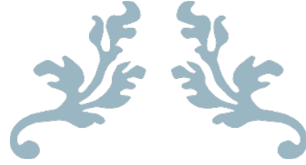
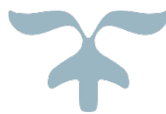


COMPILED ANNUAL PERFORMANCE OUTCOME REPORTS OF CCMHB FUNDED PROGRAMS FOR CONTRACT YEAR 2024



Compiled Annual Performance Outcome Reports of CCMHB Funded Programs for Contract Year 2024

Allocation Awards may have been adjusted by amendment or through the return of excess revenue. The amounts listed are the original funding awards.

Agency	Program	Allocation Award*
Champaign County Christian Health Center	Mental Health Care at CCCHC	$33,000
Champaign County Children's Advocacy Center	Champaign County Children's Advocacy Center	$63,911
Champaign County Health Care Consumers	CHW Outreach & Benefit Enrollment	$86, 501
Champaign County Health Care Consumers	Disability Services	$91,500
Champaign County Health Care Consumers	Justice Involved CHW Services & Benefits	$90,147
CCRPC-Community Services	Homeless Service System Coordination	$54,281
CCRPC-Community Services	Youth Assessment Center	$76,350
CU Early	CU Early	$73,141(MH) $4,043 (I/DD)
CU at Home	Shelter Case Management	$256,700
CCRPC-Head Start	Early Childhood Mental Health Services	$197,569 (MH) $149,666 (I/DD)
Community Service Center of Northern Champaign County	Resource Connection	$68,609
Courage Connection	Courage Connection Program	$127,000
Crisis Nursey	Beyond Blue-Champaign County	$90,000

Cunningham Children's Home	ECHO Housing & Employment Support	$127,249
Cunningham Children's Home	Families Stronger Together	$398,092
DSC	Family Development	$656,174
Don Moyer Boys & Girls Club	CU Change	$75,000
Don Moyer Boys & Girls Club	CU Neighborhood Champions	$110,000
Don Moyer Boys & Girls Club	Community Coalition Summer Initiatives	$90,000
Don Moyer Boys & Girls Club	Youth and Family Services	$160,000
East Central IL Refugee Mutual Assistance Center	Family Support & Strengthening	$62,000
Family Service of Champaign County	Counseling	$30,000
Family Service of Champaign County	Self-Help Center	$28,430
Family Service of Champaign County	Senior Counseling & Advocacy	$178,386
First Followers	First Steps Reentry House	$39,500
First Followers	Peer Mentoring for Reentry	$95,000
GROW in Illinois	Peer-Support	$129,583
Immigrant Services of CU	Immigrant Mental Health	$90,000
Promise Healthcare	Mental Health Services	$330,000
Promise Healthcare	PHC Wellness	$107,087
Rape Advocacy, Counseling & Education Services	Sexual Trauma Therapy Services	$140,000

Rape Advocacy, Counseling & Education Services	Sexual Violence Prevention Education	$75,000
Rosecrance Central Illinois	Benefits Case Management	$80,595
Rosecrance Central Illinois	Child & Family Services	$73,500
Rosecrance Central Illinois	Criminal Justice PSC	$320,000
Rosecrance Central Illinois	Crisis Co-Response (CCRT)	$207,948
Rosecrance Central Illinois	Recovery Home	$100,000
Rosecrance Central Illinois	Specialty Courts	$178,000
Terrapin Station Sober Living	Recovery Home	$79,677
The UP Center of Champaign County	Children, Youth, & Families Program	$190,056
WIN Recovery	Community Support Reentry	$110,000

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 Christian Health Center

Program Name: Access to Mental Health Care: Closing the Gap Program

Year: 2023-2024

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.

   CCCHC performed very well in all categories except treatment plan clients. This lower number was due partly from the availability of mental health practitioners.

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.

   All those eligible engaged in the available services

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

   Length of participant engagement went as expected

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 started collecting two categories of data - how people heard about the clinic and

where they would go if the clinic was not available. Early indications are WOM and the ER respectively.

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

200 patients will be screened to assess mental health needs - while this number did not reach our intended goal due to limited provider availability, a change in processes at the clinic with CCCHC primary care providers increased this number in the 4th quarter and will do moving forward. Assessment tool was CCCHC's EMR system Source of information was he participant.

Outcome #2

800 people will interact with CCCHC services- CCCHC greatly exceeded this goal through the work of the Outreach & Wellness Director along with the Clinic Director. Both ensured CCCHC participation in many community events where screenings, physicals, health education, and other services were provided Assessment tool was CCCHC's EMR system and sign up forms at events Source of information was the participant.

Outcome #3

CCCHC would host or participate in 8 events throughout the year to reach potential patients and the community at large. This goal was greatly exceeded was well due to the staff and volunteers of CCCHC. Assessment tools were a general tallying of the number of events CCCHC were involved with Source of information was the participant

Outcome #4

Equitable and wholistic care was provided by CCCHC throughout the year by regular training of volunteers and an annual training of the board and staff

(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? Approx 1600

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 outcome information was gathered from those using CCCHC services appropriate to the level of interaction (i.e. patients vs. contacts at community events)

3. How many people did you *attempt* to collect outcome information from? 1600
4. How many people did you *actually* collect outcome information from? 1600
5. How often and when was this information collected? *(e.g. 1x a year in the spring; at client intake and discharge, etc)*

   At client intake or interaction (if at an event)

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.*

   CCCHC has a consistent demand for mental health services from patients/clients. The goal for CCCHC is to increase provider availability to meet these demands. It is anticipated that this demand will remain level or increase in the future as awareness of the importance of mental health increases and services continue to be limited in the community.

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.

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?

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 CAC
Program Name: Champaign County CAC
Program Year: 2024

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.
   All 182 clients who were referred to the CAC by law enforcement or DCFS began services on the date that the assessment was completed.

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 estimate was that 90% would receive services within 2 days. 100% of actual clients received 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.
   The application estimated that the average length of the time clients engaged in services would be 6-12 months. The year-end result is that the CAC cases were open an average of 79 days. We have a new report available to us that show's exact number of

days open per closed case. We will now utilize this report for future application estimates.

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

90% satisfaction with perceived neutral, safe, child and family friendly environment. The Initial Caregiver Survey was used to track this goal (client caregivers). This survey was mailed to 169 caregivers (this can include a child's parent, guardian, or temporary guardian). 17 Surveys were returned and 100% of the surveys reported that the CAC was safe, perceived neutral, and was a child & family friendly environment.

Outcome #2

85% of children referred will attend counseling based on the trauma screening in order to initiate/facilitate the healing process.

79 Children had a trauma screening score that indicated that a counseling referral was necessary. 49 of these children were referred to counseling. 31/49 (63%) of children who were referred to counseling attended at least one counseling session.

Outcome #3

90% information gathered in a legally sound manner (based on 115-10 hearings). This information is gathered from the forensic interview reports and subpoena spreadsheet. There were 4 cases where CAC forensic interviewers were subpoenaed to testify in court for 115-10 hearings. All 4 hearings determined that the CAC forensic interviews were conducted in a legally sound manner, therefore admitted for trial.

Outcome #4

100% of caregivers report that they know why they are at the CAC. The initial caregiver survey assessment tool utilized for this outcome. Caregiver includes the child's parent, guardian, or temporary guardian. The CAC mailed this survey to 169 caregivers. 15 surveys were returned and 100% of the surveys reported that the CAC staff made sure the caregiver understood the reason for their visit to the Center.

Outcome #5

95% child victims have a perceived feeling of being safe while at the CAC. The youth feedback survey is the assessment tool used to measure this outcome. The youth feedback survey is offered to each child victim ages 10-17 who receives a forensic interview at the CAC. The survey was mailed to all 76 children ages 10-17 who received a forensic interview at the CAC this program year. The CAC received 11 completed surveys. 100% of the surveys reported that the CAC staff helped the child victim feel safe while at the CAC.

(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? The CAC had 182 child victims for program year 24 and 169 caregivers.

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 Surveys were sent to all caregivers and each child victim ages 10-17

3. How many people did you *attempt* to collect outcome information from? The CAC attempted to collect information from all 169 caregivers and all 76 child victim ages 10-17.

4. How many people did you *actually* collect outcome information from? The CAC actually received surveys back from 15 caregivers and 11 youth.

5. How often and when was this information collected? *(e.g. 1x a year in the spring; at client intake and discharge, etc)* The OMS Qualtrics initial caregiver survey is sent out within 7 days of the caregiver and child's initial visit to the CAC for a forensic interview. The OMS Qualtrics Youth Survey is also sent out within 7 days of the initial visit to the CAC

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.

The survey return rate for caregivers and youth was lower this year than in the past. The CAC will attempt to collect surveys via text message instead of mailing the surveys for program year 2025.

The amount of time that a client engaged in services has also decreased this program year. I believe that part of the change to the average number of days a case is open is because court schedules are "back to normal" after COVID. We had some cases that were open 3-4 years because of the back log and continuances that were created because of the pandemic.

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 CAC provided forensic interviews to three male siblings ages 14, 16 and 17. During the forensic interview of the 14-year-old, he disclosed the sexual abuse his biological father subjected him to for years. The 14-year-old was the outcry which initiated the case. The 16- and 17-year-old siblings were then brought to the CAC a couple of days later as risk of harm cases (siblings interviewed to make sure they were not also abused). Neither older brother disclosed abuse during their forensic interviews. They were both very angry and spoke very little. The biological mom of the boys did not support them, refused to participate in the CAC process or any subsequent court involvement. After the disclosure of the 14-year-old, the perpetrator was admitted to a psychiatric hospital after a failed suicide attempt. Before he was discharged from the hospital, he was interviewed by law enforcement where he admitted that he had abused his son and subsequently was arrested. The mother was angry and punished the boys by telling them it was a financial hardship for the family now that her husband and their father was incarcerated and offered them very little to eat. The 16-year-old requested to come back to the CAC to talk about what had happened to him. During his second forensic interview he disclosed about his mother's addiction to alcohol which had led to the physical abuse of the 16-year-old. He also disclosed that one night when his mother was intoxicated that he heard her yell at his dad for sexually abusing his older brother. Due to the physical abuse the mother was arrested, and the boys were placed into protective custody by DCFS. Because the perpetrator admitted to the abuse the case was set for trial just two months after the initial forensic interview. During court preparation with the courthouse advocate and State's Attorney, the 17-year-old admitted that he was also sexually abused by his father and requested a 2nd forensic interview.

While this is not typical of all CAC cases I want to point out how common it is for children to disclose abuse and have the non-offending caregiver not believe them. These are very hard cases for detectives, CAC staff, and DCFS investigators, simply because it is unimaginable for a child to have to endure abuse AND not have the support of the other caregiver. I also wanted to point out that it is also common for children to withhold information about the abuse until they feel safe. This is also not typical, but the jury trial was scheduled for July 15, 2024, and the defendant requested to plea guilty and forgo the trial, which is exactly what happened. I am writing this report on July 15, 2024, and it is with such great joy that these children got the justice they deserved. When the 14-year-old came to the CAC, the last thing he said during his forensic interview is that he never wanted to see his father again. Thankfully, since the case did not have to be heard at trial, he was given that wish. Again, this is not a very typical ending for the cases that we see, but there are occasions where we do get to see some very good endings. Although the ending is not typical, it is a great account of the tireless hard work by all multidisciplinary team members involved in the case, which we are fortunate to see on a daily basis.

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?

   The CAC will change the way that surveys are distributed to caregivers and youth in program year 2025. The surveys will be texted to clients instead of mailed in attempts to obtain a higher return rate.

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 Health Care Consumers (CCHCC**)______________
Program Name: ____**CHW Outreach and Benefit Enrollment** ___________________________
Program Year: ___**2024**_________

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. All clients served through this program are a) residents of Champaign County; b) have evidence of a need for this service based on assessment; and c) have limited financial resources. The specific target population for this program is Champaign County residents with behavioral health issues in need of public benefits and access to healthcare services, including behavioral 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.

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.

   In the application, we estimated 2 days from assessment to start of services. But in most cases, start of services began immediately after assessment, as long as the client had their

information available. The exception might be if someone contacts CCHCC on a weekend or during a holiday. But these are rare circumstances.

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 the application, we estimated that 90% of individuals seeking these services would engage in services in the timeframe stated above. We were able to hit this target in almost all cases.

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 client engagement for months or years, depending on the client, and that, at minimum, we would have contact with most clients every six months for the purposes of redeterminations for Medicaid or SNAP. However, most clients whom we serve through this program contact us more frequently with various questions or requests for help with other things, including energy assistance, rent assistance, etc. If a client requires help with a disability application, we create an internal referral to our Disability Application Services Program. We typically estimate and report on the number of new clients each quarter; however, we are carrying a much heavier case load because our clients tend to stick with us and we continue to work with them for many years, typically, unless they move out of the area or die. We are able to work with them for years because we have the capacity to help them transition to Medicare, for example, once they become eligible for that – so, in other words, we can serve clients throughout their lifespans. Once we have established trust with the client, and shown that we are effective in the services we provide, we often become a lifeline or a trusted resource for that client.

