COMPILED ANNUAL PERFORMANCE OUTCOME REPORTS OF CCDDB, IDDSI, AND CCMHB I/DD FUNDED PROGRAMS FOR CONTRACT YEAR 2025

Compiled Annual Performance Outcome Reports of CCDDB, IDDSI, and CCMHB I/DD Funded Programs for Contract Year 2025

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Annual Performance Outcome Report Form

In the Program Plan Narrative submitted with your application, you identified measures of Consumer Access, Consumer Outcomes, and Utilization. While Utilization data and comments have been captured in the quarterly service activity reports, Consumer Access and Consumer Outcome findings are reported only at the end of the program year. Download and complete this form and upload it to the online system reporting page, Performance Outcome Section.

Agency Name: CCRPC

Program Name: Community Life Short-Term Assistance Program

Program Year: 2025

CONSUMER ACCESS

In the Program Plan Narrative, you identified eligibility criteria for the program's services, how those criteria are established, how the target population learns about the program, and expected timelines. Please comment on each area below.

1. **YES/NO - Did the stated criteria serve the purpose of providing people the services/ supports they were seeking? If NO, comment on causes and possible solutions.**

   Yes, the stated criteria of eligibility for the program served the purpose of providing people the services and supports they were seeking in PY25. In PY25, we provided funding to individuals with IDD in Champaign County that were registered on PUNS or receiving Medicaid-waiver funding, aged 18 or older and have exited school services, and meet income guidelines at or below 60% annual median income. Individuals or their support person had to complete an application for this funding and turn in required documentation. Funding also had to meet certain criteria to be approved including increasing community involvement, socialization, family contact, education and/or entrepreneurial activities, independence, or improving overall wellbeing related to physical or mental health.

2. **YES/NO - Did the stated process for determining that the person and program were right for each other work well? If NO, comment on causes and possible solutions.**

   Yes, the stated process for determining that the person and program were right for each other worked well in PY25. Documentation was required for proof of disability, residency, and income.

3. **YES/NO - Did the stated outreach activities support appropriate matches between people and program services? If NO, comment on causes and possible solutions.**

   Yes, outreach activities supported appropriate matches between people and programs in PY25. In PY25, flyers for the Community Life Short-Term Assistance program were sent out to all individuals that were registered on PUNS on 6/30/23 when CCRPC transitioned the ISC program over to Prairieland. CLSTA flyers were also sent out to HBS clients living in

Champaign County. In addition to this, CLSTA flyers were also provided to area providers and the local ISC agency, Prairieland Services Coordination, Inc. The program coordinator for this program also met with several local agencies in PY25 to discuss programs offered through RPC's Developmental Disability Services team. The agencies that program coordinator met with included Community Service Center of Northern Champaign County, Daily Bread Soup Kitchen, PACE, and the Salvation Army. RPC's Developmental Disability Services team also participated in several outreach events including the Scott Bennett Family Resource Day at Lincoln Square Mall, Rantoul Community Resource Fair, Ability Resource Event in Mahomet, DisAbility Resource Expo at Market Place Mall, CU-Autism Network's Autism Walk, and CUSR's Summer Bash.

4. **Compare year-end actual result with the application estimate of days from completed assessment to start of services. Comment on findings, especially if unexpected.**

   17 out of the 26 intakes in PY25 for the CLSTA program were completed within the estimated 10-day time frame. Intakes were completed on average within 5 days of receipt of application and the longest it took to start services was 15 days. Delays in completing intake visit included difficulty getting in touch with the individual, cancellations, and scheduling conflicts.

5. **Compare the year-end result with the application estimate of % of eligible people who engaged in program services within the above timeframe. Comment on the finding.**

   RPC's application for the CLSTA program estimated that 95% of eligible people would be engaged in services within the 10-day time frame. In PY25, 65% of eligible people were engaged in services within the estimated time frame.

6. **Compare year-end result with the application estimate of length of participant engagement. Especially if the result was unexpected, comment on this finding.**

   RPC estimated that length of participant engagement in the CLSTA program would be approximately 30 days. In PY25, we have found that the average length of engagement is based on the type of funding being requested. For instance, those planning a vacation often required support from our short-term case manager and were engaged in services for up to two months, while others with one-item requests might be engaged in services as little as 2 weeks. This program was new in PY25 and is still identifying the average length of participant engagement.

7. **If your program collected demographic information beyond the standard categories reported each quarter, comment on the data and what they suggest for the program.**

   The CLSTA program collected the required demographic information needed for quarterly reporting.

CONSUMER OUTCOMES

In the Program Plan Narrative, you identified positive outcomes people would experience as a result of participating in the program. You also identified measurement tools and targets for each outcome. Include original information and comment on the actual results.

- **Use (and expand) the space below to copy each numbered Outcome (expected program impact on participants) from your Program Plan. Include the specific target and add the actual result.**
- **For each outcome, list the specific assessment tool used to collect information. *If different from the tool indicated in the application, include a note explaining the change.***
- **For each outcome, indicate the source of information, e.g. participant, participant's guardian(s), clinician/service provider, 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 #1

90% of participants who receive financial assistance to purchase technology or technology assistive equipment will report increased knowledge, skills and ability to engage in social or entrepreneurial opportunities.

Target: The Community Life Short-term Assistance program will work to provide financial assistance along with supportive services as needed to individuals living in Champaign County with I/DD either registered on the PUNS list or receiving Medicaid-Waiver funding that meet income guidelines at or below 60% of the Annual Median Income. Direct funds may be used towards expenses that increase independence, community involvement, socialization with peers, family contact, education, and/or entrepreneurial opportunities. Funds can also be used to promote individual's overall physical or mental well-being.

Tools: Information was gathered by the program coordinator and short-term case manager through completion of satisfaction surveys by each client served under the CLSTA program.

Result: 90% of participants who received financial assistance to purchase technology or technology assistive equipment reported an increase in knowledge, skills, or abilities to engage in social or entrepreneurial opportunities.

Outcome #2

80% of adults receiving financial assistance toward the purchase of social events or classes will report an increase in knowledge, skills, ability to engage socially or in overall wellbeing.

Target: The Community Life Short-term Assistance program will work to provide financial assistance along with supportive services as needed to individuals living in Champaign County with I/DD either registered on the PUNS list or receiving Medicaid-Waiver funding that meet income guidelines at or below 60% of the Annual Median Income. Direct funds may be used

towards expenses that increase independence, community involvement, socialization with peers, family contact, education, and/or entrepreneurial opportunities. Funds can also be used to promote individual's overall physical or mental well-being.

Tools: Information was gathered by the program coordinator and short-term case manager through completion of satisfaction surveys by each client served under the CLSTA program.

Result: 90% of participants who received financial assistance toward the purchase of social events or classes reported an increase in knowledge, skills, and/or ability to engage socially or in overall wellbeing.

Outcome #3

50% of participants receiving funds to assist with travel will report an increase in overall well-being.

Target: The Community Life Short-term Assistance program will work to provide financial assistance along with supportive services as needed to individuals living in Champaign County with I/DD either registered on the PUNS list or receiving Medicaid-Waiver funding that meet income guidelines at or below 60% of the Annual Median Income. Direct funds may be used towards expenses that increase independence, community involvement, socialization with peers, family contact, education, and/or entrepreneurial opportunities. Funds can also be used to promote individual's overall physical or mental well-being.

Tools: Information was gathered by the program coordinator and short-term case manager through completion of satisfaction surveys by each client served under the CLSTA program.

Result: 1 client received financial assistance for purpose of a trip. This individual did not use CLSTA short-term case management services for assistance with trip planning as this person's parent was accompanying them on the trip. This individual was administered survey questions designed for individuals that did not receive short-term coaching sessions. Results from their survey reveal that they reported an increase in overall well-being.

We had 4 clients receive funding for trips that were then connected with CLSTA's Short-Term Case Manager. The Short-Term Case Manager assisted with trip planning and taught them how to use UBER. These individuals were administered surveys that were designed for those receiving short-term coaching sessions. Overall well-being was not assessed in this case; however, participants self-reported an increase in knowledge, skills, & ability to engage in desired activities. Results from these four surveys revealed that 75% of participants reported an increase in knowledge, skills, & ability to engage in desired activities.

Outcome #4

90% of participants utilizing case management coaching or supportive services through the Community Life Short Term Assistance program will report an increase in their confidence to engage in the activity in which they have received financial assistance toward.

Target: The Community Life Short-term Assistance program will work to provide financial assistance along with supportive services as needed to individuals living in Champaign County with I/DD either registered on the PUNS list or receiving Medicaid-Waiver funding that meet income guidelines at or below 60% of the Annual Median Income. Direct funds may be used towards expenses that increase independence, community involvement, socialization with peers, family contact, education, and/or entrepreneurial opportunities. Funds can also be used to promote individual's overall physical or mental well-being.

Tools: Information was gathered by the program coordinator and short-term case manager through completion of satisfaction surveys by each client served under the CLSTA program.

Result: 100% of participants utilizing case management coaching or supportive services through the Community Life Short Term Assistance program reported an increase in their confidence to engage in the activity in which they received financial assistance toward.

CONSUMER PARTICIPATION IN DATA COLLECTION

1. **How many total participants did the program have?** 28

For each of the following questions, if there are different responses per outcome, please identify the numbered outcome and the relevant detail.

2. **If outcome information was NOT gathered from every participant, how did you choose who to collect outcome information from**?

   Survey information was attempted to be gathered from all participants who received funding, and funds had been paid out for in PY25. Several individuals' applications have been approved but invoices have not yet been received for payment to be issued. Survey information will be collected from these individuals once payment has occurred and should be reflected in the PY26 report accordingly.

3. **How many people did you *attempt* to collect outcome information from?** 100%
4. **How many people did you *actually* collect outcome information from**? 15
5. **How often and when was this information collected? *(e.g. 1x a year in the spring; at client intake and discharge, etc)***

   CLSTA client satisfaction surveys are completed at the close of specific instance of funding/service.

RESULTS

1. **What did you learn about the participants and the program from this outcome information? *Be specific when discussing any change or outcome and give quantitative or***

descriptive information when possible. You might report: Means and, if possible, Standard Deviations; Change Over Time, if assessments occurred at multiple points; Comparisons, e.g., of different strategies related to recruitment, of rates of retention for clients of different ethnic or racial groups, or of characteristics of all clients engaged versus clients retained.

In reflecting on the information above, it should be noted that 30 participants total were reflected in CLSTA quarterly reports, however, 2 individuals were mistakenly counted twice. The correct number of overall participants for the CLSTA program in PY25 was 28.

Overall, in looking at program numbers we have the highest number of people interested in accessing CLSTA funds for trips or for other items such as household needs. Household needs such as furniture, appliances, etc. have been considered in certain circumstances given the person's individual situation and the request's relationship to their wellbeing. Other items that we have funded in PY25 include a gym membership, a dress for the Night to Shine prom, denture implants, etc. These are items that likely had a positive impact overall on the individuals' well-being. CCRPC has collected a great deal of qualitative data describing the benefits of this program. Some individuals noted on surveys that their CLSTA-funded items have helped them with drinking more water, positive thinking, being healthier, and getting stronger. Other notes include being more comfortable, no longer having to sleep on the floor, being able to express oneself, and getting out of the house more. While this only captures some of the qualitative data, it is a good representation of the kinds of benefits individuals expressed in the survey.

Also, since opening the eligibility criteria to include individuals enrolled in Medicaid-Waiver funded services through DHS' Division of Developmental Disabilities, the CLSTA program has seen an uptick in referrals. It's possible that total household income guidelines are preventing individuals that are living at home with family from qualifying for the program. Additionally, most individuals served under the CLSTA program are already connected with a service provider through county funded services or have Medicaid-Waiver funding. Few referrals have come in from individuals that are on PUNS but not connected to any service provider.

2. OPTIONAL: Describe a typical service delivery case to illustrate the work. This may be a "composite case" that combines information from multiple actual cases.

<u>Case #1</u>

A referral was received from an ISC at Prairieland to RPC's Community Life Short-Term Assistance program for an individual wanting to connect more with others. This individual needed assistance with filling out CLSTA application, so the RPC Case Manager met with the

individual to learn more about their needs and funding area preferences. The individual lives in a rural community and reports that all their income is spent on monthly rent and household expenses. They do not have money left over for activities outside of their home or even transportation or gas money to go out after paying required bills. The individual had a list of ideas of things they might like to do, all centering around being able to get out into the community and take part in activities with others. The RPC Case Manager spoke with the individual about different programs in the community that they could participate in to increase their opportunity for connecting with others. The Case Manager also assisted the individual in exploring possible programs that could assist with transportation for activities. After looking through CUSR Program Guide, the individual chose two trips to participate in. Case Manager reached out to CUSR to verify that there is no financial assistance available for out-of-town trips or for those living outside of Champaign-Urbana city limits. The Case Manager assisted individual with completion of CLSTA application and gathering necessary documentation. The Case Manager also assisted individual with filling out required CUSR forms. The individual chose to participate in a weekend trip to Branson, Missouri and a daytrip to Raging Rivers Water Park. The individual also needed luggage to pack their clothing and other needed items in for the trip. The individual worked with the CLSTA Case Manager to find a luggage set that they liked on Amazon, and this was purchased & delivered to their home. The individual reported that they are happy that the funding helped them to get out of their house and made it possible for them to go on trips. This individual is looking forward to applying for funding again in PY26 to continue taking part in activities with others.

Case #2

A referral was made to RPC's CLSTA program for an individual in need of extensive dental work. Dental issues had caused this individual pain and difficulty with chewing certain foods. Medicaid would not cover the cost of the dental work needed, and the expense was too much for the individual to pay out of pocket. The CLSTA program, CCAMR, and Community Choices were able to collaborate to cover the costs of the dental procedures for this person. Since having necessary dental work completed, this individual has felt empowered to take control of their health and future. The individual has opened an ABLE account, scheduled an appointment with a primary care physician at Christie Clinic to be established as a patient, scheduled an appointment with a women's health physician, and has made an appointment for an eye exam.

Composite Case:

Referrals were received to RPC's Community Life Short-Term Assistance program for two different couples who wished to take vacations with their spouses. One couple chose to go to St. Louis for their "honeymoon"/second wedding anniversary. The other couple chose a weekend in Chicago to watch a Cubs & White Sox game and visit other area attractions. CLSTA connected these couples with the CLSTA program's Short-Term Case Manager to assist each couple with planning out their trips. The couples provided the case manager with a list of activities they wished to take part in and/or places they wanted to visit, and the case manager worked on mapping out an itinerary that made sense ensuring that locations closer together would be visited on the same day. The Case Manager worked with couples on how to access e-gift cards for restaurant meals. They also learned how to use the Uber application to get around

in the community. Program Coordinator worked on purchasing all necessary tickets, providing them to individuals in paper and email format when available. Phone numbers for Program Coordinator and Case Manager were programmed into cell phones so that the couples could reach out as needed with questions while on their trips. Both couples reported having a great time and looking forward to their next trip. They also expressed increased confidence in ability to plan future trips.

3. OPTIONAL: In what ways has the evaluation supported the current practice or changes in practice? What changes were made or are planned, based on findings?

Changes should be made to the CLSTA survey to better align with the outcomes that are currently being measured by the program. Number of short-term case manager visits might also need to be increased as we are finding that it sometimes takes multiple visits to assist with the trip planning and preparation.

Annual Performance Outcome Report Form

In the Program Plan Narrative submitted with your application, you identified measures of Consumer Access, Consumer Outcomes, and Utilization. While Utilization data and comments have been captured in the quarterly service activity reports, Consumer Access and Consumer Outcome findings are reported only at the end of the program year. Download and complete this form and upload it to the online system reporting page, Performance Outcome Section.

Agency Name: CCRPC

Program Name: Decision Support Person Centered Planning

Program Year: 2025

CONSUMER ACCESS

In the Program Plan Narrative, you identified eligibility criteria for the program's services, how those criteria are established, how the target population learns about the program, and expected timelines. Please comment on each area below.

1. **YES/NO - Did the stated criteria serve the purpose of providing people the services/ supports they were seeking? If NO, comment on causes and possible solutions.**

   Yes, the stated criteria of eligibility for the program served the purpose of providing people the services and supports they were seeking in PY25. In PY25, we provided services to individuals receiving county-funded services needing Person-Centered Planning, adults who were dually diagnosed and registered on the PUNS list, and students with I/DD at transition age (18-22).

2. **YES/NO - Did the stated process for determining that the person and program were right for each other work well? If NO, comment on causes and possible solutions.**

   Yes, the stated process for determining that the person and program were right for each other continued to work well in PY25.

3. **YES/NO - Did the stated outreach activities support appropriate matches between people and program services? If NO, comment on causes and possible solutions.**

   Yes, outreach activities supported appropriate matches between people and program services in PY25. In PY25, flyers for our Transition Consultant, Dual Diagnosis, and CLSTA programs were sent out to all individuals that were registered on PUNS on 6/30/23 when CCRPC transitioned the ISC program over to Prairieland. CLSTA flyers were also sent out to HBS clients living in Champaign County in PY25. In addition to this, program flyers were also provided to area providers and the local ISC agency, Prairieland Services Coordination, Inc. The program coordinator for RPC Developmental Disability Services also met with several local agencies in person to discuss programs offered through RPC's Developmental Disability Services team. The agencies that the program coordinator met

with included Community Service Center of Northern Champaign County, Daily Bread Soup Kitchen, PACE, and the Salvation Army. RPC's Developmental Disability Services team also participated in several outreach events including the Scott Bennett Family Resource Day at Lincoln Square Mall, Rantoul Community Resource Fair, Ability Resource Event in Mahomet, DisAbility Resource Expo at Market Place Mall, CU-Autism Network's Autism Walk, and CUSR's Summer Bash.

4. **Compare year-end actual result with the application estimate of days from completed assessment to start of services. Comment on findings, especially if unexpected.**

   Upon receipt of all appropriate documentation, all referrals from providers were assigned to an RPC PCP Case Manager within the estimated 10-day time frame. RPC Case Managers initiated services with new clients by reaching out to schedule Discovery process within 10 days of receiving client assignment in 9 out of 12 instances. Discovery interviews were most often held with individual/guardian within 30 days of initial phone contact compared to the estimated 10 days in grant application. Delays noted by RPC PCP Case Managers in starting the discovery process included scheduling conflicts such as individual/guardian vacations, work schedules, and difficulty contacting individuals/families. Our PCP Case Management team staffing has remained stable over the last year and continues the ability to accept new referrals immediately and schedules with clients and their guardians at times most convenient for them.

   RPC's Dual Diagnosis program received 4 referrals in PY25. All referrals who chose to engage with services (2 out of the 4 referrals) were contacted & started services with our Dual Diagnosis Case Manager within 10-days of referral being received. The 2 other individuals referred chose not to proceed with services.

   In PY25, RPC's Transition Consultant attended 45 IEP meetings. IEP meetings were most often held at the student's school and date was determined by school staff and family. RPC's transition consultant program had 3 TPC client in PY25. All meetings with TPC individuals and families were completed within 10-day time frame.

5. **Compare the year-end result with the application estimate of % of eligible people who engaged in program services within the above timeframe. Comment on the finding.**

   It was estimated that 95% of referred clients would be engaged in services within ten business days. During PY25, 75% of clients to RPC's Person-Centered Planning Case Management program were engaged in services within the estimated 10-day time frame. This is a drastic improvement from last year's 18%. This can be contributed to RPC's staffing stability over the past year and staffs' dedication to providing high quality case management services to the clients served.

100% of new clients to RPC's Dual Diagnosis program began receiving services within the estimated 10-day time frame. 2 referrals chose not to proceed with services.

RPC's transition consultant program was able to schedule with clients within 10-day time frame 100% of time.

CCRPC's Developmental Disability Services Program has maintained stable staffing over PY25 which has contributed to improving and mostly meeting engagement numbers. All participants have up to date plans and are receiving no less than quarterly visits with an RPC Case Manager.

6. **Compare year-end result with the application estimate of length of participant engagement. Especially if the result was unexpected, comment on this finding.**

   The estimated length of participant engagement for the PCP Case Management program is one to five years. This is based on the estimated 5 years on PUNS before selection following an individual reaching the age of 18 and being in the seeking services category. Currently our PCP program has clients that have been active with the program for approximately 7 years since its start in 2018. Clients that have been engaged with us longer than 5 years might be in the "Planning" category on PUNS. This means that they are not currently eligible for PUNS selections. Individuals have continued to remain engaged with the PCP program until they receive a PUNS selection or are closed out of county-funded services for various reasons.

   The estimated length of participant engagement for the Dual Diagnosis program is one to three years. This is a new program and still too soon to measure actual length of engagement. Thus far, individuals have engaged with Dual Diagnosis Case Manager up to 2 years.

   The average length of engagement for transition consultant services continues to be approximately 1 to 3 months.

7. If your program collected demographic information beyond the standard categories reported each quarter, comment on the data and what they suggest for the program.

   Our program collected demographic information necessary for the completion of quarterly reports.

CONSUMER OUTCOMES

In the Program Plan Narrative, you identified positive outcomes people would experience as a result of participating in the program. You also identified measurement tools and targets for each outcome. Include original information and comment on the actual results.

- **Use (and expand) the space below to copy each numbered Outcome (expected program impact on participants) from your Program Plan. Include the specific target and add the actual result.**
- **For each outcome, list the specific assessment tool used to collect information. *If different from the tool indicated in the application, include a note explaining the change.***
- **For each outcome, indicate the source of information, e.g. participant, participant's guardian(s), clinician/service provider, 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 #1

By end of fiscal year 2025, RPC's Transition Consultant will strengthen community connections to increase referrals for students transitioning out of secondary education by at least 3% from years prior**.**

Target: Efforts will focus on maintaining good working relationships with school districts served. This work supports the outcome of IEP meetings for individuals with I/DD that are preparing to age out of services through school district. Through this service, families will receive greater support during the transition process, allowing for more individualized matching of services.

Tools: Information was gathered by the transition consultant through Preference Assessment, Individualized Education Plan (IEP), Satisfaction Surveys.

Result: RPC's Transition Consultant program attended approximately 45 IEP meetings in PY25. This is 7 more IEP's than were attended than in FY24, which is an 18% increase. Transition Consultant was invited to IEP meetings at Champaign, Urbana, Rantoul, and Mahomet school districts.

Outcome #2

By the end of PY2025, the Dual Diagnosis Case Manager will have identified & provided linkage to community mental health supports for 75% of individuals served.

Target: The Dual Diagnosis Case Manager will stay abreast to mental health providers in Champaign County. Dual Diagnosis Case Manager will work with the person to identify their individual needs and preferences. If person is not already receiving outpatient

mental health and it is identified that this additional support would be beneficial to individual, Case Manager will provide linkage or referral information as necessary to community mental health provider.

Tools: Information was gathered by Dual Diagnosis Case Manager and Program Coordinator from ICAP Assessment tool, Preference Assessment, Discovery tool, and Person-Centered Plan.

Results: Through the tracking of this outcome, it was found that most individuals enrolled in the Dual Diagnosis Case Management program had been connected with community mental health supports prior to initial meeting with RPC case manager. The case manager assisted 100% of those not yet connect by making referrals to local mental health providers.

Outcome #3

During fiscal year 2025, 95% of Individuals working with PCP Case Manager will have up to date personal plan with a minimum of one identified outcome.

Target: The Decision Support Person Centered Planning Program will work with individuals during Discovery to identify preferences for home, personal life, work, recreation, and community life. Through this process, case managers will work with individuals to identify outcomes of priority to them. Outcomes identified as important by individual will be written in individual's person-centered plan, then forwarded to person's provider agency of choice. Case Manager will meet with the individual minimum of 4 times per year to monitor progress towards identified outcome(s) and satisfaction with services being received.

Tools: Information was gathered by PCP Case Managers and Program Coordinator through completion of ICAP Assessments, preference assessments, and discovery tools.

Results: At the end of the PY, 99% of clients in the PCP program have an up-to-date Discovery tool and person-centered plan with at least one identified outcome. There is one plan that was fully drafted but awaiting individual/guardian signature for completion at the end of the PY.

CONSUMER PARTICIPATION IN DATA COLLECTION

1. How many total participants did the program have? 141 (98 TPC & 43 NTPC)

For each of the following questions, if there are different responses per outcome, please identify the numbered outcome and the relevant detail.

2. If outcome information was NOT gathered from every participant, how did you choose who to collect outcome information from?

Outcome information, as applicable, was gathered from each participant served. Outcome information was collected based on the service provided.

3. How many people did you *attempt* to collect outcome information from? 100%
4. How many people did you *actually* collect outcome information from? 131
5. How often and when was this information collected? *(e.g. 1x a year in the spring; at client intake and discharge, etc)*

   For individuals in the Person-Centered Planning Case Management Program preference assessments are administered at intake and then annually thereafter.

   Due to the ISC transition, CCRPC no longer has an updated PUNS list available for the administration of Preference Assessments. In PY25, RPC sent out preference assessments to individuals who were active on the PUNS list at the time of ISC transition to Prairieland. This list has become shorter since that time though, due to individuals/guardians moving and no forwarding address being available. Developmental Disability Services Program Coordinator sent out 173 preference assessments either by mail or email depending on the information available to RPC at time of mailing. Approximately 33 preference assessments were received back from those on PUNS list awaiting Medicaid-Waiver funding. RPC also held a focus group in February 2025 at the Champaign Public Library. 130 invitations were sent out targeting individuals that RPC knew were on PUNS at time of transition to Prairieland and that were at or nearing age of transition from school services. A Know Your Options training presented by Annie Bruno with the Arc of Illinois was also offered as part of the focus group time. 3 families attended the focus group, and all had completed preference assessments.

RESULTS

1. What did you learn about the participants and the program from this outcome information? *Be specific when discussing any change or outcome and give quantitative or descriptive information when possible. You might report: Means and, if possible, Standard Deviations; Change Over Time, if assessments occurred at multiple points; Comparisons, e.g., of different strategies related to recruitment, of rates of retention for clients of different ethnic or racial groups, or of characteristics of all clients engaged versus clients retained.*

   Our treatment plan client numbers were lower as a result of receiving fewer referrals to the PCP Case Management program from providers in PY25 and more regular PUNS Selections. This resulted in lower-than-expected caseload sizes. In PY26, CCRPC will attempt to increase PCP Case Management referrals by taking new referrals from Community Choices Connect program. RPC PCP Case Managers are excited to begin working with these individuals and

assist them with person-centered planning and linkage with desired services/supports in the community.

The Dual Diagnosis program outcome was changed for PY26 as we learned through tracking of the PY25 outcome that most of the individuals referred to the program have already been connected with a community mental health provider. Our Dual Diagnosis Case Manager will continue to work informally with the individuals she serves to make sure that referrals are made as necessary. Referrals were lower to the Dual Diagnosis program in PY25, and only half of the individuals referred engaged in services. Outreach was conducted at community service events and through mailing out flyers to local mental health providers, individuals registered on PUNS, providers, and Prairieland Service Coordination.

Our Transition Consultant Program received the highest number of referrals in PY25 from Champaign Unit #4 School District. These referrals came in the form of IEP meeting requests. RPC's Transition Consultant attended IEP meetings and provided information to families on resources available/needed for adult DD services. Despite the 18% increase in referrals, RPC's Transition Consultant Program experienced a lack of engagement in ongoing services (TPC). In PY26, RPC's Transition Consultant will focus efforts on regular follow-ups with families at regular intervals following IEP meetings to check-in on how things are going and if greater support is needed at that time. Often at IEP meetings, families are taking in the information being presented at that time and not yet ready to engage in services. Families have expressed that they know preparation for adults services is important but they are trying to manage the most immediate needs first.

2. OPTIONAL: Describe a typical service delivery case to illustrate the work. This may be a "composite case" that combines information from multiple actual cases.

Dual Diagnosis Program:

When individual first began working with RPC's Dual Diagnosis Case Manager, they were very guarded. Individual refused to meet alone, often canceled appointments, and did not engage much with case manager. The individual spent most of their time isolated, dealing with symptoms of their anxiety and depression. At the time, the individual had very few coping skills and little motivation to care for themself or their space. The individual struggled to keep their apartment clean, including it being cluttered with trash. Throughout the course of working with the Dual Diagnosis program, the individual's mental health and their circumstances began to improve. The Case Manager continued to work to build trust and rapport with the individual. The Case Manager worked with the individual for several meetings to deep clean and organize their living room and kitchen areas of their apartment, as having a cluttered space has been indicated to negatively impact a person's mental health. The individual is now keeping these areas of their home clean through

routine weekly cleanings. The RPC Dual Diagnosis Case Manager also assisted the individual in creating a coping skills bucket with tools to use when feeling overwhelmed. The individual no longer needs reminders to pull from their coping skills bucket and is now using their learned coping skills independently.
The Dual Diagnosis Case Manager has also observed that individual appears to be taking more pride in their self. The individual has started doing their hair, wearing clean clothing other than pajamas, and, in individual's own words, "making herself pretty." They even shared pictures of their self and their clean apartment with a close friend. The individual also recently stepped out of their comfort zone to visit a local park with their RPC Case Manager, and they were able to use coping skills during this time. The individual is also learning to set healthy boundaries and respect others.
The individual has come a long way from barely engaging with the dual diagnosis program and struggling with daily activities, to actively managing their mental health and starting to dream about the future. Their progress shows how powerful the Dual Diagnosis program can be as it supports individuals in working to manage their mental health symptoms, use appropriate coping skills, and believe in themselves.

Transition Consultant Program:

While attending an IEP, RPC's Transition Consultant learned that the student was not yet enrolled on the PUNS list. The student's mother and their siblings were new to the community and had been homeless prior to moving to the Champaign-Urbana area. Their mother had just been offered a job in this area and had depleted all financial resources on temporary housing.

The Transition Consultant and the student's mother scheduled to meet individually a few weeks later to discuss PUNS further and the risk of the family becoming homeless again. The Transition Consultant acknowledged how difficult it must be to focus on planning for her son's future when the family had an immediate housing need. The Transition Consultant provided information regarding RPC's programs that may be able to assist with housing and other needed services. With permission, Transition Consultant referred her to one of RPC's housing assistance program. The mother followed through with those services and was approved for assistance. The Transition Consultant and student's mother agreed to meet to plan for her son's adult services after she gets settled into her new permanent housing.

RPC PCP Case Management:

The individual's interdisciplinary team consists of RPC's PCP Case Management, Dual Diagnosis Case Management, and Community Services Housing Voucher Specialist. In addition to RPC, individual is receiving services from Cunningham Township Supervisors' Office, and Case Coordination from DSC.

RPC Case Manager has been working with the individual since 2023. Within those years, the individual has put their guard down and increasingly allowed the Case Manager to assist them. The individual went from being wary and not reaching out, to reaching out whenever they need assistance or even just to include Case Manager in an email, so that they know follow up will occur.

In January 2025, the individual was struggling to pay their Ameren bill. RPC Case Manager and the individual worked together to gather the paperwork necessary to have LIHEAP assist them with the funds for this. The Case Manager brought individual into the RPC office and worked alongside RPC's LIHEAP program to get them the much-needed funds to assist in paying for their bill.

