting/ affiliation of primary attendees (If multiple audiences/settings, consider the primary intended audience)	Dropdown selection; see response options in a following table ("Workshop Attendee Affiliation/Context")

Workshop Attendee Setting/Context	
Standard	Standard UP Cultural Competency Workshop
Extended	Standard workshop plus addition of calling in/calling out and roleplay section
Customized	Workshop including components outside of the standard/extended training templates (e.g., asexuality spectrum workshops)

Core Assessment Item Language:	
Item Prompt: "PRIOR TO participating in the training, how would you rate yourself?"	
Pre_1	*"My knowledge about LGBTQ+ issues in general"*
Pre_2	*"My knowledge about trans experiences"*
Pre_3	*"My confidence to share my pronouns"*
Pre_4	*"My confidence to correct someone who uses the wrong pronouns for another person"*
Pre_5	*"My confidence to correct someone who uses the wrong name for another person"*
Pre_6	*"My awareness of the impact of correct language use for the LGBTQ+ community"*
Pre_7	*"My intent to improve experiences for LGBTQ+ people"*

Item Prompt: "AFTER participating in the training, how would you rate yourself?"	
Post_1	*"My knowledge about LGBTQ+ issues in general"*
Post_2	*"My knowledge about trans experiences"*
Post_3	*"My confidence to share my pronouns"*
Post_4	*"My confidence to correct someone who uses the wrong pronouns for another person"*
Post_5	*"My confidence to correct someone who uses the wrong name for another person"*
Post_6	*"My awareness of the impact of correct language use for the LGBTQ+ community"*
Post_7	*"My intent to improve experiences for LGBTQ+ people"*

Workshop Attendee Affiliation/Context:	
	Education Professionals
	Mental/Behavioral Health Professionals
	Medical Professionals
	Students/Youth
	Family Members/Close Allies
	Religious Organization
	Another Type of Affiliation/Organizational Setting

Core Assessment Rated Items Response Options and Assigned Values	
Response Option	Numeric Value
10 (High)	10
9	9
8	8
7	7
6	6
5	5
4	4
3	3
2	2
1 (Low)	1
No response	*"No data"*

Rated Items:

	Relevance_Rating	*"How would you rate the relevance of this training?"*
	Knowledge_Rating	*"How would you rate the knowledge level of the presenter?"*
	Recommend_Rating	*"Please rate how likely are you to recommend this training to other people"*
When Applicable	**Corrections_Rating**	*"How would you rate the helpfulness of the Corrections/Calling In vs. Calling Out and Role Play section of this training?"*
		If not applicable (i.e., question is not asked), enter N/A in relevant cells

Data Field Name:	Item Language:
Age	"What is your age, in years?"
Gender	"What is your gender? (Select all that apply)"
Gender Identity	"Do you identify as transgender?"
Sexual Orientation/Identity	"What is your sexual identity or orientation? (Select all that apply)"
Race	"What is your race? (Check all that apply)"
Ethnicity	"What is your ethnicity? (Check all that apply)"
Zipcode	"What is your home zipcode?"

Respondent Data Entry Notes:	UP Data Entry Method and Format:
Manually entered by respondent	Respondent data is copied and pasted from intial data file to the "Data_Aggregated Demographics" worksheet in this workbook.
Respondents select from pre-created categories; see response options below.	
Respondents select "Yes" (indicating they identify as transgender) or "No".	
Respondents select from pre-created categories; see response options below.	
Respondents select from pre-created categories; see response options below.	
Respondents select from pre-created categories; see response options below.	
Manually entered by respondent.	

Respondent Gender:
Agender
Genderqueer or genderfluid
Māhū
Man
Muxe
Nonbinary
Two-Spirit
Woman
Questioning or unsure
My gender is not listed (please specify):
Prefer not to answer *[Consider adding]*
(No response)

Respondent Gender Identity
Yes [i.e., I **do** identify as transgender]
No [i.e., I **do not** identify as transgender]
Prefer not to answer [Consider adding]
(No response)

Respondent Sexual Orientation/Identity:
Aromantic
Asexual
Bisexual
Fluid
Gay
Lesbian
Pansexual
Queer
Questioning or unsure
Same-gender loving
Straight (heterosexual)
Omnisexual
My sexual identity is not listed
Prefer not to answer [Consider adding]
(No response)

Respondent Racial Identity:
White
Black or African American
American Indian or Alaskan Native
Asian or Asian American
Native Hawaiian or other Pacific Islander
My race is not listed (Please Specify)
Prefer not to answer [Consider adding]
(No response)

Respondent Ethnicity:
Hispanic or Latinx
Not Hispanic or Latinx
My ethnicity is not listed (Please Specify)
Prefer not to answer [Consider adding]
(No response)