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 the required demographic information, we also collect data on language preferences/needs, and homelessness status. We do not explicitly collect data on immigration status, but we are exposed to this information in the course of providing help to individuals who are immigrants, and we have to understand the complex eligibility criteria for the different immigration statuses. Our data suggest that there are increasing populations of immigrants from various countries, and that it is not unusual to find that members of the immigrant community are struggling with depression, anxiety, and PTSD and are often unsure where to turn for help. Thankfully, we are familiar with service

providers who can meet these needs and who are bi-lingual or will work with interpreters to meet the clients' needs.

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

We estimated that we would serve 140 new TPC clients, and 40-50 continuing clients. We ended up serving 30 continuing clients in Q1, and many more throughout the rest of the year, so we met our goal for the continuing clients. In terms of new clients, we served 121 new clients in this Program Year.

The assessment tool used to collect information and data includes the Client Intake form, where we document all the services with which the client needs help. Then, we track the client data, including services requested, performed, and the outcome of those services (for example, Medicaid or SNAP approvals) in our SalesForce database.

Outcome #2

We estimated that eligible clients would need a range of services including benefits applications for Medicaid or Medicare and Medicare-related programs, SNAP, and hospital financial assistance, as well as help with health care navigation to access behavioral health services, oral health services, vision, and medical care.

Our outcome data, documented in our SalesForce system, show that all TPC cases applied for benefits were approved for those benefits. And those seeking access to care or health care navigation services were, for the most part, successfully helped in getting those services. Approximately 82% of clients who required that assistance were helped. The remaining 18% ended up not following through for a number of reasons, so they did not access the services the initially requested (for example, mental health counseling or substance use treatment).

Outcome #3

We estimated that, on average, most clients would require two applications – whether for Medicaid, SNAP, Medicare or Medicare-related programs, hospital financial assistance, prescription assistance, access to affordable dental or vision care, etc.

Our outcome data, documented in our SalesForce database, shows that our estimates were too low, and that almost all clients required more than two applications, with many requiring 3 applications or more at one time. Our data show that, on average, these CHW clients required 3.4 applications.

Outcome #4

(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? ___**151 TPC and 27 NTPC for a total of 178**___________

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? ___**151 TPC individuals**___________
4. How many people did you *actually* collect outcome information from? ____**151**_________
5. How often and when was this information collected? *(e.g. 1x a year in the spring; at client intake and discharge, etc)*

   This information is collected on an ongoing basis. For example, if we help someone apply for SNAP, we find out very soon after the application if they are approved, and for how much. We then verify that they have started to receive their benefits. And if they contact us about another service, or a problem they are having, we track the request and the outcome in real time. The initial data collection takes place at Intake.

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.*

We learned that many of the individuals who came to us had many pressing needs and were eligible for more programs than the ones for which they requested help. For example, an individual might come to CCHCC seeking help to find an appropriate mental health counselor, and they might mention that they need one who will accept uninsured patients, because they might not know that they can qualify for health insurance through Medicaid, or through the Marketplace, for example. In our application, we estimated that most clients served through our program would require two applications, but in fact, the average number of applications done for program participants was 3.4 applications. That means that some clients may have had as many as 5 or 6 applications done for them, depending on their circumstances. For example, most low-income seniors in this program qualified for SNAP, Medicare Savings, Medicare Extra Help, hospital financial assistance, and senior discounts through the Secretary of State's Office.

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.

Mrs. H is an older lady who cannot afford her prescription medication and is very concerned. A local pharmacy referred her to CCHCC for prescription assistance. In the course of working with Mrs. H, we learn that she has a very affordable, but very inadequate Medicare Part D plan (for prescription benefits). An unscrupulous insurance agent sold her a plan that does not work in our area and that does not cover her more expensive prescriptions, which include a psych med. We work with her first to secure her prescription so that she does not have a gap in taking that prescription. So, we help her through our Rx Fund program. Next, we work with her to review her Medicare-related health insurance and we get her a special enrollment period so that she can drop her bad Medicare Part D insurance, and we sign her up for a plan that works with local pharmacies and that has good coverage for the prescriptions she needs. Then, based on the information about her income, we apply her for Medicare Savings and Medicare Extra Help, and now her Medicare Part B monthly premium is covered and does not have to be deducted from her Social Security retirement income, and her Part D premium is covered as well and her out of pocket costs have a cap on them, making her prescriptions covered and more affordable. And we determine that she is eligible for SNAP, so we apply and get her approved for SNAP benefits and we teach her how to use her LINK card. Then we learn that she owns her home and is in need of some repairs to her home, which she cannot afford. We help her apply for assistance through her local City, and she is approved for some home repairs. She is still an anxious person, but is feeling more secure and more financially stable.

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 firmly believe that we are on the right track with this program and our data supports the need for, and effectiveness of this program. Many of our clients in this program are highly anxious and/or experiencing depression, and applying for basic benefits or services can be overwhelming and might seem unattainable. Many people in this program are easily overwhelmed by paperwork or mail coming at them and do not feel that they have the capacity to sort through information or do applications themselves. They are very grateful for our help, and our services connect them to important resources and benefits as well as provide a therapeutic relationship which is beneficial to our clients. We are patient, understanding, and effective in what we do, and we go the extra mile for our clients to make things as easy for them as possible, given their struggles and their need for care.

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 Health Care Consumers** __________________________
Program Name: ____**Disability Application Services** ____________________________________
Program Year: ___2024_________

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. All clients served are Champaign County residents who have behavioral health issues, are low-income (or no income), and need help applying for disability benefits.

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. CCHCC is rapidly becoming the trusted resource for help with Disability applications and questions about Disability benefits. Our partner and referring agencies are increasing the number of referrals now that they know that CCHCC is able to help with this service, and the two Townships in CU now routinely refer their clients to CCHCC for this help. In addition, we spend time every week at Strides so that we can pick up as many homeless clients as possible, and we are at Daily Bread twice a month to do the same.

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.

   In the application, we estimated 2 days from intake to assessment for eligibility of services. But in most cases, start of services began immediately after or during assessment, as long as the client had their information available. Some clients take more

time before we can start applying them for disability benefits because they might a) have other very pressing needs, like impending homelessness; and/or b) they might not be getting regular health care, which is needed to document their disabling condition. If they have other issues that must be addressed first before we can being the disability application, we work with them on those issues and we try to stabilize them.

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 the application, we estimated that approximately 70% of eligible clients will engage in services within the identified timeframe. Our finding is that this is a good and solid estimate.

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

   In our application, we estimated participant engagement for months or even years. And this has proven to be correct, based on previous years' clients, and clients new to us this year. The Disability application process is daunting, tedious, and brutal, and has many deadlines that must be met. Nowadays, it can take Social Security Administration up to 6 months to make a decision on an initial application, and it is almost always an adverse decision that then requires that an appeal be filed. We always work with the clients to file an appeal, as people are far more likely to be approved on appeal than in the initial application. The Social Security Administration is now routinely "losing" clients' paperwork and appeals, even when CCHCC hand delivers it to the local SSA office. Of course, we keep copies of everything and we document every action we take. But things have gotten VERY bad at Social Security since the pandemic. In addition the SSA often makes mistakes and enacts clawbacks or dropped benefits that we have to fight on behalf of the client. We often succeed in these fights, but they can take weeks or 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.

   The additional data we gather has to do with homelessness status and language needs/preferences. With our non-English speaking clients, we have found several instances when the client was denied a chance to apply for Disability because the SSA claimed that they were ineligible based on their immigration statuses, even if they were in fact eligible. Documenting these instances has been very important. We will create a report in a few months detailing the failures of the SSA and the impact on our most vulnerable community members, along with policy and practice-change recommendations.

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

We estimated that we would serve 30 new TPC clients, and 7 continuing clients. We ended up serving 7 continuing clients in Q1, and 24 more continuing clients throughout the rest of the year, so we met our goal for the continuing clients. In terms of new clients, we served 65 new clients in this Program Year, exceeding our Target of 30 new clients for this Program Year.

The assessment tool used to collect information and data includes the Client Intake and Disability Intake forms, where we document all the services with which the client needs help, and specific items related to a Disability Application. Then, we track the client data, including services requested, performed, and the outcome of those services (for example, Medicaid or SNAP approvals, Disability approvals or denials and appeals) in our SalesForce database.

Outcome #2

We estimated that we would be able to take on 2 new clients per month, for the purposes of starting new applications, even as we continue to work with existing clients through the progression of their cases. In fact, we have been taking on anywhere from 2 or 3 new clients per month, up to 9 or 10 per month, depending on the month. So, we are exceeding the target of working with 2 new clients per month.

Outcome #3

We anticipated that many clients would need help with additional services and applications, such as Medicaid and SNAP. This has proven true, but the reality is more serious. We have worked with clients who were homeless or on the verge of eviction and who were in desperate

need of housing help. And although we are not a “housing navigator” organization, we have often jumped into this role because we know the systems in place and how to help people apply for these resources. We are often called on to do work that helps stabilize the person before they can even begin their disability application. In the course of doing this work, we have rescued abused persons and animals and extricated them from dangerous situations and helped them find housing, or rehoming for the animals. Some of the conditions under which people are existing and experiencing are truly heartbreaking, dangerous, and ghastly. Most of our clients are helped with multiple applications, beyond their disability applications. They are referred internally for help with Medicaid and SNAP, while our Disability Application Specialist has helped with housing navigation and the disability application.

Outcome #4

(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? ___**72 TPC and 17 NTPC for a total of 89 clients**__________

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? ___**72 TPC individuals**___________
4. How many people did you *actually* collect outcome information from? __72____________
5. How often and when was this information collected? *(e.g. 1x a year in the spring; at client intake and discharge, etc)*

   The information is collected on an ongoing basis, due to the process of providing application help and referrals to other services. The initial data collection takes place at intake. CCHCC staff do SalesForce data entry every week, on every clients with whom they have interacted with during that week, or for whom they have worked on their disability application.

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.*

   We have learned that clients are presenting themselves to us with very significant needs. Working with most of these individuals is like peeling an onion, with layer after layer of need or a program failure, or even life-threatening conditions. By definition, all of the participants in the MHB-funded portion of this program are individuals who are struggling with behavioral health issues, making all of these challenges much harder.

   We have experienced some shocking situations, including a young adult held captive and living without ID or resources or money, and animals in poor condition who needed to be rescued and rehomed, as well as individuals who had Orders of Protection against former partners but who were being stalked and harassed and who needed our help to be relocated so that they could "hide" from their former partners. Sometimes these needs took precedence above starting the disability application, so we helped with these needs.

   We retain most clients, including some who are severely mentally ill and struggling as they go off their medications. A very few clients do not want to engage in services but are made to do so as a consequences of receiving General Assistance from Township. They do not really want to apply for Disability but they are made to do so, and sometimes they disengage from services. But that is a small minority of our clients.

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.

   J is homeless and currently staying at a cheap motel. He is functionally disabled and needs help applying for disability benefits and other benefits. He becomes a client at Township on our referral, and he begins receiving Township General Assistance, which helps pay for his motel, along with panhandling. We refer him internally, and he receives Medicaid and SNAP. He needs help getting a new ID, but first he needs a birth certificate. We help him with these things. We also help him apply for free phone service. This makes communication easier.

   J is very mentally ill and takes his medications infrequently. On top of that, when he drinks, he becomes belligerent and abusive to anyone around him, including those who are trying to help him. Little by little, we make progress on getting him resources and benefits, and we start working on his Disability application. We take him to doctor's appointments to

make sure he is getting the care he needs and that his conditions are being documented. We work with the doctor's offices to ensure that they are documenting his inability to work and the reasons for that.

We also request home health services for him, which are prescribed, and he gets a walker that he desperately needs. The home health nurse helps him organize his medications and we learn his schedule and we text him reminders to take his medications. We also gently remind him not to drink alcohol, and he begins to stabilize and become more effective in helping with his disability application.

We also apply him for housing vouchers through RPC based on his disabling conditions. He is approved for a voucher but needs help finding a place to live. We help him find a new apartment at a local apartment complex, and we help him do the application with this place because they do accept the housing voucher. In a few weeks, he is ready to move into his new apartment but he needs help with bedding and furniture, etc., so we link him with programs to help with that.

And we continue to work on his application and get it submitted. After that, we have to continually monitor his Social Security online account for updates and also his mail. In order to monitor his mail, we have to text him every day to find out if he got any mail from Social Security.

Eventually, J gets denied (unjustly), and we have a certain number of days to file the appeal. J becomes discouraged and despondent, but we remind him that the statistics are that the likelihood of being approved on appeal is far greater than on application, and we remind him of the amazing progress he has made.

We read the denial letter and see the basis for the denial, and then we work on an appeal that counters that basis. And every time J gets health care of any sort, we submit updates to his case. And then we wait to see if his appeal goes through.