In February, the individual needed assistance with paying their rent. The Individual's management company for their apartment had changed several times over the course of the year which caused the individual to have heightened anxiety about their rent not being paid on time and the potential of facing eviction. This included the payment system changing which caused them anxiety. The Case Manager assisted the individual in paying their rent by talking with the management company and finding out that the best way for them to pay rent was using a money order.

The individual moved to a new apartment in April 2025 with the assistance of their RPC Housing Voucher Specialist. They feel safe in this neighborhood and are not fearful of leaving their apartment. They report that the neighborhood is quiet, and they can access the community better. The individual has reported going out into the community more frequently and even taking an Uber. This is something that has been outside of their comfort zone in the past. They are also sleeping better at night as they are feeling safer in their new apartment.

Today, the individual reaches out when they need support as well as to provide informative updates. They most recently reached out indicating that they had been in contact with DRS about having a job coach assist them with employment. They also reached out about frustrations with their doctor for not filling a form out for them for Social Security Income purposes. They were encouraged to follow up with their doctor and let them know that this is an urgent request for their Social Security appeal. With the encouragement, they reached out to their doctor and were able to obtain the needed record.

3. OPTIONAL: In what ways has the evaluation supported the current practice or changes in practice? What changes were made or are planned, based on findings?

   In PY25, there was a reduction in referrals to RPC's Dual Diagnosis program. As a result, RPC has developed more clearly defined outcomes and curriculum for this program. Outcomes for this program in PY26, will focus on individuals increasing knowledge and use of coping skills and individuals reporting improved positive outcomes related to increased motivation, overall mental health, and/or awareness of thought patterns. The program will also implement the use of the Adult Self-Report Mood & Feelings Questionnaire: Short Form at initial meeting and every 6 months thereafter. In addition to this, during PY25 the program implemented a Dual Diagnosis visit note. The visit note clearly states goals worked on during the visit and outlines visit summary, coping strategies discussed, and any challenges that were presented during the visit.

   As mentioned earlier, we have noticed a reduction in the numbers of individuals served in our Person-Centered Planning Case Management Program. For this reason, we are expanding the PCP Case Management program's eligibility to also include individuals that are being served through Community Choices Connect program. We also plan to continue outreach efforts in PY25 to rural school districts to raise awareness of the services available to individuals & families through our Transition Consultant Program.

Annual Performance Outcome Report Form

In the Program Plan Narrative submitted with your application, you identified measures of Consumer Access, Consumer Outcomes, and Utilization. While Utilization data and comments have been captured in the quarterly service activity reports, Consumer Access and Consumer Outcome findings are reported only at the end of the program year. Download and complete this form and upload it to the online system reporting page, Performance Outcome Section.

Agency Name: Champaign County Regional Planning Commission
Program Name: _ RPC Early Childhood Education Program- Head Start ___
Program Year: ___24-25_____

CONSUMER ACCESS

In the Program Plan Narrative, you identified eligibility criteria for the program's services, how those criteria are established, how the target population learns about the program, and expected timelines. Please comment on each area below.

1. YES/NO - Did the stated criteria serve the purpose of providing people the services/ supports they were seeking? If NO, comment on causes and possible solutions.
   Yes, children are eligible for services funded by this grant if they score within range of concern on the DECA screening. Additionally, the Social-Emotional Committee may identify a child, teacher, or parent needing additional support. Adults can self-refer for support.

2. YES/NO - Did the stated process for determining that the person and program were right for each other work well? If NO, comment on causes and possible solutions.
   Yes, members of the site-level Social-Emotional Committee (Teachers, SSPC, Site Managers, Family Advocate, Off Site Programs Manager, ECMHC) determined eligibility for ongoing supports. The committee met bi-weekly and was successful in getting support to classrooms as quickly as possible.

3. YES/NO - Did the stated outreach activities support appropriate matches between people and program services? If NO, comment on causes and possible solutions.
   Yes, all staff learn about the coaching and consultation offered by the Social-Emotional team during orientation. RPC shares information with families about the social-emotional services provided by the Social-Emotional Committee at parent meetings, during one-on-one conversations with teachers and family advocates.

4. Compare year-end actual result with the application estimate of days from completed assessment to start of services. Comment on findings, especially if unexpected.

Children who were referred for intensive support were seen within 7 days which is the estimate stated in the application.

5. Compare the year-end result with the application estimate of % of eligible people who engaged in program services within the above timeframe. Comment on the finding.

We estimated that 100% of students identified by the committee would receive support via caregiver intervention. At the end of the year we found that 100% of our students identified were seen within the estimated time frame of 7 days.

6. Compare year-end result with the application estimate of length of participant engagement. Especially if the result was unexpected, comment on this finding.

We estimated that identified students would participate in tiered services from between 3 months and 2 years. We have consistently found that around half of our identified students needed less intensive interventions by the end of the year.

7. If your program collected demographic information beyond the standard categories reported each quarter, comment on the data and what they suggest for the program.

8. Total # of Children in HS and in EHS: 549
9. Total # of Expectant Mothers in EHS/Expansion: 29
10. Total # of Families: 517
11. Total # of children with a IFSP or IEP: 47
12. Total # of children referred for DD or Special Ed: 65
13. Total # of Homeless families: Families-57 children-58
14. Total # of family served with income below 100% FPG: 101
15. # of families at 100-130% FPG : 42
16. # of children/families in foster care system: 26
17. # of children/families on public assistance: TANF=21; SNAP=310
18. # of children/families over income: 56
19. # of families who speak:
    a. English – 475
    b. Spanish – 43
    c. Middle Eastern – 22
    d. African – 1
    e. East Asian –0
    f. European and Slavic – 37
    g. Native Central American – 0
20. Education level
    a. Advanced degree or baccalaureate degree – 61

CONSUMER OUTCOMES

In the Program Plan Narrative, you identified positive outcomes people would experience as a result of participating in the program. You also identified measurement tools and targets for each outcome. Include original information and comment on the actual results.

- Use (and expand) the space below to copy each numbered **Outcome** (expected program impact on participants) from your Program Plan. Include the specific **target** and add the **actual result**.
- For each outcome, list the specific **assessment tool** used to collect information. *If different from the tool indicated in the application, include a note explaining the change.*
- For each outcome, indicate the **source of information**, e.g. participant, participant's guardian(s), clinician/service provider, 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 #1

Children will demonstrate improvement in social skills related to resilience such as:

a. Self-Regulation
b. Initiative
c. Relationship building/Friendship skills
d. Emotional Literacy
e. Problem-Solving

Pre and post resilience related social skills are assessed using the DECA-P2 and DECA I/T. Students are assessed at the beginning of the program year or when they are enrolled and are assessed again at the end of the program year. The DECA-P2 and DECA I/T are completed by both the parent and the teacher.

Pre and post resilience related social skills are assessed using the DECA-P2 and DECA I/T. Students are assessed at the beginning of the program year or when they are enrolled and are assessed again at the end of the program year. The DECA-P2 and DECA I/T are completed by both the parent and the teacher.

CCHS saw a 13% decrease in needs that were identified regarding Total Protective Factors, Initiative, Self-Regulation and Attachment and Relationships throughout the school year.

Throughout the school year, documentation is collected by teachers in teaching strategies GOLD regarding social emotional skills and evaluated during fall, winter, spring and summer checkpoints. Based on program results, CCHS saw an increase in social emotional skills with children meeting or exceeding social emotional developmental expectations for their age group. For children 6 weeks-3 years, CCHS saw an 6% increase in skills from the Fall Checkpoint to the Summer Checkpoint. For our English language learners, 6 weeks- 3years, we saw a 4% increase. Program-wide, 85% of children ages 6 weeks-3 years were meeting or exceeding

social emotional developmental expectations for their age group by the end of the school year. For children 3 years- 5 years, CCHS saw a 29% increase in social emotional skills. And for children 3 years-5 years who are English language learners, we saw an increase of 31% in social emotional skills. For children who were Kindergarten bound, we saw an increase of 29% in social emotional skills from the Fall Checkpoint to the Summer Checkpoint. Program-wide, 73% of children ages 3 years to 5 years were meeting or exceeding social emotional developmental expectations for their age group by the end of the school year.

Outcome #2

ProQOL Measure of Burnout, Compassion Fatigue, and Vicarious Trauma; and Adult DECA

Due to program changes, staff shortages as well as changes to management, the ProQOL was not given out for the teachers to complete therefore this information was not collected. The plan for FY26 is to have staff fill out the ProQOL during staff in-service in August and then reassess at the end of the school year in July.

Outcome #3

Parenting Stress Index; and Adult DECA

Due to staffing shortages as well as low attendance at family events, the Parenting Stress Index was not able to be given out for parents to complete therefore this information was not collected. The plan for FY26 is to assess parent stress within the first 45 days of enrollment.

Outcome #4

TPOT/TPITOS - classroom management

CCHS saw an overall high-quality score in classroom management demonstrating social emotional sensitive interactions across the sites. 83% of classroom observations indicated that each domain of Emotional Support, Classroom Organization and Instructional Support were happening consistently and effectively. For the other 17% of classroom observations, they were scored within a mid-quality score indicating that each domain was happening effectively but may not have been happening consistently. All classrooms were continually supported through coaching utilizing the Pyramid Model for guidance on effective practices in the classroom.

CONSUMER PARTICIPATION IN DATA COLLECTION

1. How many total participants did the program have? ___549_____

For each of the following questions, if there are different responses per outcome, please identify the numbered outcome and the relevant detail.

2. If outcome information was NOT gathered from every participant, how did you choose who to collect outcome information from?

   We attempted to gather pre-post data from every student in our program. We did not get post data from every child however. Likely due to students being withdrawn from the program early because of family relocating, loss of employment, or transportation issues.

3. How many people did you *attempt* to collect outcome information from? __549____
4. How many people did you *actually* collect outcome information from? ____422_____
5. How often and when was this information collected? *(e.g. 1x a year in the spring; at client intake and discharge, etc)*

   4 times per year.

RESULTS

1. What did you learn about the participants and the program from this outcome information? *Be specific when discussing any change or outcome and give quantitative or descriptive information when possible. You might report: Means and, if possible, Standard Deviations; Change Over Time, if assessments occurred at multiple points; Comparisons, e.g., of different strategies related to recruitment, of rates of retention for clients of different ethnic or racial groups, or of characteristics of all clients engaged versus clients retained.*

2. This year, our Head Start program saw significant growth in children's social-emotional development. At the Fall checkpoint in October, 44% of children met the expected benchmark. By June, that number had risen to 73% of preschool-aged students—an improvement not only from the start of the year but also compared to last year's outcomes.

   At the same time, we faced notable challenges. Managers and coaches reported high levels of teacher burnout, primarily due to the growing number of children with high needs and developmental delays. In particular, the rise in Autism Spectrum Disorder (ASD) diagnoses led some staff to doubt their abilities in the classroom. At our West Champaign location, we saw an increase in children dually enrolled with Unit 4 due to significant learning delays and diagnoses. Dual enrollment with Unit 4 has strict guidelines in order to meet the needs of all children in Champaign but due to the high needs of our enrolled children, 15 children over 6 classrooms were eligible for dual services. To address this, we are prioritizing professional development during in-service and throughout the year, equipping staff with tools to feel confident and supported in creating inclusive, high-quality classrooms. We have also strengthened partnerships with community organizations specializing in Autism resources.

Due to continued staffing shortages, we were unable to track parent outcomes this year.

However, our ongoing coaching model proved to be a critical support for staff and classrooms. Through consistent reflective consultation, teachers were able to process challenges, explore strategies, and receive individualized support. Over time, this approach led to improved classroom behaviors, greater fidelity in services, reduced teacher stress, and stronger teacher-child relationships.

3. OPTIONAL: Describe a typical service delivery case to illustrate the work. This may be a "composite case" that combines information from multiple actual cases.

   Child transitioned from a school setting to an in-home provider. The provider requested SSPC observe due to child displaying behaviors consistently. SSPC utilized DECA assessment results that highlighted area of need and provided strategies around Conscious Discipline. SSPC was able to speak with provider prior to meeting to gather information and review incident reports. After review, SSPC and provider met and discussed the results together and SSPC observed. SSPC coached around the provider being more curious in the unmet need as opposed to the behavior, meaning what other reasons could the child be displaying these episodes, and how the child might be feeling. The incident reports showed these escalated periods of dysregulation were approx. 9:30a-10:30a daily, regardless of activity. The child's drop off time is 9a. SSPC coached provider around mood and hunger and how they correlate. Provider
   problem solved and now offers child a snack (cheese stick, fruit, etc) within 15 minutes of drop off. This child's behaviors decreased significantly. Due to the food insecurities our children face, this Provider offers snack at the same time to all children making their space universal.

4. OPTIONAL: In what ways has the evaluation supported the current practice or changes in practice? What changes were made or are planned, based on findings?

Annual Performance Outcome Report Form

In the Program Plan Narrative submitted with your application, you identified measures of Consumer Access, Consumer Outcomes, and Utilization. While Utilization data and comments have been captured in the quarterly service activity reports, Consumer Access and Consumer Outcome findings are reported only at the end of the program year. Download and complete this form and upload it to the online system reporting page, Performance Outcome Section.

Agency Name: **CU Early – USD #116**
Program Name: **CU Early**
Program Year: **2025**

CONSUMER ACCESS

In the Program Plan Narrative, you identified eligibility criteria for the program's services, how those criteria are established, how the target population learns about the program, and expected timelines. Please comment on each area below.

1. YES/NO - Did the stated criteria serve the purpose of providing people the services/ support they were seeking. If NO, comment on causes and possible solutions.

Yes, the CU Early bilingual home visitor served a total of 26 children and 24 families. 7 of which were prenatal. She also had 8 teen parents on her caseload. Throughout the program year, she provided biweekly home visits assisted with community events and got families connected to community resources such as food assistance, childcare, housing assistance, immigration assistance, mental health resources, medical appointments, etc. The final count for service contacts (home visits and parenting groups) was 456. The estimated number in the original application was 464. All the families on the bilingual home visitor's caseload identified as Hispanic/Latino and or Mayan.

2. YES/NO - Did the stated process for determining that the person and program were right for each other work well? If NO, comment on causes and possible solutions.

Yes, the same families remained on the bilingual home visitor's caseload until they transitioned out of the program (aged out)

3. YES/NO - Did the stated outreach activities support appropriate matches between people and program services? If NO, comment on causes and possible solutions.

Yes, all of the families on the bilingual Spanish speaking home visitor's caseload identified as Hispanic/Latino/Mayan

4. Compare year-end actual result with the application estimate of days from completed assessment to start of services. Comment on findings, especially if unexpected. **The original**

application stated 3 days from the completed assessment to start of services. CU Early met this timeline.

5. Compare the year end result with the application estimate of % of eligible people who engaged in program services within the above timeframe. Comment on the finding.

98% of eligible people who engaged in program services were enrolled within the 3 day timeframe.

6. Compare year-end result with the application estimate of length of participant engagement. Especially if the result was unexpected, comment on this finding.

Families that were enrolled stayed in the program for the entire year except for 3 children who aged out and transitioned to Prek services.

7. If your program collected demographic information beyond the standard categories reported each quarter, comment on the data and what they suggest for the program. **NA**

CONSUMER OUTCOMES

In the Program Plan Narrative, you identified positive outcomes people would experience as a result of participating in the program. You also identified measurement tools and targets for each outcome. Include original information and comment on the actual results.

- Use (and expand) the space below to copy each numbered **Outcome** (expected program impact on participants) from your Program Plan. Include the specific **target** and add the **actual result**.
- For each outcome, list the specific **assessment tool** used to collect information. *If different from the tool indicated in the application, include a note explaining the change.*
- For each outcome, indicate the **source of information**, e.g. participant, participant's guardian(s), clinician/service provider, 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 #1

Outcome – Improvement of Parenting Skill and Knowledge

Target-95% in each area of the tool

Actual result- Affection 100%, Responsiveness 83%, Encouragement 85%, Teaching 66%

Assessment Tool- Piccolo Parenting Interactions with Children observational tool

Source of Information- The Piccolo tool is completed and scored by the bilingual home visitor. Scores are shared with the parent and goals from this tool are often set on the Individual Family Goal Plan.

Improvement of Parenting Skill and Knowledge- The Piccolo Parent Child Interaction tool is a completed by the CU Early home visitor alongside the parent for children who are 8 months or older. The bilingual home visitor completed 12 Piccolo observation tools in FY 25. For the children that Piccolo was not completed, the children were under 8 months of age and/or entered the program later in the program year. Home visitors observe child/caregiver interactions and score on the following behaviors:

1. **Absent is scored as Zero- no behavior observed**
2. **Barely- is scored as brief, minor or emerging caregiver behaviors**
3. **Clearly- definite, strong or frequent caregiver behaviors**

Affection- Warmth, physical affection and positive expressions towards the child.

100 % of families consistently displayed affection to their child.

Responsiveness- Responding to child's cues, emotions, words and interests (83%) of caregivers consistently displayed responsiveness to their child.

Encouragement- Active support of exploration, skills, initiative, curiosity, creativity and play

85% of caregivers consistently displayed encouragement to their child.

Teaching- Shared conversation and play, cognitive stimulation, explanations and questions.

66% of caregivers consistently displayed teaching strategies to their child. For the families that will be continuing with our program in FY 26 the CU Early bilingual home visitor will work with the family on goals to improve these scores on the families Individual Family Goal plan.

Outcome #2

Outcome- Child Development
Target- 95% of children will make developmental progress
Actual result- 92 % of children made progress from one ASQ checkpoint to the next
Assessment tool- Ages and Stages Developmental Screening tool
Source of Information-ASQ scoring sheet completed by the parent and home visitor together
Child Development – The Ages and Stages Developmental Screening tool is completed by the parent and home visitor together at least two times per year. There were 31 Ages and stages developmental screenings completed in FY 25 for the children on the bilingual home visitor's

caseload. Children who have an Individual Family Service Plan (IFSP) are not required to have the screenings completed twice per year.

On the bilingual home visitor's caseload, the ASQ screening tool showed that 15 children were developing on target for typically developing children of their age group. 3 children were found to have identified delays and were referred to Early Intervention for services. 8 children on the bilingual home visitor's caseload are currently receiving Early Intervention and have an ISFP in place. The bilingual home visitor works in tandem with the specialists at Early Intervention to support the child's ongoing development and provide parental support as needed.

Outcome #3
Target- 95%
Actual result 100 %

Tool- Health/Immunization, well baby check records
Source of information- Parent and Health clinic/hospital

Health Care- the Well child exam and immunization record is collected for every child within 45 days of enrollment into the program and reviewed annually. Out of the 26 children who received CU Early services, all 26 were on schedule for their well-baby checks and up to date on their immunizations by the end of the program year.

The CU Early bilingual home visitor also served 7 prenatal persons. All 7 prenatals were connected with a physician and received excellent prenatal care and maintained the required schedule for prenatal visits with their physician.

CONSUMER PARTICIPATION IN DATA COLLECTION

1. How many total participants did the program have? **26 Children and 24 parents (50 total)**

For each of the following questions, if there are different responses per outcome, please identify the numbered outcome and the relevant detail.

2. If outcome information was NOT gathered from every participant, how did you choose who to collect outcome information from? **NA**
3. How many people did you *attempt* to collect outcome information from? **24**
4. How many people did you *actually* collect outcome information from? **24**
5. How often and when was this information collected? *(e.g. 1x a year in the spring; at client intake and discharge, etc)*

   ASQ screenings are completed twice per year upon enrollment and then every 6 months.

   Piccolo observational tools are completed once per year with families who have children 8 months or older.

   Well baby checks and immunization records are collected once per program year.

RESULTS

1. What did you learn about the participants and the program from this outcome information? *Be specific when discussing any change or outcome and give quantitative or descriptive information when possible. You might report: Means and, if possible, Standard Deviations; Change Over Time, if assessments occurred at multiple points; Comparisons, e.g., of different strategies related to recruitment, of rates of retention for clients of different ethnic or racial groups, or of characteristics of all clients engaged versus clients retained.*

This program year was very busy and very productive. The CU Early home visitor maintained full enrollment and as soon as children aged out she was able to enroll new families quickly. Overall, we were pleased with the program data that we reviewed. The CU Early home visitor

worked hard to connect with families at the beginning of the program year to ensure that all of the children were connected to a physician and immunizations were tracked throughout the program year.

One area of concern identified in the outcome's findings using the PICCOLO observational tool is the "Teaching" domain, which scored 66%. This domain focuses on how parents explain, extend, repeat, describe, engage in pretend play, and ask questions to encourage conversation with their child. Teaching consistently presents the greatest challenge for parents, as many share that they lack time to incorporate these strategies. Our home visitors emphasize that these practices can be integrated into everyday routines, such as mealtimes and bath time, making them both practical and meaningful. To improve scores in this domain for the next program year, our goal is to more intentionally model these strategies during visits and to continue reinforcing the importance of play and learning within daily family routines.

2. OPTIONAL: Describe a typical service delivery case to illustrate the work. This may be a "composite case" that combines information from multiple actual cases.

This past program year, the CU Early bilingual home visitor provided essential support to Magdelena, a 19-year-old first time parent who came to this country at age 14 as an unaccompanied minor and later entered foster care. When she enrolled in CU Early, Magdelena was five months pregnant and in need of guidance and resources to prepare for motherhood. The home visitor assisted her with prenatal visits, ensuring she had access to the medical care necessary for a healthy pregnancy. In addition, the home visitor helped Magdelena secure a medical card, SNAP benefits, and WIC, and is now assisting her with navigating the child support process. Recognizing the importance of education, the home visitor worked closely with high school staff to support Magdelena's academic progress, ultimately celebrating her accomplishment as she graduated high school. Through advocacy, encouragement, and practical support, the home visitor has empowered Magdelena to overcome significant barriers and begin building a stable and healthy future for herself and her baby.

Annual Performance Outcome Report Form

In the Program Plan Narrative submitted with your application, you identified measures of Consumer Access, Consumer Outcomes, and Utilization. While Utilization data and comments have been captured in the quarterly service activity reports, Consumer Access and Consumer Outcome findings are reported only at the end of the program year. Download and complete this form and upload it to the online system reporting page, Performance Outcome Section.

Agency Name: Community Choices
Program Name: Customized Employment
Program Year: FY26

CONSUMER ACCESS

In the Program Plan Narrative, you identified eligibility criteria for the program's services, how those criteria are established, how the target population learns about the program, and expected timelines. Please comment on each area below.

1. YES/NO - Did the stated criteria serve the purpose of providing people the services/ supports they were seeking? If NO, comment on causes and possible solutions.

YES

2. YES/NO - Did the stated process for determining that the person and program were right for each other work well? If NO, comment on causes and possible solutions.

YES

3. YES/NO - Did the stated outreach activities support appropriate matches between people and program services? If NO, comment on causes and possible solutions.

YES

4. Compare year-end actual result with the application estimate of days from completed assessment to start of services. Comment on findings, especially if unexpected.

I believe this response is referencing the question on the application about time from assessment to start of services. Because the ISC agency assesses for eligibility, rather than that being something that happens in house. I believe that a more meaningful answer for this question would be regarding the time a person waits on the Employment waiting list (after eligibility assessment, but before specific services actually begin).

Our goal for this was 60 days from entry on the waiting list (which generally happens as soon as a person completes an intake and states their interest in employment services). [This was stated within our Consumer Outcomes of the application].

Our actual average was 64 days for people who were starting initial services. Averages were different for those who were starting with our Workforce Empowerment Program as this is offered at set times, and for people who requested services ahead of their actual desired start date (such as those who reached out prior to graduation).

5. Compare the year-end result with the application estimate of % of eligible people who engaged in program services within the above timeframe. Comment on the finding.

64% of people requesting initial employment services were on the waiting list less than 60 days.

We would like to see more individuals start services earlier, though we are still doing much better than we were pre-covid when the wait times were approaching ¾ of a year. One effort we made this year was to stay in good communication with those waiting, so that they felt seen. This also helped us to work with the timelines and priorities that each individual was experiencing. Working around trips, family responsibilities, and other factors sometimes allowed us to tailor start times based somewhat on need and not just someone's place on the list.

6. Compare year-end result with the application estimate of length of participant engagement. Especially if the result was unexpected, comment on this finding.

Our estimate for participant engagement was for discovery and job matching to take between 2-6 months and for ongoing support to last around 18 months. This goal is truly an estimate as it takes people vastly different amounts of time to work through our employment processes. This depends on many factors - the person's previous job experience, interest and motivation for the job search, job skills, other life obligations, specificity of desired job roles or environments, family obligations, etc. It also depends significantly on the job market and employers. Once people are hired, some are comfortable and confident within a few weeks, others take much longer.

7. The average length of time to find employment (people who were hired this fiscal year): **76** Days from beginning of Job Development (end of Discovery). There was a range of 15-140 days.
8. Average length of time to job independence: **37 Days** - time it takes for the person to work a shift independently. There was a range of 4-45 days.
9. The range of time that people stay in the program also varies widely. We estimate that support will last around 18 months when a person finds a position. This doesn't necessarily mean that this is how long they will remain open in the program. Many people have a job for a year or two, but then want to find a new job. In these types of situations, the total length of time in the program may appear much longer, but it is because their support has spanned multiple job searches and positions.

10. If your program collected demographic information beyond the standard categories reported each quarter, comment on the data and what they suggest for the program.

Beyond the basic demographic information required for all CCMHB/CCDDB programs, Community Choices also gathers the individual's RIN number, their PUNs eligibility, what type of medical insurance they have access to (Private Insurance, Medicare, Medicaid, etc), as well as information about involvement with other service providers to ensure supports are not duplicated. No meaningful analysis can be gleaned from this data other than that our members were all eligible for services.

CONSUMER OUTCOMES

In the Program Plan Narrative, you identified positive outcomes people would experience as a result of participating in the program. You also identified measurement tools and targets for each outcome. Include original information and comment on the actual results.

- Use (and expand) the space below to copy each numbered **Outcome** (expected program impact on participants) from your Program Plan. Include the specific **target** and add the **actual result**.
- For each outcome, list the specific **assessment tool** used to collect information. *If different from the tool indicated in the application, include a note explaining the change.*
- For each outcome, indicate the **source of information**, e.g. participant, participant's guardian(s), clinician/service provider, 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 #1: Program Outcome - With strength-based vocational assessment and person-centered support, individuals with I/DD can find, obtain, and keep community-based competitive employment.

1a - 100% of participants with I/DD who have participated with CE supports in the past year will report engagement and support in the employment process.

ACTUAL: Participants were asked if their engagement in the employment process was better, the same, or worse with CC Support.

- Engagement: 17/20 or 85% respondents felt their engagement with the process was BETTER with CC Support. Broken down by group:
  - Person w/ Disability (PwD): 6/8 or 75%
  - Family: 12/13 or 92%
- Support: 21/22 or 95% of respondents indicated their feelings of being supported were BETTER with CC involvement. Broken down by group:
  - PwD: 8/9 or 89%
  - Family: 13/13 or 100%

***Discrepancies between the grand total numbers and the totals broken down by participant vs family member is due to not all respondents choosing to identify which group they felt they were part of and not all participants answering all questions.*

**No respondents felt that outcomes were WORSE with CC Involvement

ASSESSMENT: Annual Satisfaction Survey

SOURCE: Participants and Participants' families - if family members participated, they were asked to answer the questions in reference to their perception of their family members' experiences.

1b - 85% will report that their strengths and interests are important to the employment process.

ACTUAL:

- 15/20 or 75% of respondents felt that the connection between their job or job search and their strengths and interests was BETTER with CC Support. Broken down by group:
    - PwD: 7/8 or 88%
    - Family: 9/13 or 69%
- Grown and Built Skills w/ Support: 18/20 or 90%
    - PwD: 6/8 or 75%
    - Family: 13/13 or 100%
- Felt Motivated even when hard: 16/20 or 80%
    - PwD: 7/8 or 88%
    - Family 10/13 or 77%

***Discrepancies between the grand total numbers and the totals broken down by participant vs family member is due to not all respondents choosing to identify which group they felt they were part of and not all participants answering all questions.*

*****No respondents felt that outcomes were WORSE with CC Involvement*

When given the choice of many words to describe the Employment Process with CC, the three most common words chosen (respondents could choose as many as they wished) were:

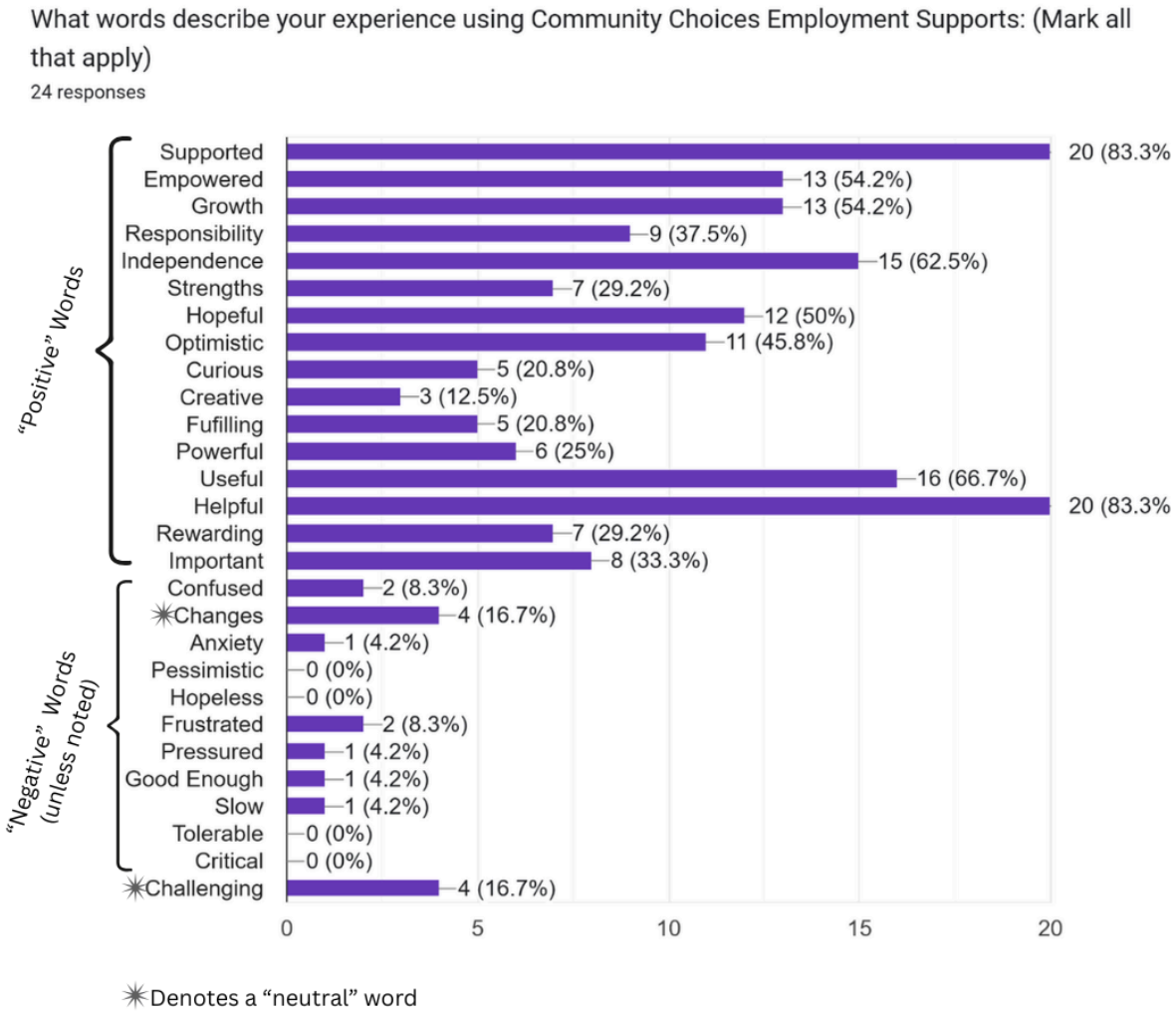
- Supported (20/24 - 83%)
- Helpful (20/24 - 83%)
- Useful (16/24 - 67%)
- In close 4th place was "Independence" with 15/24 (63%) people choosing this word.