Once he is approved, we celebrate and we explain what it means and how long it will take for him to start receiving benefits. Township gets paid back for the support they provided to him, and then the rest of the lump sum payment is his. We update RPC so that the portion of rent that he pays after his voucher is appropriate, and we help him establish a monthly budget and go shopping for other items he might need, including winter coats, etc.

And we continue to work with him from a case management perspective, and also to maintain his other benefits such as Medicaid and SNAP.

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?

   The evaluation very much supports our current practice. The changes that we have made is mostly in the form of building relationships with Housing Authority and other housing-related agencies, and some senior service agencies in order to help some of our clients to be able to "age in place" or avoid losing their homes. We will continue to build on these relationships and these networks because many people who need help with disability applications also really need help with stabilizing their lives, both health-wise and economically, and in terms of food security.

   Our community REALLY needs a program that will help to pay for non-traditional things like car repairs, or vet services and pet food, etc. More robust rental assistance and home-repair programs are also desperately needed, as is more accessible housing for individuals with mobility issues. We also feel that a robust community-based case management program is really needed. There are some clients of ours for whom we have taken on that function because they need case management help in order to remain stably housed and for their income to be used wisely and to meet basic expenses.

   Under ideal circumstances, CCHCC would have 10 Disability Application Specialists to serve the desperate need in this community and to be able to provide more of the case management services that many of these clients need (specifically, the clients who struggle with behavioral health issues).

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 Health Care Consumers (CCHCC)**___________________
Program Name: ____**Justice Involved CHW Services & Benefits**___________________________
Program Year: __**2024**__________

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. All clients served through this program are a) residents of Champaign County; b) have evidence of a need for this service based on assessment; and c) have limited financial resources. The specific target population for this program is Champaign County residents with criminal justice involvement and/or going through Reentry following incarceration who are experiencing behavioral health issues. Homeless individuals are also included and often have criminal justice system involvement.

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.

In the application, we estimated 2 days from assessment to start of services. But in most cases, start of services began immediately after assessment, as long as the client had their information available.

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 the application, we estimated that 80% of individuals seeking these services would engage in services in the timeframe stated above. We were able to hit this target in almost all cases.

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 client engagement on an annual basis, or in some cases, every 6 months in order to go through Medicaid or SNAP redeterminations. This has proven to be the case. The only exceptions are for individuals who are mandated to IDOC or who move out of the area. But even returning individuals are contacted and re-engaged in services, so engagement in services can go on for multiple years. Our clients tend to stick with us because we provide effective and reliable services, so they remember us and come back to us for help as needed.

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 do collect additional data, including homelessness status and language needs and preferences. For this Justice Involved Program, most of the clients came on referral through the County Jail, by Jail personnel or the Rosecrance staff member in the jail. However a few clients were homeless – approximately 11% of clients for this program were identified as homeless. What these data suggest is that justice-involved clients are represented among the homeless population in our community, and sometimes these are individuals who are released from IDOC without being on parole and they have no home or relatives to whom to discharge, so they end up at shelters or on the streets, or "couch surfing". This is in line with what we have experienced in previous years.

   And, although sex/gender is a demographic category that is collected, we have noticed that we are seeing more females/women clients through the jail, thanks in large part to the Pregnancy & Parenting Class that CCHCC staff members are teaching in the jail every week. The female/women inmates who attend these classes learn more about CCHCC's services and that they can get services from Chris Garcia while they are in the jail, simply by filling out a "yellow slip" request form.

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

We estimated that we would serve approximately 75 to 100 individuals through this program. Outcome data shows that we served 104 individuals.

The assessment tool used to collect information includes the Client Intake form, where we document all the services with which the client needs help. Then, we track the client data, including services requested, performed, and the outcome of those services (for example, Medicaid or SNAP approvals) in our SalesForce database.

Outcome #2

We estimated that all eligible clients (the TPC clients) would be approved for various benefits including Medicaid, SNAP, hospital financial assistance, prescription assistance, etc., depending on their needs. Our outcome data, documented in our SalesForce system, show that all TPC cases applied for benefits were approved for those benefits.

Outcome #3

We estimated that, on average, most clients would require two applications – whether for Medicaid, SNAP, hospital financial assistance, prescription assistance, access to affordable dental or vision care, etc.

Our outcome data, documented in our SalesForce database, shows that our estimates were correct, and that almost all clients required more than one application, with most requiring 2 or

3 applications at one time. Our data show that, on average, the Justice Involved clients require 2.5 applications.

Outcome #4

(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? __**134, with 30 being NTPC, and 104 being TPC. The NTPC cases were typically individuals who were adjudicated to IDOC and whose benefits would be terminated/suspended when going to IDOC.**__________

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? _**104 – the TPC cases**___________
4. How many people did you *actually* collect outcome information from? __**104**______________
5. How often and when was this information collected? *(e.g. 1x a year in the spring; at client intake and discharge, etc)* **This information is collected on an ongoing basis. For example, if we help someone apply for SNAP, we find out very soon after the application if they are approved, and for how much. We then verify that they have started to receive their benefits. And if they contact us about another service, or a problem they are having, we track the request and the outcome in real time.**

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.*

We learned that virtually all individuals incarcerated in the Champaign County Jail are in need of some service or another from CCHCC – whether it is applying for or renewing Medicaid and SNAP, or applying for hospital financial assistance, free phones, rental assistance, etc. And sometimes BOTH the client and the county requires CCHCC's help when it comes to extremely expensive prescriptions that are not covered by Medicaid. **All** the clients who worked with our Justice Involved program were/are low-income, so they qualified for benefits or were able to re-establish benefits.

Typically, NTPC individuals are those who are getting adjudicated to IDOC, so simply had questions about terminating benefits or about helping their relatives get access to CCHCC.

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.

CCHCC's Chris Garcia receives a referral from the Rosecrance case worker stationed at the County Jail. Mr. M is the client referred and he will be leaving the jail in a few weeks and he wants to be able to continue his Rosecrance service plan once he gets out, but he is unsure if his Medicaid is still active. He has also lost his job, so when he gets out, he will need SNAP benefits as well. Chris receives actionable information from his Rosecrance counterpart, so he starts looking up the client's status in Medicaid and SNAP, and starts preparing applications if needed. He also makes arrangement to meet with the client, Mr. M, at the jail on a Wednesday morning when Chris is stationed at the jail. Chris and Mr. M meeting, and Chris completes the applications for the client, but then also finds out that the client needs hospital financial assistance for a bill with Carle. Because of completing the Medicaid and SNAP applications, Chris has all the information he needs to complete the hospital (and clinic) financial assistance application. Once the client is approved for benefits and hospital financial assistance, Chris contacts his Rosecrance counterpart at the jail so she can inform the client. Then, when Chris sees the client next, he informs Mr. M that there will be mail in a few months regarding redeterminations for Medicaid and SNAP, and when that mail comes, to contact Chris so he can help with the redeterminations. The client agrees. But Chris will also know as a result of tracking the case information, so if Mr. M fails to reach out to Chris, Chris will follow up with Mr. M. Then Mr. M asks Chris if Chris can help some of Mr. M's family members. These family members are then referred to CCHCC. If they have justice-involvement, Chris will work with them. If not, they are internally referred to another staff member.

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?

The evaluation shows that we are on the right track. This program is working! People in jail are getting services and benefits that should help stabilize their health and their lives. While all the clients for this program do not all come from the jail, the majority do, so the collaboration with the Champaign County Sheriff's Department and Jail, and Rosecrance, are key to the success of this program. This program will be especially important and beneficial in the future, as Illinois has been approved for a waiver that will allow it to expand Medicaid to non-clinical services including rent assistance, and also having certain benefits be suspended but not terminated while the person is incarcerated, rather than having the person lose their benefits entirely and have to reapply when getting out of prison.

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: __23-24__

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.

   We stated that, Children are eligible for services funded by this grant if they score within rage 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.

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.

   Demographics this year seem similar to our typical demographics. Head Start enrollment rules prioritize children and families that are at risk or experiencing stressors like CPS involvement, homelessness, poverty, or who have a disability.

   - Total # of Children in HS and in EHS: 526
   - Total # of Expectant Mothers in EHS/Expansion: 24
   - Total # of Families: 469
   - Total # of children with a IFSP or IEP: 63
   - Total # of children referred for DD or Special Ed: 73
   - Total # of Homeless children/families: 71 children
   - Total # of family served with income below 100% FPG: 134
   - # of families at 100-130% FPG : 41
   - # of children/families in foster care system: 31
   - # of children/families on public assistance: TANF=6; SNAP=169
   - # of children/families over income: 66

- # of families who speak:
    - English – 429
    - Spanish – 35
    - Middle Eastern – 21
    - African – 3
    - East Asian –0
    - European and Slavic – 38
    - Native Central American – 0
- Education level
    - Advanced degree or baccalaureate degree – 66

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.

CCHS saw an overall decrease in needs that were identified regarding Total Protective Factors, Initiative, Self Regulation and Attachment and Relationships. At our Elizabeth Murphy site location, we saw our biggest overall decrease in needs identified by 22% at the end of 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 8% increase in skills from the Fall Checkpoint to the Summer Checkpoint. For children 3 years- 5 years, CCHS saw a 28% increase in social emotional skills and for children who were Kindergarten bound, we saw an increase of 36% in social emotional skills from the Fall Checkpoint to the Summer Checkpoint. For children 3 years-5 years, the increase in social emotional skills exceeded last years findings.

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 FY25 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 FY25 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. 80% of classroom observations indicated that each domain of Emotional Support, Classroom Organization and Instructional Support were happening consistently and effectively. For the other 20% 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.

(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? _____________

    Total
    NTPC: 318
    TPC: 126

    First Q:
    NTPC: 83
    TPC: 46

    Second Q:
    NTPC: 188
    TPC: 13

    Third Q:
    NTPC: 23
    TPC: 22

    Fourth Q:
    NTPC: 24
    TPC: 45

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? __526____
4. How many people did you *actually* collect outcome information from? ____223_________
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.

We learned that the children in our Head Start program had significant social emotional skills improvement from the Fall checkpoint in October, where 43% of the Head Start children met the expected benchmark for social emotional development. By June, 83% of our preschool aged students met the bench mark for social-emotional development. This was an improvement from our outcomes from last year.

This year we experienced self-reported high burnout levels in our teachers from managers and coaches due to the increased numbers in children with high needs and developmental delays. Autism Spectrum Disorder diagnoses have significantly increased and has caused staff doubt in their abilities in the classroom. We are exploring ways to address staff professional development during in-service and throughout the year so staff have the supportive tools to feel confident to support all children and provide high quality inclusive classrooms. We have also strengthened community ties with Autism resources.

This year we didn't track outcomes with parents because of our staff shortage issues.

We found that through our ongoing coaching model, we saw improvements in classroom behaviors and fidelity of services over time. Significantly, we saw improvement in teacher stress and relationships with children when we provided them weekly reflective consultation to process and brainstorm new strategies.

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.

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.

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?

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: Homeless Services System Coordination
Program Year: 2024

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. Agencies, organizations, community members, and businesses that had an interest in preventing, addressing, and serving households in Champaign County that are homeless or at risk for homelessness were provided regular updates on the activities of the Continuum of Services Providers to the Homeless (CSPH) through monthly meetings with agendas and minutes from the prior meeting emailed out in advance by the CoC Coordinator, regular email communications to the CSPH email group list by the CoC Coordinator, and CSPH full board meeting minutes were posted to the CSPH website. Additionally, the CoC Coordinator held one on one meetings with organizations who were interested in joining the CSPH as a member organization. Finally, the CoC Coordinator conducted presentations to key community stakeholders (such as the Urbana City Council, Urbana Community Development Commission, Champaign County Board, and City of Champaign Neighborhood Services Advisory Board, to name a few) throughout the program year to share key priority areas from the recently developed CSPH 3-year Strategic Plan.

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. As of July 31, 2024, the CSPH currently has 45 members and 19 affiliates. The CoC Coordinator held individual meetings with representatives from the following organizations to share more information about the CSPH and welcome their participation as member organizations: Dimension-F, El Roi House, Friend in Me, Greater Community Aids Project, Promise Healthcare, and Rosecrance. The CoC Coordinator also held meetings with the following member organizations to increase involvement and participation with the CSPH:

Champaign County Veteran's Assistance Commission, Courage Connection, City of Champaign Township, and UIUC Office of the Dean of Students.

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. The CoC Coordinator participated in 41 Community Service Events (CSE) (target was 26) during the program year which is defined in the program application as:

- Number of contacts (meetings) to promote the program, including individual meetings with non-member entities focused on increasing membership, public presentations (including mass media shows and articles), consultations with community groups, school class presentations, and small group workshops.
- Number of Homeless Services System Coordination program coordinated trainings.
- Number of focus groups conducted to receive feedback from people with lived experience.
- Number of meetings related to the annual homeless Point in Time (PIT) count to inform the community about the event and the event results, solicit and train volunteers, and the actual event.

The CoC Coordinator also had 201 Service Contacts (SC) (target was 40) during the program year which is defined in the program application as:

- Number of persons participating in trainings coordinated by the Homeless Services System Coordination program.

Both CSE and SC targets were exceeded during the program year.

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.

   Estimate = 14 days
   Actual (average) = less than 1 day
   Explanation = Upon inquiry about the CSPH, the CoC coordinator responded to all organizations within one day of inquiry.

Organization	**Date of Inquiry About CSPH**	**Response Date from CoC Coordinator**	**Business Days Between Inquiry and CoC Coordinator Response**
Dimension-F	7/10/2023	7/10/2023	0
Rosecrance	7/25/2023	7/26/2023	1
El Roi House	8/21/2023	8/28/2023	5 (on vacation week of 8/21)

Greater Community Aids Project (GCAP)	8/28/2023	8/28/2023	0
Terry Townsend (community member)	11/27/2023	11/27/2023	0
Friend In Me	11/28/2023	11/29/2023	1
Village of Rantoul	12/19/2023	12/19/2023	0
Promise Healthcare	1/10/2024	1/10/2024	0
Reintegration Haven Homes	1/19/2024	1/19/2024	0
Champaign County Veterans Assistance Commission	5/16/2024	5/17/2024	1

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.

Estimate = 100%
Actual = 100%
Explanation: The CoC Coordinator engaged with 100% of organizations within 14 days of inquiry.

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

Estimate = Each member of the CSPH will participate in at least 5 of 11 meetings each year.
Actual = 31 out of 45 member organizations attended at least 5 meetings during the last program year (69%, a 12% improvement from FY23).
Explanation: The CoC Coordinator continues to outreach to organizations that have not been attending CSPH meetings and working to establish reengagement. FY24 engagement was a 12% overall improvement in the number of meetings attended compared to FY23.

CSPH Member Organization	**# of CSPH Meetings Attended During Program Year (July 1, 2023 – June 30, 2024)**
Carle Community Health Initiatives	12
Center for Youth and Family Solutions	5
Champaign County Emergency Management Agency	5
Champaign County Healthcare Consumers	8
Champaign County Mental Health and Developmental Disabilities Boards	9

Champaign County Public Health District	6
Champaign County Regional Planning Commission	12
Champaign-Ford Regional Office of Education #9	0
Champaign-Urbana Mass Transit District (MTD)	10
Champaign Park District	0
Child Care Resource Service	1
City of Champaign	10
City of Champaign Township and STRIDES	11
City of Urbana	11
Community Choices	0
Community Service Center of Northern CC	6
Courage Connection	6
Crisis Nursery	9
C-U at Home	9
Cunningham Children's Home	12
Cunningham Township	9
Developmental Services Center	8
Dimension-F	5
Eastern Illinois Foodbank	2
El-Roi House	5
First Followers	0
Greater Community AIDS Project	3
Hope Center of Vineyard Church	0
Habitat for Humanity	9
Housing Authority of Champaign County	6
Land of Lincoln Legal Assistance	7

LifeLinks	0
Merci's Refuge	0
OSF Community Resource Center	7
The Pavilion	9
Reintegration Haven Homes	3
Rosecrance	7
Salvation Army	10
Street Outreach Movement	3
United Way	11
Uniting Pride of Champaign County	0
University of Illinois, Office of the Dean of Students	6
Veterans' Affairs / Illiana Health Care System	9
Village of Rantoul	1
At-Large Member (Nathan Alexander)	10

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 45 organizations that comprise the CSPH membership, below is a breakdown into each of the following categories:

Public/Governmental Entity	**Private/Not for Profit Entity**	**Business**	**Homeless/Formerly Homeless Person**
13 CSPH Members	30 CSPH Members	1 CSPH Member	1 CSPH Member

The CoC Coordinator and CSPH Executive Committee has been diligently working to recruit people with lived experience to the CSPH Executive Committee. A first round of applications was accepted and reviewed; however, the application process will be opened for a second round by 8/30/24.

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: The IL-503 CSPH will be represented in the development of an alternative to the VI-SPDAT.
Specific Outcome Goals: The Coordinator will attend no less than 4 consultations, webinars, and/or TA opportunities relating to the development of an alternative to the VI-SPDAT for use with the CSPH Coordinated Entry System (CES).
Description: The VI-SPDAT is used to assist with prioritizing participants for homeless-specific resources. The VI-SPDAT fulfills this role in Continuums across the country. In 2021, the VI-SPDAT's developer discontinued the product, citing concerns for racial equity. The Coordinator will work with other Continuums and organizations to develop an equitable tool for use in the CSPH.
Survey/Assessment Tool: Consultation with other CoC's in Illinois who are using an alternative to the VI-SPDAT, such as Heartland CoC which also serves as a one county CoC covering Sangamon County.
Result: On 2/28/24, the developer of the Place Value Assessment Tool, Storm Walker, provided a demonstration of the tool to the CSPH Coordinated Entry Committee. On 3/22/24, the CoC Coordinator attended a demonstration and Q and A training for the Matching to Appropriate Placement (MAP) Assessment Tool. Additionally, the CoC Coordinator discussed alternatives to the VI-SPDAT with other CoC's in Illinois at the February 2024 Statewide CoC meeting. After review and discussion with the Coordinated Entry Committee at both in person monthly meetings from July 2023 – June 2024 as well as through online surveys, it was unanimously decided to move forward with the Place Value Assessment Tool. On 6/13/2024, CCRPC signed the contract to move forward with the implementation of the Place Value Assessment Tool. Next steps include training for all staff in the Coordinated Entry System and reassessing individuals on the prioritization list for permanent housing options who were previously assessed with the VI-SPDAT.

Outcome #2: A Racial Equity Assessment will be conducted within the CSPH.

Specific Outcome Goals: The Coordinator will complete racial equity analyses for the CSPH CES and Continuum exit destination data. Results from the analyses will be shared with the CSPH and other groups to solicit feedback and recommendations to improve CSPH systems.
Description: Analyses will use the HUD CoC Racial Equity Analysis Tool and other tools as necessary including HUD's STELLA P tool. Equity analyses have been part of competitive applications in the past. As additional tools become available, more advanced analyses are possible, allowing for a more equitable Continuum.
Survey/Assessment Tool: HUD CoC Racial Equity Analysis Tool available at https://www.hudexchange.info/resource/5787/coc-analysis-tool-race-and-ethnicity/. HUD Stella P Race and Ethnicity Analysis Guide available at https://files.hudexchange.info/resources/documents/Stella-P-Race-and-Ethnicity-Analysis-Guide.pdf.
Result: The CoC Coordinator utilized the HUD CoC Racial Equity Analysis Tool to review the CSPH's 2021 Point-in-Time Count racial and ethnic demographic data as compared to US Census Bureau data for Champaign County. The CoC Coordinator presented findings to the CSPH Executive Committee on 7/19/23 and full CSPH on 8/1/23. In addition, two members of the CSPH Executive Committee, City of Champaign, and Cunningham Township Supervisor's Office, participated in several trainings offered by the Department of Housing and Urban Development focused on racial equity. From these trainings, the CSPH established a Racial Equity Committee. The current CSPH Chair and CoC Coordinator are working with HUD to host a training for the CSPH on racial equity.

Outcome #3: The CSPH will receive feedback and recommendations from people with lived experience through a series focus groups.
Specific Outcome Goals: The Coordinator will facilitate no less than 3 lived experience focus groups. Participants may include currently homeless persons, participants of Continuum programs, and recent participants of Continuum programs. Minutes and summaries will be provided to the CSPH.
Description: Lived experience is a crucial part of system planning. Focus groups will allow direct feedback and recommendations from lived expertise and may facilitate recruitment of additional lived experience onto the Executive Committee.
Survey/Assessment Tool: Minutes and summaries from the focus groups will be provided to the CSPH. Focus group questions will be developed in collaboration with the CSPH Executive Committee.
Result: The CSPH hosted a focus group for homeless families on 8/30/2023 and a focus group in conjunction with Cunningham Children's Home's Runaway and Homeless Youth Program on 6/11/2024. Summaries and key takeaways from these focus groups are in the results section of this report.

Outcome #4: A new 5-year strategic plan will be created with IL-503 CSPH.
Specific Outcome Goals: The Coordinator will lead the planning process for the Continuum, complete one-on-ones with MOU agencies, facilitate groups, and make recommendations to the CSPH Board for strategic plan goals.

Description: The last CSPH Strategic Plan expired in 2020. Through this process, a 5-year strategic plan will be produced. Strategic planning is an important piece of homeless service coordination. The plan will be informed by best practices, analysis of neighboring CoC's plans and will receive input from TA partners.
Survey/Assessment Tool: Review of other CoC's in Illinois' Strategic Plans and review of HUD's guidance on strategic planning available at https://files.hudexchange.info/resources/documents/Guide-to-Strategic-Planning-for-Rural-and-Balance-of-State-Continuums-of-Care.pdf.
Result: The CoC Coordinator and CSPH Executive Committee established a CSPH Strategic Planning Committee who met monthly from July 2024 – November 2024. A proposed 3-year Strategic Plan was presented and approved by the full CSPH on at the November 2023 CSPH meeting on 11/7/2023. Key priority areas include permanent housing, data utilization and quality, equity, landlord engagement, and lived experience representation. Since 11/7/2023, the CoC Coordinator presented the CSPH Strategic Plan to the following community stakeholders to create community awareness and public support for the initiatives of the CSPH: Urbana City Council, City of Urbana Community Development Commission, Champaign County Mental Health and Developmental Disabilities Agencies Council, City of Champaign Neighborhood Services Advisory Board, and Champaign County Mental Health Board.

CONSUMER PARTICIPATION IN DATA COLLECTION

1. How many total participants did the program have?

   During the program year, the Homeless Services System Coordination Program had a total of 70 treatment plan clients. Treatment plan clients are defined as CSPH member organizations and individuals with current or recent lived experience of homelessness engaged with CSPH Strategic Planning efforts.

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 Data was collected for each of the four identified outcomes.

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

   Outcome Data was collected for each of the four identified outcomes.

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

   Outcome Data was collected for each of the four identified outcomes.

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

Outcome data was tracked weekly by the CoC Coordinator via Microsoft Outlook and compiled quarterly on an Excel Spreadsheet.

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.*

Important summary information from the two focus groups held in FY24 are below.

Summary of CSPH Focus Group – August 2023

The Continuum of Service Providers to the Homeless (CSPH) conducted a focus group in August 2023 open to people with lived experience of homelessness (both currently and formerly homeless). The focus group was held at First United Methodist Church in downtown Champaign at 3:30pm on Wednesday, August 30th. The group was facilitated by Katie Harmon, Continuum of Care Coordinator with Champaign County Regional Planning Commission and Danielle Chynoweth, Cunningham Township Supervisor at Cunningham Township Supervisor's Office. All participants were provided with a $25 Visa Gift Card for their participation. Four people attended the event. Two participants identified as female and two identified as male. Three participants identified as white, and one identified as Hispanic/Latino. Ages of the participants ranged from 31 to 60 years old.

The goals of the focus group were:

- To understand the factors that lead to or exacerbate homelessness locally
- To identify gaps or inefficiencies in local CSPH systems
- To develop improvements for CSPH systems

A special thank you to Cunningham Township Supervisor's Office for providing food for the event and Crisis Nursey and Courage Connection for volunteering to provide childcare.

Facilitated conversations covered three key areas:

- Learning participants experiences with local homeless systems in Champaign County
- Exploring suggestions for improvement of local homeless systems
- Understanding participants homeless situation and contributing factors to homelessness

Key Takeaways

- It would be helpful for organizations to increase their outreach efforts to directly reach people who are experiencing homelessness for them to learn about services they may be eligible for.
- Education about homelessness in the broader community is vital to dismantle myths about homelessness and to strengthen support for people experiencing homelessness.
- Better understanding and support are needed to support people who are experiencing homelessness and dealing with mental health and substance abuse concerns. Additionally, more mental health resources are needed particularly for those who are experiencing homelessness and do not have health insurance.
- Peer support and engagement efforts are needed.

Summary of CSPH Focus Group – June 2024

The Continuum of Service Providers to the Homeless (CSPH) conducted a focus group in June 2024 in partnership with Cunningham Children's Home. The focus group was held at Crystal Lake Park at 12pm on Tuesday, June 11th and the group was facilitated by Katie Harmon, Continuum of Care Coordinator with Champaign County Regional Planning Commission and Angie Bertauski-Pierce, Associate Director of Community Services with Cunningham Children's Home. All participants were provided with a $25 Visa Gift Card for their participation. Fourteen young adults aged 18-24 who were currently in enrolled in Cunningham Children's Home's Runaway and Homeless Youth Program attended the event. Thirteen of the participants identified as female and one identified as male. Seven of the participants identified as Black, 5 identified as white, and 2 identified as multi-racial.