Of the 28 possible choices of descriptive words, 16 could be categorized as positive, 2 neutral, and 10 as negative.

Of the total 186 words that were chosen by the 24 respondents:

- 167 (90%) fell into the Positive Category,
- 8 (4%) fell into the Neutral Category
- 11 (6%) fell into the Negative Category

The full data is below:



ASSESSMENT: Annual Satisfaction Survey

SOURCE: Participants and Participants' families

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

2a - Within 60 days of indicating desire for support, a total of 15 individuals identify their work interests and strengths in the Discovery process

ACTUAL:

Total discoveries completed: 13

Average length of time on waiting list: 64 days - (based on 9/13 total Discoveries - 4 individuals chose not to begin right away due to current job responsibilities [e.g. wanting to finish a job before looking for something new], family needs, taking part in our Workforce Empowerment Program, etc. These individuals' wait times were not factored into the average.)

ASSESSMENT: Discovery Assessments and Plan & Employment Tracking Sheet

SOURCE: Participant and team input, Staff observations and record keeping

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

3a - 13 Individuals will work to obtain paid employment within the year and 80% will find a job within 6 months.

ACTUAL:

7 Individuals found paid employment. 100% of individuals found their job in less than 6 months.

The average length of time from the start of job development to hire date is 76 days (2.5 months).

ASSESSMENT: Employment Tracking Sheet

SOURCE: Staff observations and record keeping

3b - 7 individuals will work to obtain volunteer jobs or internships within the year and 80% will find that role within 6 months.

ACTUAL:

4 individuals found volunteer positions. 100% of these individuals found their positions within 6 months.

The average length of time from start of job development to hire is 115 days (3.8 months).

ASSESSMENT: Employment Tracking Sheet

SOURCE: Staff observations and record keeping

3c - 100% of job matches relate to a person's employment themes

ACTUAL:

100% of job matches related to the person's employment themes. Some examples:

THEME	**->**	**JOB**
Sports		Rally House
Animals		Prairie Farms
Hospitality		Good Judy's Bagels
Outside work		Clark Lindsey Grounds Crew

ASSESSMENT: Employment Tracking Sheet

SOURCE: Staff observations and record keeping

Outcome #4 - SHORT-TERM SUPPORT: Individuals with I/DD, negotiate and learn their duties to be successful at their jobs.

4a - 20 individuals become independent at their jobs through job negotiation and coaching within two months of their start date.

ACTUAL:

18 individuals received short term support/job coaching (Job Coaching - defined as the length of time before a person is able to work a full shift without support from our Employment Specialists).

Average length of time of job coaching for new placements: 37 days (1.25 months)

Job Coaching is also offered to people needing extra support for ongoing jobs. For these individuals, the average length of job coaching support is 10 days.

ASSESSMENT: Employment Tracking Sheet, Case Notes & Quarterly Narratives

SOURCE: Staff observations and record keeping

Outcome #5 - LONG TERM SUPPORT: Individuals with I/DD maintain their jobs through ongoing support and job expansion.

5a - 70% of individuals keep their jobs for at least 1 year.

ACTUAL:

40 program participants were employed at the beginning of FY25. Of those 30 were still employed at end of FY25, or 75**%**

Of the 31 people still employed who had been at their jobs over 1 year at the start of FY25, the average length of employment was 40 months or 3.3 years, with a minimum of 14 months or 1.16 years, and a max of 88 months or 7.3 years. Hire dates range from 2018 through 2023.

Of the 10 who lost or left their employment during FY25:

- 2 left because their positions were seasonal, but they were told they should return for the following year (one since has)
- 5 left due to their own choosing
- 1 left because of personal medical reasons
- 1 person moved away from the area
- 1 person was terminated

These individuals were at their positions for an average of 1.2 years.

ASSESSMENT: Employment Tracking Sheet, Case Notes & Quarterly Narratives

SOURCE: Staff observations and record keeping

Outcome #6 - WORKFORCE EMPOWERMENT PROGRAM: Participants build skills, experience, and employment self-determination through 2 rounds of our structured 1st Time Job Seekers program.

6a - 100% of the 10 participants show growth in knowledge and/or professionalism after 12 weeks

ACTUAL:

70% of the 10 participants showed growth via their pre/post assessments.

All participants grew in professionalism according to informal assessments and observational data collected by staff facilitators.

ASSESSMENT: First Time Job Seeker Key Skills Pre/Post Assessment and Weekly Tracking

SOURCE: Participant Responses, staff observation and record keeping

6b - 80% of participants find community jobs within one year of program completion, if they choose to seek employment

ACTUAL:

11 people participated in our Workforce Empowerment Program in FY24 (last year). Of those, 6 chose to seek employment. 4/6 or 67% found jobs during FY25.

ASSESSMENT: First Time Job Seeker Key Skills Pre/Post Assessment and Weekly Tracking

SOURCE: Participant Responses, staff observation and record keeping

CONSUMER PARTICIPATION IN DATA COLLECTION

1. How many total participants did the program have? ___55_____

For each of the following questions, if there are different responses per outcome, please identify the numbered outcome and the relevant detail.

2. If outcome information was NOT gathered from every participant, how did you choose who to collect outcome information from?

Information for Outcome 1 was based on an anonymous survey that was sent to all participants and their families, if involved. Those responses were voluntary so do not reflect the experiences of everyone involved.

All other data was collected from all participants as applicable.

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

For Outcome 1 - we sent surveys out 3 times to a group of 116 individuals. This included participants and their families.

For other outcomes we collected data from all participants as applicable. (We only collected WEP data from WEP participants, for example.)

4. How many people did you *actually* collect outcome information from?
    - Outcomes 1 - We received 24 responses. 15 from Family Members and 9 from Participants with I/DD.
    - Outcome 2-4 - Data was based on the experiences of all 55 participants.
    - Outcome 5 - This was mostly based on the data related to 40 individuals who were employed at the beginning of the FY. Additional data was referenced for more people who were previous participants, but not currently active. We attempt to keep up with people after they are officially closed to determine how long they stay at their jobs.
    - Outcome 6 - Data was based off of this year's 10 participants and last year's 11 participants.

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

    - Outcome 1 - This is collected 1x per year in the spring/summer.
    - Outcome 2-5 - This is tracked throughout the year and summarized in full in late spring/summer when the FY ends.

- Outcome 6 - This is collected at the beginning and end of each WEP session (1x in Fall, 1x in Spring). Information about last year's participants is updated quarterly and summarized when the FY ends.

RESULTS

1. What did you learn about the participants and the program from this outcome information? *Be specific when discussing any change or outcome and give quantitative or descriptive information when possible. You might report: Means and, if possible, Standard Deviations; Change Over Time, if assessments occurred at multiple points; Comparisons, e.g., of different strategies related to recruitment, of rates of retention for clients of different ethnic or racial groups, or of characteristics of all clients engaged versus clients retained.*

OUTCOME 1:

Our hope with this program is not just to get individuals with disabilities jobs, but to help them feel empowered and part of the economic fabric of our community. For so many of us, our work defines important parts of our identities and stands as a bridge to other opportunities and relationships. Our goal is that our participants have this same experience. Rather than repeating the woeful history of people with I/DD being "placed" (into homes, programs, jobs, relationships, services, etc), we want people to seek and find what they are looking for and in that process see themselves as important and valued members of the workforce.

The data we collected related to our participants' experience indicate that they are having a positive experience with the employment process. 85% overall respondents stated that our support increased their sense of engagement in the process. This suggests that our job seekers are feeling like active participants in the process and thus, their own lives. They also indicate that they feel supported in that process, which aligns with our philosophy of doing with rather than for. We know that looking for employment is challenging for almost everyone, and feeling that you have an advocate can be monumental in keeping up motivation and considering new ideas for yourself.

When asked about if participants felt that their strengths and interests were important and respected within the job search process, 75% indicated that this was better with our support. For people with I/DD, 88% felt that this was better, while families had a lower opinion with 69% indicating that these were important parts of the process. This aligns with our real world experience. When we work with someone, we love when families are involved and supportive, but their ideas about what their family member should do, or enjoys best, don't always correspond to what participants are telling us during 1:1 meetings. At the end of the day, we are always going to go with what the person wants over their parent if forced to choose. So this data point, in some ways, is very encouraging as it indicates that our participants are feeling centered in their job searches, perhaps more than their families are.

Other data suggests that our participants and their families are seeing value, growth, and support with motivation in the employment process we've developed. 90% of respondents felt that the process had helped them to grow and build skills. Interestingly, families respondents unanimously felt this was true of our support compared to only 75% of our participants with I/DD. This is not a surprising difference. It can often be difficult to identify or acknowledge growth within ourselves right away, while to those around us, these subtle changes may be more marked. In regards to the sustained motivation that it takes to find employment, 80% said that this was improved with our support. Here, our participants with I/DD were slightly more positive, with 88% indicating that our support made keeping motivation when things were hard better with our involvement. Here too, this distinction makes sense, since the bulk of our support is directed toward the person, they are more likely to feel the benefit of our guidance or encouragement.

In addition to these more quantitative responses, we also asked our respondents to describe their experience with our employment services by choosing from 28 descriptive words. They were allowed to choose as many as they liked. Of the choices, as noted above, 16 would be considered positive, 2 neutral, and 10 negative. This provided participants with a way to express a range of feelings about their support and their journey toward employment. Respondents were welcome to choose both positive and negative responses as both could be reflective of their experiences.

Responses were overwhelmingly positive. Out of the total 186 words that were chosen by the 24 respondents, 90% fell in the positive category,, 4% in the neutral category, and 6% in the negative. The most common responses were the words "Supported", "Helpful", "Useful", and "Independence". When we compare these words to our overall goals for the program, they perfectly align. We want our job seekers to feel supported, to feel our collaborative efforts are useful, and that they can gain independence through the process.

Looking at the negative words most commonly chosen, "frustrated" and "confused" were the most common responses. These also feel very honest to the challenging process that is a job search. While over overall average time for a job search to last is around 2.5 months, for some, the process takes a lot longer. It is exceedingly reasonable that people would feel frustrated. Likewise, the job search process can be fickle. It can be difficult to know why leads aren't coming together, or what one can do differently to have more success. So feeling confused during the journey is a very fair response to have.

OUTCOMES 2-5:

These outcomes comprise the various steps in our employment process - Discovery, Job Development, Short Term Support (or Job Coaching), and Long term support (or maintenance/troubleshooting). While we didn't quite meet our goal for job matches this year, we did see improvement in our placements from FY24 and overall saw a very consistent and steady stream of individuals looking for and finding employment.

We had a strong influx of new people seeking employment and completing our discovery process. Once in the job search phase, all 11 of the individuals who found positions did so within six months. Job coaching went well, and the participants were all able to gain independence in their new roles very efficiently. To us, this is an indicator that jobs were good matches, both in skill and interest. This bears out in the connections that this year's job finds had with the person's employment themes. We were able to identify and customize some very well matched positions and a number of new-to-us employers. An sports-loving participant was able to find a position at Rally House surrounded by his favorite teams merch. We had several people who were interested in helping others and doing various care-taking roles. These individuals found jobs as engagement and activity aids in a nursing home and in food service with a catering company and at a small local bakery and cafe.

Of the 11 positions we found with our participants this year, 50% were at new employers. In addition to these 11 positions, we supported our participants to interview at 31 different businesses across the county. Stepping back and looking at hiring and employer trends, this type of data is very exciting. While we don't keep detailed historical data on if employers are new to working with us or our clients, we do look at it anecdotally each year. Six to seven years ago, we were much more likely to find jobs at businesses that were known to us and known to be supportive of our job seekers with disabilities. While finding jobs with new employers is not an expressed goal of this program, it is a bit of a bellwether for how our community is responding to the ever increasing number of people with I/DD entering and remaining in the workforce. Seeing a shift toward so many new employers working with our participants feels like an indication that inclusive hiring is becoming more the rule, rather than the exception.

Data related to job longevity also keeps steadily increasing. In FY24, we reported that 70% of the individuals we were working with at the start of the fiscal year were still employed at the end. This year, that number has increased to 75% and of those who left, only 10% were due to termination compared to 50% in FY24. We also look, informally, at people's job sustainability once they reach 1 year of employment. Data here also keeps improving. Last year, we found that if our participants stayed at their jobs for at least 1 year, those who were still employed had been there for an average of 2.5 years and counting. This year, that number has increased to 3.3 years and counting. We frequently hear sound bites that say people with I/DD tend to be very hardworking, loyal, and long-term employees. Once again, we are seeing that play out here in our own community.

OUTCOME 6:

Our Workforce Empowerment Program (WEP) continues to be a great resource to our overall employment program, as well as benefit to the individual participants. As with many of our classes, getting enough pre and post assessment data is challenging due to inconsistent attendance by some participants, and others simply opting out of completion. Because of this, and the overall small number of total participants from which to gather data, it is somewhat difficult to draw strong conclusions from straight assessment scores. More indicative of growth

may be the facilitator's weekly log of individuals participation and professional behavior. Looking at this more qualitative source, we are able to see that all participants were able to show growth.

Each year, we see trends in who participates in this program. In FY24, we had a large group of younger participants, many of whom were recently out of school. Of these 11 individuals, 6 decided to seek jobs this year and 67% were successful. This is not extremely surprising. We often find that younger folks or those with less experience do take longer to find positions or hone in on what a successful placement looks like to them.

This year, we saw more individuals join the program who had worked before and were a bit older, but had had bad experiences, or were just unsure of what type of work they might enjoy or excel at. It will be interesting to see in a year, if perhaps the age and maturity level of the FY25 participants will lead to a greater rate of subsequent employment than those from FY24.

2. OPTIONAL: Describe a typical service delivery case to illustrate the work. This may be a "composite case" that combines information from multiple actual cases.

In an effort to manage our program data in a functional way, we've developed a few different tags or "processes" to help sort and organize participant engagement timelines needed for our grants and program evaluation. We've also found that these various processes help to provide a clearer narrative about what the different pathways through our services look like. We will continue to review and refine these, but for now they have been helpful in defining how we are serving our various participants:

INITIAL SEARCH - This defines a person's initial contact or "episode" of support with us. It would begin with a person reaching out (or being referred to us) about employment support. Specifically, it would be someone who we are either not working with currently, or who is stable at a current job but is looking to find a new job. With this "track", a person would start on our waiting list, have the option of participating in WEP if they choose, but then engage in our full Discovery process, followed by job development until they are hired. Then they would receive support with job coaching until they are comfortable independently in their role at which time they would go into "maintenance" for 6-18 months while continuing to have our support checking in and troubleshooting with their job. This tag is basically applied to any instance of support where we are starting from scratch with the person and giving it fully fresh eyes.

Sometimes, a job doesn't work out. This could be because it was truly not a good fit, it was a seasonal position, or because they were laid off or fired. In these instances, we would begin a new job search with the person, but generally we would not redo Discovery unless the person requested or it had been more than 1 year. In these instances, the new job search would be part of our:

“NEW SEARCH” - This process looks the same as the INITIAL SEARCH, but we would frame job development around the themes from their previous discovery. In general, we try to begin these searches right away with very little wait, though depending on circumstances, there could be a short wait before we can actively begin the new search. This “New Search” tag is helpful in tracking a process, which for some people, is not linear, but involves multiple attempts and efforts.

Other people are not yet committed to a dedicated job search process and want to begin our services with our Workforce Empowerment Program only. They can then decide if they’d like to start an “Initial Search” afterward. This process, we’re giving the tag:

WEP-ONLY - Here the person would sign up for one of our two annual WEP Sessions. These currently occur in the Fall and Spring for 12 weeks each. At the end of the session, we check in to see if they would like to pursue employment further. If so, we’d begin an “Initial Search”. In these cases, we’d note that they had completed WEP, so that we can track the outcomes of our WEP participants, and adjust our tracking of waiting periods accordingly.

Finally, we will occasionally support a new person who is currently employed. This happens sometimes when a person has found themselves a job, the schools have supported them and they’ve graduated, or services elsewhere have fallen through. In these instances, we’ll step in and call this:

MAINTENANCE ONLY - Here we work with the person just as we would have if we’d gotten the job for them. If they need some short term job-coaching this is an option, but for some, they are just interested in having someone available if there’s a problem, or to manage small issues related to their ongoing employment. This is by far the least common path through our employment services.

These tags have been helpful in our management of data for this program, but I believe that they are also helpful in understanding the different ways people work into, through, and out of our services. When we look at how people use our services over time, these identifiers have helped us more meaningfully track the narrative of what our participants' experiences are like. They are often not linear. They reflect the common circumstances that we all encounter- looking for work, experiencing setbacks and unexpected opportunities, working through periods of reflection and redirection, and changing needs and desires over time.

3. OPTIONAL: In what ways has the evaluation supported the current practice or changes in practice? What changes were made or are planned, based on findings?

As noted above with our process tags, our efforts at program evaluation have helped us to better organize and understand the flow of people through our services. We are into our third full year of using this organizational system and it is providing a much clearer picture of how our services are working and what may be a typical experience for our participants. As we continue to consistently grow and organize our data over time, we are able to look at long term trends and patterns.

Overall, evaluation has always been a driving factor in our program development and design. We've used our program data, participant feedback, and our staff observations to identify the need for our Workforce Empowerment Program and are now using its outcome data to further measure the success of the program and needs of our participants.

Evaluation with employment has always been on the easier side, as it has very clear measurable outcomes. Even with its relative simplicity, we've still found it to be a complicated process, but a very useful one that we are always looking to improve.

In FY24's report, we noted the following conclusions and insights. Responses to those as they compare in FY25 are provided in blue and are italicized. .

Finding a job that is suited to the person and based on their preferences/themes is critical to ongoing success.

- This means that a long job search that results in a great job match is ultimately better than a quick job search that may end in premature termination. When supporting job seekers with higher support needs, or less experience, we can assume that job matches will take longer and fewer can be expected in a given period.
- *While we were quite successful this year in finding great job matches for our participants, there were others whose job searches continued past the 6 month goal. Many of these individuals were, as noted previously, folks who had higher support needs or less experience.*

Providing the needed support upfront is critical since the likelihood of someone losing their position is greater in the first year.

- Our Workforce Empowerment program is one way that we are providing people with additional upfront support.
- We have also been discussing additional tools and methods that we can build into the discovery and job matching processes, such as additional job shadows and tours, skill building sessions, and complementary supports for social connections and daily living needs (which we often can provide through our other programs and departments). As the needs of our job seekers continue to shift, these adjustments will continue to be important.
- *During FY25, we had a number of our employment participants also take part in the Community/Social Coaching that we have developed and started offering through our Connect Department. While we don't have any specific data in this area, anecdotally,*

having an outlet to work on social skills, building connections, working through discomfort in social situations, and even receiving instruction on technology for communication (phones, email, etc), was reported by our Employment Specialists as a very helpful addition to the job search efforts.

It is possible that the slight decrease in participants' satisfaction in our employment services could be related to the slower pace of job matching that we experienced this year.

- Keeping our participants motivated during long job searches and parents supportive of well-matched jobs that take longer than hoped is an important part of our work. If we are seeing the beginning of a trend of slower hiring, we will need to work on ways to address these concerns on our participants' parts and on the behalf of their involved families.
- *Though modest, there was a slight increase in the quantitative reports of satisfaction data for the program this year. This could be due to a higher rate of job matching, though it is difficult to say with certainty.*

If we are seeing an ongoing trend of slower hiring, we will need to be very mindful of the potential for longer waiting periods for services.

- This is not something that we are seeing yet, but the trends in the data could indicate that longer job searches would limit the number of new people each of our Employment Specialists are able to support.
- This is something that we will continue to track and work on strategies to address. As noted, prior to the pandemic, it was common for people to wait over six months for services. This impacted motivation, morale, and was just generally disruptive to many people's life-goals. It also impacted the morale of employment staff, who thrive on the success and motivation on our participants' parts. We will be looking at different ways we can avoid moving back toward these unacceptable timelines.
- *As suspected, we are beginning to see slightly longer waiting periods for support and generally longer waiting lists. We are still doing much better than compared to periods before the pandemic, but it is an issue we continue to pay attention to. One thing that we have found helpful is to keep in contact with those on the waiting list and when appropriate try to move forward during periods when it is most convenient for the family. We still prioritize a first come first served basis, but sometimes individuals are not in a hurry, or have other priority issues and are OK with waiting. Having open lines of communication helps us to address people in a fair and equitable way.*

Annual Performance Outcome Report Form

In the Program Plan Narrative submitted with your application, you identified measures of Consumer Access, Consumer Outcomes, and Utilization. While Utilization data and comments have been captured in the quarterly service activity reports, Consumer Access and Consumer Outcome findings are reported only at the end of the program year. Download and complete this form and upload it to the online system reporting page, Performance Outcome Section.

Agency Name: Community Choices
Program Name: Inclusive Community Support
Program Year: FY25

CONSUMER ACCESS

In the Program Plan Narrative, you identified eligibility criteria for the program's services, how those criteria are established, how the target population learns about the program, and expected timelines. Please comment on each area below.

1. YES/NO - Did the stated criteria serve the purpose of providing people the services/ supports they were seeking? If NO, comment on causes and possible solutions.

Yes, it worked somewhat well. One of the determining eligibility criteria for this program is that the person must have a documented disability as defined by the PUNS screening. There were times that families had a longer wait time in the PUNS screening process.

2. YES/NO - Did the stated process for determining that the person and program were right for each other work well? If NO, comment on causes and possible solutions.

No - We are finding that we have to turn away more potential participants for the program because the screening process for enrollment on the PUNS database has become much more rigid. Participants who may have qualified in the past for PUNS enrollment or Medicaid Waiver services are being denied, which leaves them in a gray area without resources and services.

3. YES/NO - Did the stated outreach activities support appropriate matches between people and program services? If NO, comment on causes and possible solutions.

Yes, we find the vast majority of our participants find us through referrals and word of mouth. We find very few participants through tabling at informal community outreach events.

4. Compare year-end actual result with the application estimate of days from completed assessment to start of services. Comment on findings, especially if unexpected.

As stated above, the wait time for confirmation that an individual is eligible for the PUNS list was sometimes longer than expected.

5. Compare the year-end result with the application estimate of % of eligible people who engaged in program services within the above timeframe. Comment on the finding.

We estimated that 90% of eligible persons would engage in services and the result was lower, around 80%. A small number of people are involved in the appeals processes with DHS to challenge their rejection from meeting the criteria to enroll on the PUNS database, or their rejection from meeting the criteria to receive the HCBS Medicaid Waiver. A small number of people also chose to not engage in program services either used the information and resources gained to continue with family support or determined they were not ready to begin in the program at that time.

6. Compare year-end result with the application estimate of length of participant engagement. Especially if the result was unexpected, comment on this finding.

Support within this program is tailored to the person. It can last a few weeks or be ongoing. We have found this to continue to be true based on the individual and what goals they choose to work on and supports they need.
Classes within this program continue to last 6-8 weeks.

7. If your program collected demographic information beyond the standard categories reported each quarter, comment on the data and what they suggest for the program.

Beyond the basic demographic information required for all CCMHB/CCDDB programs, Community Choices also gathered the individual's RIN number, their PUNs eligibility, and what type of medical insurance they have access to (Private Insurance, Medicare, Medicaid, etc) in order to provide all needed information for the with the Developmental Disability Specific program reporting and eligibility requirements. Information about involvement with other service providers was also collected to ensure supports were not duplicated.

CONSUMER OUTCOMES

In the Program Plan Narrative, you identified positive outcomes people would experience as a result of participating in the program. You also identified measurement tools and targets for each outcome. Include original information and comment on the actual results.

- Use (and expand) the space below to copy each numbered **Outcome** (expected program impact on participants) from your Program Plan. Include the specific **target** and add the **actual result**.
- For each outcome, list the specific **assessment tool** used to collect information. *If different from the tool indicated in the application, include a note explaining the change.*
- For each outcome, indicate the **source of information**, e.g. participant, participant's guardian(s), clinician/service provider, 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)."*

1. **FAMILY SUPPORT AND PLANNING: Whole families have access to the supports that are important for them to fulfill their Inclusive Community Support Plan. - Timeline: Annual Check-In**

   Please Note - In late FY25 we developed a new Family Feedback Survey that we began using at the end of this fiscal year. We have found that the Family Feedback Survey that we had been using up until this point was not giving us enough useful information with which we could draw strong conclusions regarding our desired outcomes. It depended on the same family member completing the survey year after year allowing us to compare their individual data. This did not consistently happen. Although we did get some responses each year, it was not typical for one family to respond year after year, so comparison data was repeatedly not available. The new survey will not rely on comparable data, but rather on family shared indicators. While not as clinical or granular a response, it will provide a much more consistent flow of information with which to evaluate the program. Data provided below uses indicators from both the original survey when possible as well as data from the new survey when other data was not available.

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

      ASSESSMENT: New Family Feedback Survey (Updated for end of FY25 and used in FY26)

      SOURCE OF INFORMATION: Family members of participants in the ICS program. It is noted whether the participant has been involved in the ICS program for less than 1 year or 1 year +.

ACTUAL: (⅘) 80% of family members whose participant has been involved in the ICS program for 1 year or more report that they feel they have an achievable long-term plan. (2/2) 100% of family members whose participant has been involved in the ICS program for less than 1 year report that they are "working towards a plan."

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

ASSESSMENT: Original Family Evaluation Form

SOURCE OF INFORMATION: Family members of participants in the ICS program. It is noted whether the participant has been involved in the ICS program for less than 1 year or 1 year +.

ACTUAL: We found that it was very challenging to gather data from the same people year by year in order to make this calculation. While we do have family participants respond to this assessment, they are often different subsets of families each year, so comparable information is not available. For FY26, we have redesigned the survey to provide better information regardless of which participants choose to respond.

We were able to compare answers from family participants using services for less than one year with family participant answer from those who had been engaged in services for over one year. While there was not a substantial amount of data available, the one respondent who was new to services indicated that their personal support duties were "Barely Manageable".

83% of Family participants who had been engaged for more than 1 year indicated that their personal support duties were "Quite Managable". 17% indicated that this was "Somewhat Managable".

c. Families indicate an increase in their quality of life.

ASSESSMENT: Original Family Evaluation Form

SOURCE OF INFORMATION: Family members of participants in the ICS program. It is noted whether the participant has been involved in the ICS program for less than 1 year or 1 year +.

ACTUAL:

Family Participants who had been part of the program for 1+ Years:

4/6 (67%) Respondents indicated that there had been "Some Improvement"

2/6 (33%) of respondents said there has been "Somewhat" of an improvement.

d. Family members indicate that ICS has supported their person to achieve desired housing, building natural supports, skills, and connections.

ASSESSMENT: New Family Feedback Survey

SOURCE OF INFORMATION: Family members of participants in the ICS program. It is noted whether the participant has been involved in the ICS program for less than 1 year or 1 year +.

ACTUAL: (5/5) 100% of family members whose participant has participated in the ICS program for 1 year or more report that ICS has supported their person to achieve desired goals. (2/2) 100% of family members whose participant has been involved in the ICS program for less than a year report their participant has increased their independence and skills at least "a little." We find this growth positive for participants less than a year into the program.

2. HOUSING, LEARNING, CONNECTING: Participants build lives in the community - Timeline: Annual Check-In

a. Housing

i. 95% of participants maintain stable housing

ASSESSMENT: Action Plan & Quarterly Check-In/Narrative Reports

SOURCE OF INFORMATION: Service Provider

ACTUAL: 95% of participants maintain stable housing

ii. 85% of participants indicate they are satisfied with their housing

ASSESSMENT: Independent Living Skills Checklist

SOURCE OF INFORMATION: Program Participants

ACTUAL: 95 % of participants are satisfied with their housing

iii. 50 % of participants indicate ICS has been helpful in finding/sustaining preferred housing.

ASSESSMENT: Independent Living Skills Checklist

SOURCE OF INFORMATION: Program Participants

ACTUAL: 50% of participants indicated that ICS has been helpful in finding and/or sustaining their housing

b. Learning

i. 90% of participants develop skills they identified as critical for community living

ASSESSMENT: Action Plan & Quarterly Check-In/Narrative Reports

SOURCE OF INFORMATION: Service Provider

ACTUAL: 91% of participants developed skills they identified as critical for community living

ii. 90% of participants indicate that Inclusive Community Supports have been helpful in skill building

ASSESSMENT: Independent Living Skills Checklist

SOURCE OF INFORMATION: Program Participants

ACTUAL: 89% of participants indicated that ICS has been helpful in skill building

c. CONNECTING

i. 90% of participants identify a desire to build connections, find belonging with people, places or groups in their community

ASSESSMENT: Action Plan & Quarterly Check-In/Narrative Reports

SOURCE OF INFORMATION: Service Provider

ACTUAL: 100% of participants that identify a desire to build connections found belonging with people, places or groups in their community

ii. 80% of participants indicate ICS has been helpful to their building community connections.

ASSESSMENT: Independent Living Skills Checklist

SOURCE OF INFORMATION: Program Participants

ACTUAL: 88% of participants indicate that ICS has been helpful to their building community connections

iii. 100% of participants have people and places where they are comfortable

ASSESSMENT: Independent Living Skills Checklist

SOURCE OF INFORMATION: Program Participants

ACTUAL: 95% of participants have people and places where they are comfortable

3. PERSONAL OUTCOME MEASURES - Timeline: Annual Check-In Score compared to initial POM.

a. **90% of participants increase their POM scores in targeted outcomes**
ASSESSMENT: POM
SOURCE OF INFORMATION: Program Participants

ACTUAL: 55% of participants who have been in the ICS program for more than 1 year increased their POM scores in targeted outcomes; 22% of participants targeted outcomes POM scores remained the same

b. **90% of participants increase their POM supports for targeted outcomes**
ASSESSMENT: POM

SOURCE OF INFORMATION: Service Provider

ACTUAL: 33% of participants who have been in the ICS program for more than 1 year increased their POM supports for targeted outcomes; 44% of participants targeted support POM scores remained the same

4. PERSONAL DEVELOPMENT CLASSES - Timeline: Individuals with I/DD build independent living skills during 6-8 week courses

a. **100% of participants will indicate growth/skill development based on course assessments**

ASSESSMENT: Class Pre & Post Evaluations

SOURCE OF INFORMATION: Class Participants

ACTUAL: 93% of class participants indicated they learned a new skill or improved in their skills.