The goals of the focus group were:

- To understand the factors that lead to or exacerbate homelessness locally
- To identify gaps or inefficiencies in local CSPH systems
- To develop improvements for CSPH systems

A special thank you to Cunningham Children's Home staff and volunteers for assisting with transportation to the event, providing childcare and lunch, and offering a supplemental gift card to participants.

Facilitated conversations covered four key areas:

- Learning participants experiences with local homeless systems in Champaign County
- Exploring suggestions for improvement of local homeless systems
- Understanding participants homeless situation and contributing factors to homelessness
- Identifying current barriers to moving into permanent housing

Key Takeaways

- Our community needs more programs that have year-round availability and increased capacity.
- Consistent with feedback from prior focus groups in 2022 and 2023, it would be advantageous for staff working at homeless programs to have a better understanding of the contributing factors to homeless, more training on offering services in a client-centered manner, as well as additional education/training on mental health first aid.
- Long waitlists and lack of communication from staff regarding their status on waitlists is extremely frustrating to those experiencing homelessness and affects their morale.
- Programs need to improve communication and awareness or program guidelines and processes.
- Budgeting and financial management skills are needed and starting at a younger age.
- Having a case manager who is supportive, listens, and follows through is critical to best supporting people who are experiencing homelessness in achieving their goals.

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.

Some achievements to highlight from our CSPH this past program year include:

- **Development and Approval of a Strategic Plan:** Over the past year, Champaign County Continuum of Service Providers to the Homeless (CSPH) developed and approved a 3-year strategic plan. Key stakeholders were involved in the development of the plan and key priority areas of focus include permanent housing, data utilization and quality, equity, landlord engagement, and lived experience representation. The CoC Coordinator has focused on presenting the plan to key groups for support and buy in.
- **Recruitment of People with Lived Experience of Homelessness for CoC Executive Committee:** The CoC Coordinator in consultation with the CoC Executive Committee developed marketing materials to recruit people with lived experience of homelessness to join the CoC Executive Committee as well as establish a lived experience advisory board. Additionally, a compensation plan was developed with financial assistance from Housing Action Illinois to provide monetary stipends for people with lived experience for contributing their time and expertise.
- **Establishment of a Shelter Diversion Program:** With new funding from the Illinois Department of Human Services, Champaign County Regional Planning Commission established a shelter diversion program to assist people identified through our CoC's Coordinated Entry System with exploring alternative living arrangements as a preventive measure to prevent shelter stays, if possible.
- **Participation in the Illinois Data Quality Collaborative:** Our CoC is currently participating in the Illinois Data Quality Collaborative program to work on improving local data quality and establishing a more accurate by name list for adults who are

literally homeless. The CoC Coordinator and HMIS Data Specialist have been working together on this project for our CoC.

- **Development of Hope Village:** Champaign County Healthcare Consumers in collaboration with Care Foundation Hospital and the University of Illinois are undertaking a project called Hope Village. Hope Village is a development of 30 "tiny" homes and a community center that will provide Permanent Supportive Housing to individuals who are medically fragile and experiencing chronic homelessness. This project received City of Urbana Council approval to move forward with project development.

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?

Based on the development of the CSPH Strategic Plan and feedback from CSPH Focus Groups, the following progress has been made since the end of calendar year 2023:

Data Utilization and Quality

- Participation in Illinois Data Quality Collaborative to improve local data quality. Monthly meetings started in August 2023 and are ongoing for a year and a half.

Equity

- Conducted initial Racial Equality Analysis of CSPH in July 2023.
- LGBTQ+ Workgroup of the CSPH hosted training for the full CSPH in August 2024 focused on Understanding LGBTQ+ Identities and Homelessness.
- Replacement of the VI-SPDAT assessment tool with Place Value is underway.
- Participation in HUD's Racial Equity Workshop Series (City of Champaign and Cunningham Township Supervisor's Office).

Landlord Engagement

- CCRPC implemented the Landlord Risk Mitigation Fund pilot program and hosted an information session for landlords in March 2024.

Lived Experience Representation

- Developed and implemented a recruitment and retention plan for people with lived experience of homelessness on the CSPH Executive Committee. Flyer and application sent out to CSPH in April 2024.
- Created a position description for CSPH Executive Committee Members with lived experience of homelessness. Position description sent out to CSPH in April 2024.
- Created funding for stipends/compensation for people with lived experience of homelessness to participate on the CSPH Executive Committee. Compensation plan sent out to CSPH in April 2024.

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: Youth Assessment Center
Program Year: FY24

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, services and supports were provided based on the stated criteria.

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.**

Youth at-risk or involved with the criminal justice system are being referred to the Youth Assessment Center and services are a positive match. However, youth who have experienced trauma may not be presenting symptoms until a rapport is established with Case Manager.

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, staff attend outreach events and continue to expand partnerships with community agencies to support appropriate matches between people and agencies.

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.**

Youth are typically being serviced sooner than 21 days, with an average of 14 days between the referral and service start date.

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 program had 67% compared to the estimated 70% of eligible youth who engaged in program services within the above 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.**

Youth engage in the program for an average of 3-6 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.**

In addition to race, ethnicity, age, gender, and zip code information, household information such as composition and referral sources were collected. The data demonstrates that 52% of our clients reside in homes where the head of household is female. 89% of our clients are between the ages of 13 and 18. 65% of our clients identify as Black, while 32% identify as White, and 3% are Asian, Pacific Islanders, Multiracial, or other. Only 5% of our clients identify as Hispanic. Most of our clients are male covering 66% of the caseload, while 34% are female.

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

Diversion of youth from justice system. The YAC aims to divert youth from the justice system, for both youth who have had police contact and been referred for station adjustment services and youth exhibiting behavioral issues.

Target: The YAC strives to divert at least 90% of youth from a juvenile court adjudication within one year of their YAC services.

Tools: Court Services Records/Database: A comparison of juvenile court records tracked through court services with YAC Client Database to determine how many have been adjudicated during the fiscal year.

Result: The Youth Assessment center exceeded this outcome by diverting 97% of youth from a juvenile court adjudication within one year of their YAC services.

Outcome #2

Decrease in the level of risk for youth to reoffend upon program exit.

Target: The goal is at least 10% of youth assessed at exit will have decreased from moderate/high to low risk to reoffend.

Tools: The Youth Assessment Screening Inventory (YASI) tool is used to measure difference in level of risk, along with protective factors, at intake and exit The YASI system's reporting tool provides aggregate data for youth risk levels and protective factors at entry and at exit.

Result: Based on the YASI scores, 34% of the youth entered the program with a low risk to reoffend, while 66% of the youth entered programming with a moderate to high risk to reoffend. Upon exiting the program, 52% of the youth demonstrated a low risk to reoffend, while 48% remained a moderate to high risk to reoffend. These numbers may vary as some of the Quarter 4 referrals are still open due to youth being currently engaged in services. Overall, the Outcome 2 goal was met with a 18% decrease in the percentage of youth assessed with Moderate/High Risk to Reoffend at exit as compared to the percentage at intake.

Outcome #3

Increase of resiliency within the youth referred. Service connection based on needs assessment will support individualized, meaningful services. Individuals/ families will be better informed of the services and resources available to assist them leading to increased utilization of services.

Target: At least 90% of participants will endorse having been informed of resource options and 50% will report successful linkage and utilization of recommended services.

Tool: The YASI will be used to identify individualized needs and guide the recommended service referrals. A pre and post service survey will be used to evaluate participants' increased knowledge of services available to address their needs.

Result: All youth receiving a Formal Station Adjustment/ Engagement Agreement receive referral information to community resources at intake. Ensuring successful linkage and utilization of recommended services have been a challenge due to the limited communication with partnering agencies. YAC will be working with internal case note database Sierra in FY25 to improve accuracy of referral and linkage records.

Outcome #4

N/A

(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**? 297

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?**

   The Youth Assessment Center collects outcome information from every youth.

3. **How many people did you *attempt* to collect outcome information from**? 297
4. **How many people did you *actually* collect outcome information from**? 135
5. **How often and when was this information collected? *(e.g. 1x a year in the spring; at client intake and discharge, etc)***

   Information is collected from the clients at the beginning and end of their engagement with the program.

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.***

The data provided offers valuable insights into both the participants and the overall program effectiveness at the Youth Assessment Center (YAC). Several patterns emerge when analyzing participant demographics, program efficiency, and outcomes, which shed light on the effectiveness of services and areas for improvement. The participant demographic information is pivotal in understanding the specific population that the YAC serves. The data highlights that the program predominantly serves Black male teenagers from female-headed households, providing critical context for tailored service delivery. Given that Hispanic, Asian, and female youth make up a smaller percentage of the participants, targeted outreach could help diversify the program’s impact and ensure that a wider spectrum of the community benefits from YAC services. The program data highlights impressive efficiency in service delivery. Youth are typically being services within 14 days of referral, well under the 21-day threshold set by the program. The quick turnaround reflects the YAC’s capacity to process referrals and engage

youth swiftly a vital factor in effective intervention for at-risk youth. The gap in engagement rates signals that some improvements in outreach and follow-up may be necessary to engage all eligible youth within the desired time frame. A key success for the YAC is reflected in its impact on the juvenile court adjudication. 97% of the youth served by the program were successfully diverted from a court adjudication within one year of receiving services. This outcome demonstrates the program's ability to intervene effectively in the lives of at-risk youth, helping them avoid deeper involvement in the justice system. This success rate surpasses expectations and speaks to the strength of the diversion strategy employed by the YAC. The YASI scores provide a clear view of changes in participants' risk levels throughout the program. An 18% decrease in moderate to high-risk participants over time, underscore the program's effectiveness in mitigating risk factors associated with recidivism. This shift in risk level is significant, as it shows that the YAC is not only preventing youth from entering the juvenile system but also actively reducing the likelihood that participants will reoffend. Despite the successes in diversion and risk reduction, challenges persist in ensuring that youth are successfully connected with the recommended community resources. Limited communication with partnering agencies has made it difficult to verify whether these linkages are being utilized effectively. This challenge signals the need for better coordination and tracking systems, which the YAC plans to address by improving the accuracy of its referral and linkage records through the Sierra database. Collaboration with agencies is being strengthened to facilitate streamlined intervention services. These strategic adjustments aim to enhance community engagement and create a more responsive service model that is aligned with the needs of both youth and referring partners. In summary, the data reflects that the YAC program is making meaningful progress in reducing recidivism and preventing court adjudication for the youth it serves. By leveraging data-driven insights and community feedback, the YAC is well-positioned to continue improving its outcomes and deepening its impact in the years to come.

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 following testimony is an illustration of the transformative power of our program. YAC assists the youth in navigating personal challenges with resilience and support, ultimately pioneering stability and growth. Mariah was referred to the Youth Assessment Center by the State's Attorney due a fight at her school where she was a perpetrator. The YASI assessment indicated an overall moderate risk to reoffend and moderate strengths at opening and was assessed at an overall low risk, with strengths very high at the closing. During the assessment, we discovered severe trauma the youth was working through, and she requested a referral for counseling, which we were able to facilitate through Cunningham Children's Home- Families Stronger Together program. Mariah was very receptive to the Reflections program. Upon transferring schools, she faced struggles, however this youth was able to incorporate the Reflections program into her daily life to help her deal with the situations and was able to work

things out with the other youth, without fighting. This success story highlights the importance of our holistic approach in empowering youth to overcome obstacles and thrive.

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?**

The YAC has been working on community engagement to increase community referrals and rebuild past referral partnerships. Through a community needs assessment forum with a focus group for youth, common themes and services were identified to implement program changes based on the identified needs and to avoid duplication of services. Moving forward, the YAC will be utilizing participatory research for youth feedback, collaborating with law enforcement agencies for prompt intervention scheduling, and working with schools to increase community referrals.

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: _Courage Connection____

Program Name: __Courage Connection____

Program Year: __FY2024______

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.
   Our clients received services within 3 days of contacting the hotline. Most of our clients receive contact before the 3 days are up.

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% -- All of our clients received services within 3 days of contacting the hotline. Clients begin receiving safety and support with the first hotline contact.

6. Compare year-end result with the application estimate of length of participant engagement. Especially if the result was unexpected, comment on this finding.
   These results were as expected. In the summer of 2023, we did an evaluation of our counseling program and found that we needed to provide additional safety planning resources during the first counseling session. This led to better outcomes for clients and some clients needed fewer overall counseling sessions.

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

For ensuring survivors achieve an improved sense of safety and self-empowerment, we will measure the degree to which residential clients discharge into improved, safer environments. Based on exit data (assessment tool), we will measure "reason for leaving", using the categories "completed program", "left for housing opportunity before completing program", and "needs could not be met by project" as positive indicators of an improved, safer environment. Anticipating clients, with some duplication, we expect at least 60% will meet this goal (75% met in FY23). Source of information: participant

Outcome #2

We will also measure a survivor's skills and confidence to move to a more positive situation (or a more rapid removal of a dangerous one) by asking clients to report improvements following service provision in their understanding of items such as understanding of safety planning, community resources, legal rights, the effects of abuse, and sense of safety and knowledge that abuse is not their fault. This survey (assessment tool) covers all programs within the agency, and we expect 90% of responses to be positive (96% were positive). While we attempt to survey every client upon termination and start of services, due to InfoNet's restrictions on recording more than one survey per client ever, the base number of surveyed client is lower, Source of information: residential (emergency shelter and transitional housing programs) participant

Outcome #3

N/A

Outcome #4

N/A

(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? __473________

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?