CONSUMER PARTICIPATION IN DATA COLLECTION

1. How many total participants did the program have?

   Inclusive Community Support: 35 participants
   Personal Development Classes: 23 participants (14 unique individuals)

For each of the following questions, if there are different responses per outcome, please identify the numbered outcome and the relevant detail.

2. If outcome information was NOT gathered from every participant, how did you choose who to collect outcome information from?
   Outcome 1: Attempted to get information from all involved family members
   Outcome 2 & 3: Outcome information was collected from participants in the Inclusive Community Support Program, but which information was dependent upon where the person is at in the program and types of support requested
   Outcome 4: Collected data from people who participated in Personal Development Classes.

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

   Outcome 1: 22
   Outcome 2 & 3: 35
   Outcome 4: 23

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

   Outcome 1:
   7 Original Family Feedback Survey Respondents
   7 New Family Feedback Survey Respondents
   The original Family Feedback Survey was not anonymous. The new Family Feedback Survey was. This makes it impossible for us to know if there were any family participants who completed both.

Outcome 2 & 3: 35
Outcome 4: 15

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

   Outcome 1: Family members of the ICS program participants were previously asked to complete a survey after the initial family planning session, then annually as part of the annual planning process. However, beginning in the 4th quarter of FY25 we changed the assessment and process in hopes to provide a more consistent flow of information for which to evaluate the program. ICS program participants are now asked to complete a survey at the end of the Spring. It is noted whether their program participant has been involved in the ICS program for less than 1 year or 1 year+.

   Outcome 2 & 3: Formal assessments are completed as part of the goal development process and annually following. Formative assessment on self-determined goals occurs at least quarterly.

   Outcome 4: Data was collected via pre-class survey prior to each first class meeting and a post-class survey during the last meeting of each class.

RESULTS

1. What did you learn about the participants and the program from this outcome information? *Be specific when discussing any change or outcome and give quantitative or descriptive information when possible. You might report: Means and, if possible, Standard Deviations; Change Over Time, if assessments occurred at multiple points; Comparisons, e.g., of different strategies related to recruitment, of rates of retention for clients of different ethnic or racial groups, or of characteristics of all clients engaged versus clients retained.*

FAMILY SUPPORT & PLANNING

As stated earlier, In late FY25 we developed a new Family Feedback Survey that we began using at the end of this fiscal year. We have found that the Family Feedback Survey that we had been using up until this point was not giving us enough useful information with which we could draw strong conclusions regarding our desired outcomes. It depended on the same family member completing the survey year after year allowing us to compare their individual data. This did not consistently happen. Although we did get some responses each year, it was not typical for one family to respond year after year, so comparison data was repeatedly not available. The new survey will not rely on comparable data, but rather on family shared indicators. While not as clinical or granular a response, it will provide a much more consistent flow of information with which to evaluate the program.

We also hope that the new format and process will result in a larger number of family members completing the survey. We continue to struggle with receiving limited responses and feedback from families. 20% ongoing participants in the program had family members respond to requests for feedback. Some of this is due to some participants not having involved family, while other families just didn't respond. However the data that we were able to collect continues to show positive trends in the Inclusive Community Support program.

Of the families that responded, 100% reported that Inclusive Community Support had helped their adult child meet their determined goals. This was true for all family members whose participant had participated in the program for less than a year, and also for those who have been involved in the program for a year or more. Also a high percentage of family members felt that they either had an achievable long term plan for the adult child to live in the community, or that they felt like they had help in working towards a plan.

HOUSING, LEARNING & CONNECTING
PERSONAL OUTCOME MEASURE

We've worked to develop methods that accurately measure outcomes based on specific goals: tracking whether participants have housing, skills, or connection goals and using the corresponding survey responses. However, data is still limited due to the long term nature of the program, and the willingness of some participants to respond to formal assessments and surveys. The data that we have collected indicates that the program has a positive impact on participants' lives, and that participants find our support helpful.

The flexibility of having a program that is a combination of case management and skill work has allowed us to provide the different areas and levels of support people need within one program. The most common type of goals we're working with participants on are related to skill building. People are working in very practical areas like cooking, cleaning/organizing, grocery shopping, etc. We've also supported people in accessing and maintaining benefits, attending routine medical appointments, and navigating major life transitions. For some participants and families our support has been helpful in meeting their basic needs. In some cases our supports and services have been critical for people to continue to live a more independent community-based life and not a more confined existence. The ICS program continues to allow people with I/DD the opportunity to live a more autonomous life in the community by combining different types of support to make it happen - agency-based support, waiver funding and paid supports, natural supports, and public resources.

We had fewer ICS participants working on connection-based goals in FY25. However, it's not because participants had less desire for connection. When appropriate, we referred participants with connection-based goals, who are also Community Choices members, to the Community Coaching program in our Connect Department. The addition of this more structured support through that department has been a helpful and complementary service to our participants and this program.

Personal Outcome Measures are an annual assessment used to identify if core targeted outcomes, and support for those outcomes, are present in an individual's life. It can be difficult to monitor progress over time as outcomes may be present or not present based on life events

at the time, or even how the individual is feeling that day. So while the Personal Outcome Measures is a good baseline measure, it doesn't report on the progress participants are making in the "how" those outcomes are present. Within the ICS department we're attempting to help program participants have more autonomy, self-direction, and activity engagement in assuring those outcomes and supports are present. Growth can be uncomfortable. Program participants have built up comfort with old methods and ways of doing things, methods and ways that may not be sustainable as their lives change over time. It will not be surprising to us if program participants self-reporting whether or not outcomes are present in their lives may vary slightly based on the "how" or context surrounding the outcomes being present or not. Participants need to be intrinsically motivated and active in working towards their goals in order for supports to be successful. This is true of all people, so of course it is true for folks with I/DD, too. Lasting change and improvements happen over a period of time.

Personal Outcome Measures also report the supports present in a person's life. We had anticipated that participation in this program would increase the supports participants had access to. There is nuance to this as well. At times we may be working with people to reduce the amount of support they have over time. This does not mean that people are losing services. It potentially means that that person may not have the need for additional support in that given area of their life. With this, both an increase and a decrease have the possibility of being positive impacts.

PERSONAL DEVELOPMENT CLASSES

We take a deliberate approach when planning the schedule and topics of personal development classes each year. We base our decisions on trends that have been noticed in each department, what our members say they need, and additional suggestions from family members. The classes held during FY25 include: Voting & Civic Engagement, Cooking with Countertop Appliances, Media Literacy & Safety, Healthy Sexuality with CUPHD, and a Women's Empowerment Group.

Classes that involve cooking and baking are usually very popular. We think one of the reasons is that this is one of the few opportunities people may have to cook or bake. It's difficult for families to carve out the time during the day to spend 60 minutes supporting their adult children to cook what might only take them 30 minutes to prepare on their own.

We value partnering with organizations like CUPHD and RACES to offer classes like Healthy Sexuality. We believe in supporting our members to learn valuable information, while also connecting them with people and places that can provide additional individualized support, if needed. In addition, the Voting & Civic Engagement class was also popular in the Fall of FY25. The objectives of the class were: (1) Understand what voting is and who can vote, (2) Understand what are local issues vs national issues, and (3) Meet and understand the responsibilities of local elected officials. By the end of the class, all participants had registered to vote and understood they had a choice whether to vote or not in the upcoming November elections.

2. OPTIONAL: Describe a typical service delivery case to illustrate the work. This may be a "composite case" that combines information from multiple actual cases.

Within the Inclusive Community Support Program, supports provided typically fall into one of three composites as described below: Outcome AA, Outcome AB, Outcome AC.

Participant A: Participant A and their mom express interest in our ICS program and schedule a Family Planning Meeting. At the meeting Community Choices staff facilitate discussion about components of community living: housing, daily living skills, connections, health and wellness, transportation, budgeting and benefits, and resource coordination. Discussion focuses on where Participant A is right now, and where they would like to be in the future. Time is also spent discussing what types of support Participant A's mom provides right now, what supports Community Choices can provide, what natural supports exist, and what community resources are available.

During Participant A's meeting, it became apparent that A would like to live in their own apartment someday and their mom wants to support that in happening, but has financial concerns about if A will be able to afford rent. A has no problems remembering to take their daily medication, but forget to refill the prescriptions. Participant A may also need some help paying bills on time and creating a personal budget if they were to live on their own. Transportation isn't really a concern because A already uses the MTD and understands that system. A is able to do basic cooking and cleaning, but doesn't right now since he lives with his mom. His mom is concerned that he'll eat the same thing all the time or never clean without reminders to do so. Participant A is on the PUNs list, but hasn't been pulled for funding yet.

After the meeting, Community Choices staff summarize the discussion by stating the goal A has to live in their own apartment, and the barriers and challenges to that. Staff list the community resources that are available, and strategies and supports to remove those barriers. These would include registering for the HACC Housing Voucher program, creating meal plans and cleaning schedules, having someone help him remember to get his prescription filled each month, setting up automatic payments for rent, utilities and other monthly expenses, and creating a monthly budget and scheduled finance check-ins. Community Choices staff send the Family Planning Meeting Summary to Participant A and their mom.

Outcome AA: Participant A and their mom feel confident in their ability to take next steps on their own and implement the strategies suggested and continue forward without Inclusive Community Support services.

Outcome AB: Participant A and their mom want to move forward with working in the Inclusive Community Support program, but A will not be able to afford to move out without rental assistance. Participant A registers for the HACC Housing Voucher list. When a voucher becomes available, Community Choices staff will assist the family in looking for apartments that accept vouchers.

In the meantime, Community Choices staff work with Participant A and their mom to set up a weekly cleaning and chore schedule for A (includes laundry, cleaning the bathroom, picking up their room, etc). Staff meet with Participant A once a week at the home to check in on if any skill development is needed for cleaning and chores. Staff assists Participant A in setting up automatic refills for their prescription so A will get a text when the refill is ready. A can then take the bus to the pharmacy to pick it up. Finally A has set a goal of cooking dinner for his mom once a week without repeating the same meal for 8 weeks.

Outcome AC: While waiting for a housing voucher to become available, Participant A is pulled for HBS funding. Participant A and their mom decide they would like Self-Direction Assistance (SDA) from Community Choices. Community Choices assists Participant A in managing their HBS funding and hiring Personal Support Workers who help A explore their outdoor interests in community park district programming. Using the Inclusive Community Support services, Community Choices work with Participant A and their mom to set up a weekly cleaning and chore schedule for A (includes laundry, cleaning the bathroom, picking up their room, etc). Staff meet with Participant A once a week at the home to check in on if any skill development is needed for cleaning and chores. A sets a goal of cooking dinner for his mom once a week without repeating the same meal for 8 weeks.

Using SDA billing through Participant A's HBS waiver, Community Choices supports A in setting up automatic refills for his prescription so A will get a text when the refill is ready. A can then take the bus to the pharmacy to pick it up. Community Choices staff is also able to support A in scheduling his medical appointments by using HBS waiver funding. A expresses that he would like someone to attend appointments with him as his advocate. HBS waiver funding allows Community Choices to bill SDA for providing this assistance.

3. OPTIONAL: In what ways has the evaluation supported the current practice or changes in practice? What changes were made or are planned, based on findings?

In talking with families over the past few years, we have found that it is often one or two areas that participants and families feel are holding them back from taking bigger steps for community-based living. It is the intent of the Inclusive Community Support Program to provide support that can fill in the gaps and provide the support that a person may need in order to live in the community.

Data and results collected in FY25 continues to support this. Over the past year, the number of ongoing supports we provided to program participants increased from 24 in FY24 to 38 in FY25. The ongoing supports we provided include assisting in reporting wages to social security, routinely reviewing budgets and spending habits, supporting people in scheduling and attending routine medical appointments, helping people fill their weekly med box and schedule prescription refills, routinely organizing and discarding mail items, regular basic home maintenance, etc. Looking at the variety of ongoing supports we provided, it's evident that the

things that keep people with I/DD from living independently in their community vary greatly. The different skills we've supported participants in gaining is also evidence of this.

In the 4 years since starting the program we've seen participants reach goals and no longer need support in some skill areas, or make progress in some areas. But there have also been examples of people not being able to progress in a certain area. Needing ongoing support over time shouldn't keep anyone from living community-based lives.

Annual Performance Outcome Report Form

In the Program Plan Narrative submitted with your application, you identified measures of Consumer Access, Consumer Outcomes, and Utilization. While Utilization data and comments have been captured in the quarterly service activity reports, Consumer Access and Consumer Outcome findings are reported only at the end of the program year. Download and complete this form and upload it to the online system reporting page, Performance Outcome Section.

Agency Name: Community Choices
Program Name: Self-Determination
Program Year: FY25

CONSUMER ACCESS

In the Program Plan Narrative, you identified eligibility criteria for the program's services, how those criteria are established, how the target population learns about the program, and expected timelines. Please comment on each area below.

1. YES/NO - Did the stated criteria serve the purpose of providing people the services/ supports they were seeking? If NO, comment on causes and possible solutions.

Yes, it worked somewhat well. One of the determining eligibility criteria for this program is that the person must have a documented disability as defined by the PUNS screening. There were times that families had a longer wait time in the PUNS screening process.

2. YES/NO - Did the stated process for determining that the person and program were right for each other work well? If NO, comment on causes and possible solutions.

No - We are finding that we have to turn away more potential participants for the program because the screening process for enrollment on the PUNS database has become much more rigid. Participants who would benefit from services and who may have qualified in the past for PUNS enrollment or Medicaid Waiver services are being denied, which leaves them in a gray area without resources and services.

3. YES/NO - Did the stated outreach activities support appropriate matches between people and program services? If NO, comment on causes and possible solutions.

Yes, we find the vast majority of our participants find us through referrals and word of mouth. We find very few participants directly through tabling at informal community outreach events.

4. Compare year-end actual result with the application estimate of days from completed assessment to start of services. Comment on findings, especially if unexpected.

As stated above, the wait time for confirmation that an individual is eligible for the PUNS list was sometimes longer than expected. It is also outside of our control as it is coordinated between the person/family and the ISCs.

5. Compare the year-end result with the application estimate of % of eligible people who engaged in program services within the above timeframe. Comment on the finding.

100% of members are continually given the opportunity to participate in services like social opportunities, community coaching, leadership opportunities, parties, etc. through our monthly social calendar, newsletter, and targeted communication.

65% of our members with disabilities participated in these opportunities during FY25. Some people are members because their family wishes to participate in the family-focused opportunities, but we've also taken steps to ensure that more members will be able to participate in program services. Those steps will be covered in more detail later in the report.

6. Compare year-end result with the application estimate of length of participant engagement. Especially if the result was unexpected, comment on this finding.

Membership lasts for one year, at which point individuals have the opportunity to renew which includes updating paperwork and eligibility. We found that 85% of FY24 members with disabilities renewed their membership for FY25.

7. If your program collected demographic information beyond the standard categories reported each quarter, comment on the data and what they suggest for the program.

Beyond the basic demographic information required for all CCMHB/CCDDB programs, Community Choices also gathers the individual's RIN number, their PUNs eligibility, what type of medical insurance they have access to (Private Insurance, Medicare, Medicaid, etc), as well as information about involvement with other service providers to ensure supports are not duplicated. No meaningful analysis can be gleaned from this data other than that our members were all eligible for services.

CONSUMER OUTCOMES

In the Program Plan Narrative, you identified positive outcomes people would experience as a result of participating in the program. You also identified measurement tools and targets for each outcome. Include original information and comment on the actual results.

- Use (and expand) the space below to copy each numbered **Outcome** (expected program impact on participants) from your Program Plan. Include the specific **target** and add the **actual result**.
- For each outcome, list the specific **assessment tool** used to collect information. *If different from the tool indicated in the application, include a note explaining the change.*
- For each outcome, indicate the **source of information**, e.g. participant, participant's guardian(s), clinician/service provider, 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)."*

1. **FAMILY SUPPORT AND EDUCATION:** ***Members support each other and gain knowledge through:***

- 5 Co-op meetings
  ACTUAL: 5 Meetings were held
- 3 Family Parties and 1 Holiday Event
  ACTUAL: 4 Family Parties were held (including 1 for the holidays)
- 8 Family Support Group Meetings
  ACTUAL: 9 sessions held

Expected outcomes:

A. 80% of Support Group participants indicate a strategy/resource learned or increased connection after meeting.
ASSESSMENT: Family Support Group Survey
SOURCE OF INFORMATION: Families via google forms
ACTUAL: 100% of Responding participants indicated that they learned about a new resource, disability service systems, or got answers to questions they were dealing with.

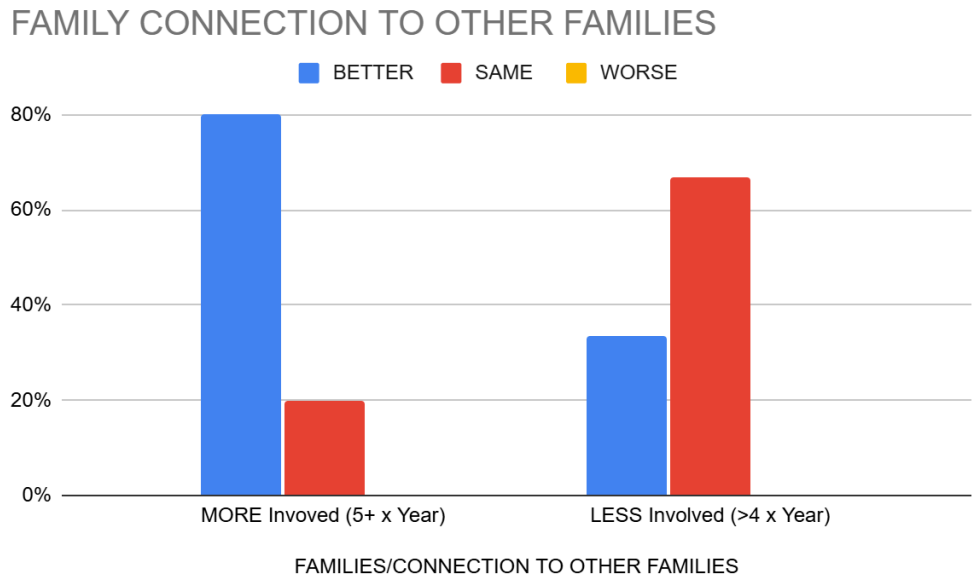
B. Family Members who participate, or whose adult participates, in more events/activities throughout the year, report higher rates of connections to others.
ASSESSMENT: Annual Member Survey
SOURCE OF INFORMATION: Family members of CC members with disabilities. Both family members and CC members with disabilities can fill this out but are asked to choose who they identify as.
ACTUAL: 100% of family members who reported participating in activities monthly or more than 1 time per month, or that their adult participated in activities monthly or more than 1 time per month also reported that with Community Choices they felt more connected to others, more connected to other families, and had a higher sense of community and wellbeing.

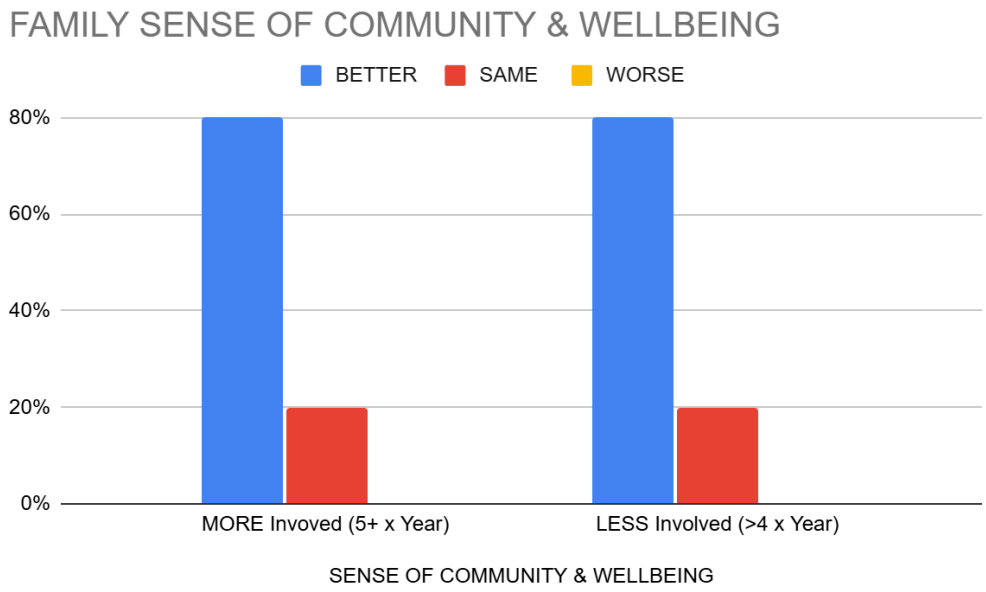
Family Members who participated MORE Often *(5x per year - More than 1x per month)*
Connections to other families:
4/5 (80%) report this was BETTER w/ CC Involvement
1/5 (20%) report this was the SAME w/ CC Involvement

Sense of Community:
4/5 (80%) report this was BETTER w/ CC Involvement
1/5 (20%) report this was the SAME w/ CC Involvement

Family Members who participated LESS Often *(Never - 1-4 times per year)*
Connections to other families:
2/6 (33%) report this is BETTER w/ CC Involvement
4/6 (67%) report this the SAME/NO CHANGE w/ CC involvement

Sense of Community:
4/5 (80%) report this is BETTER W/ CC Involvement
1/5 (20%) report this is the SAME w/ CC Involvement





C. 75% of family members who engage in programming report greater knowledge of the service system and belonging.

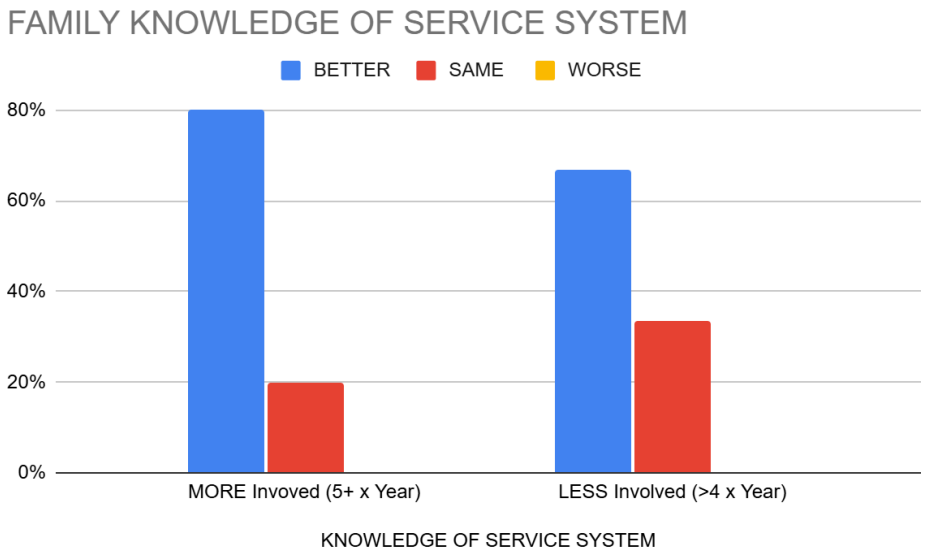
ASSESSMENT: Annual Member Survey
SOURCE OF INFORMATION: Family members of CC members with disabilities. Both family members and CC members with disabilities can fill this out but are asked to choose who they identify as.
ACTUAL: 77% of family members who engaged in any amount of programming reported a greater knowledge of the service system and knowledge of resources in our community and state.

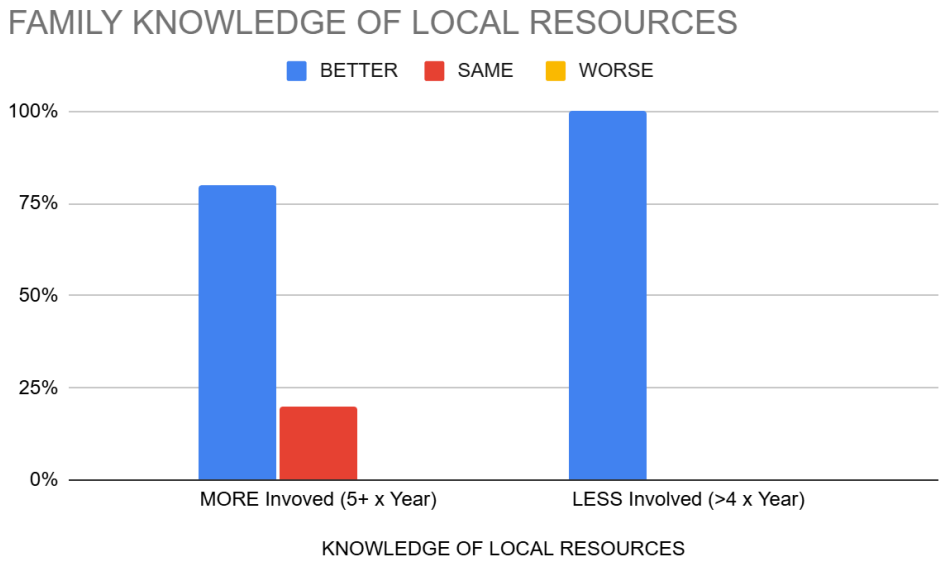
Family Members who participated MORE Often *(5x per year - More than 1x per month)*
Knowledge of DD Service System
4/5 (80%) report this was BETTER w/ CC Involvement
1/5 (20%) report this was the SAME w/ CC Involvement

Knowledge of Local Resources:
4/5 (80%) report this was BETTER w/ CC Involvement
1/5 (20%) report this was the SAME w/ CC Involvement

Family Members who participated LESS Often *(Never - 1-4 times per year)*
Knowledge of DD Service System
4/6 (67%) report this was BETTER w/ CC Involvement
2/6 (33%) report this was the SAME w/ CC Involvement

Knowledge of Local Resources:
6/6 (100%) report this was BETTER w/ CC Involvement
0/6 (0%) report this was the SAME w/ CC Involvement





2. LEADERSHIP AND SELF ADVOCACY: ***Individuals with disabilities build leadership skills to better direct their services, and shift mindsets in the community through:***

- 1 Leadership Course
  ACTUAL: 1 Leadership Course was held
- 1 Human Rights and Advocacy Group (HRA)
  ACTUAL: 1 Group ran throughout the year
- Ongoing involvement with anti-stigma, visibility, and leadership projects including:
  - Accessible Champaign Partnership
  - Balancing Act International research involvement

- On demand self-advocacy consultation and appearances

ACTUAL: Continued involvement in Balancing Act international research project, HRA group and additional members with I/DD presented to U of I classes and provided feedback on disability services, the phase of the Accessible Champaign Partnership that required input from self-advocates has ended

Expected Outcomes:

A. 80% of leadership class participants indicate a growth in leadership skills
ASSESSMENT: Leadership Class Pre/Post Surveys
SOURCE OF INFORMATION: Class participants
ACTUAL: 80% (⅘) of class participants showed growth in leadership skills

B. HRA members identify areas to grow self-advocacy skills and rate their growth every 6 months
ASSESSMENT: Quarterly Narrative Report, based on in-group assessment of skills
SOURCE OF INFORMATION: Participant input and staff observations
ACTUAL: 100% of HRA members showed growth in self-advocacy skills throughout the 12 months

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

- 44 Social Opportunities
ACTUAL: 75 Opportunities occured

- 2 6-week sessions of Urban Explorers
ACTUAL: 2 sessions were hold

- 4 Community Coaching 10-week Sessions (18 individuals coached, 30 members reached)
ACTUAL:
4 Coaching Sign-Ups were offered
10 Unique People participated in Coaching, 4 people participated in multiple sessions, 3 people signed up but did not continue past 1-2/10 weeks.
23 Unique People Coached or Reached/Included in Coaching related activities (Club members, etc)

- 1 Members only Website, Facebook group, and resource dissemination
ACTUAL: 1 Members-only Facebook group - shared upcoming Community Choices social opportunities and events, shared information about state and federal issues that affect members and their families, Views of posts have increased but interaction with posts remains small

Expected Outcomes:

A. 75% of members with I/DD indicate that CC provides them with a supportive community after a year.
ASSESSMENT: Annual Membership Survey and Quarterly Narrative Reports
SOURCE OF INFORMATION: Member input through survey responses

ACTUAL: 87% of members with I/DD reported that CC "definitely" provides them with a supportive community

B. 75% of members who participate in structured opportunities connect to other members or initiate community engagement within a year.
ASSESSMENT: Quarterly Narrative Reports
SOURCE OF INFORMATION: Staff observations
ACTUAL: 56% of members who participated in structured opportunities connected to other members

C. 50% of members who initiate a desire for community engagement report or have an observed connection to people, groups, or places within 3 months.
ASSESSMENT: Community Coaching Survey and Quarterly Narrative Reports
SOURCE OF INFORMATION: Member input through survey responses and staff observations
ACTUAL: 50% of members who initiated a desire for community engagement had a connection to people, groups or places within 3 months

D. 50% of members who initiate a desire to increase a skill related to connection report or have an observed increase in skill within 3 months.
ASSESSMENT: Community Coaching Survey and Quarterly Narrative Reports
SOURCE OF INFORMATION: Member input through survey and staff observations
ACTUAL: 55% of members who desired to increase a skill related to connected had an increase in skill development within 3 months

CONSUMER PARTICIPATION IN DATA COLLECTION

1. How many total participants did the program have? __262___

For each of the following questions, if there are different responses per outcome, please identify the numbered outcome and the relevant detail.

2. If outcome information was NOT gathered from every participant, how did you choose who to collect outcome information from?

   We attempted to collect information from all applicable participants. Responses are always optional, however, and people may opt not to respond.

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

   - Outcome 1a: 20 - Attempted from all participants in Family Support Group

- Outcome 1b & 1c: 147 - Attempted from participants - family members of members with I/DD
- Outcome 2a: 5 - Attempted from all participants in Leadership Class
- Outcome 2b: 6 - Attempted from all participants in the Human Rights and Advocacy Group
- Outcome 3a: 115 - Attempted from all members with I/DD
- Outcome 3b: 45 of unique members with I/DD, some were contacted more than once depending on the number and type of activities they participated
- Outcome 3c & 3d: 10 - Members with I/DD who participated in Community Coaching

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

- Outcome 1a: 14 family support group participants
- Outcome 1b & 1c: 8 family members of members with I/DD
- Outcome 2a: 3 Leadership class participants
- Outcome 2b: 6 participants in the HRA group
- Outcome 3a: 15 members with I/DD
- Outcome 3b: 45 members with I/DD who participated in social opportunities and/or Urban Explorers
- Outcome 3c & 3d: 10 members with I/DD who participant in Community Coaching

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

- Outcome 1a: At the end of the fiscal year we send the survey out to everyone who participated during the past 12 months.
- Outcome 1b &1c: We send this out during the spring. We send multiple emails to our member list, include a link as part of the person's membership renewal, include the link on the membership renewal payment page, and post the link in our newsletter during multiple months.
- Outcome 2a: The leadership class uses a pre-survey/assessment on the first day of class and a post survey/assessment on the last day of class.
- Outcome 2b: The HRA did skill and knowledge check-ins at multiple points during the year
- Outcome 3a: We send this out during the spring. We send multiple emails to our member list, include a link as part of the person's membership renewal, include the link on the membership renewal payment page, and post the link in our newsletter during multiple months.
- Outcome 3b: We collect this information on an ongoing basis observationally for each event and using a pre and post assessment Urban Explorers participants.

- Outcome 3c & 3d: We collect this information on an ongoing basis observationally and using a pre and post assessment with Community Coaching participants.

RESULTS

1. What did you learn about the participants and the program from this outcome information? *Be specific when discussing any change or outcome and give quantitative or descriptive information when possible. You might report: Means and, if possible, Standard Deviations; Change Over Time, if assessments occurred at multiple points; Comparisons, e.g., of different strategies related to recruitment, of rates of retention for clients of different ethnic or racial groups, or of characteristics of all clients engaged versus clients retained.*

OVERALL OBSERVATIONS:

The Connect Program (Our Self-Determination Support grant funded program) remains one of the more difficult programs to evaluate. By nature, it is a program that is defined by choice and opportunity. This means that each person's involvement and experience in it is going to look very different based on their own choices. We expect that not all members will want or be able to participate in every opportunity the Connect Program offers. As we grow it will be impossible to meet every need and expectation of every member. We strive to provide *something for everybody*, knowing we will never be *everything for everyon*e.

When someone does choose to participate, we often have only limited control over what a person's experience might actually be. This is determined by the myriad of factors that affect all of us on a daily basis. Did the person I sat next to have similar interests as me? Was the environment friendly? Did I know how to respond when someone asked me an unexpected question? These are all things that we as a staff can nurture and support toward a positive outcome, but they will never be things we can control. This makes anticipating and collecting strong program wide data very challenging.

An additional barrier is the proportionally few survey responses compared to our actual number of participants. We had 44 individual members with disabilities participate in at least one of our 77 social opportunities. Many attended far more. We had a total of 134 members (those with I/DD and families) attend our Family Parties. We hosted our Annual Members meeting with 43 members present and many additional events, opportunities, and supports. Despite this and our extensive efforts at both sharing the importance and value of member feedback and input, we only received a total of 26 responses to our Feedback Survey. When we compare this with the abundant qualitative data, experiences, and observations that our staff make at each of our many opportunities, it makes it difficult to feel that the quantitative review of our program

outcomes is truly reflective of our members' experiences and the impact that we hope we're making on their lives.

This lack of rich data feels particularly unfortunate, because The Connect Department did some phenomenal work this year. With the support of some new staff with amazing energy, ideas, and many years for honing our methods, we created numerous creative and inclusive opportunities for our members with disabilities. We had multiple people start clubs that were based on their core interests. Not only did these get off the ground, they often happened in partnership with other area organizations, and with inclusive attendee groups. Our Family Parties were more popular than ever, with 3 out of 4 parties drawing over 60 attendees. Our Community Coaching process hit its stride with more people signing up and expressing interest in working on their personal social goals than ever before. Our members actively participated in an international research project and helped to create new knowledge around the participation of people with I/DD in formal research. It will always be challenging for quantitative data to capture the nuance, growth, learning, and humanity that occurs within these types of supports and opportunities.

While feedback provided in the survey is very consistently positive, the limited quality makes it challenging to draw clear conclusions. It does seem that there is a correlation between the level or frequency of involvement and degree to which members feel that Community Choices makes a positive impact in their lives. But given the breadth of our work and the variety of peoples' involvement, it is hard not to wonder if we asked the wrong questions, presented them in the wrong way, or if our outcomes are in fact different than we expect.

FAMILY SUPPORT & EDUCATION:

Families have always been a core part of this program and our Cooperative. Specific services and supports for them include our monthly Family Support Group, our Quarterly Family Parties, and our Co-op Informational meetings. These options were all very popular this year and well attended. It has always been our assumption that the more a person participates in these various opportunities, the more value they will derive out of the cooperative. Data indicates that this bears out, though limited responses do make a strong conclusion somewhat difficult to draw.

Qualitative feedback helps us to feel more confident that this is true. Conversations at our Co-Op Meetings have been particularly illustrative of the importance that these family educational opportunities have. Topics for our Co-Op meetings this year included ABLE Accounts, Special Needs Trusts & Financial Planning, I/DD and Dementia, and a presentation on Waiver options with the local Arc of IL Ligas Family Advocate. At all of them, families shared with each other, asked questions, shared resources, and provided CC staff with input on what issues were brewing in the community and what supports might be useful.

Our Family Support group gives us another, less formal, opportunity to hear from family members. We are able to observe them getting to know each other, sharing stories, and offering

each other suggestions. There is never one of these meetings that goes by that doesn't provide the staff present with multiple ideas on possible supports or a better, though informal, understanding of our programs impacts.

Our family parties are another opportunity for us to see the intangible ways that our coop is impacting lives. They are safe and welcoming spaces where families and our members with I/DD can relax, celebrate, and connect to each other. At our most recent holiday party, we had a mother approach us to say that this was the first time she'd ever been invited to a Christmas Party. She was dressed up in holiday garb and seemed to be having a wonderful time.

Our data doesn't capture a lot of these moments, but in total it has helped our staff to identify some of the needs of the cooperative that we've put into our plans for the next fiscal year. In response to more family conversations about the need for future planning and getting their finances and supports organized, we'll be offering a series of Family Resource Workshops in the upcoming year. Here, families will get the opportunity to better understand key systems and how they are linked up with them. They will also be guided through a workbook to help them organize their papers, processes, and key information so they can take additional planning steps if needed, or feel confident that someone will be able to pick up where they left off if something terrible should happen.

LEADERSHIP & SELF ADVOCACY:

It is important to us that projects and work within the HRA is driven by our members. In FY25 we took great efforts to connect the HRA to other groups, organizations and people in our community who are involved in self-advocacy, community building and social justice work. Our goals were to expose the members of the HRA group to other local efforts, support them in learning how other people involved in this work create goals and choose efforts and activities that work towards their goals, and how disability intersects with the work other groups are involved in. The HRA met and talked with groups like Free CU, CUrbanism, Uniting Pride, Champaign Independent Media Center, and individuals doing grassroots advocacy. Over the course of the year HRA members showed interest in new advocacy areas, excitement about potential partnerships, and even some positive shifts in mindset and attitude toward other underrepresented and marginalized community members.

The HRA members have always shown high interest in speaking with others about their experiences. Continuing to maintain connections with the U of I Special Education Department and School of Social Work provide opportunities for HRA members to share their experiences and influence future professionals and best practices in supporting people with I/DD.

BUILDING COMMUNITY:

Community Building is a core part of this program and of the organization overall. This category is what the bulk of our supports and opportunities are looking to impact. It includes most of "Social" programming, such as social opportunities, our Urban Explorers program, and our

Community Coaching supports. On a basic level, our community and cooperative grew significantly this year with 28 new members, probably our largest increase in any single year. This was energizing for staff and other members alike. We started our Welcome Crew to help these new additions to the community gain a sense of belonging and learn some of the practical information they might need to get involved. During periods of these large influxes, those meetings were very well attended. Our crew of long-time members enjoyed the opportunity to have ownership over the events and options within the cooperative, and the new members benefited from having additional information on how to get involved in events and meet new people.

As part of this expansion in membership, the interest in our social opportunities skyrocketed. For many years, we'd been offering four events per month which was generally enough for those who were interested to participate. Half-way through FY25, this was clearly no longer true. Events were filling up as soon as the sign-up calendar went out and we received complaints from people disappointed that they had not gotten to attend their desired opportunity. In response, we increased the number of events each month, changed the sign up process to be more equitable, and planned for an even greater number in FY26.

As we've discussed, there are lots of different ways that people are involved in our cooperative. As such, there is never going to be one clear trajectory of support that is ideal or the "right" way to engage. That being said, we have always envisioned these supports as having multiple entry points on a pathway upward toward greater connection. We see social opportunities as the simplest, most structured way to start this journey. For some people, this type of engagement is enough and the journey stays stable here. Others hope to build deeper, more organic relationships and connections. Our more indepth structured opportunities, like Urban Explorers might be a good next option on that journey, while a fully personalized approach through our Community Coaching supports are an even more in-depth step on this path.

We've worked to design our outcomes to express this potential pathway, with goals for members engaged in structured opportunities to either make a connection, or to reach out with interest in working more on a possible social goal. This was one area where we did not fully reach our target of 75% of members doing one of these two things. We believe there are a few possible reasons for this. First, with so many new members, it's possible that they will need more time engaging before they have an observable connection, or feel comfortable enough to reach out about more in depth supports. Another possible explanation is just that connection is very hard to observe. We look for things like members telling us they plan to return to a space, hearing members exchange information, or make plans with each other. It's quite possible that those things are happening, but that we don't know. It's also possible that people who participate are *feeling* connected, but not in a way that we can measure. This is supported by data that indicates that 87% of members, even those who don't participate that often, feel that Community Choices provides them with a supportive Community.

For individuals who do reach out about more in depth supports through our Community Coaching process, we have found that, as expected, 50% of participants achieve their desired social goal for connection by the end of their coaching session. While we would love for everyone who we work with to accomplish this, we knew, and have been accurate, that this is not realistic. When looking at the type of goals that our coaching participants are working on, there are many that focus more on the internal skills that are needed in order to build an organic connection. We have been supporting members to build their confidence by just talking with people, identifying emotions, and learning expected or appropriate conversational skills. These are critically important, but not necessarily likely to result in an observable community engagement or skill mastery after just a few months.

Overall, we see this as being a very exciting and eventful year in the evolution of our Connect Department and self-determination supports. It is our program with the fewest roadmaps to follow. This has made it difficult to define effective processes and options that are approachable and user-friendly to our members, but the programs and structures we've put into place over the past year and a half seem like they are going well and have lots of capacity for growth and refinement. The outcome data for this grant, as well as the anecdotal and qualitative data that we gather about our members' experiences does seem to indicate that we are on the right track.

2. OPTIONAL: Describe a typical service delivery case to illustrate the work. This may be a "composite case" that combines information from multiple actual cases.

Members of Community Choices have full freedom to participate or not in the supports and opportunities that we provide. Our goal is to help people be more connected and to build their relationships, self-determination, and social capital. Below you will read about what the services and supports, and some of the potential outcomes might be for individuals who are both highly involved and those with more limited involvement during this past year.

<u>Highly Engaged Member with I/DD</u>
Member A and their family members have been members at Community Choices for over 3 years. Over the past year Member A participated in weekly social opportunities, and was also participating in another member's monthly co-op club where 4 friends get together for coffee at a local coffee shop. Member A may also participate occasionally in classes or other opportunities that present themselves throughout the year.

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

Limited Engagement Member with I/DD

Member C is new to Community Choices. In the first couple of months, they attended one or two social opportunities, but were discouraged when they didn't see the same people at the second event. Because of this they told their parents they didn't want to go any more. Their families continued to be involved by attending occasional family support groups and the quarterly co-op meetings. At one of these meetings, they hear about a cooking class that's coming up. They encourage Member C to sign up because they think they will have the chance to see the same people week after week.

Member C does sign up for the class but misses three of the eight meetings because of an appointment, not feeling well, and forgetting. They do report having a good time. A few months later, with some encouragement from family they attended another social opportunity. The same staff who taught the class was also supporting at the event and Member C felt more comfortable and began to warm up to the idea of trying out more opportunities in the future.

Limited Engagement Moving Toward More Active Engagement ….

After their more positive second experience at a Social Opportunity they were a little more willing to consider other options with Community Choices. A month or so later, they and their family receive an email that Community Coaching sessions are opening for the quarter. They decide to sign up. Within a couple of weeks they have their first meeting with a Social Coach from the Connect Department. They spend a meeting getting to know each other and doing a few simple interviews to determine what type of goals and work they should undertake over the next nine weeks. Member C explains that they don't really know anyone who likes to fish (their favorite hobby) and also aren't very familiar with how to use their phone. Their Social Coach offers a dual goal of a) spending time building confidence with phone use, and b) looking into local fishing options, clubs, or groups. Member C agrees and they move forward. They decide to spend the first couple of sessions working on phone skills leaving a few minutes at the end to begin looking into fishing options. After a few weeks of working on phone use and communicating with their social coach and family to practice, they decide to spend the next couple of weeks focusing on Member C's fishing hobby. They start by meeting to look online for options. They find a few things with the park district, one meetup group and a message board about good fishing in the area. They make plans to visit these options in person in future weeks. Their social coach also encourages them to attend a few social opportunities and ask others there if they might also be interested in fishing. Member C does this, but doesn't meet anyone who knows much about fishing. There is one person who is curious and the Social Coach works with the Membership Coordinator to add a learn-to-fish event from the park district onto the next month's calendar. Member C is encouraged to reach out to the other curious members and encourage them to attend the fishing event. By the end of the 10 week session, Member C is feeling more confident with his phone and has used it to reach out to one other member. They decide to sign up for a second session where they will continue working on the fishing hobby - specifically on finding more people who are interested in doing this hobby together.

Active Family Member

Just like our members with disabilities, some families are more and less active. Parent A is more active. They come to most family support groups. At these meetings they come primarily to socialize, but generally end up asking questions to staff and other families about an issue they are having with social security, transportation, or some other service/support that they coordinate for their adult family member who lives with them. A few times a year they will call one of the staff they know the best and ask for some time to talk through a more acute issue they are dealing with. Within those conversations, the staff person has the chance to describe some of the opportunities that are coming up at Community Choices and explain how some of the other services in town work and who their first contact for that might be.

With the encouragement of their parents, Parent A's adult child (Member X) decides to sign up for a few various CC opportunities. They connect with another member (Member Y) at one of these and do some texting through facebook. It turns out that the parents of Member Y and X have also met each other at a CC event. This helps facilitate ongoing communication and gatherings between the families and friends.

<u>Less Active Family Member</u>
Parent B is less involved in the Community Choices coop. They have an adult son with autism who is not interested in taking part in group activities or being associated with a "support" organization. Parent B is looking for information on how to support their adult child, however, and is happy to be part of the Co-Op as a way to access additional resources. They typically read the newsletter and will occasionally respond to emails with questions about the various resources they are presenting. Once or twice a year they attend a family support group. They continue to renew their membership year after year. When staff reach out to see if they or their son would like to be engaged in other services, they say no, but that they appreciate the information that they get through their membership.

3. OPTIONAL: In what ways has the evaluation supported the current practice or changes in practice? What changes were made or are planned, based on findings?

We are continually evaluating and adjusting our programs based on the formal and informal feedback from our members. One noteworthy example of this in FY25 was some informal feedback we received during the spring from members who had not been able to sign up for social opportunities in multiple months because the spots were repeatedly full. In response we increased the number of monthly Social Opportunities from 4 to 6, starting in April 2025. Then will again increase the number of Social Opportunities from 6 to 8 per month starting in FY26.

We also changed the sign up process for Social Opportunities. Opening the sign-up for all Social Opportunities at the beginning of each month seemed to be allowing those who were able to sign up right away, sign up for every monthly opportunity, not leaving available spots for people who might not be able to access their email or the sign-up form immediately. In order to create more equal access, sign ups for social opportunities now open for each event on a rolling basis,

seven days before the actual event. This decreases the likelihood that a small number of members will fill all of the sign up spots at social opportunities.

Our formal evaluation at the end of the year supported these changes. 65% of members with disabilities participated in Connecting programming in FY25. This is down from 74% in FY24. There are multiple reasons why this percentage may have decreased. But so far informal feedback from our members has told us that we are addressing one cause that is within our control.

Annual Performance Outcome Report Form

In the Program Plan Narrative submitted with your application, you identified measures of Consumer Access, Consumer Outcomes, and Utilization. While Utilization data and comments have been captured in the quarterly service activity reports, Consumer Access and Consumer Outcome findings are reported only at the end of the program year. Download and complete this form and upload it to the online system reporting page, Performance Outcome Section.

Agency Name: Community Choices
Program Name: Staff Recruitment and Retention
Program Year: FY25

CONSUMER ACCESS

In the Program Plan Narrative, you identified eligibility criteria for the program's services, how those criteria are established, how the target population learns about the program, and expected timelines. Please comment on each area below.

1. YES/NO - Did the stated criteria serve the purpose of providing people the services/ supports they were seeking? If NO, comment on causes and possible solutions.

YES

2. YES/NO - Did the stated process for determining that the person and program were right for each other work well? If NO, comment on causes and possible solutions.

YES

3. YES/NO - Did the stated outreach activities support appropriate matches between people and program services? If NO, comment on causes and possible solutions.

YES

4. Compare year-end actual result with the application estimate of days from completed assessment to start of services. Comment on findings, especially if unexpected.

N/A

5. Compare the year-end result with the application estimate of % of eligible people who engaged in program services within the above timeframe. Comment on the finding.

We estimated that 100% of people would engage in the use of the bonuses within the 90 day timeframe of being hired and receiving the bonus.

For more applicable detail: We hired for 3 positions during FY25 and received a total of 42 applications. Of those three positions all received Sign-on bonuses within the anticipated timeline.

6. Compare year-end result with the application estimate of length of participant engagement. Especially if the result was unexpected, comment on this finding.

We estimated a goal of 3 years of employment or more.

Employees who were employed on 7/1/22 (3 years ago) and earlier and are still employed have an average of 7.8 years with Community Choices.

Taking all employees working at CC as of 7/1/2025 (end of the fiscal year) - our average length of employment is: 4.4 years.

Looking at all the employees who left during the two year period of this grant (7/1/23-6/30/25), the average length of their employment with CC was: 3.6 years.

7. If your program collected demographic information beyond the standard categories reported each quarter, comment on the data and what they suggest for the program.

We collect data on staff hire and termination dates, why they leave and information about any other jobs they've held in the DD Field.

We have consistently been able to hire individuals who have had significant experience in the DD field. Our staff longevity is also very strong.

We have a small staff so specific trends are difficult to identify, but available data indicates that staff have generally left to pursue higher paid employment or positions that better match their education or life goals.

CONSUMER OUTCOMES

In the Program Plan Narrative, you identified positive outcomes people would experience as a result of participating in the program. You also identified measurement tools and targets for each outcome. Include original information and comment on the actual results.

- Use (and expand) the space below to copy each numbered **Outcome** (expected program impact on participants) from your Program Plan. Include the specific **target** and add the **actual result**.
- For each outcome, list the specific **assessment tool** used to collect information. *If different from the tool indicated in the application, include a note explaining the change.*
- For each outcome, indicate the **source of information**, e.g. participant, participant's guardian(s), clinician/service provider, 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 #1: DSP COMPENSATION - 100% of CC Staff compensated at a rate that is equal or greater than the equivalent annual salary proposed by the Guidehouse rate study for DSPs in FY24 within the FY24 fiscal year ($19.50/hour, $40,560/annually).

ACTUAL: 100% of staff were paid at least the amount recommended by Guidehouse**.** The average employee salary was $45,366 with a range of $42,500 to $51,140.

ASSESSMENT: CC Budget & Accounting Systems

SOURCE: Personnel Records within the Accounting System

Outcome #2: RECRUITMENT - CC is able to fill all open staff positions within 60 days.

ACTUAL: CC was able to fill open positions in an average of 34 days.

ASSESSMENT: Job Posting Logs and Hire/Term Tracking Spreadsheet

SOURCE: Administrative records of job postings on Indeed and Admin Staff tracking document.

Outcome #3: RETENTION - At the end of FY24, CC's average length of employee service (for employees hired prior to FY24) remains greater than 4 years.

ACTUAL: Considering ALL CC Employees hired before FY25, the average length of their employment is 4.1 years. (This includes all previous and current employees)

ASSESSMENT: Employee hire and termination tracking sheet

SOURCE: Administrative Records and Recording

CONSUMER PARTICIPATION IN DATA COLLECTION

1. How many total participants did the program have? 19

For each of the following questions, if there are different responses per outcome, please identify the numbered outcome and the relevant detail.

2. If outcome information was NOT gathered from every participant, how did you choose who to collect outcome information from?

Data was collected for all participants/staff. For Outcome 1, we did not include Drivers into our average wage calculations. Because of the nature of their positions and their differing schedules from that of our office staff, their salary information would inappropriately skew the average. Data for this outcome included all Full Time Direct Support Office staff.

3. How many people did you *attempt* to collect outcome information from? 19
4. How many people did you *actually* collect outcome information from? 19
5. How often and when was this information collected? *(e.g. 1x a year in the spring; at client intake and discharge, etc)*

Data was collected during the recruitment period of jobs, when employees started or left positions.

Regular data was also collected quarterly for current employees receiving retention bonuses.

RESULTS

1. What did you learn about the participants and the program from this outcome information? *Be specific when discussing any change or outcome and give quantitative or descriptive information when possible. You might report: Means and, if possible, Standard Deviations; Change Over Time, if assessments occurred at multiple points; Comparisons, e.g., of different strategies related to recruitment, of rates of retention for clients of different ethnic or racial groups, or of characteristics of all clients engaged versus clients retained.*

OUTCOME 1: Pay Rates

This grant successfully supported us in exceeding the salary amount recommended in the Guidehouse Rate study for FY24. The Guidehouse rate study was a very important resource for us, and for the field overall, to create some benchmarks for DSP wage growth since it was shared in 2020. But as we mentioned in last year's outcome report, the 2024 median family income for a household of one in our area was approximately $74,000 according to the Department of Housing and Urban Development. When we compare this to the provided Guidehouse benchmarks, it's clear that we have a long way to go before we make direct support positions financially advantageous for many people looking to live a comfortable life.

Community Choices has always strived to pay a living wage, and historically been able to pay more than other similar jobs in the field. As inflation has risen and other providers have (happily) been able to pay more, our head start has greatly diminished. Because of this, the extra financial boost that this grant has provided for our staff is all the more important. Along with it, the issue of starting salaries and fair pay for long time employees continues to be an important discussion point for the CC board and leadership. We were pleased that we have been able to continue to raise pay rates generally and grow our starting salaries for incoming employees. This will continue to be a critical issue as we grow and navigate our quickly changing economic landscape.

OUTCOME 2: Recruitment

Community Choices has a very well qualified and committed workforce. We strive to continue our strong track record of excellent participant support and professionalism by hiring people who have experience in the field and understand the reasons behind our philosophy and method of support. This has sometimes meant that it can be difficult to find candidates who are a good fit, especially when pay rates at other comparable jobs in our area are similar to ours. The availability of sign-on bonuses are a way to communicate to potential employees both that the financial benefits of working here could be a favorable match for their needs, but also that we are an organization that values them as a worker and believes in generous practices. Last year, when we polled staff on their opinions about the availability of sign-on and recruitment bonuses, this was overwhelmingly the message we received. It was not just that the extra money was welcome, but that the money also communicated the organization's commitment to them and their value.

A concrete goal of this grant was to ensure that new staff could be hired in a timely manner to ensure that services to our participants were not impacted by turn-over or delays in new supports. We hired comparatively less people during FY25 than we did in FY24, when we began the Transportation program, so the raw numbers are more difficult to accurately compare. Our average of 34 days from job posting to start was a very positive trend overall and better than our average the previous year. I believe that our hiring bonuses were supportive in this outcome, but it also seemed that the trends of the hiring landscape overall shifted a bit this year.

Following the high pandemic, we observed job applicants as having somewhat of an "advantage" in the market. There were open positions across all fields and a massive shift in the economy that disrupted the routines, patterns, and formalities around hiring were. We found that this shake up had positive impacts on our Customized Employment department, where employers were more willing to be flexible and creative in their employment practices and hiring more people with I/DD, but for our own hiring, there were more challenges. During FY24 we saw many applications, but a comparatively smaller number of applicants who were responsive to communication, would provide cover letters, or even show up for planned interviews. During FY25, we saw this trend shift again. We remarked throughout the year that we had not had such a professional and responsive set of candidates since before the pandemic. It is difficult to tie this directly to our ability to offer sign-on bonuses, but it does underscore the

importance of looking at recruitment and hiring through a multifaceted lens - by reflecting on our internal values and processes as well as being observant of hiring trends in our area and in the economy overall.

OUTCOME 3: Retention

As was the case with the first year of this grant, our staff retention remains very high. There are many ways to look at this type of data since there are always some staff starting and others leaving. The most basic approach that we took to determine our 4.1 year average retention rate, was to look at all employees who had ever worked at Community Choices as long as they had been hired before FY25 and calculated their total length of employment. Another way to look at this would be to look at the average length of employment for people who had left. Looking at just these former employees, our average remains high at 3 years, especially considering this includes a few employees who ultimately were not good fits for their roles and chose not to stay very long.

Good staff retention has been a critical factor in Community Choices' success. With long term employees, we have been able to use our collective knowledge and experience to learn and adjust our services to best meet the needs of our participants and members without having to retrain new employees continually. We have been able to grow, because our staff have been able to grow along with the needs and priorities of the organization.

As we discussed last year, there are limits and barriers to our retention. With a small staff and a smaller number of true leadership positions, committed employees who would like to grow and be promoted into new roles do not have many opportunities. This is always going to be the nature of small organizations, but it is an issue we are taking seriously. While we always try to find projects and responsibilities for interested staff, we are hesitant to ask for additional labor from our employees without compensating them accordingly.

To address this, with our FY26/FY27 renewal of this grant, we added an additional opportunity of providing staff with bonuses for completing these additional projects, or taking on additional responsibilities. Our hope is that having access to both additional compensation and additional leadership responsibility may be another tool to keep our talented and long term employees happy, interested, and fairly paid.

2. OPTIONAL: Describe a typical service delivery case to illustrate the work. This may be a "composite case" that combines information from multiple actual cases.

N/A

3. OPTIONAL: In what ways has the evaluation supported the current practice or changes in practice? What changes were made or are planned, based on findings?

As noted above, and mentioned in last year's reports, this year we will be offering staff opportunities to use and grow their skills while meeting the needs of the organization through

additional leadership bonuses. We're excited to implement this new strategy for staff retention and eager to see if its non-hierarchical approach is a good fit for us. As an organization with cooperative values at its core, we are interested in finding more ways to incorporate these ideals into not just our support to participants, but to our employment practices as well.

Annual Performance Outcome Report Form

In the Program Plan Narrative submitted with your application, you identified measures of Consumer Access, Consumer Outcomes, and Utilization. While Utilization data and comments have been captured in the quarterly service activity reports, Consumer Access and Consumer Outcome findings are reported only at the end of the program year. Download and complete this form and upload it to the online system reporting page, Performance Outcome Section.

Agency Name: Community Choices Inc.
Program Name: Transportation Support
Program Year: FY25

CONSUMER ACCESS

In the Program Plan Narrative, you identified eligibility criteria for the program's services, how those criteria are established, how the target population learns about the program, and expected timelines. Please comment on each area below.

1. YES/NO - Did the stated criteria serve the purpose of providing people the services/ supports they were seeking? If NO, comment on causes and possible solutions.

YES

2. YES/NO - Did the stated process for determining that the person and program were right for each other work well? If NO, comment on causes and possible solutions.

YES

3. YES/NO - Did the stated outreach activities support appropriate matches between people and program services? If NO, comment on causes and possible solutions.

YES

We received many calls and referrals for our programs overall that started with questions about Transportation. Additionally, because we updated information in resource guides, 211, etc to include our transportation program, we received many calls from individuals who do not qualify for the service. Many individuals with physical disabilities, mental health disabilities, older residents, and people simply without the means to afford other transportation reached out to us about the service, underscoring the community-wide issue of transportation access.

4. Compare year-end actual result with the application estimate of days from completed assessment to start of services. Comment on findings, especially if unexpected.

Because we don't screen or assess eligibility in-house, we are somewhat at the mercy of the ISCs to return information about a person's PUNs status before we can move forward with services. This process has gotten better since Prairieland initially took over, but there are times when results are not immediate. Additionally, we are dependent on the individual providing us

with the information and releases needed to reach out to the ISCs. In general, this takes less than the 14 day estimate provided in the application.

Once we receive confirmation that a person meets the PUNS enrolment criteria, services can begin immediately.

5. Compare the year-end result with the application estimate of % of eligible people who engaged in program services within the above timeframe. Comment on the finding.

There is no waiting period to use Transportation services once a person completes their membership intake and eligibility is confirmed, so everyone has the opportunity to begin services immediately. Not all individuals choose to do this however. Looking at new members for FY25 (n=27), 16 or 59% began using transportation services within the same quarter as they initiated services. We do not know that all 27 individuals who joined the co-op in FY25 did so with the intent to use ride services. But given the high percentage of those individuals who quickly began using the transportation services, we feel that our methods indicate a streamlined and accessible process.

6. Compare year-end result with the application estimate of length of participant engagement. Especially if the result was unexpected, comment on this finding.

The nature of this program is episodic, so there is not a good way to measure a person's ongoing engagement with the program. Individuals can use the service once a year or nearly once per day. Looking at overall data, there were an average of 36 riders each month and on average they used 7.5 rides per month out of their available 16.

7. If your program collected demographic information beyond the standard categories reported each quarter, comment on the data and what they suggest for the program.

Beyond the basic demographic information required for all CCMHB/CCDDB programs, Community Choices also gathers the individual's RIN number, their PUNs eligibility, what type of medical insurance they have access to (Private Insurance, Medicare, Medicaid, etc), as well as information about involvement with other service providers to ensure supports are not duplicated. No meaningful analysis can be gleaned from this data other than that our members were all eligible for services.

CONSUMER OUTCOMES

In the Program Plan Narrative, you identified positive outcomes people would experience as a result of participating in the program. You also identified measurement tools and targets for each outcome. Include original information and comment on the actual results.

- Use (and expand) the space below to copy each numbered **Outcome** (expected program impact on participants) from your Program Plan. Include the specific **target** and add the **actual result**.
- For each outcome, list the specific **assessment tool** used to collect information. *If different from the tool indicated in the application, include a note explaining the change.*
- For each outcome, indicate the **source of information**, e.g. participant, participant's guardian(s), clinician/service provider, 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 #1: COMMUNITY ACCESS - 90% participants will report increased experiences of community access measures after each 3-month period of use:

a. **Feeling able to participate in life with family and friends**
   ACTUAL:
   27/33 (82%) Responses report this was BETTER with CC support.
   6/33 (18% Responses report this was THE SAME with CC Support
   0/33 (0%) Responses report this was WORSE with CC Support
b. **Able to maintain a job**
   ACTUAL:
   20/33 (61%) Responses report this was BETTER with CC support.
   13/33 (39% Responses report this was THE SAME with CC Support
   0/33 (0%) Responses report this was WORSE with CC Support
c. **Able to do things they are interested in**
   ACTUAL:
   31/33 (94%) Responses report this was BETTER with CC support.
   2/33 (6% Responses report this was THE SAME with CC Support
   0/33 (0%) Responses report this was WORSE with CC Support
d. **Able take care of basic errands and needs**
   ACTUAL:
   **Due to an error, this specific question was omitted from the evaluation survey. It will be corrected for FY26's survey.*

   Ride use data does indicate that participants used 113 rides to complete errands and basic tasks. This accounts for 4% of rides.

ASSESSMENT: Quarterly Transportation Survey

SOURCE: Participant Riders and the families of participant riders. 19 of 59 participants provided feedback at least once during the year.