   Participation in documentation is always optional for our clients, this is a requirement of the domestic violence program guidelines (provided by ICADV - Illinois Coalition Against Domestic Violence). If the client refused, we respected their wishes.

3. How many people did you *attempt* to collect outcome information from? _100% of those served_
4. How many people did you *actually* collect outcome information from? _194____________
5. How often and when was this information collected? *(e.g. 1x a year in the spring; at client intake and discharge, etc)*

   We collect survey data at intake and upon termination of services. Sometimes we wait after a few (up to 3) interactions with our clients before we ask for them to complete the survey document. The reason being is because our clients tend to be in crisis and we respect that fact by allowing them time to process and then complete any documentation necessary. For departure destinations, we ask for this information as the resident is departing our housing services (emergency shelter and transitional housing programs).

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.*

We continue (as in past years) to work to improve survey responses to community resources. We discussed this at all team meetings in FY24. Staff still believes this is because our clients are coming to us when they are in imminent danger and experiencing trauma that directs their immediate focus to safety planning. Further, some clients (by choice) do not receive services long enough that we have time to provide community resources. They are most interested in immediate safety and stabilization. We understand that understanding community resources is a key part of service plans and are working diligently to accelerate case management to ensure our clients are served in our community to our fullest capacity.

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.

   We had a client who called the hotline on three different occasions as she was preparing to leave her abuser. She had four school aged children. From the first call, we provided safety planning and encouraged her to enter the shelter and to seek an Order of Protection. Her first two attempts to flee were discovered by her abuser. We were heartened that we had built enough trust with the client that she continued to call so that we could help her plan. She was able to flee on her third attempt. Once she entered the shelter with her children, she was reluctant to seek an Order of Protection for fear of retaliation from her abuser. Our legal advocates explained that because the abuser was the father of her children, he could pick them up from school without her consent at any time. The next day she sought and received an OP that covered herself, her children, car, and house. One week later she and her children were able to safely return to their home.

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 shared earlier in this document, we undertook an evaluation of our counseling program in the summer of 2023 with help from a highly-trained consultant. This process led to our counselors integrating a new safety assessment into first and second counseling sessions. The assessment also brought to light that we were providing therapy to young children (under the age of 12) that our counselors were not fully trained in providing. This led us to building partnerships with Elliott Counseling to provide confidential referrals for young children.

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: _____Crisis Nursery______

Program Name: __Beyond Blue

Program Year: _FY24

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 number of days from completed assessment to start of services for FY24 was 14 days. Contributing factors to this included 1-3 attempts to reach families once the referral was received as well as families needing to reschedule enrollment visits due to illness or 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.

50% of those who were identified as eligible for services and engaged in program services within the identified time frame above.

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

Average length of participation for those enrolled between July-June was around 5 months, with the longest participant engagement being 10 months. 2 participants enrolled at the end of quarter 4 and were only enrolled for the last month of the fiscal year. Three participants had their children age out of the program during the fiscal year which impacted their length of enrollment.

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.

   Income, number of family members in the home, status of living for the family (homeless vs. housed), involvement with DCFS, eligibility services through DCFS.

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
Mothers will gain information about the effects of perinatal depression on baby.

Assessment Tool: The Edinburgh Postnatal Depression Scale (EPDS)

Source of information: Parent to Family Specialist

Outcome #2
Mothers will have a decrease in depressive symptoms.

Assessment Tool: The Edinburgh Postnatal Depression Scale (EDPS)

Source of information: Parent to Family Specialist

Note: Original tool indicated within application states the Ages and Stages Questionnaire will be utilized, however, the Ages and Stages Questionnaire aligns with outcome number 3 related to understanding of child development. The EPDS is used to assess progress of depressive symptoms reported.

Outcome #3

Mothers will develop greater understanding of their child's developmental needs and an ability to meet those in positive and growth producing interaction.
Assessment Tool: The Ages and Stages Questionnaire (ASQ), which assesses child developmental progress (physical and social-emotional).

Source of Information: Parent and Family Specialist

Note: Original tool indicated within application states the ARCH CR1 survey will be utilized, however, the Ages and Stages Questionnaire aligns with outcome number 3 related to understanding of child development. The ARCH CR1 survey aligns with outcomes 4 and 5.

Outcome #4

Mothers will learn to reduce their stress, seek resources and broaden networks.

Assessment Tool: The ARCH CR1 which measures a client's sense of well-being and his/her acquisition of parenting skills.

Source of Information: Parent

Outcome #5

Mothers will improve their capacity to engage fully in a reciprocal relationship with their babies, resulting in the optimal development of the baby, more successful and satisfying parenting and greater security for both.

Assessment Tool: The ARCH CR1 which measures a client's sense of well-being and his/her acquisition of parenting skills.

Source of information: Parent and Family Specialist

CONSUMER PARTICIPATION IN DATA COLLECTION

1. How many total participants did the program have? 14

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?

   Not Applicable.

3. How many people did you *attempt* to collect outcome information from? __14___

4. How many people did you *actually* collect outcome information from?
    a. ASQ- 9
    b. EPDS-14
    c. ARCH CR1- 10

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

   The Edinburgh Postnatal Depression Scale is completed once contact with the family is made, after receiving the initial referral. The EPDS is used to determine eligibility based on their score, along with a list of additional risk factors identified by the CDC. Once eligibility and enrollment are complete, the EPDS is administered by the Family Specialist to the parent, once per quarter. Depending on the score, an EPDS may be administered more than once per quarter.

   ARCH CR1 is completed once a year after the families first completed visit with their Family Specialist.

   Ages and Stages Questionnaire is completed at enrollment and then after 6 months of engagement with the program. If a potential or noted delay is discovered during the initial screening, the proceeding screenings will be completed every 3 months during engagement.

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.*

Crisis Nursery and the other six Illinois crisis nurseries use a program outcome survey developed by ARCH, a national resource center for crisis and respite care. This survey is used to measure the impact our programming has on the stress levels of our clients, how our services have impacted their parenting skills, and to what degree they feel our services reduce the risk of harm to children. Of our Beyond Blue clients who completed the survey in FY24:

- 60% showed a decrease in their level of stress after using services
- 100% felt there was an improvement in their parenting skills
- 100% believed that our services reduced the risk of harm to children.

Our Family Specialists completed two support group sessions, each lasting 8 weeks. These groups were held in the community to open access to those who had children aged birth to one and were looking for support. Out of the two groups for the year, our Family Specialists successfully completed 17 group sessions. For crisis care/respite care hours, those enrolled in Beyond Blue programming were provided 696.50 crisis care/respite hours, by Crisis Nursery. In FY23 for comparison, only 297.50 hours of crisis care/respite care were provided.

Our biggest challenge during FY24 was recruiting and enrolling rural mothers into the Beyond Blue program. During the second quarter of FY24, our Family Specialists spent the month of October travelling to rural communities to meet with organizations who work directly with families, child care centers and health care centers to discuss Beyond Blue programming, walk through the referral process and ensure that the agency had all of our program materials. Our home visiting team participated in various outreach opportunities, held Open Houses at Crisis Nursery and completed agency presentations in the community to continue efforts in recruiting mothers in rural communities. Unfortunately, we were unable to enroll the number of rural mothers we had hoped to. Moving into FY25, the first month of the quarter will be dedicated to completing these efforts again, regarding travelling to rural communities and scheduling presentations and/or meetings with referral sources. Regarding general programming, 24% of referrals received were no longer interested in enrolling after the program information was explained to them and 32% did not return phone calls from our Family Specialists, after 3-4 attempts of trying to make contact to schedule enrollment visits.

66% of families who completed more than one EPDS showed a decrease in scores. 13% of families who received more than one EPDS reported the same score. 16% of families who completed more than one EPDS showed an increase in scores 1-2 points from initial assessment. The EPDS is used to monitor the intensity of depressive symptoms in parents and is recognized as successful when scores decrease or stay the same. With this data we have recognized that through participation in the Beyond Blue program 64% of enrolled families showed improvement in their level and intensity of their depressive symptoms or experienced lower levels of depressive symptoms within their first assessment. When discussing this data, Family Specialists reported that maintenance or decrease in depressive symptoms had a large impact on the type of engagement they saw from families and ultimately positively impacted the relationship and bond that parents had with children. This was evidenced by increased discussions around the child in a positive light, increased positive body language directed towards the child during visits, an increase of positive physical touch and improvement of parents being able to identify the source of their symptoms and the coping skills they utilize to decrease them in the moment or participating in more positive activities in general, to experience a more positive mood.

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.

We served a mother this fiscal year who, at the time of enrollment, had just given birth to her fourth child. She has experienced severe post-partum depression with every pregnancy and was

struggling again with her new baby. Her partner had not been supportive during her other pregnancies, and she does not have a large support system within the area. Three of her children have developmental delays, and managing their additional needs is an extra mental burden on her. All the children have additional medical needs as well, and she manages these needs by herself. She really opened up during visits with her Family Specialist and candidly shared a lot of her history with her other pregnancies, and how post-partum depression is affecting her and her children. She and her Family Specialist quickly developed a great rapport, and she was able to engage well with the curriculum our program uses, Mothers and Babies. She has been charting her moods to notice common trends and working on better balancing her stress. She acknowledges ways in which her moods directly affect her baby's mood and has a desire to reduce her stress for him and her other children. Mom has begun reporting that she is noticing improvements in her mood, her relationship with her partner and attentiveness to her baby and other children as well. If it were not for the Beyond Blue program, this mom's feelings may not have been truly seen or heard, and she would continue to live with increasingly unmanageable levels of stress and depression.

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?

   Based on findings from this fiscal year through both challenges and successes, our Family Specialists will move forward with various activities to increase participation in services and increase retention efforts within the Beyond Blue program. These will include continuing to host Open Houses at Crisis Nursery, attending community meetings where other family service agencies are present in order to discuss program updates, participate in community resource fairs or other family events to continue reaching families in the community and continuing to connect with our Crisis Support Specialists for internal referrals of families seeking crisis care services.

   To continue increasing participation in Post-Partum Support Groups, Family Specialists will continue to be facilitating all support groups outside of the agency. This will include locations within Champaign-Urbana as well as other rural communities so we can continue to reach more rural families as in previous program years. Not only will this reach additional participants, but it will also allow Family Specialists to create and improve connections with other community partners and outreach efforts. We will also offer incentives for participants who attend these group sessions. These may come in the form of goods such as diapers, formula, wipes etc. or offering respite hours for crisis care for parents who may wish to utilize our childcare services for parental stress breaks.

   When referrals are received, Family Specialists will reach out to families within 48 business hours and aim to schedule first service visit within 7 days of initial phone call and completed assessment. Family Specialists will complete two home visits monthly with participants.

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 Service Center of Northern Champaign County_______

Program Name: ________Resource Connection________________________________

Program Year: ___PY24____

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.

   Given the nature of our services, it is not often that people are not serviced in some way or another, but we do not track that data. Based on our count of PY24 unmet needs from information and referral inquiries, only about .193% are classified as unmet needs. This is a reduction of .68% from last year.

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.

   We ask about education, employment, and disability status as needed, to offer information on related 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

People living in the area have better access to mental health/other social services. We use the revised, evidence-based consumer satisfaction survey developed by the University of Illinois outcome evaluation staff. On this annual customer service survey, we ask clients to check all the services they have used at our agency, and other agencies in the building, allowing us to estimate the number and type of different services people use. Additionally, the staff document the number and type of referrals we make in our database. The program's impact is how much it enhances access to a variety of services whether directly, or indirectly through other agencies' services. The program provides basic needs and related services directly. Information and referrals to other services elsewhere are given as well. We conducted our annual customer service survey during July-August last year, where we completed 150 responses. 81.8% of respondents said they used two or more services from our program or others offered by agencies in our facility, which is an increase over last year of over 20%. We have 15+ agencies seeing clients in our building. Our staff also conducted over 3,100 information and referrals to area agencies in PY24.

Outcome #2
People can receive immediate assistance with emergency food, clothing referral, prescription assistance, and utility assistance. In our database, staff document with client intake the number of households and individuals that are linked to our immediate services.

Outcome #3
Overall improved linkage and access to a variety of social services in one location. We can obtain linkage data by asking the agencies where we refer clients, to share how many of their clients came from our referral. We have established this line of communication with the Clothing Center and continue to work on doing so with others, if possible. We have 15+ agencies seeing clients at our facility as well.