Outcome #2: CONFIDENCE IN COMMUNITY & COMMUNITY TRAVEL - 80% of participants will report increased experiences of the following measures of community confidence after each 3-month period of use:

a. **Confidence/Comfort being in the community**

ACTUAL:

28/33 (85%) Responses report this was BETTER with CC support.
5/33 (15% Responses report this was THE SAME with CC Support
0/33 (0%) Responses report this was WORSE with CC Support

b. **Confidence/Comfort traveling in the community**

ACTUAL:

29/33 (88%) Responses report this was BETTER with CC support.
4/33 (12% Responses report this was THE SAME with CC Support
0/33 (0%) Responses report this was WORSE with CC Support

c. **Knowledge/Confidence using technology related to transportation**

ACTUAL:

18/33 (55%) Responses report this was BETTER with CC support.
15/33 (45% Responses report this was THE SAME with CC Support
0/33 (0%) Responses report this was WORSE with CC Support

d. **Parent comfort with family member traveling in the community**

ACTUAL:

Not enough parents specifically responded to provide good data on this outcome.

ASSESSMENT: Quarterly Transportation Survey

SOURCE: Participant Riders and the families of participant riders. 19 of 59 participants provided feedback at least once during the year.

Outcome #3: QUALITY OF LIFE - 90% of participants will report increased quality of life in the following areas after each 3-month period of use:

a. **Overall quality of life**

ACTUAL:

30/33 (91%) Responses report this was BETTER with CC support.
3/33 (3% Responses report this was THE SAME with CC Support
0/33 (0%) Responses report this was WORSE with CC Support

b. **Emotional wellbeing/stress**

ACTUAL:

28/33 (85%) Responses report this was BETTER with CC support.
5/33 (15% Responses report this was THE SAME with CC Support
0/33 (0%) Responses report this was WORSE with CC Support

c. **Feeling in control of one's life**

ACTUAL:
28/33 (85%) Responses report this was BETTER with CC support.
5/33 (15% Responses report this was THE SAME with CC Support
0/33 (0%) Responses report this was WORSE with CC Support

d. Feeling respected and equal to others

ACTUAL:
28/33 (85%) Responses report this was BETTER with CC support.
5/33 (15% Responses report this was THE SAME with CC Support
0/33 (0%) Responses report this was WORSE with CC Support

ASSESSMENT: Quarterly Transportation Survey

SOURCE: Participant Riders and the families of participant riders. 19 of 59 participants provided feedback at least once during the year.

CONSUMER PARTICIPATION IN DATA COLLECTION

1. How many total participants did the program have? 59

For each of the following questions, if there are different responses per outcome, please identify the numbered outcome and the relevant detail.

2. If outcome information was NOT gathered from every participant, how did you choose who to collect outcome information from?

We attempted to collect data from all participants and their families at different points throughout the year.

3. How many people did you *attempt* to collect outcome information from? 59 participants and 33 family members.
4. How many people did you *actually* collect outcome information from? We received 33 responses from 19 unique participants, overwhelmingly the individual using rides.

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

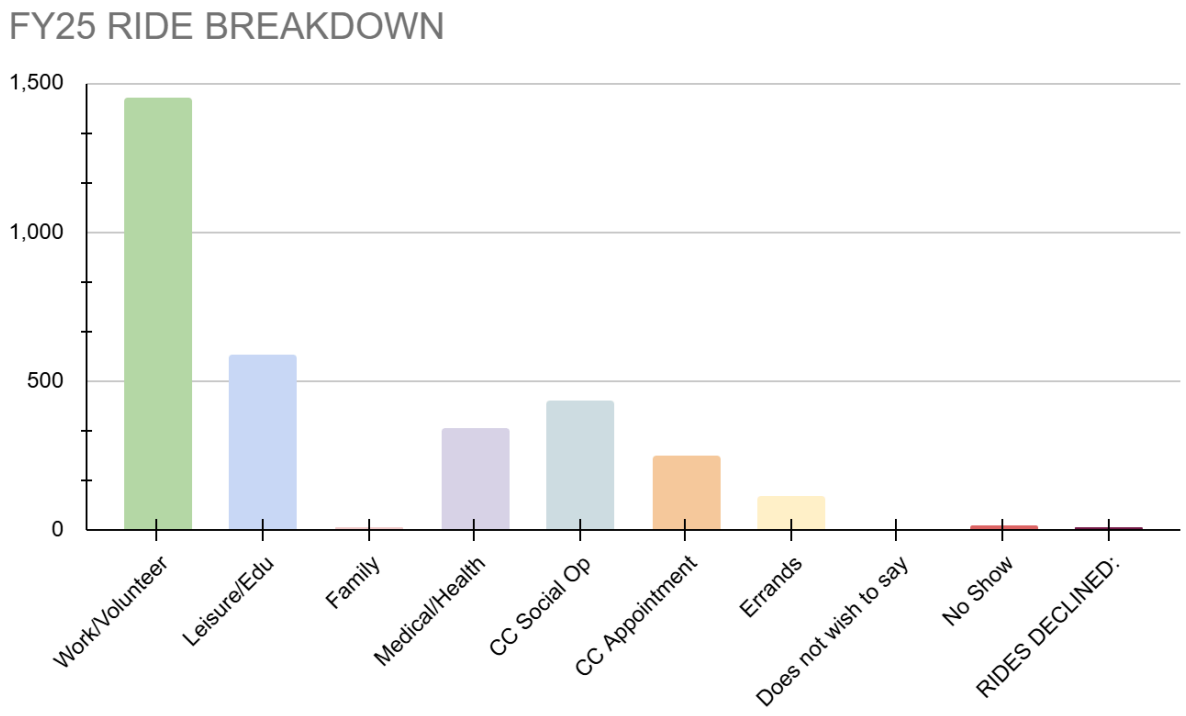
We attempted to collect data quarterly. Participation in the survey varied throughout the year.

RESULTS

1. What did you learn about the participants and the program from this outcome information? *Be specific when discussing any change or outcome and give quantitative or descriptive information when possible. You might report: Means and, if possible, Standard Deviations; Change Over Time, if assessments occurred at multiple points; Comparisons, e.g., of different strategies related to recruitment, of rates of retention for clients of different ethnic or racial groups, or of characteristics of all clients engaged versus clients retained.*

USEAGE:

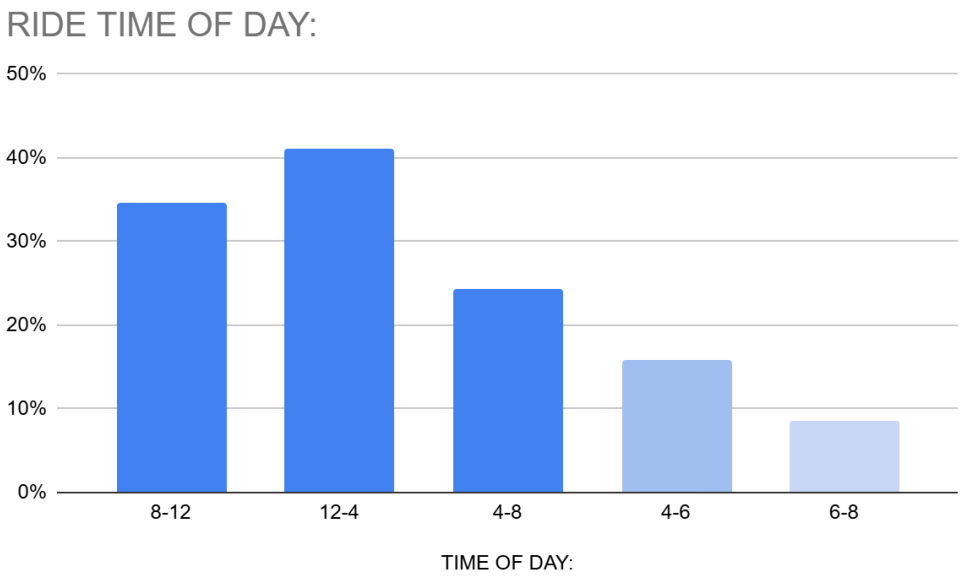
During this year, the 2nd of the program's existence, we provided 3207 rides to 59 individuals. This is 2.5x as many rides as we provided in the program's first year. The most common reason for rides continued to be for work and volunteering, with 1449 rides or 45%. This was followed by leisure or educational activities outside of Community Choices with 591 rides or 18%. An additional 437 rides (14%) were provided for participants to attend CC-organized social opportunities. As you can see in the chart below, rides were also provided for health and medical reasons, appointments with CC staff (such as for job development or classes), and for errands. While we did attempt to keep track of how many rides were requested and then declined due to driver availability, we found this number to be less distinct and har and thus less robust than the other data.



The program ran extremely smoothly this year. Many of the logistical issues had been worked out in the first year, and our members and participants were very comfortable with the various

systems we put in place for requests and communication. With the expansion of the Transportation Coordinator role into a full time position starting in July of 2024, we were able to increase the number of rides available to each person to 16 per month up from 12. With the coordinator's increased hours, they were able to cover additional rides that were requested when drivers were already booked and supported the program overall. This increase in rides was met with enthusiasm from members, though few of the program's participants actually used their full allotment each month. On average riders used about 7.5 rides each month with only 3-7 people using their full 16 rides on any given month. Over the course of the year, our ride frequency and general busyness also grew. For the first 6 months, we had an average 239 rides each month. For the second half, this average increased to 296 or a 24% jump.

We also looked at the time of day that participants are using rides. The 8am-4pm period remains consistently our most busy period. The overall breakdown of rides did even out a bit compared to last year, but the later hours of the evening shift continued to be the least used period of our coverage. We also began offering more social opportunities overall and more in the evenings specifically. This may account for some of the shift later in our ride time distribution. This data supported our choice to add another daytime driver to the schedule for FY26.



We surveyed our membership overall and asked people who had not used the service for the reasons. The most common reasons were cited as using the MTD public bus and ADA service systems, and walking, biking, and looking to family and friends for rides. Only one respondent indicated that the hours of the program did not align with their family's needs.

OUTCOMES OVERALL:

Once again, quantitative and anecdotal data indicates that this program is very successful in achieving the outcomes we've laid out for it and addressing a substantial barrier in the lives of people with I/DD. When given the opportunity to share their general feedback about the program here are some examples of the comments we received [identifying details redacted or shortened]:

"We appreciate this service so much. It encourages J to be more independent and confident. He is more involved in planning transportation now and even open to possibly using ADA bus in the future."

"A feels very independent being able to use the transportation program to get home after his volunteer job at _____. He is always proud of himself when I get home later and ask about his day that he was able to get home with support."

"C is so excited for the independence of Community Choices rides. He feels safe with drivers and looks forward to what he is able to do each month because of the service. Thank you!"

"An amazing program with professional staff that care!"

Negative feedback was nearly non-existent this year. There were a few comments from people requesting more rides, earlier or later hours, rides on weekends, or comments on wanting last minute rides. These were generally combined with notes about their excitement and positive experiences with the program. Given the small size of our staff and administrative structure, at this time, those types of changes to the program are beyond our current capacity.

OUTCOME 1: **COMMUNITY ACCESS**

We achieved our goal for this outcome in one of the four sub-indicators areas - The Ability to do things one is interested in, with 94% of the respondents citing that this was increased with the use of our Transportation Program. Of all of these sub-indicators, we consider this one to be the most fundamental and one of the core goals of our program. We know that people with I/DD often have limited access to the community and to participate in the types of activities and experiences that they would like. Knowing that our program has allowed 94% of participants to have better access to the things they are interested in means that their daily choices are more self-determined, which is one of the key elements of our philosophy of support.

Responses about transportation's impact on work and life with family and friends were more varied. Only 61% of participants indicated that it supported them to maintain a job. This was an interesting statistic, especially given the overwhelming majority of rides that are devoted to giving participants rides to work. It could be that while the program is supportive in this way, it is not the core piece of what is helping them keep their jobs. This may be because they are very committed to their positions and know that they would get there with other means if needed. It is also possible that data was skewed by the people who used the service for something other than work.

Responses regarding the program's impact on life with family and friends were 82% positive. This corresponds well with ride data that shows rides for leisure and social experiences were the next two most common uses after rides to work. Unlike work, trips to see friends, or to fun events in the community are much easier to decline due to lack of transportation compared to a shift at work, which often takes priority. This could account for the difference in responses compared to this previously discussed work sub-category.

OUTCOME 2: **CONFIDENCE IN COMMUNITY & COMMUNITY TRAVEL**

When we started this program, we gathered a lot of data and input from our members about what made transportation with current community resources challenging. A lot of the feedback revolved around fear and a sense that travel in the community was dangerous or vulnerable. This was not surprising. We hoped that by providing our members with a safe, reliable, and consistent way to get into the community, that the fear around community travel overall might decline.

Data overall supports our hypothesis. Respondents rated their confidence and comfort with *being* in the community and *traveling* in the community at 85% and 88% respectively, better with CC support. These data were very close to our goal. It's difficult to say why more people didn't respond this way, but it could simply be that some individuals were already very comfortable and confident while being in the community. This would align with our anecdotal knowledge of the people who use the program most frequently, who we know to be very confident members of the community.

One area where our responses were well below our goal, was the sub-category of Knowledge and Confidence using technology related to transportation. Our intention with this program was never to be the one travel resource for our members. We always wanted part of the goal to be to encourage people to understand and use the many community transport resources available, such as MTD, Uber, Lyft, etc. We have consistently offered the opportunity for 1:1 coaching sessions with our Transportation Coordinator to support both participants with I/DD and their families to learn more about transportation resources and ways they could support their particular situations. As with the first year of this program, very few people were interested in accessing this element of the program, so a lower positive response rate for this data point is not surprising.

We did anticipate this going into year 2 of the program and decided to try a group-approach to this educational program element. During the spring, we offered four Transportation workshops which were open to members and their families. Each session was offered twice, once in person in the evening and once during the lunch hour over zoom. Topics included learning more about the MTD apps, Uber and Lyft features for safety, and common misconceptions about community travel. We did get a few participants in these sessions, though attendance was not as high as we'd hoped.

Going into year 3 of the program, we decided we'll be trying yet a different method. Starting in FY26, we'll be asking all program participants to complete a Transportation Orientation prior to beginning their ride use. As part of this, the Transportation Coordinator will sit down with the person and get a sense of their overall travel needs and help them to learn more about additional resources and technology that could be useful. If they are interested or needed, 1:1 coaching sessions on these resources will be available. We're hopeful that this will be a better approach to greater success with this facet of the program.

OUTCOME 3: **QUALITY OF LIFE**

Of all our evaluation data, this outcome received the most consistently positive evaluation feedback with 91% of respondents reporting that our Transportation program improved their quality of life. The more nuanced questions relating to stress and wellbeing, feeling in control of one's own life, and feeling respected also all received very positive feedback (85%, 85%, and 85%, respectively).

Like Outcome 1, this was another core goal of this program. By nature, many of our programs and supports are asking our members and participants to push themselves and work on goals

and life outcomes that are hard and uncomfortable. With our transportation services, we wanted to do something different as a counterpoint to the difficult work we are asking of people. We wanted to create a simple support that just made things easier by offering a dignified way to show up in the world. Data for this outcome indicate that this effort has been successful.

We are thrilled to see these types of responses. In a time when so many things are getting more complicated, more difficult, and less accessible, and when we are expecting more of those barriers in the coming years, we are gratified to know that we have been able to offer something that may help to balance out some of those barriers and improve lives.

2. OPTIONAL: Describe a typical service delivery case to illustrate the work. This may be a "composite case" that combines information from multiple actual cases.

How does our transportation program work?

If one of our members wants a ride, they have a few different methods to make that request. There is a google form that they can fill out that gives the option to schedule multiple different types of rides:

- A 1-Way Ride (a single trip to a destination)
- A roundtrip ride (less than 15 minutes at the destination)
- A multi-way ride (more than 15 minutes at the destination)
- A repeating ride (a ride that happens on a regular schedule)
- A flexible ride (a ride that has flexible pick-up or drop-off times)

Members are also able to call the coordinator, text, or email. While we don't keep data on how people make reservations, anecdotally, we can confirm that our members regularly use all these methods to request their rides.

Requests must be in by 1pm the day prior to the ride. Rides can also be made ahead of time. We open reservations for the upcoming month on the 15th of the current month. Many people who have recurring rides take advantage of this feature.

Once a request comes in, the Coordinator looks it over and adds it to the shared google calendar that we use to communicate the schedule and locations of the rides to our drivers. Rides are not considered scheduled until the Coordinator sends a confirmation email to the rider or their contact person.

When a ride has been added to the calendar, it will include in the subject the pick up time and the individual's first name. All drivers can see the calendar. The body of the calendar event will list the following information:

- The person's name
- Their contact info

- The pick up location which has been linked to a google map of the place.
- The drop off location, also linked to google maps
- How we should notify the rider that the driver has arrived (the person can choose a call, text, or knock on the door)
- If we should notify a contact person when the person has reached their destination. If so, we'll include that person's name and phone number for the driver to call with that confirmation.
- Any other pertinent information, for example: *This person uses a walker which you will need to assist with folding up and storing* or *This is Person's first day at their new job*, etc.

The afternoon before a ride, the Coordinator will send out a reminder to the rider and their contact person, if they wish to be included. This email will include all the information included above and the drivers name, phone number and the type of car they're driving. For some of our members who are avid users of online calendars, we can also send them an invite to their ride so it shows up automatically on their personal calendar.

At times, someone will make a request that cannot be honored. This happens most frequently when someone requests a ride when we are already booked. If this happens we do our best to accommodate them. If possible, we may schedule a group ride if it is agreeable to both riders and works with the timeline, or we'll suggest another time when the schedule is open if the ride is not time sensitive.

For our Social Opportunities, the process is slightly different. We use Sign-Up Genius for all our Social Op RSVPs. For each event, there are a limited number of ride sign-ups. If someone wishes to book a ride for these events, they need to do so using sign-up genius. These rides, unlike most other rides, are with a group. In the days leading up to the event, the Coordinator will reach out to the group of riders to let them know when their specific pick up time is expected.

3. OPTIONAL: In what ways has the evaluation supported the current practice or changes in practice? What changes were made or are planned, based on findings?

We have used evaluation in many ways to develop, shape, and hone this program. As discussed in year 1's report, we did extensive surveys and data gathering before fully designing and initiating the service. We got feedback on what barriers to transportation people experienced, what issues caused them the greatest amount of distress or discomfort in transportation, and what features would make a transportation service most accessible to them. We then designed and piloted the program extensively using this feedback.

During the 1st year, we held several program info sessions and shared our plan, listened to questions, and used this to further adjust the program into something that would work well for our particular users.

Since the initial implementation, we've continued to look at evaluation data to make small adjustments and to plan for the future of the program. Going into FY26, we looked especially at trends in the ride usage to determine that we needed to expand capacity to avoid turning away many riders. We also surveyed our entire membership to get feedback on what they had been using rides for, and if they hadn't been using the service, the reasons they had not. Additionally, we asked questions about potential expansions of the program for the future, such as if people would use rides at different times or days, if they needed accessible vehicles. While we are not in a place to add these expanded services currently, keeping a good pulse on the needs of our members and community remains an important element of our work and our structure as a cooperative.

Annual Performance Outcome Report Form

In the Program Plan Narrative submitted with your application, you identified measures of Consumer Access, Consumer Outcomes, and Utilization. While Utilization data and comments have been captured in the quarterly service activity reports, Consumer Access and Consumer Outcome findings are reported only at the end of the program year. Download and complete this form and upload it to the online system reporting page, Performance Outcome Section.

Agency Name: **DSC**
Program Name: **Clinical Services**
Program Year: **2025**

CONSUMER ACCESS

In the Program Plan Narrative, you identified eligibility criteria for the program's services, how those criteria are established, how the target population learns about the program, and expected timelines. Please comment on each area below.

1. YES/NO - Did the stated criteria serve the purpose of providing people the services/ supports they were seeking? If NO, comment on causes and possible solutions.

Yes

2. YES/NO - Did the stated process for determining that the person and program were right for each other work well? If NO, comment on causes and possible solutions.

Yes

3. YES/NO - Did the stated outreach activities support appropriate matches between people and program services? If NO, comment on causes and possible solutions.

Yes

4. Compare year-end actual result with the application estimate of days from completed assessment to start of services. Comment on findings, especially if unexpected.

Once determined to need Clinical Services, 27/29 individuals started services within 30 days.

5. Compare the year-end result with the application estimate of % of eligible people who engaged in program services within the above timeframe. Comment on the finding.

93% engaged within the designated time frame. Two individuals required more than 30 days to engage in services due to an unexpected medical issue for the clinical consultant, which resulted in a pause in services for a couple of weeks.

6. Compare year-end result with the application estimate of length of participant engagement. Especially if the result was unexpected, comment on this finding.

Services are maintained as needed. During this fiscal year, Clinical Services served a total of 76 individuals for a combination of psychiatry, counseling, occupational therapy, and psychological services. 19 individuals were closed from Clinical Services due to having their psychological evaluation completed, started receiving psychiatry or counseling services at another community location, or had no further follow up needs for continued occupational therapy intervention.

7. If your program collected demographic information beyond the standard categories reported each quarter, comment on the data and what they suggest for the program.

In addition to standard demographics, disability and referral source information was also collected. Of the screening contacts for this year, referral sources included DSC team members, families, and individuals requesting services. Disability data continues to highlight that many of the individuals supported, especially in the psychiatric practice, deal with multiple mental health diagnoses in addition to their developmental disability.

CONSUMER OUTCOMES

In the Program Plan Narrative, you identified positive outcomes people would experience as a result of participating in the program. You also identified measurement tools and targets for each outcome. Include original information and comment on the actual results.

- Use (and expand) the space below to copy each numbered **Outcome** (expected program impact on participants) from your Program Plan. Include the specific **target** and add the **actual result**.
- For each outcome, list the specific **assessment tool** used to collect information. *If different from the tool indicated in the application, include a note explaining the change.*
- For each outcome, indicate the **source of information**, e.g., participant, participant's guardian(s), clinician/service provider, 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 #1 - Clinical Coordinator will conduct quarterly reviews regarding the assessment, progress, and frequency of appointments for all people receiving counseling support.
Target was 100%.
Results: 100%. Contracted counselors submit quarterly reports regarding progress and recommendations. The Clinical Coordinator reviews these. In addition to the quarterly reports, communication between the Clinical Coordinator and counselors is ongoing as needs arise.

Outcome #2- DSC Psychiatric Practice will review patient progress on a regular basis and attempt to reduce the number and dosage of psychotropic medications when deemed clinically appropriate and document such attempts in the psychiatric notes.
Target was 100%.
Results: 100%. Psychiatric notes reflect overall progress with therapeutic goals, medication administration, and medication changes. Reduction in amount and dosage of psychotropic medications discussed with the individual and their team as well as reflected in the documentation. Five individuals in the psychiatry practice had medication reductions this fiscal year.

Outcome #3- Clinical Manager will conduct annual individual self-assessments regarding effectiveness of clinical services on the person's overall sense of wellbeing. Assessment was created using resources from Evaluation Capacity Building Team online measure bank. Target of 80% of the responses will have a rating of four or higher.
Results: 36 Clinical Wellbeing Assessments were distributed to those who were actively involved in the psychiatry or counseling services. 17 assessments were returned. 82% of those returned had a rating of four or higher indicating satisfaction in their counseling and/or psychiatric services and an overall sense of positive wellbeing.

Assessments utilized in Clinical Services in FY25:
Wechsler Adult Intelligence Scale (WAIS)- Psychologist
Abnormal Involuntary Movement Scale (AIMS) – Psychiatrist
Adult Sensory Profile – Occupational Therapist
Sensory Integration Inventory- Occupational Therapist
Mental Status Assessment – Psychiatrist
Clinical Wellbeing Assessment – Clinical Coordinator

Utilization Targets and Results:

- Treatment Plan Clients: Target of 59. **69 were served in FY25**
- Non-Treatment Plan Clients: Target of six. **7 were served in FY25**
- Service Contacts: Target of 10. **Exceeded at 32.**
- Community Service Events: Target of two. **Two completed.**

CONSUMER PARTICIPATION IN DATA COLLECTION

1. How many total participants did the program have? **76**

For each of the following questions, if there are different responses per outcome, please identify the numbered outcome and the relevant detail.

2. If outcome information was NOT gathered from every participant, how did you choose who to collect outcome information from?

Outcome 1- All counseling participants
Outcome 2- All psychiatry participants

Outcome 3- Collected information from a random sample of those receiving psychiatric and/or counseling services. Did not assess individuals that were opened for psychological evaluations or occupational therapy only since their overall wellbeing may not be impacted merely by an evaluation.

3. How many people did you *attempt* to collect outcome information from**?**
Outcome 1: 33 people
Outcome 2: 24 people
Outcome 3: 36 people

4. How many people did you *actually* collect outcome information from?
Outcome 1: 33
Outcome 2: 24 people
Outcome 3: 17 people

5. How often and when was this information collected? *(e.g., 1x a year in the spring; at client intake and discharge, etc.)*
Outcome 1- quarterly
Outcome 2- at each appointment, minimum quarterly
Outcome 3 – sent out assessment during 4th quarter to a random sample of those actively engaged in psychiatric and/or counseling services.

RESULTS

1. What did you learn about the participants and the program from this outcome information? *Be specific when discussing any change or outcome and give quantitative or descriptive information when possible. You might report: Means and, if possible, Standard Deviations; Change Over Time, if assessments occurred at multiple points; Comparisons, e.g., of different strategies related to recruitment, of rates of retention for clients of different ethnic or racial groups, or of characteristics of all clients engaged versus clients retained.*

In terms of counseling and psychiatry, outcome tracking through quarterly reports and progress notes has proven effective in identifying individual needs, common struggles, and a steady pace of improvement for most individuals engaged in clinical services. The referral process continues to expose significant gaps in community resources, particularly the shortage of providers who accept Medicaid and the lengthy wait times for appointments. Additionally, there is a pressing need for more specialized training among providers to better address co-occurring intellectual/developmental disabilities (I/DD) and mental health diagnoses. A more team-centered approach would also be beneficial, as local provider documentation often inaccurately reflects individuals as "doing fine," despite the DSC team's deeper understanding of their needs. Health advocates are communicating concerns to medical and mental health professionals, yet they still encounter barriers to securing appropriate support. Data from the overall wellbeing survey indicates that many individuals

and their families report a sense of satisfaction and wellbeing with their clinical services provider.

OPTIONAL: Describe a typical service delivery case to illustrate the work. This may be a "composite case" that combines information from multiple actual cases.

The DSC Clinical Services program delivers individualized mental health support designed to promote overall wellbeing for each participant. Services are tailored to meet unique needs, whether through counseling, psychiatry, occupational therapy, or a combination.

One recent success story illustrates the program's effectiveness and collaborative approach. A participant began exhibiting escalating aggressive behaviors toward staff, peers, and even family members, with incidents occurring both at home and in community settings. The DSC team had multiple meetings to explore environmental modifications and proactive behavioral strategies. During discussions with the participant's family, it became clear that recent changes at home and in the day program were contributing to increased anxiety. The family had been relying on a general physician for support but had not yet accessed psychiatric care. Recognizing the urgency, the Clinical Coordinator contacted multiple area psychiatrists, only to find wait times ranging from four to six months. With DSC's contracted psychiatrist, the participant was seen within 21 days. Following a comprehensive evaluation, medication adjustments were made, the Occupational Therapist completed a sensory assessment to decipher true behavioral issues vs. sensory needs, and the DSP Support Specialist collaborated with the day program team to implement a positive behavioral support strategy aimed at de-escalating anxiety early. This integrated approach led to a marked reduction in maladaptive behaviors and the complete cessation of major physical aggression. The participant now is engaging positively with peers, staff, and family. Support remains in place to ensure continuity of care as the individual plans to transition to a community residential setting in a few months. This case exemplifies the program's commitment to timely, team-based, and person-centered care that makes a meaningful difference in the lives of those served.

2. OPTIONAL: In what ways has the evaluation supported the current practice or changes in practice? What changes were made or are planned, based on findings?

Annual Performance Outcome Report Form

In the Program Plan Narrative submitted with your application, you identified measures of Consumer Access, Consumer Outcomes, and Utilization. While Utilization data and comments have been captured in the quarterly service activity reports, Consumer Access and Consumer Outcome findings are reported only at the end of the program year. Download and complete this form and upload it to the online system reporting page, Performance Outcome Section.

Agency Name: **DSC**

Program Name: **Community Employment**

Program Year: **2025**

CONSUMER ACCESS

In the Program Plan Narrative, you identified eligibility criteria for the program's services, how those criteria are established, how the target population learns about the program, and expected timelines. Please comment on each area below.

1. YES/NO - Did the stated criteria serve the purpose of providing people the services/ supports they were seeking? If NO, comment on causes and possible solutions.

Yes

2. YES/NO - Did the stated process for determining that the person and program were right for each other work well? If NO, comment on causes and possible solutions.

Yes

3. YES/NO - Did the stated outreach activities support appropriate matches between people and program services? If NO, comment on causes and possible solutions.

Yes

4. Compare year-end actual result with the application estimate of days from completed assessment to start of services. Comment on findings, especially if unexpected.

The estimate of days from completed assessment to start of services was 45 days in the application. All of the people new to the program in FY25 opened within 45 days of presentation to the Admissions Committee.

5. Compare the year-end result with the application estimate of % of eligible people who engaged in program services within the above timeframe. Comment on the finding.

Application estimated 75% of people would engage in services within 45 days and this was achieved with 100% engaging within that time frame.

6. Compare year-end result with the application estimate of length of participant engagement. Especially if the result was unexpected, comment on this finding.

Job coaching support is available for as long as necessary to help individuals maintain their employment. This fiscal year, nine participants exited the program: Five opted out of community employment, one retired, one relocated, one no longer required job support, and one passed away.

7. If your program collected demographic information beyond the standard categories reported each quarter, comment on the data and what they suggest for the program.

Over 75% of the participants have an intellectual disability with approximately 15% also having a diagnosed mental illness. Approximately 18% have a diagnosis of autism. Referrals to the program are from individuals, families, schools, community agencies, the ISC, and DRS.

CONSUMER OUTCOMES

In the Program Plan Narrative, you identified positive outcomes people would experience as a result of participating in the program. You also identified measurement tools and targets for each outcome. Include original information and comment on the actual results.

- Use (and expand) the space below to copy each numbered **Outcome** (expected program impact on participants) from your Program Plan. Include the specific **target** and add the **actual result**.
- For each outcome, list the specific **assessment tool** used to collect information. *If different from the tool indicated in the application, include a note explaining the change.*
- For each outcome, indicate the **source of information**, e.g., participant, participant's guardian(s), clinician/service provider, 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 #1
26 people will participate in job development activities including discovery, volunteering, and supported employment.
An Employment Specialist is assigned and monthly progress is documented. Direct service hours are documented in the CCDDB direct service hour database.
Results: 25 individuals participated in job development activities.

Outcome #2
80% of people will maintain employment.
This information is maintained in a database and monthly progress is documented via the Employment Specialist.
Results: In FY25, this outcome was surpassed, with 84% of the program participants maintaining their employment.