Outcome #4
Decreased food insecurity. We assess clients' basic needs and whether they are being met through our annual survey where we use two items from the U.S. Household Food Security Survey to assess food insecurity, which are validated as a screening tool to identify families at risk for food insecurity (Hager, E.R. et al., 2010). Our survey revealed that 81.8% of our clients used two or more of our services or others offered in the building, and daily intake statistics show an overall significant increase in our food pantry usage, returning to pre-COVID levels.

Outcome #5

Increased psychological well-being. In our annual survey, we utilize the Person Well-Being Index-Adult, a measure of well-being with high-reliability and validity. Clients provide this data. The PWI score reflected in our annual survey was 67.14, while down slightly from last year, still shows normal levels of subjective well-being.

Outcome #6

Perceived cultural competency of staff. Our annual survey utilizes six items from the Iowa Cultural Understanding Assessment. The cultural competency survey score was 4.4, which is very high on a (1-5 scale) and reflected well on the cultural competency of staff.

Outcome #7

Satisfaction with services. Our client satisfaction with services score on our customer service satisfaction survey mean is 4.79. This is very high on a (1-5 scale).

CONSUMER PARTICIPATION IN DATA COLLECTION

1. How many total participants did the program have? ______1,525______

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 Choice

3. How many people did you *attempt* to collect outcome information from? 150
4. How many people did you *actually* collect outcome information from? 150
5. How often and when was this information collected? *(e.g. 1x a year in the spring; at client intake and discharge, etc.)*

   We began the survey in July and finished in August.

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.*

   We learned that we have a very high customer satisfaction survey score with a mean of 4.79 (Score from 1-5) and a standard deviation of 0.66. 81.8% of our clients use two or more of our services or other programs available in our building. 4.4 is our average cultural competency score, which is high on a 1-5 scale, and the PWI score was 67.14. We reflect continually on the survey results to glean information on client needs and overall provision of services.

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.

   A client enters requesting food and assistance in paying their utilities and rent. In the intake process we find out they also need mental health counseling. We give immediate help with food and information on the pantry (i.e. how often they can come, hours, etc.). We give them CCRPC's rental application and information on any other programs providing rental assistance, LIHEAP's, our information, or any other providing agencies for utility assistance. The client would be given assistance contacting Rosecrance services in Rantoul to set up an appointment with a counselor. The client returns in the weeks following to see a counselor and to further inform us that LIHEAP and CCRPC were able to help, and their housing is stabilized as a result. Due to underemployment, the client returns monthly to get assistance with food. They also get information about upcoming special food distributions at our location and any job fairs and other local employment opportunities to help increase employment income in the future.

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 noticed that some clients, over time, come in for basic needs but later inform us of mental health related needs that we assist them in accessing help for.

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: C-U at Home

Program Name: Shelter Program

Program Year: 24

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.

   Most clients received services within 2-3 days after assessment, except for individuals in treatment for SAD or in a residential mental health program such as Rosecrance CRC. In certain instances, clients would reach out to us two weeks before their discharge to secure housing and prevent homelessness after leaving the program. Our team performed an initial assessment while clients were in treatment, and services began once they moved into our shelter homes.

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.

C-U at Home has successfully completed a year of operating the Mid-Barrier shelter program. During this period, we have continuously enhanced our program structure to increase efficiency and provide better outcomes for our clients. In our program, individuals entering the shelter must commit to participating in case management and developing a personalized case plan. While some tasks are standard, clients also set their own client-centered goals to take charge of their stability. This strategy has resulted in a 100% compliance rate in case plan development and an approximately 80% consistent engagement rate, including meeting the required three weekly contacts with the case management team.

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

Clients in the program for FY 24 had an average length of engagement at 12-months. The average length of engagement in the house was between 9-12 months with 3 months of extended care provided. We have several clients who remained in the program for the entire 18-month period.

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

Target: 60% of program clients who participate in the program will graduate

Result: Half of the program clients who took part in the Mid-Barrier Program successfully graduated. We expect a higher graduation rate next year since those who completed the full 18-month program will be included in the count as graduates for FY 25.

Outcome #2
Target: 100% of program clients will be entered into HMIS system for data tracking purposes.

Result: 100% of program clients were entered into HMIS system for data collection purposes.

Outcome #3
Target: 100% of program clients will have an initial screening for mental health and addiction issues and referred to resources

In the Pathways to Progress Program, 90% of clients have undergone either a mental health assessment or a Substance Abuse Diagnosis (SAD). To be part of the program, clients must have these assessments completed. They can enter with assessments already done and documented within 90 days, or complete them within the first 90 days at CUH. Clients can opt for a mental health assessment at Rosecrance or Promise. For the SAD, clients can choose Rosecrance or complete an in-house assessment with our CADC.

Outcome #4

Target: 100% of clients will develop goals and actions steps from 4 levels of stability. These include mental health, physical health, financial health and housing/life skills.

All clients who stayed in the Pathways to Progress Program set goals and action steps. In FY 24, the levels of stability increased to encompass seven goal areas, including mental health, physical health, recovery support, life skills, financial health, spiritual needs, and housing, with clients setting goals in each area and progress assessed every 90 days. Moving into FY 25, we have implemented a 4-Phase system to enable clients to establish goals in these seven crucial areas and closely track their progress.

Outcome #5

100% of program clients will receive monthly goal evaluations

Clients discuss their goals and progress with case management staff on a weekly basis. Additionally, 100 % of clients receive a monthly goals evaluation. Clients and case management staff adjust the client's plan based on the goals they have accomplished and any identified barriers. After 90 days, clients undergo a formal evaluation of their progress and overall program involvement. In FY 25, these assessments will help decide if clients can

progress to the next phase of the program. Graduation from the program requires completion of all program phases.

Outcome #6

100% of Mid-Barrier clients who participate in the program will have a case manager assigned to their case and receive intensive case management.

100% of Mid-Barrier clients enrolled in the program are matched with a case manager and provided with comprehensive case management services. These services consist of a weekly goal-setting session, followed by two additional weekly check-in meetings with the clients. The Mid-Barrier homes are also staffed 24/7 with our Life Skills Team Members. Additionally, clients engage in a weekly peer support group and attend monthly house meetings.

Outcome #7

100% of clients who engage in the Advanced Shelter Program will receive case management services

Clients enrolled in the Advanced Shelter Program have all been provided with case management support. They actively participate in weekly sessions with their designated case managers to work on establishing and reaching their objectives. The Advanced Shelter clients are not under constant supervision. In the FY 25 plan, the Advanced Shelter is denoted as Phase 4.

Outcome #8

Clients will receive a pre and post survey rates their mental health, living skills, stress levels, substance use and physical health. At the end of the program and client will:

70% of clients will report overall improved mental health

80% of clients reported overall improved mental health

80% of clients will report improved independent living skills

75% of clients reported improved independent living skills

70% of client report less stress

85% of clients reported less stress

60% of clients will report less substance use

85% of clients reported less substance use

60% of client will report improvement of overall physical health

65% of clients reported improvement of overall physical health

(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? _______53______

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?

   Staff attempted to collect all information at discharge. Some clients discharged without completing the discharge packet, however the goal is 100%.

3. How many people did you *attempt* to collect outcome information from? _____50________
4. How many people did you *actually* collect outcome information from? _________43______
5. How often and when was this information collected? *(e.g. 1x a year in the spring; at client intake and discharge, etc)*

Information was collected at intake and at discharge.

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.*

   Clients entering the program often report high stress levels, possibly stemming from both past trauma and the current experiences of homelessness. Initially, there is a decrease in stress within the first 30 days as the program emphasizes safety and security. However, as clients move past the orientation phase, stress tends to rise as they work on goals aligned with seven key areas of instability. This increased stress is

evident through job loss, interpersonal conflicts within the program and housing. Nevertheless, with consistent support, clients typically start to see a reduction in stress around the 90-120 day mark. By this point, clients have established a sense of safety in the environment, built relationships with staff, and made progress towards their objectives.

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.

Our case manager participates in a Drug Court staffing session where it is revealed that a new entrant to Drug Court is homeless, having completed treatment but lacking post-treatment housing. The staff member agrees to conduct an interview with the client at Rosecrance, their current treatment facility. Following an initial assessment, the case manager deems the client suitable for the program and presents the case to the team during a case management meeting. The team reaches a consensus to proceed with the interview phase. Subsequently, two team members conduct the intake, inquiring about mental health, substance abuse, physical well-being, and criminal history. Additionally, they assess the client's motivation and willingness to engage in the CUH Program. After the interview, the case management team provides a final recommendation to the group, granting approval for the individual to move into the shelter.
The client visits the office to meet with their case manager, signs the house rules, and then proceeds to the house where they are acquainted with their room, meet their roommate, and commence the orientation process. Weekly meetings are scheduled between the client and their case manager to review goals, with additional check-ins arranged to monitor goal progress. Initially, the client's objectives focus on recovery-related tasks like attending support meetings, securing a sponsor, and participating in IOP. While each client advances through the program at their own pace, formal evaluations are conducted every 90 days to assess progress.
The client will go through the program and establish goals in specific areas. Some examples are:

- **Physical Health: Finding a primary care physician and adhering to their advice**
- **Mental Health: Completing a Mental Health Assessment and following up on recommendations**
- **Financial Health: Securing income or enrolling in an educational program, and saving money**
- **Housing: Completing a Centralized Intake process and securing housing**
- **Recovery: Finishing a Substance Abuse Disorder assessment and following recommendations**
- **Life Skills: Ensuring upkeep of personal and physical space, handling grocery shopping, cooking meals, and acquiring a bus pass.**
- **Spiritual Health: Clients can freely discuss any spiritual health-related concerns or requirements.**

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?

   Our plan for FY 25 has been adjusted based on the data and information gathered throughout FY 24. One significant change is the breakdown of each point of instability (substance use, physical health, mental health, financial health, housing, life skills, spiritual needs) into phases. These phases have distinct, consistent objectives and a clear path towards graduation. This approach helps clients track and comprehend their progress, while providing staff with a consistent method to assess client advancement. Clients are still able to progress at their own pace as long as they are moving forward. Despite the structured objectives of the Phase system, clients are also encouraged to set their own goals within this client-centered framework.

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**
***Program Name:* CU Early**
Program Year: 2024

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 28 children and 26 families. Four of which were prenatal. She also had 8 teen parents on her caseload. For all these families she provided 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, etc. The final count for service contacts (home visits and parenting groups) was 478. The estimated number in the original application was 506. The reasons for the lower numbers are mainly because parents missed a scheduled visit often due to child illness. All the families on the bilingual home visitor's caseload identified as Hispanic/Latino.

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 and were Spanish speaking.

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 staff 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.

   100% 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 6 children that aged out (turned 3) during the program year and transitioned to PreK.

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 93%, Responsiveness 93%, Encouragement 90%, Teaching 90%
Assessment Tool – Piccolo Parenting Interactions with Children observation tool
Source of Information- The Piccolo tool is completed and scored by the bilingual home visitor. Scores are shared with the parent.

Improvement of Parenting Skill and Knowledge – The Piccolo Parent Child Interaction Tool is completed by the home visitor alongside the parent for children who are 8 months and older. The bilingual home visitor completed 15 Piccolo observation tools this past year. For the children that the Piccolo was not completed, the children were under 8 months of age. Home visitors observe child/caregiver interactions and score on the following behaviors:

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

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

16 families (93%) of caregivers consistently displayed affection to their child.

Responsiveness- Responding to child's cues, emotions, words and interests

(93%) of caregivers consistently displayed responsiveness to their child.

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

90% of caregivers consistently displayed encouragement to their child.

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

90% of caregivers consistently displayed teaching strategies to their child.

Outcome #2

Outcome- Child Development

Target – 95% of children will make developmental progress

Actual result – 95% 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 with 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 26 Ages and stages developmental screenings completed this program year for the children on the bilingual home visitor's caseload. Children who have an Individualized Service plan (IFSP) are not required to have the screenings done two times per year.

On the bilingual home visitor's caseload, the ASQ screening tool showed that 18 children were developing on target for typically developing children of their age group. 5 children were found to have identified delays and were referred to Early Intervention for services. 9 children on the bilingual home visitor's caseload are receiving Early Intervention and have an Individualized Family Service Plan (IFSP) in place. The bilingual home visitor worked 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- 86%
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 enrolled child within 45 days of enrollment into the program and reviewed annually thereafter. Out of the 28 children receiving services, 24 were on schedule for their well-baby checks and up to date on their immunizations (86%). 4 children are catching up on their immunizations and well-baby checks. The CU Early bilingual home visitor has set goals with parents of these 4 children who are behind to ensure that they continue to stay on track to getting up to date. All these children have medical homes, and a pediatrician is assigned to their family.

CONSUMER PARTICIPATION IN DATA COLLECTION

1. How many total participants did the program have? **26 families and 28 children**

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**

The Piccolo parenting observation tool is completed by the bilingual home visitor on families who have children aged 8 months and older.

In addition, the ASQ developmental screenings are not completed on children who have an IFSP in place. And/or are under 2 months of age.