Outcome #3
Ninety percent of people who return the satisfaction survey will be satisfied with their Community Employment services.
Results: This outcome was met with 100% of people indicating they are satisfied with their support through Community Employment.

Utilization Targets and Results:

- Treatment Plan Clients with target of 88: **Exceeded with 90 people receiving employment support during the fiscal year.**
- Service Contacts with a target of 10: **There were nine service contacts in FY25.**
- Community Service Events with a target of two: **There were two CSEs this FY.**

CONSUMER PARTICIPATION IN DATA COLLECTION

1. How many total participants did the program have? ___**90**_____

For each of the following questions, if there are different responses per outcome, please identify the numbered outcome and the relevant detail.

2. If outcome information was NOT gathered from every participant, how did you choose who to collect outcome information from?

Outcome information for #1 and #2 was gathered from all program participants. For #3 a sample was chosen to receive satisfaction surveys.

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

All for Outcomes #1 and #2. 25 for Outcome #3.

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

All for Outcomes 1 and 2. For Outcome 3, only five people returned completed satisfaction surveys that receive CE services.

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

Outcome information is gathered monthly and included in a quarterly report. Satisfaction Surveys are distributed in the fourth quarter.

RESULTS

1. What did you learn about the participants and the program from this outcome information? *Be specific when discussing any change or outcome and give quantitative or descriptive information when possible. You might report: Means and, if possible, Standard Deviations; Change Over Time, if assessments occurred at multiple points; Comparisons, e.g., of*

different strategies related to recruitment, of rates of retention for clients of different ethnic or racial groups, or of characteristics of all clients engaged versus clients retained.

Community Employment serves a diverse group of individuals throughout the community who enjoy a variety of jobs, many of whom have been working for many years. There are some individuals we serve who are satisfied with their job and they are supported to remain stable in these positions. Skills like maintaining healthy relationships with coworkers, working shifts scheduled, and using technology to access employment platforms are developed and applied.

Several individuals are re-entering the job market after being employed at one place for many years or may have never had a job in the community. After gaining valuable job skills through other work experiences, job development activities, and often times volunteering, these individuals are ready to make a change. Employment Specialists (ES) work with these individuals to learn what areas of the job sector interest them most, design resumes, and build solid interview skills. Individuals have been successful in landing jobs and becoming employed in areas of their choosing.

This year, the satisfaction survey was distributed electronically, which did generate responses, but not as many as we had hoped. To increase participation in future surveys, we plan to offer multiple modes of access, ensuring that everyone has a convenient way to share their feedback. Of the responses that were returned individuals in CE indicated they are satisfied with their services and feel respected and supported by their CE staff.

2. OPTIONAL: Describe a typical service delivery case to illustrate the work. This may be a "composite case" that combines information from multiple actual cases.

Traditional Community Employment:
Sally, a recent high school graduate, has always exceeded every goal she has set for herself. She has accomplished her dreams of being on stage, becoming a pageant queen, and has even marched in a parade. There has, however, been one thing on her list that she had not yet accomplished, and that was finding a job. She had been working towards this goal for over a year with no leads, before advocating for herself by requesting a job developer for support. She was quickly paired with a DSC Employment Specialist and together, they worked on interview skills, resume building, and even how to ask for accommodations. Sally and her job developer searched throughout the community for the perfect job, and within a couple of months, received her first ever job offer at a local sports outfitter. Her primary role is to greet customers with her warm and welcoming personality, and she has even learned to run a cash register! She has strong natural supports in the workplace along with assistance from her community employment staff.

Supported Employment:
After a few months of settling into his daily routine, Atlas accepted the offer of a week-long trial at one of the supported employment sites where a few of his friends also worked. His trial sessions were added to his picture schedule, and he was provided with visual checklists of specific cleaning tasks throughout the period. His Employment Specialist recognized that Atlas needed some additional support to remain focused on a few of his tasks, so he also broke down the visual steps into time increments and set timers for each step. With the introduction of these tools, Atlas demonstrated greater attention to detail, increasingly longer work periods, and real pride in his accomplishments. He also provided feedback to his Employment Specialist about each task and by the end of the trial he decided that he wanted to become a permanent member of the crew with his assignment being floor maintenance. In addition to the gratification of a job well done and the camaraderie he displayed with his crew members and Employment Specialist, Atlas also displayed obvious delight in receiving a paycheck for first time in his life.

3. OPTIONAL: In what ways has the evaluation supported the current practice or changes in practice? What changes were made or are planned, based on findings? **N/A**

Annual Performance Outcome Report Form

In the Program Plan Narrative submitted with your application, you identified measures of Consumer Access, Consumer Outcomes, and Utilization. While Utilization data and comments have been captured in the quarterly service activity reports, Consumer Access and Consumer Outcome findings are reported only at the end of the program year. Download and complete this form and upload it to the online system reporting page, Performance Outcome Section.

Agency Name: **DSC**

Program Name: **Community First**

Program Year: **2025**

CONSUMER ACCESS

In the Program Plan Narrative, you identified eligibility criteria for the program's services, how those criteria are established, how the target population learns about the program, and expected timelines. Please comment on each area below.

1. YES/NO - Did the stated criteria serve the purpose of providing people the services/ supports they were seeking? If NO, comment on causes and possible solutions.

Yes

2. YES/NO - Did the stated process for determining that the person and program were right for each other work well? If NO, comment on causes and possible solutions.

Yes

3. YES/NO - Did the stated outreach activities support appropriate matches between people and program services? If NO, comment on causes and possible solutions.

Yes

4. Compare year-end actual result with the application estimate of days from completed assessment to start of services. Comment on findings, especially if unexpected.

The estimated length of time from assessment to engagement in services was 90 days in the application. All 14 people opened in the program in FY25 were within this time frame.

5. Compare the year-end result with the application estimate of % of eligible people who engaged in program services within the above timeframe. Comment on the finding.

100% of eligible people engaged in program services within the target timeframe of 90 days.

6. Compare year-end result with the application estimate of length of participant engagement. Especially if the result was unexpected, comment on this finding.

People participate in the program until they no longer have an interest or need for services. In FY25, eleven participants exited the program: six were not interested in the current group opportunities and five received state funding for day program services.

7. If your program collected demographic information beyond the standard categories reported each quarter, comment on the data and what they suggest for the program.

90% of the participants have an intellectual disability with 10% also having a diagnosed mental illness. Approximately 31% have a diagnosis of autism. Referrals to the program are generally from individuals, families, schools, community agencies, and the ISC.

CONSUMER OUTCOMES

In the Program Plan Narrative, you identified positive outcomes people would experience as a result of participating in the program. You also identified measurement tools and targets for each outcome. Include original information and comment on the actual results.

- Use (and expand) the space below to copy each numbered **Outcome** (expected program impact on participants) from your Program Plan. Include the specific **target** and add the **actual result**.
- For each outcome, list the specific **assessment tool** used to collect information. *If different from the tool indicated in the application, include a note explaining the change.*
- For each outcome, indicate the **source of information**, e.g. participant, participant's guardian(s), clinician/service provider, 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 #1
80% of participants will be satisfied with chosen activities.
The CF Program Manager will maintain survey results as each series of groups end.
Results: 100% of participants stated they were satisfied with their chosen activities at the end of each group series.

Outcome #2
Five new groups will be developed based on participant feedback. The program manager will maintain a list of new opportunities that result from surveying participants.
Results: Ten new groups were developed based on expressed interests of surveyed participants.

Utilization Targets and Results:

- Treatment Plan Clients: Target of 45. **59 people received support this fiscal year.**
- Non-treatment Plan Clients: Target of 45. **Over the fiscal year, the program supported 134 non-treatment plan clients.**

- Service Contacts: Target of six. **Thirteen were completed.**
- Community Service Events: **Target of two met.**

CONSUMER PARTICIPATION IN DATA COLLECTION

1. How many total participants did the program have? ____**59**_____

For each of the following questions, if there are different responses per outcome, please identify the numbered outcome and the relevant detail.

2. If outcome information was NOT gathered from every participant, how did you choose who to collect outcome information from? **Outcome information is gathered from every participants.**
3. How many people did you *attempt* to collect outcome information from? ___**all**_____
4. How many people did you *actually* collect outcome information from? ___**all**_____
5. How often and when was this information collected? *(e.g. 1x a year in the spring; at client intake and discharge, etc.)* **Quarterly**

RESULTS

1. What did you learn about the participants and the program from this outcome information? *Be specific when discussing any change or outcome and give quantitative or descriptive information when possible. You might report: Means and, if possible, Standard Deviations; Change Over Time, if assessments occurred at multiple points; Comparisons, e.g., of different strategies related to recruitment, of rates of retention for clients of different ethnic or racial groups, or of characteristics of all clients engaged versus clients retained.*

Participants are overall satisfied with the group offerings and are enjoying repeated options as well as new group opportunities. Relationships amongst newer participants continue to strengthen. They often collaborate in expressing their requests for new groups.

2. OPTIONAL: Describe a typical service delivery case to illustrate the work. This may be a "composite case" that combines information from multiple actual cases.

Jeremy is a recent high school graduate who wanted to explore work and recreational opportunities post-graduation. His single mother also wanted these options for him, but more practically, wanted consistency in his routine, social connections, continued supervision throughout his day due to his inability to self-direct/remain safe, and maintenance of her own employment. Living in rural Champaign County, Jeremy also needed door-to-door transportation services. Jeremy joined the Community First (CF) program where he had some

initial transition issues reflected by his repetitive questioning about going home on the bus, leaving his group to hide out in the restroom, and periodic pounding on furniture.
As with many new participants, CF scheduled a Speech Evaluation and an OT Evaluation for Jeremy, along with the completion of an Interest Inventory. Based on observations and results of these assessments, CF developed: a picture schedule that included daily activities noting departure time, along with built-in restroom and proprioceptive/vestibular breaks; visual social stories; and a new On-The-Go group for same-age guys to explore C-U that included volunteering at the Eastern Illinois Foodbank. With these supports and consistent staff guidance Jeremy began making connections with friends, became comfortable with his routine, and started making suggestions of local attractions his On-The-Go group could visit.

3. OPTIONAL: In what ways has the evaluation supported the current practice or changes in practice? What changes were made or are planned, based on findings?

Activities and individual interests within the program are continuously assessed to ensure relevance and engagement. Group dynamics, formats, topics, and levels of support are adjusted as needed to meet participants where they are. This approach allows for the introduction of both new and familiar activities.

Annual Performance Outcome Report Form

In the Program Plan Narrative submitted with your application, you identified measures of Consumer Access, Consumer Outcomes, and Utilization. While Utilization data and comments have been captured in the quarterly service activity reports, Consumer Access and Consumer Outcome findings are reported only at the end of the program year. Download and complete this form and upload it to the online system reporting page, Performance Outcome Section.

Agency Name: **DSC**

Program Name: **Community Living**

Program Year: **2025**

CONSUMER ACCESS

In the Program Plan Narrative, you identified eligibility criteria for the program's services, how those criteria are established, how the target population learns about the program, and expected timelines. Please comment on each area below.

1. YES/NO - Did the stated criteria serve the purpose of providing people the services/ supports they were seeking? If NO, comment on causes and possible solutions.

Yes

2. YES/NO - Did the stated process for determining that the person and program were right for each other work well? If NO, comment on causes and possible solutions.

Yes

3. YES/NO - Did the stated outreach activities support appropriate matches between people and program services? If NO, comment on causes and possible solutions.

Yes

4. Compare year-end actual result with the application estimate of days from completed assessment to start of services. Comment on findings, especially if unexpected.

The application estimated a 45-day period from assessment to the engagement of services. This fiscal year, all individuals who joined the program met this timeframe.

5. Compare the year-end result with the application estimate of % of eligible people who engaged in program services within the above timeframe. Comment on the finding.

The application estimated that 90% of individuals would engage in services within 45 days. This goal was surpassed, with 100% of participants engaging in services within the specified timeframe.

6. Compare year-end result with the application estimate of length of participant engagement. Especially if the result was unexpected, comment on this finding.

Services are provided as long as a person has a need and actively chooses to participate. Of the 76 individuals supported in the program throughout the fiscal year, five exited due to relocating out of the area, moving to a setting that could better address their need for more advanced care, or no longer requested services.

7. If your program collected demographic information beyond the standard categories reported each quarter, comment on the data and what they suggest for the program.

All participants have a diagnosis of a developmental disability with approximately 72% having an intellectual disability, 16% have an autism diagnosis, and 21% report having a mental illness. Referrals for the people enrolled in the program came from the Independent Service Unit, families, and self-referral.

CONSUMER OUTCOMES

In the Program Plan Narrative, you identified positive outcomes people would experience as a result of participating in the program. You also identified measurement tools and targets for each outcome. Include original information and comment on the actual results.

- Use (and expand) the space below to copy each numbered **Outcome** (expected program impact on participants) from your Program Plan. Include the specific **target** and add the **actual result**.
- For each outcome, list the specific **assessment tool** used to collect information. *If different from the tool indicated in the application, include a note explaining the change.*
- For each outcome, indicate the **source of information**, e.g., participant, participant's guardian(s), clinician/service provider, 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 #1
75% of the CLP participants will pass monthly housekeeping and safety reviews at 80% or greater. Data is maintained by the Program Manager on a spreadsheet and is gathered from reviews completed by CLP staff and the individual.
Results: This outcome was met at 89% of participants passing their monthly housekeeping and safety inspection for the fiscal year.

Outcome #2
90% of CLP participants will experience new or maintain community engagements of their choosing.
Data is gathered from the participants on community activities.
Results: 89% of CLP participants engaged regularly in community activities of their choosing.

Outcome #3
80% of completed satisfaction surveys will have a score of four points or higher.
Data is gathered from the annual satisfaction survey.
95% of individuals stated they were satisfied with the services and supports they receive through CLP.

Utilization Targets and Results:

- Treatment Plan Clients: Target of 78. **76 people served in CLP in FY25.**
- Service Contacts: Target of six. **6 service contacts completed.**

CONSUMER PARTICIPATION IN DATA COLLECTION

1. How many total participants did the program have? ____**76**_____

For each of the following questions, if there are different responses per outcome, please identify the numbered outcome and the relevant detail.

2. If outcome information was NOT gathered from every participant, how did you choose who to collect outcome information from? **All participants were included in both outcomes.**
3. How many people did you *attempt* to collect outcome information from? __**All**_____
4. How many people did you *actually* collect outcome information from? ____**All**_____
5. How often and when was this information collected? *(e.g., 1x a year in the spring; at client intake and discharge, etc.)* **Quarterly**

RESULTS

1. What did you learn about the participants and the program from this outcome information? *Be specific when discussing any change or outcome and give quantitative or descriptive information when possible. You might report: Means and, if possible, Standard Deviations; Change Over Time, if assessments occurred at multiple points; Comparisons, e.g., of different strategies related to recruitment, of rates of retention for clients of different ethnic or racial groups, or of characteristics of all clients engaged versus clients retained.*

CLP continues to see that participants' ability to maintain safe and healthy living environments vary. In response, staff in the program have implemented a range of teaching and training strategies to reinforce the importance of health, safety, and compliance with leasing standards. In FY25, these efforts contributed to all participants maintaining safe living conditions, with no instances of eviction threats due to unsanitary environments. This outcome reflects the effectiveness of proactive support and individualized interventions.

The "Connecting to the Community" outcome showed that individuals in CLP participate in a wide variety of activities outside of their home. Many participants continue to engage in the monthly group experience organized by participants with staff support.

Overall satisfaction with the program remains high. Through multiple feedback methods including quarterly tenant meetings, annual meetings, and regular face-to-face interactions issues are identified and resolved promptly. This responsiveness contributes to higher satisfaction among participants.

2. OPTIONAL: Describe a typical service delivery case to illustrate the work. This may be a "composite case" that combines information from multiple actual cases.

The Community Living Program (CLP) offers a range of services to support individuals in living in the least restrictive environment possible. Each person receives an individualized service plan tailored to their unique needs. Some areas of focus in CLP include:

- **Medical Support**
- **Transportation Navigation**
- **Home Safety**
- **Financial Management**
- **Food security**
- **Community Engagement**

As participants' support needs evolve, CLP staff adapt services to ensure continuity of care. For example, one participant underwent major surgery this year, requiring a brief rehabilitation stay before returning to her apartment. Through close collaboration between the rehabilitation team and the Community Living Specialist (CLS), her living space was modified with adaptive equipment and reorganized to maximize accessibility. Upon her return home, the CLS provided daily support during the initial weeks to ensure her safety and comfort. As her independence improved, the frequency of visits was gradually reduced until she returned to her previous level of functioning. This individualized approach demonstrates the program's commitment to supporting participants through transitions and ensuring their well-being.

OPTIONAL: In what ways has the evaluation supported the current practice or changes in practice? What changes were made or are planned, based on findings? **N/A**

Annual Performance Outcome Report Form

In the Program Plan Narrative submitted with your application, you identified measures of Consumer Access, Consumer Outcomes, and Utilization. While Utilization data and comments have been captured in the quarterly service activity reports, Consumer Access and Consumer Outcome findings are reported only at the end of the program year. Download and complete this form and upload it to the online system reporting page, Performance Outcome Section.

Agency Name: **DSC**

Program Name: **Connections**

Program Year: **2025**

CONSUMER ACCESS

In the Program Plan Narrative, you identified eligibility criteria for the program's services, how those criteria are established, how the target population learns about the program, and expected timelines. Please comment on each area below.

1. YES/NO - Did the stated criteria serve the purpose of providing people the services/ supports they were seeking? If NO, comment on causes and possible solutions.

Yes

2. YES/NO - Did the stated process for determining that the person and program were right for each other work well? If NO, comment on causes and possible solutions.

Yes

3. YES/NO - Did the stated outreach activities support appropriate matches between people and program services? If NO, comment on causes and possible solutions.

Yes

4. Compare year-end actual result with the application estimate of days from completed assessment to start of services. Comment on findings, especially if unexpected.

The estimate of days from completed assessment to start of services from the application was 90 days. This was met.

5. Compare the year-end result with the application estimate of % of eligible people who engaged in program services within the above timeframe. Comment on the finding.

It was estimated that 75% would be engaged in services within 90 days of assessment and this was met.

6. Compare year-end result with the application estimate of length of participant engagement. Especially if the result was unexpected, comment on this finding.

People participate until they are no longer interested in the services. The focus of the groups changes every four months. Participants select which groups to join based on their interests and other commitments. Out of the 38 individuals who received services at The Crow this fiscal year, 11 attended every quarter.

7. If your program collected demographic information beyond the standard categories reported each quarter, comment on the data and what they suggest for the program.

Referrals to the program were made by the participants themselves, joining the groups/activities that interest them. All 38 have a diagnosis of intellectual disability and several identify as being on the autism spectrum.

CONSUMER OUTCOMES

In the Program Plan Narrative, you identified positive outcomes people would experience as a result of participating in the program. You also identified measurement tools and targets for each outcome. Include original information and comment on the actual results.

- Use (and expand) the space below to copy each numbered **Outcome** (expected program impact on participants) from your Program Plan. Include the specific **target** and add the **actual result**.
- For each outcome, list the specific **assessment tool** used to collect information. *If different from the tool indicated in the application, include a note explaining the change.*
- For each outcome, indicate the **source of information**, e.g., participant, participant's guardian(s), clinician/service provider, 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 #1

Participants will host or engage in five special events to connect people with developmental disabilities to the greater community. The program manager will maintain records of events hosted and community engagements.

Results: This outcome was met with five events including selling items at the Urbana Farmer's Market, being a host site for the Boneyard Arts Festival, hosting the annual holiday open house where Crow artists and others sold their creations, hosting the CU Teachers Art Show, and Crow artists participating with community artists at Ebertfest.

Outcome #2

90% of participants will be satisfied with experiences at the Crow at 110. Satisfaction results will be gathered. Satisfaction surveys will be administered to each participant this fiscal year.

Results: This outcome was met. According to surveys conducted at the end of each round of groups, all participants were satisfied with their experience at The Crow. Many participants also offered new ideas and suggested activities they would like to see repeated.

Outcome #3
Two collaborations with community artists teaching classes. Program manager will document artist collaborations.
Results: This outcome was met. Participants enjoyed classes conducted by CU Create. Classes focused on creating pixel art, art to showcase elements of one's own life and perspective, and printmaking and other forms of tactile art expression.

Utilization Targets and Results:

- Treatment Plan Clients defined as those people from the Community First Program interested in pursuing their creative interests and talents at the Crow at 110. Target of 25 people: **Met with 38 people participating this fiscal year.**
- Non-treatment Plan Clients defined as people participating in activities who are not receiving county funding. Target of 12 people: **Met with 33 people.**
- Community Service Events defined as the number of events hosted at the Crow at 110 and engagement in community venues. Target of five: **Met with five events.**

CONSUMER PARTICIPATION IN DATA COLLECTION

1. How many total participants did the program have? ___**38**____

For each of the following questions, if there are different responses per outcome, please identify the numbered outcome and the relevant detail.

2. If outcome information was NOT gathered from every participant, how did you choose who to collect outcome information from? **Outcomes were gathered from all participants.**

3. How many people did you *attempt* to collect outcome information from? ___**all**_____
4. How many people did you *actually* collect outcome information from? ____**all**_____
5. How often and when was this information collected? *(e.g., 1x a year in the spring; at client intake and discharge, etc.)* **At the end of each round of groups- approximately every 4 months.**

RESULTS

1. What did you learn about the participants and the program from this outcome information? *Be specific when discussing any change or outcome and give quantitative or descriptive information when possible. You might report: Means and, if possible, Standard Deviations; Change Over Time, if assessments occurred at multiple points; Comparisons, e.g., of*

different strategies related to recruitment, of rates of retention for clients of different ethnic or racial groups, or of characteristics of all clients engaged versus clients retained.

Art groups and the mediums offered continue to get more specific as participants are introduced to new content. Based on feedback, each round of group offerings include favorites as well as adding artistry techniques that participants want to explore further. At least three program participants shared through the surveys that they have started to create art as hobbies or in other community offerings aside from the program.

2. OPTIONAL: Describe a typical service delivery case to illustrate the work. This may be a "composite case" that combines information from multiple actual cases.

Logan, a recent high school graduate, who has shown his work in prior events at The Crow, recently opened in the program for full time participation. Logan's skillset is drawing, particularly cartoon and anime styles. After spending some time in the Cartoon Art group, Logan decided to share an idea with the group leader. Knowing that more opportunities for selling and showing his art will be just around the corner, he thought of an idea to maximize his works by turning them into buttons. The group leader thought that button making was an excellent idea, allowing people to make multiple copies of their drawings, and turning them into wearable art pieces. The Crow was able to secure a quality button maker, and Logan has been busy making pins! He has become so good at using the machine, he is teaching his peers how to use it independently.

3. OPTIONAL: In what ways has the evaluation supported the current practice or changes in practice? What changes were made or are planned, based on findings? **N/A**

Annual Performance Outcome Report Form

In the Program Plan Narrative submitted with your application, you identified measures of Consumer Access, Consumer Outcomes, and Utilization. While Utilization data and comments have been captured in the quarterly service activity reports, Consumer Access and Consumer Outcome findings are reported only at the end of the program year. Download and complete this form and upload it to the online system reporting page, Performance Outcome Section.

Agency Name: **DSC**
Program Name: **Employment First**
Program Year: **2025**

CONSUMER ACCESS

In the Program Plan Narrative, you identified eligibility criteria for the program's services, how those criteria are established, how the target population learns about the program, and expected timelines. Please comment on each area below.

1. YES/NO - Did the stated criteria serve the purpose of providing people the services/ supports they were seeking? If NO, comment on causes and possible solutions.

Yes

2. YES/NO - Did the stated process for determining that the person and program were right for each other work well? If NO, comment on causes and possible solutions.

Yes

3. YES/NO - Did the stated outreach activities support appropriate matches between people and program services? If NO, comment on causes and possible solutions.

Yes

4. Compare year-end actual result with the application estimate of days from completed assessment to start of services. Comment on findings, especially if unexpected.

The estimated 30 days from assessment/request to engagement was met.

5. Compare the year-end result with the application estimate of % of eligible people who engaged in program services within the above timeframe. Comment on the finding.

The estimated 100% of engaging businesses within 30 days of their request was met.

6. Compare year-end result with the application estimate of length of participant engagement. Especially if the result was unexpected, comment on this finding.

The training is 60 minutes. Contact with most businesses was beyond just the training with follow-up and other communication occurring throughout the fiscal year.

7. If your program collected demographic information beyond the standard categories reported each quarter, comment on the data and what they suggest for the program.

The following information was collected and reported on the quarterly reports submitted to DDB:

- **Number of businesses LEAP certified in the fiscal year**
- **Zip codes of LEAP certified businesses**
- **Number of employees in attendance at trainings and their job titles**
- **Business sector of LEAP certified businesses**
- **Networking events attended**

CONSUMER OUTCOMES

In the Program Plan Narrative, you identified positive outcomes people would experience as a result of participating in the program. You also identified measurement tools and targets for each outcome. Include original information and comment on the actual results.

- Use (and expand) the space below to copy each numbered **Outcome** (expected program impact on participants) from your Program Plan. Include the specific **target** and add the **actual result**.
- For each outcome, list the specific **assessment tool** used to collect information. *If different from the tool indicated in the application, include a note explaining the change.*
- For each outcome, indicate the **source of information**, e.g., participant, participant's guardian(s), clinician/service provider, 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 #1: Ten people will be hired by business who have been LEAP trained. The LEAP Coordinator will maintain records of those hired by LEAP trained businesses.
Results: In FY25, nine individuals supported by DSC or Community Choices were hired by LEAP-trained businesses. Job applicants who gain employment without the help of an agency will not be included in these numbers if the employer or employee does not reach out to report.

Outcome #2: 80% of LEAP attendees will provide satisfactory feedback on the benefits of training. The LEAP Coordinator will provide and maintain survey results.
Results: This outcome was met with 100% of participants surveyed indicating that the training was beneficial.

Utilization Targets and Results:

- Community Service Events defined as the number of LEAP and front-line staff trainings conducted. Target was 25: **29 were completed in FY25.**

CONSUMER PARTICIPATION IN DATA COLLECTION

1. How many total participants did the program have? **29 different businesses and 120 different staff**

For each of the following questions, if there are different responses per outcome, please identify the numbered outcome and the relevant detail.

2. If outcome information was NOT gathered from every participant, how did you choose who to collect outcome information from? **Information was gathered from all participating businesses.**
3. How many people did you *attempt* to collect outcome information from? ___**all**_____
4. How many people did you *actually* collect outcome information from? ____**all**_____
5. How often and when was this information collected? *(e.g., 1x a year in the spring; at client intake and discharge, etc.)* **Quarterly**

RESULTS

1. What did you learn about the participants and the program from this outcome information? *Be specific when discussing any change or outcome and give quantitative or descriptive information when possible. You might report: Means and, if possible, Standard Deviations; Change Over Time, if assessments occurred at multiple points; Comparisons, e.g., of different strategies related to recruitment, of rates of retention for clients of different ethnic or racial groups, or of characteristics of all clients engaged versus clients retained.*

This fiscal year, a new LEAP Coordinator was hired and began by familiarizing herself with the services offered through Community Employment, as well as gaining insight into local businesses across Champaign County. She actively participated in networking events to build relationships and raise awareness about the LEAP Program. At each event, she shared information about the LEAP Program and educated employers on the benefits of hiring individuals with disabilities. Many employers were unaware of how job carving can align employment opportunities with both the needs of the business and the strengths of job seekers with disabilities. We are excited to have engaged with 29 different businesses and reached over 120 staff members within our community to promote inclusive hiring. These efforts are expected to expand employment opportunities for individuals with disabilities in our community and strengthen partnerships with local employers.

2. OPTIONAL: Describe a typical service delivery case to illustrate the work. This may be a "composite case" that combines information from multiple actual cases.

The Employment First/LEAP Coordinator, networks around the community often. She also loves to build relationships with program participants on her way in and out of her office site. One day, Jackson, a participant on the CU Park District Supported Employment team, shared with the Leap Coordinator that his mom got a job as the manager of a new local restaurant. The Leap Coordinator reached out to the parent, asked if she wanted to learn more about LEAP, and how Employment Services might assist in job carving some tasks. The parent was thrilled to invite the DSC and Community Choices LEAP Coordinators to the restaurant to learn more. The business jumped at the opportunity to participate in the trainings and even invited job developers out to introduce any potential candidates for open positions.

3. OPTIONAL: In what ways has the evaluation supported the current practice or changes in practice? What changes were made or are planned, based on findings? **N/A**

Annual Performance Outcome Report Form

In the Program Plan Narrative submitted with your application, you identified measures of Consumer Access, Consumer Outcomes, and Utilization. While Utilization data and comments have been captured in the quarterly service activity reports, Consumer Access and Consumer Outcome findings are reported only at the end of the program year. Download and complete this form and upload it to the online system reporting page, Performance Outcome Section.

Agency Name: **DSC**
Program Name: **Family Development**
Program Year: **2025**

CONSUMER ACCESS

In the Program Plan Narrative, you identified eligibility criteria for the program's services, how those criteria are established, how the target population learns about the program, and expected timelines. Please comment on each area below.

1. YES/NO - Did the stated criteria serve the purpose of providing people with the services/ supports they were seeking? If NO, comment on causes and possible solutions.

Yes. Eligibility criteria included:

- **Child/family were residents of Champaign County as shown by address**
- **Child has evidence of need for service based on screening/assessment**
- **Child, birth-age 5, with or at-risk for developmental delay or disability**

2. YES/NO - Did the stated process for determining that the person and program were right for each other work well? If NO, comment on causes and possible solutions.

Yes

3. YES/NO - Did the stated outreach activities support appropriate matches between people and program services? If NO, comment on causes and possible solutions.

Yes

4. Compare year-end actual result with the application estimate of days from completed assessment to start of services. Comment on findings, especially if unexpected.

Year-end actual results align with application estimate. Mass screening opportunities and early intervention teaming assisted in achieving this goal.

5. Compare the year-end result with the application estimate of % of eligible people who engaged in program services within the above timeframe. Comment on the finding.

Year-end actual results align with application estimate. Group therapy opportunities and consultative/coaching support assisted with large caseload numbers.

6. Compare year-end result with the application estimate of length of participant engagement. Especially if the result was unexpected, comment on this finding.

The duration of participant engagement differed, as indicated in the application. Some children were screened and assessed, and were determined to be age-appropriate with no risk for developmental delay or disability. Others have been receiving services for several years, having been identified at a young age and continuing to receive services since they are not yet six years old.

7. If your program collected demographic information beyond the standard categories reported each quarter, comment on the data and what they suggest for the program.

During FY25, 51% of children served were children of color, and 43% resided outside of Champaign-Urbana. The Family Development program remains committed to expanding outreach to marginalized populations. Referrals for services were received through multiple channels, including Child and Family Connections, local daycare centers, individual families, and organized developmental screening events.

CONSUMER OUTCOMES

In the Program Plan Narrative, you identified positive outcomes people would experience as a result of participating in the program. You also identified measurement tools and targets for each outcome. Include original information and comment on the actual results.

- Use (and expand) the space below to copy each numbered Outcome (expected program impact on participants) from your Program Plan. Include the specific target and add the actual result.
- For each outcome, list the specific assessment tool used to collect information. *If different from the tool indicated in the application, include a note explaining the change.*
- For each outcome, indicate the source of information, e.g. participant, participant's guardian(s), clinician/service provider, 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 #1: 90% of caregivers will feel more competent/comfortable in meeting/supporting/advocating for their child's needs. Caregiver survey will be shared with random samples of families at the end of the fiscal year.
Results: Outcome met at 98% according to the FD Satisfaction Survey provided to a random sampling of families involved in services.

Outcome #2: 90% of children will progress in goals identified on their Individualized Family Service Plan (IFSP). File reviews analyze child's therapy session notes, six-month progress updates, and annual evaluation reports to determine progress towards IFSP goals.
Results: Outcome met at 91% according to file reviews completed each quarter.

Utilization targets and results:

- Treatment Plan Clients target of 655: **Exceeded with 982 receiving supports.**
- Service Contacts defined as the number of developmental screenings conducted with a target of 200: **186 screenings for children in Champaign County completed in FY25**
- Community Service Events with a target of 15: **Met. 16 CSE in FY25**

CONSUMER PARTICIPATION IN DATA COLLECTION

1. How many total participants did the program have? **982**

For each of the following questions, if there are different responses per outcome, please identify the numbered outcome and the relevant detail.

2. If outcome information was NOT gathered from every participant, how did you choose who to collect outcome information from?

Random sample of 15 files were reviewed each quarter for outcomes one and two.

3. How many people did you *attempt* to collect outcome information from? **60**
4. How many people did you *actually* collect outcome information from? **60**
5. How often and when was this information collected? *(e.g. 1x a year in the spring; at client intake and discharge, etc.)* **Quarterly**

RESULTS

1. What did you learn about the participants and the program from this outcome information? *Be specific when discussing any change or outcome and give quantitative or descriptive information when possible. You might report: Means and, if possible, Standard Deviations; Change Over Time, if assessments occurred at multiple points; Comparisons, e.g., of different strategies related to recruitment, of rates of retention for clients of different ethnic or racial groups, or of characteristics of all clients engaged versus clients retained.*

Collaboration across the community has been instrumental in helping families access wrap around services. Specifically, Family Development works closely with the Champaign County Home Visiting Consortium, Salt & Light, CU Able, TAP, and Larkins Place in order to support young children and their families in accessing the resources and services they need. We are identifying additional gaps in service through our screenings and referrals, and thus better able to network with other entities to advocate for children and families' needs.

2. OPTIONAL: Describe a typical service delivery case to illustrate the work. This may be a "composite case" that combines information from multiple actual cases.

When screening requests come in, an FD provider completes The Ages and Stages Questionnaire (ASQ) with the family and makes referrals based on results. For children age birth-3 who are flagged for further evaluation, we make a referral to Early Intervention/Child & Family Connections. On occasion, families have struggled with getting EI evaluations completed in accordance with state mandates. Our providers work to help families advocate and understand their child's rights while also working with the EI system/CFC office to figure out barriers to referral linkage. While waiting on other services to start, these children are eligible to participate in playgroups which are open to the community. This helps bridge the gap in service delivery so that the child and family still have some supports while awaiting more formalized services.

3. OPTIONAL: In what ways has the evaluation supported the current practice or changes in practice? What changes were made or are planned, based on findings? *N/A*

Annual Performance Outcome Report Form

In the Program Plan Narrative submitted with your application, you identified measures of Consumer Access, Consumer Outcomes, and Utilization. While Utilization data and comments have been captured in the quarterly service activity reports, Consumer Access and Consumer Outcome findings are reported only at the end of the program year. Download and complete this form and upload it to the online system reporting page, Performance Outcome Section.

Agency Name: **Developmental Services Center**

Program Name: **Individual and Family Support**

Program Year: **2025**

CONSUMER ACCESS

In the Program Plan Narrative, you identified eligibility criteria for the program's services, how those criteria are established, how the target population learns about the program, and expected timelines. Please comment on each area below.

1. YES/NO - Did the stated criteria serve the purpose of providing people the services/ supports they were seeking? If NO, comment on causes and possible solutions.

Yes

2. YES/NO - Did the stated process for determining that the person and program were right for each other work well? If NO, comment on causes and possible solutions.

Yes

3. YES/NO - Did the stated outreach activities support appropriate matches between people and program services? If NO, comment on causes and possible solutions.

Yes

4. Compare year-end actual result with the application estimate of days from completed assessment to start of services. Comment on findings, especially if unexpected.

The application estimated 60 days from completed assessment to start of services. This was met for all people opened in IFS during FY25.

5. Compare the year-end result with the application estimate of % of eligible people who engaged in program services within the above timeframe. Comment on the finding.

The target that 80% would start services within 60 days of assessment was met at 100%.

6. Compare year-end result with the application estimate of length of participant engagement. Especially if the result was unexpected, comment on this finding.

Services remain available as long as they are needed. Utilization was monitored quarterly. Six people opened and two closed throughout the fiscal year – ending with 35 in services. The two closures were due to individuals receiving state funding for HBS services. The program provided various services to a total of 37 people over the fiscal year.

7. If your program collected demographic information beyond the standard categories reported each quarter, comment on the data and what they suggest for the program.

Of the 37 people in the IFS program for Respite, all presented with a developmental disability or a developmental delay for those under the age of three. Referrals came from families, schools, and community agencies. For advocacy activities, individuals referred themselves when presented with opportunities to be involved. All 33 individuals involved in advocacy have a diagnosis of intellectual disability.

CONSUMER OUTCOMES

In the Program Plan Narrative, you identified positive outcomes people would experience as a result of participating in the program. You also identified measurement tools and targets for each outcome. Include original information and comment on the actual results.

- Use (and expand) the space below to copy each numbered **Outcome** (expected program impact on participants) from your Program Plan. Include the specific **target** and add the **actual result**.
- For each outcome, list the specific **assessment tool** used to collect information. *If different from the tool indicated in the application, include a note explaining the change.*
- For each outcome, indicate the **source of information**, e.g., participant, participant's guardian(s), clinician/service provider, 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 #1

Twenty individuals will actively participate in educational opportunities and advocacy efforts to include community and virtual options during the fiscal year. The Resource Coordinator will document the number of opportunities presented and mode of access.

Results: 33 individuals participated in opportunities including the virtual Speak Up Speak Out Summit, CQL presentations, CCMHB/CCDDB study session presentation, Spread the Word event at the Champaign YMCA, in-person self-advocacy classes, speaking at the annual TPC event, and They Deserve More Advocacy Day in Springfield where advocates spoke with local and state legislators regarding Direct Support Professional wages.

Outcome #2

90% of families receiving IFS Respite will be satisfied with services annually. A survey will be provided to all families receiving supports.

Results: The annual satisfaction survey results indicated 100% of respondents were satisfied with Respite services.

Utilization Targets and Results:

- Treatment Plan Clients – target of 40: **37 received services.**
- Non-treatment Plan Clients – target of 20**: Exceeded with 33 receiving services.**
- Service Contacts- target of 8**: 11 individuals were presented to admission for review. Other individuals/families spoke with the intake coordinator, but were not eligible for services or sought support from other respite providers. These were not counted as official screening contacts since they were not presented to the admissions committee.**
- Community Service Events with a target of 3: **Met. Four community service events occurred in FY25.**

CONSUMER PARTICIPATION IN DATA COLLECTION

1. How many total participants did the program have? **37 Respite & 33 Advocacy**

For each of the following questions, if there are different responses per outcome, please identify the numbered outcome and the relevant detail.

2. If outcome information was NOT gathered from every participant, how did you choose who to collect outcome information from?

Outcome #1 was for advocacy which could include individuals from other DSC programs Outcome #2 was for those receiving Respite services.

3. How many people did you *attempt* to collect outcome information from? __**all**_____
4. How many people did you *actually* collect outcome information from? _____**all for #1 and 9 for #2**_____
5. How often and when was this information collected? *(e.g., 1x a year in the spring; at client intake and discharge, etc.)* **Quarterly for Outcome #1, 4th quarter for Outcome #2.**

RESULTS

1. What did you learn about the participants and the program from this outcome information? *Be specific when discussing any change or outcome and give quantitative or descriptive information when possible. You might report: Means and, if possible, Standard Deviations; Change Over Time, if assessments occurred at multiple points; Comparisons, e.g., of different strategies related to recruitment, of rates of retention for clients of different ethnic or racial groups, or of characteristics of all clients engaged versus clients retained.*

Based on the outcomes listed above, the annual survey, as well as discussion by the Resource Coordinator with Respite participants, families are satisfied with their services. Statements from families about the impact of respite services included:

- **“We are SO thankful for the DSC respite hours. It really is life changing for us and allows us to have a chance to breathe and connect as a family instead of always having to say no or make plans around my daughter.”**
- **“It is a great service that is offered, and we are very lucky!”**
- **“I have some time for myself to do errands, rest, or just go with adult friends. I love my son, but I need some time to do things myself. It takes the worry about out of pocket sitter when he needs supervision. It is greatly appreciated!!”**
- **“Being able to have a physical and mental break from being my son’s caregiver”**

A few families indicated they would like more hours, but others are satisfied with the amount they have. All families are encouraged to use the State Respite programs as well.

In terms of advocacy, collaboration with The Alliance and their advocacy training program continues to be utilized. Advocates had opportunities to speak up for themselves and others through local and state events throughout the FY.

2. OPTIONAL: Describe a typical service delivery case to illustrate the work. This may be a “composite case” that combines information from multiple actual cases. **N/A**

3. OPTIONAL: In what ways has the evaluation supported the current practice or changes in practice? What changes were made or are planned, based on findings? **As the Resource Coordinator position continues to evolve and the Respite and Advocacy program grows, ongoing assessment of the program’s needs remains a priority. In FY26 more options for paid advocacy engagements will be explored as well as expanding services to as many families in need of respite as possible with the funds allotted.**

Annual Performance Outcome Report Form

In the Program Plan Narrative submitted with your application, you identified measures of Consumer Access, Consumer Outcomes, and Utilization. While Utilization data and comments have been captured in the quarterly service activity reports, Consumer Access and Consumer Outcome findings are reported only at the end of the program year. Download and complete this form and upload it to the online system reporting page, Performance Outcome Section.

Agency Name: **DSC**

Program Name: **Service Coordination**

Program Year: **2025**

CONSUMER ACCESS

In the Program Plan Narrative, you identified eligibility criteria for the program's services, how those criteria are established, how the target population learns about the program, and expected timelines. Please comment on each area below.

1. YES/NO - Did the stated criteria serve the purpose of providing people the services/ supports they were seeking? If NO, comment on causes and possible solutions.

Yes

2. YES/NO - Did the stated process for determining that the person and program were right for each other work well? If NO, comment on causes and possible solutions.

Yes

3. YES/NO - Did the stated outreach activities support appropriate matches between people and program services? If NO, comment on causes and possible solutions.

Yes

4. Compare year-end actual result with the application estimate of days from completed assessment to start of services. Comment on findings, especially if unexpected.

The average time from completed assessment to service engagement was 32 days.

5. Compare the year-end result with the application estimate of % of eligible people who engaged in program services within the above timeframe. Comment on the finding.

In FY25, 53% of participants began services within the targeted timeframe. The primary barrier to timely engagement was limited capacity within service coordination, as well as delays in availability across the other programs individuals were seeking. Moving forward DSC will track completed assessment to engagement for people who need only Service

Coordination support as those would not be reliant on capacity of other programs to open within Service Coordination.

6. Compare year-end result with the application estimate of length of participant engagement. Especially if the result was unexpected, comment on this finding.

Service Coordination offers support in all aspects of a person's life, in many cases, support continues for their lifetime. Fourteen people closed from the program in FY25 due to moving from the area, moving to long term care for medical reasons, no longer in need of services, no longer qualifying for services, or death.

7. If your program collected demographic information beyond the standard categories reported each quarter, comment on the data and what they suggest for the program.

Referrals for services are received from a variety of sources, including families, individuals seeking support, schools, physicians, community agencies, and the Independent Service Coordinator. In FY25, 74% of individuals served had a primary diagnosis of intellectual disability, 28% were diagnosed with autism spectrum disorder, and approximately 20% had a reported mental illness. Additional diagnoses included seizure disorders, genetic conditions, hearing, speech, and visual impairments, as well as physical disabilities such as cerebral palsy.

CONSUMER OUTCOMES

In the Program Plan Narrative, you identified positive outcomes people would experience as a result of participating in the program. You also identified measurement tools and targets for each outcome. Include original information and comment on the actual results.

- Use (and expand) the space below to copy each numbered **Outcome** (expected program impact on participants) from your Program Plan. Include the specific **target** and add the **actual result**.
- For each outcome, list the specific **assessment tool** used to collect information. *If different from the tool indicated in the application, include a note explaining the change.*
- For each outcome, indicate the **source of information**, e.g., participant, participant's guardian(s), clinician/service provider, 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 #1

98% of people will actively participate in the development of their personal outcomes driving the content of the implementation strategies documented by the assigned QIDP. Implementation Strategies will be reviewed as well as monthly QIDP notes in each individual's record. Self-report will be documented.

Results: Outcome met at 98%.

Outcome #2

Twenty people will participate in POM interviews this fiscal year. The Director of Program Assurance will maintain POM interview booklets. Participation in the interview will be documented in the person's file.
Results: The agency successfully completed 15 POMs. While this number doubled compared to last year, staffing patterns and staff turnover involving interviewers continue to pose a significant barrier to increasing the number of completed assessments.

Outcome #3
90% of people will be satisfied with the support they receive from Service Coordination. The annual Satisfaction Survey was distributed during the 4th quarter and results reviewed by the Director of Program Assurance.
Results: 88% of survey respondents stated they were satisfied with the services they receive from the Service Coordination program. 100% stated they felt respected by their service coordinator.

Utilization Targets and Results:

- Treatment Plan Clients with a target of 275: **290 people were served during the fiscal year.**
- Non-treatment Plan Clients with a target of 10: **Two people were served during the fiscal year. Previously this was tracking children in respite who also needed a case coordinator. This is no longer necessary since the addition of the Resource Coordinator position. Removed for FY26.**
- Service Contacts with a target of 20: **24 service contacts were completed.**
- Community Service Events with a target of two: **Service Coordination was discussed at two different community events.**

CONSUMER PARTICIPATION IN DATA COLLECTION

1. How many total participants did the program have? ____**290**_____

For each of the following questions, if there are different responses per outcome, please identify the numbered outcome and the relevant detail.

2. If outcome information was NOT gathered from every participant, how did you choose who to collect outcome information from? **A random sample of individual records was selected.**

3. How many people did you *attempt* to collect outcome information from? **Outcome #1: 60; Outcome #2: 20; Outcome #3: 142**_____
4. How many people did you *actually* collect outcome information from? **Outcome #1: 60; Outcome #2: 15; Outcome #3: 41**_____

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

RESULTS

1. What did you learn about the participants and the program from this outcome information? *Be specific when discussing any change or outcome and give quantitative or descriptive information when possible. You might report: Means and, if possible, Standard Deviations; Change Over Time, if assessments occurred at multiple points; Comparisons, e.g., of different strategies related to recruitment, of rates of retention for clients of different ethnic or racial groups, or of characteristics of all clients engaged versus clients retained.*
   Based on outcome data we can see that our commitment to person-centered services remains strong. Individuals are actively encouraged and supported in shaping their own service plans and personal goals, and we continue to prioritize their voices in the planning process.

   While staffing shortages have made it difficult to complete a higher volume of Personal Outcome Measure (POM) interviews, we have responded by identifying participants earlier and plan to expand our pool of interviewers.

   Feedback from our satisfaction survey shows that individuals and families feel respected and are generally satisfied with the services they receive. However, we recognize the need to improve communication during transitions and staffing changes. This year, the satisfaction survey was distributed electronically, which did generate responses, but not as many as we had hoped. To increase participation in future surveys, we plan to offer multiple modes of access, ensuring that everyone has a convenient way to share their feedback.

2. OPTIONAL: Describe a typical service delivery case to illustrate the work. This may be a "composite case" that combines information from multiple actual cases.

   Service delivery at DSC is tailored to meet the unique needs of each individual we serve. Our Case Coordinators continue to work diligently to ensure that clients maintain their benefits and regain them when necessary. Upon entering DSC services, a Case Coordinator will ask about the benefits they currently receive to see what assistance may be needed. After someone comes to DSC, the Case Coordinator will facilitate a 30-day meeting to see how services are going and see what ongoing support the team can work on to help them reach the desired outcomes they have established through the Person Centered Planning process. At any time if the person we serve, family, or team members feel we need to get together to brainstorm on how to best support them or celebrate their success they will reach out to their Case Coordinator to facilitate a meeting.

   This past year we supported a person who encountered some legal issues. We talked to the Public Defender with them and attended every court appearance with them. We wrote a letter detailing how we support this person and how we would continue to support this person moving forward to prevent any further situations. We were successful at keeping a charge that did not feel warranted from being on their record.

There are also a few people who have struggled with attendance at their job or with attending groups they chose to participate in at the day program. The Case Coordinator helped facilitate a meeting to see what barrier there were or reasons they were not attending. Service Coordination will often work with the team to develop a contract that outlines what the person has chosen for their schedule and the expectations involved in participating in groups or in maintaining their employment. Meeting consistently throughout the year is often helpful to people to remind them of their agreement and to keep them on task and motivated. It also helps them see how supported they are and how we want to see them succeed.

3. OPTIONAL: In what ways has the evaluation supported the current practice or changes in practice? What changes were made or are planned, based on findings?

   Service Coordination remains committed to fostering strong relationships and meaningful connections with the individuals we serve. Despite several changes in staff throughout the year, our focus has consistently been on maintaining these critical relationships. The increasing demands of paperwork has posed challenges, often diverting time and energy away from direct engagement with individuals. We continue to re-evaluate staff training and processes for timely completion of administrative duties, while still remaining focused on the needs of each individual.

Annual Performance Outcome Report Form

In the Program Plan Narrative submitted with your application, you identified measures of Consumer Access, Consumer Outcomes, and Utilization. While Utilization data and comments have been captured in the quarterly service activity reports, Consumer Access and Consumer Outcome findings are reported only at the end of the program year. Download and complete this form and upload it to the online system reporting page, Performance Outcome Section.

Agency Name: __**DSC**_____

Program Name: _**Workforce Development and Retention**_____

Program Year: __**2025**_____

CONSUMER ACCESS

In the Program Plan Narrative, you identified eligibility criteria for the program's services, how those criteria are established, how the target population learns about the program, and expected timelines. Please comment on each area below.

1. YES/NO - Did the stated criteria serve the purpose of providing people the services/ supports they were seeking? If NO, comment on causes and possible solutions.

Yes

2. YES/NO - Did the stated process for determining that the person and program were right for each other work well? If NO, comment on causes and possible solutions.

Yes

3. YES/NO - Did the stated outreach activities support appropriate matches between people and program services? If NO, comment on causes and possible solutions.

Yes

4. Compare year-end actual result with the application estimate of days from completed assessment to start of services. Comment on findings, especially if unexpected.

n/a

5. Compare the year-end result with the application estimate of % of eligible people who engaged in program services within the above timeframe. Comment on the finding.

n/a

6. Compare year-end result with the application estimate of length of participant engagement. Especially if the result was unexpected, comment on this finding.

n/a

7. If your program collected demographic information beyond the standard categories reported each quarter, comment on the data and what they suggest for the program.

n/a

CONSUMER OUTCOMES

In the Program Plan Narrative, you identified positive outcomes people would experience as a result of participating in the program. You also identified measurement tools and targets for each outcome. Include original information and comment on the actual results.

- Use (and expand) the space below to copy each numbered Outcome (expected program impact on participants) from your Program Plan. Include the specific target and add the actual result.
- For each outcome, list the specific assessment tool used to collect information. *If different from the tool indicated in the application, include a note explaining the change.*
- For each outcome, indicate the source of information, e.g. participant, participant's guardian(s), clinician/service provider, 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 #1

One annual training will be provided to support ongoing professional development, and two DSPs will attend the National DSP Conference.

These trainings were documented in the DSC employee database.

Results: Outcome met. During FY25, three NADSP trainings were offered. The trainings included:

- **Frontline Supervisor Training**
- **Leadership Training- Culture**
- **Myths about Aging and the Developmental Disability Population**

NADSP Conference: This event only occurs every two years and was not offered in FY25. Plans are underway for FY26 with two DSC DSPs identified to attend.

Outcome #2

Bonuses will be scheduled to recognize completed employee training for 25 new employees. The Director of Program Assurance maintained a comprehensive list of recipients, which was submitted to the DDB on a quarterly basis.

Results: A total of 24 training bonuses were awarded to new employees during the fiscal year.

Outcome #3

Quarterly retention bonuses will be scheduled for eligible employees. A detailed list of recipients is maintained and submitted to the DDB on a quarterly basis.

Results: Over the fiscal year, a total of 520 retention bonuses were distributed to 160 different staff members.

Utilization Targets and Results:

- "Other" defined as number of staff receiving bonuses with a target of 160 different staff. **A total of 544 total bonuses were provided to 171 different staff over the fiscal year. Outcome met.**

CONSUMER PARTICIPATION IN DATA COLLECTION

1. How many total participants did the program have? **171 different staff received bonuses**

For each of the following questions, if there are different responses per outcome, please identify the numbered outcome and the relevant detail.

2. If outcome information was NOT gathered from every participant, how did you choose who to collect outcome information from?

n/a

3. How many people did you *attempt* to collect outcome information from? **all eligible staff**
4. How many people did you *actually* collect outcome information from? **all eligible staff**
5. How often and when was this information collected? *(e.g. 1x a year in the spring; at client intake and discharge, etc.)* **Quarterly**

RESULTS

1. What did you learn about the participants and the program from this outcome information? *Be specific when discussing any change or outcome and give quantitative or descriptive information when possible. You might report: Means and, if possible, Standard Deviations; Change Over Time, if assessments occurred at multiple points; Comparisons, e.g., of different strategies related to recruitment, of rates of retention for clients of different ethnic or racial groups, or of characteristics of all clients engaged versus clients retained.*

Trainings were well received. DSC continued our partnership with the U of I Evaluation Capacity team. The survey developed with their assistance was distributed to 140 direct care staff in FY25. There was a return rate of 45% and overall, the responses regarding the retention bonuses were positive. Staff statements included:

· "I feel valued as an employee."

· "It helps retain staff and gives them a chance to see our field as a career path."

· "It shows that we matter."

· "The DSC Retention Bonus shows me that the people who are applying for grants are thinking about the people who keep DSC moving day to day. I felt recognized, thankful, and appreciated receiving it.".

2. OPTIONAL: Describe a typical service delivery case to illustrate the work. This may be a "composite case" that combines information from multiple actual cases. **N/A**

3. OPTIONAL: In what ways has the evaluation supported the current practice or changes in practice? What changes were made or are planned, based on findings? **As a direct result of the staff survey regarding retention bonuses the payout timeline will be changed to twice a year in FY26. Many staff stated they preferred to receive a larger sum of money when the retention bonuses are given, rather than smaller amounts more often throughout the year. It also simplifies administration and processing of bonuses. Any new DSP hire completing training within the six-month payout period would receive $400. Staff employed and trained prior to the start of each six-month payout period would receive $800 per payout.**

Annual Performance Outcome Report Form

In the Program Plan Narrative submitted with your application, you identified measures of Consumer Access, Consumer Outcomes, and Utilization. While Utilization data and comments have been captured in the quarterly service activity reports, Consumer Access and Consumer Outcome findings are reported only at the end of the program year. Download and complete this form and upload it to the online system reporting page, Performance Outcome Section.

Agency Name: Persons Assuming Control of their Environment Inc. (PACE, Inc.)
Program Name: Consumer Control in Personal Support
Program Year: 2025

CONSUMER ACCESS

In the Program Plan Narrative, you identified eligibility criteria for the program's services, how those criteria are established, how the target population learns about the program, and expected timelines. Please comment on each area below.

1. YES/NO - Did the stated criteria serve the purpose of providing people the services/ supports they were seeking? If NO, comment on causes and possible solutions.

   Yes

2. YES/NO - Did the stated process for determining that the person and program were right for each other work well? If NO, comment on causes and possible solutions.

   Yes

3. YES/NO - Did the stated outreach activities support appropriate matches between people and program services? If NO, comment on causes and possible solutions.

   Yes

4. Compare year-end actual result with the application estimate of days from completed assessment to start of services. Comment on findings, especially if unexpected.
   Typically, it takes 1–2 weeks after orientation to complete the process. To increase opportunities for recruiting PSWs, PACE adopted various methods for delivering PSW orientations, including in-person one-on-one sessions, Zoom orientations, small in-person group sessions, hybrid formats, and phone orientations. To boost PSW recruitment, staff ensure that orientation materials are available in PACE's lobby for prospective PSWs to pick up. These materials are also emailed to prospective PSWs along with the Zoom link. Several conversations, invitations, and reminders are conducted prior to the orientation to encourage attendance. Staff also follow up via email and phone calls to support PSWs in completing the orientation. To facilitate completion of the required paperwork, PSWs can submit documents via email, fax, or by dropping them off in person at PACE. Post-orientation follow-ups—such as reminder emails and phone calls—are conducted to ensure the return of completed paperwork. Staff also follow up to confirm that PSWs clearly understood key topics discussed during orientation. Additional program and technology support is provided to PSWs through Zoom, email, phone calls, and in-person appointments. The goal is to support PSWs in meeting eligibility requirements so they can be added to the registry and referred to consumers with I/DD and/or their families based on the consumer's preferences.

5. Compare the year-end result with the application estimate of % of eligible people who engaged in program services within the above timeframe. Comment on the finding.

   Not applicable. We recruit potential PSWs only.

6. Compare year-end result with the application estimate of length of participant engagement. Especially if the result was unexpected, comment on this finding.

   This is a PSW registry program. PSWs may remain on the registry indefinitely. Staff continue to call and email PSWs on the registry to update their information. All PSWs are updated quarterly to remain active on the registry.

7. If your program collected demographic information beyond the standard categories reported each quarter, comment on the data and what they suggest for the program.

   PACE collected only the required demographic information from the PSWs.

CONSUMER OUTCOMES

In the Program Plan Narrative, you identified positive outcomes people would experience as a result of participating in the program. You also identified measurement tools and targets for each outcome. Include original information and comment on the actual results.

- Use (and expand) the space below to copy each numbered **Outcome** (expected program impact on participants) from your Program Plan. Include the specific **target** and add the **actual result**.
- For each outcome, list the specific **assessment tool** used to collect information. *If different from the tool indicated in the application, include a note explaining the change.*
- For each outcome, indicate the **source of information**, e.g. participant, participant's guardian(s), clinician/service provider, 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 #1

PSW program and CCDDB is shared. There was a CSE target of 20 for FY25. In FY25, PACE conducted 25 outreach activities related to this outcome.

Outcome #2

People attending CSEs or receiving information who are reasonably expected to utilize it include potential PSWs, current PSWs on the registry, agencies, and families involved in hiring PSWs. There will be a CSE target of 250 for FY25. In FY25, PACE made 216 contacts related to this outcome.

Outcome #3

NTPCs, as defined under this contract, are individuals who complete PSW orientation, submit all required paperwork, and pass background checks. There will be an NTPC target of 30 for PY25. For this outcome, PACE successfully recruited 34 PSWs. The outcome was slightly impacted by

individuals who did not complete the required paperwork or did not pass the background checks.

Outcome #4

"Other" will indicate the number of successful matches between individuals with I/DD seeking to hire PSWs and PSWs listed in PACE's registry. There will be an "Other" target of 9 for FY25. In FY25, PACE had 4 successful matches.

(Add as many Outcomes as were included in the Program Plan Narrative)

CONSUMER PARTICIPATION IN DATA COLLECTION

1. How many total participants did the program have? PSW **64 registered, 4 successful matches, and 20 sets of referrals were sent to PSW consumers.**

   The following updated information was provided as the outcome of the PSW program throughout FY25:

   "The PSW program has connected him and his son with excellent people. He also stated that the support provided has allowed his son to experience success and enjoyment in life. It has also allowed his son's life to be well-rounded."

   "The meet and greet and orientations at PACE do great at pairing specific needs, even things like smokers and non-smokers. Really focused on consumer needs and things that you wouldn't normally think of. The distinction between PA & PSW is great. Hope that these services continue because of they really help a lot of people. "The consumer further stated, "SDA services would be a great addition to PSW services."

   "Hired a PSW that worked out awesome for her son's needs until he found another job." PACE continues to support the family.

For each of the following questions, if there are different responses per outcome, please identify the numbered outcome and the relevant detail.

1. If outcome information was NOT gathered from every participant, how did you choose who to collect outcome information from?

   All consumers are NTPCs in this program, there are no official outcomes. An unofficial outcome of this program was the matching of 8 PSWs with individuals seeking to hire a PSW.

2. How many people did you *attempt* to collect outcome information from? **All consumers are NTPCs, there are no official outcomes.**
3. How many people did you *actually* collect outcome information from? **All consumers are NTPCs, there are no official outcomes.**

4. How often and when was this information collected? *(e.g. 1x a year in the spring; at client intake and discharge, etc).* **All consumers are NTPCs, there are no official outcomes.**

RESULTS

1. What did you learn about the participants and the program from this outcome information? *Be specific when discussing any change or outcome and give quantitative or descriptive information when possible. You might report: Means and, if possible, Standard Deviations; Change Over Time, if assessments occurred at multiple points; Comparisons, e.g., of different strategies related to recruitment, of rates of retention for clients of different ethnic or racial groups, or of characteristics of all clients engaged versus clients retained.*

   All consumers are NTPCs, there are no official outcomes.

2. OPTIONAL: Describe a typical service delivery case to illustrate the work. This may be a "composite case" that combines information from multiple actual cases.

   PACE regularly advertises on Facebook and indeed to attract individuals to attend PSW orientations. PACE staff have traveled and distributed PSW flyers to libraries in Champaign County, Centennial High School, Urbana High School, and the Urbana Adult Education Center.

   PACE staff continue to promote the PSW program by attending community outreach events, job fairs, and resource fairs. They also continue to seek opportunities to recruit prospective PSWs so they can be added to PACE's PSW registry.

   When a prospective PSW comes across one of our postings, they typically contact us by phone, email, Indeed, or Facebook Messenger. We begin a conversation about the referral program and how it works. The individual is then invited to attend either a Zoom or in-person orientation.

   After the prospective PSW completes the orientation and paperwork, PACE conducts the required background checks. If the individual passes the background checks, they are added to the registry and referred to PSW consumers who are seeking to hire, based on matching preferences.

   The PSW consumer initiates contact with the PSW, and ideally, the PSW is successfully matched with a consumer looking to hire.

3. OPTIONAL: In what ways has the evaluation supported the current practice or changes in practice? What changes were made or are planned, based on findings?

   Each quarter, the PSW program host advisory meetings to gather feedback from consumers about our programs and to provide updates on how we are improving our services. These quarterly advisory meetings also cover topics of interest based on the needs and preferences expressed by consumers and PSWs.