3. How many people did you *attempt* to collect outcome information from? **26**

4. How many people did you *actually* collect outcome information from? **26**

5. How often and when was this information collected?

Health information is requested once per year. If families are behind on immunizations, well baby checks we request it more often to ensure that we follow up with families and they stay on track these recommended visits.

Piccolos are completed once per year. Parent evaluations are completed once per year. Individual Family Goal plans are completed and updated 2 times per year.

Ages and Stages developmental screening tools are completed alongside the parent two 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.*

Reviewing this data confirmed to me that the bilingual home visitor has made a positive impact in the lives of the families she works with. She provided resources and support to ensure that parents learned more about their child's development as gleaned from the Piccolo observation tool findings. In addition, I learned that children made developmental progress from one ASQ checkpoint to the next one that occurred approximately six months later. It can also be noted that many of the families that the bilingual home visitor works with have just moved to our community are not documented. Because of this there is a lot more work getting families connected to

community resources. Often times, getting undocumented families connected to these community resources takes precedence over working on parent education and child development education. Once families are connected to these resources then we are able to start work our work on parent education and child development.

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: Cunningham Children's Home
Program Name: ECHO (Empowering Connections through Hope and Opportunities)
Program Year: FY24

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: ECHO served participants who were lacking permanent housing, living on the streets, considered "doubled up," (referring to a situation where individuals are unable to maintain housing and are forced to stay with a series of friends and/or extended family members), previously homeless individuals released from prison or hospitals, and individuals and families at imminent risk of becoming homeless.

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: Eligibility was determined on an ongoing basis based on referral-report, self-report, and staff observation of living environments to determine if an individual or family met the criteria.

   When potential clients or individuals contacted our program directly regarding services, we directed them to contact Centralized Intake at Regional Planning Commission. Regional Planning Commission also sends referrals for case management to meet the requirements of those receiving a Permanent Supportive Housing voucher. This referral stream provides a gatekeeping function to ensure that appropriate clients are referred to our program.

   If a client was identified that was not eligible for services based on Centralized Intake criteria but was at significant risk of homelessness or living in less than ideal situations, we relied on self-report information as well as information from the referring agency (when applicable) that verified their homeless status. We obtained documentation of SSI/SSDI eligibility when available.

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: 63 Community Service Events were completed during FY24. Presentations were provided to a variety of community partners, including but not limited to PACE Inc., C-U at Home, Regional Planning Commission, Rosecrance, Housing Authority, Family Advocacy Center, and Trauma & Resilience Initiative. Program staff participated in events like One Winter Night and the Point in Time count.

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.

   Application: 30 days.
   Actual result: 67% (8 of 12) participants that enrolled in FY24 were assessed for eligibility and then 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.

   Application: 60%.
   Actual result: 0% (0 of 12) participants that enrolled in FY24 were Treatment Plan Clients (TPC) within 30 days. The average length of time from program enrollment to engagement in services was 44 days (range was 32 – 69 days). Two clients remained Non-Treatment Plan Clients (NTPC) through the duration of their admission and did not become TPC clients.

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

   Application: One year, with follow-up contact one year post-discharge. Participants with Permanent Supportive Housing (PSH) vouchers may exceed that timeframe.
   Actual result: Average length of participant engagement among those discharged in FY24 was 10.8 months. 42% (5 of 12) of those participants had a PSH voucher. Clients with a PSH voucher had an average length of engagement of 17.3 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.

   The following additional data was collected from 28 participants:

   <u>Grade Level Completed</u>
   Less than High School/Drop Out: 8 participants
   GED: 4 participants
   High School Diploma: 10 participants
   Some College: 5 participants

Bachelor's Degree: 1 participant

Marital Status
Single: 21 participants
Married: 2 participants
Divorced: 4 participants
Widowed: 1 participant

Language
English: 28 participants

Religion
None: 21 participants
Protestant: 2 participants
Other: 5 participants

Disability Type (if applicable)
None: 6 participants
Mental: 13 participants
Physical: 8 participants
Mental and Physical: 1 participant

Other System Involvement (as noted by participants)
Adult Protective Services: 1 participant
ALLSUP: 1 participant
Courage Connections: 2 participants
C-U at Home: 1 participant
Department of Children and Family Services: 1 participant
HACC: 2 participants
Healthy Families: 1 participant
Medicaid: 8 participants
Regional Planning Commission: 9 participants
Rosecrance: 2 participants
SNAP: 3 participants
Social Security: 3 participants
WIOA: 1 participant

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: Obtain Permanent Housing
Target: At least 65% of individuals will obtain permanent housing within 120 days of assessment.
Assessment Tool: Information on housing status (homeless, temporary or permanent), including changes during program enrollment and applicable dates, was collected using our Service Documentation System (SDS).
Source of Information: Staff observation, self-reports, and collateral reports.
Actual Result: Outcome Met. 79% of participants (22 of 28) obtained permanent housing. Of those with permanent housing, 95% (21 of 22) obtained permanent housing in less than 120 days of assessment.

Outcome #2: Housing Stability
Target: At least 75% of participants who obtain permanent housing will maintain this housing for more than 90 days. Participants who request program discharge prior to 90 days will be excluded from this outcome.
Assessment Tool: Information regarding changes in housing status (homeless, temporary or permanent), including relevant dates, was collected using SDS.
Source of Information: Staff observation, self-reports, and collateral reports.
Actual Result: Outcome Met. 95% of participants (21 of 22) who obtained permanent housing and remained in the program longer than 90 days maintained their housing for 90 days. One participant obtained in May 2024 and had not reached the 90-day mark, but was still maintaining their permanent housing at the end of FY24.

Outcome #3: Employment or Other Stable Income
Target: At least 70% of individuals will obtain employment within 90 days of assessment and/or will have secured applicable social security benefits prior to discharge.
Assessment Tool: Information was collected using SDS for tracking achievement of employment and any successive employment changes. Documentation of a participant's eligibility for SSI/SSDI as well as employment status was also consistently documented as part of case supervision notes in SDS.

Source of Information: Staff observation, self-reports, and collateral reports.
Actual Result: Outcome Met. 82% of participants (23 of 28) obtained employment (n = 15) and/or secured social security benefits (n = 8). Of the five participants who were not working or on SSI, all five had started the application process for SSI or were receiving SSI benefits for their children.

Outcome #4: Life Skills Mastery
Target: At least 90% of clients receiving both pre- and post- life skills assessment will show improvement in life skill mastery.
Assessment Tool: Life Skills Assessment (Pre/Post- assessments), a standardized measurement of basic life skills is administered within the first 30 days of active client engagement and every six months or upon discharge.
Source of Information: The case manager administers this assessment collaboratively with participants and uses individual results for service planning. Data was tracked upon discharge as part of a monthly program performance dashboard.
Actual Result: Outcome Not Met. The program had a total of 12 discharges during FY24. 75% of participants who completed a Life Skills Assessment at discharge (3 of 4) showed an increase in life skills mastery. One additional participant scored the maximum 100% on both the admission and discharge Life Skills Assessment. Eight participants did not complete a discharge assessment due to having an assessment that was current and completed within a six-month time period.

Outcome #5: Participant Surveys
Target: At least 70% of participants will complete a satisfaction survey. 90% of survey respondents agree or strongly agree with positive service quality statements.
Assessment Tool: Participant satisfaction surveys are developed by the agency and administered on an annual basis to all current clients (point in time). The survey consists of items rated on a 5-point Likert scale as well as open ended questions.
Source of Information: Aggregate data is reported annually by Quality Improvement staff.
Actual Result: Outcome Met. 100% of participants enrolled in May 2024 (18 of 18) during annual survey distribution completed a survey. The average overall score on the survey was a 4.44 (out of 5.00) and comments were extremely positive. Clients expressed gratitude and appreciation for the ECHO program and the team members helping them along the way. Five of the 18 items on the survey received the highest possible score of 5.00.

CONSUMER PARTICIPATION IN DATA COLLECTION

1. How many total participants did the program have?

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 was collected for participants who enrolled in the ECHO program, including Treatment Plan Clients (TPC) and Non-Treatment Plan Clients (NTPC).

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

   28

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

   Outcome 1, 2, and 3: 28
   Outcome 4: 4 (of 12 total discharges)
   Outcome 5: 18 (all clients enrolled at point-in-time survey, May 2024)

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, 2 and 3: Ongoing throughout participant's duration in the program
   Outcome 4: At client intake and discharge
   Outcome 5: Annual (May 2024)

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: Obtain Permanent Housing
Of the clients that were able to obtain permanent housing, 95% were able to do so in less than 120 days. 17 of 28 participants (60%) were recipients of Permanent Supportive Housing vouchers, which helped them obtain and maintain housing.

Outcome #2: Housing Stability
The ECHO program staff helped participants understand the importance of following their lease and worked with participants to identify and overcome potential barriers to

maintaining their housing (e.g. finding sources to assist with utility bills, providing transportation to clients so they could pay rent, helping them obtain bus passes, and conducting home visits to assess living conditions).

Outcome #3: Employment or Other Stable Income
23 of 28 participants (82%) obtained employment or SSI benefits. Eight of those clients had SSI benefits, and 15 were employed. As noted above, the remaining 5 clients are in the process of applying for SSI benefits.

Outcome #4: Life Skills Mastery
ECHO staff assist clients in increasing their life skills though case management services. When there is an area that is self-identified by a client as a need or is identified as a lower score on their Life Skills Assessment (LSA), staff and clients work together to focus on those skills. The average LSA score upon admission to the program was 94.8%, and the average score upon discharge was 99.2%.

While several discharged clients did not complete an LSA to allow for comparison, we have not found that most of our clients have had significant deficits in their knowledge of life skills. Most of the clients we have served over the past 5 years have had relatively strong life skills as measured by the LSA. Regardless, there are clients – particularly those that are younger – that benefit from building this base level set of skills which is part of our program.

Outcome #5: Participant Surveys
Participant satisfaction with the program remains consistently high from year-to-year. The program has administered the survey as a point-in-time survey for the last three years (as compared to administering on discharge in previous years). Administering the survey as a point-in-time survey has doubled participant participation (FY21 participation was 45%, FY22 participation was 93%, FY23 and FY24 participation was 100%).

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.

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?

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: Cunningham Children's Home
Program Name: FST (Families Stronger Together)
Program Year: FY24

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 Families Stronger Together program provided services to youth, age 10 through age 17 who either were involved, or were at risk of becoming involved, in the juvenile justice system. Services were also provided to the youth's family with a goal of promoting resiliency within the family system. In addition to the services provided to 41 treatment plan clients and 158 non-treatment plan clients, approximately 36 family members received services.

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 program received 50 referrals from community partners and 48 of those were determined to be eligible for services. The program admitted 21 (42%) of those eligible participants for services. The remaining referrals were either not able to be contacted, not interested in services, had moved out of the service area, or are still open on the waitlist (n = 7) going into FY25. The program received almost three times as many referrals from READY School in FY24 due to a successful partnership with one of the FST therapists.

   The referral sources and number of referrals included:
   Center for Youth and Family Solutions: 12
   Department of Children and Family Services: 1
   Other Cunningham Children's Home Programs: 1
   Parent Self-Referrals: 6
   READY School: 15
   Youth Assessment Center: 13

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: Seven (7) Community Service Events were completed during FY24. Presentations were provided to a variety of community partners, including Youth Assessment Center and Don Moyer Boys and Girls Club.

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.

   Application: 45 days
   Actual Result: 73% of eligible participants (27 of 37) completed an assessment within 45 days. This excludes four clients:
   - **Two clients were enrolled in the program for less than 45 days, and**
   - **Two clients were admitted in the program in June of 2024 and had not yet reached the 45-day mark.**

   The average timeframe for completion of an assessment across all clients was 41 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.

   Application: 70%
   Actual Result: 73% of participants (27 of 37) engaged in program services by the 45-day timeline. For those that did not meet the 45-day estimate, the average length of time for engagement in services was 66 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.

   Application: 6 months
   Actual Result: Average length of stay in the program for discharged participants was 7.8 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.

   The following additional data was collected from 51 Treatment Plan Clients:

   <u>Grade Level Completed</u>
   4th: 1 participant
   5th: 3 participants
   6th: 4 participants
   7th: 2 participants
   8th: 5 participants

9th: 6 participants
10th: 14 participants
11th: 6 participants

Language
English: 41 participants

Religion
None: 6 participants
Other: 4 participants
Unknown: 31 participants

Other System Involvement (as noted by participants)
Better Tomorrows Counseling: 1 participant
Carle Psychiatry/Carle Counseling: 5 participants
Center for Youth and Family Services: 3 participants
Department of Children and Family Services: 1 participant
Family Advocacy in Champaign County: 1 participant
Juvenile Detention Center (probation): 2 participants
LIFT Program: 1 participant
Lurie Children's Hospital: 1 participant
R3 (National Youth Advocate Program): 1 participant
Rosecrance: 1 participant
Youth Assessment Center: 10 participants
Other Counseling: 1 participant
Other Cunningham Children's Home Program: 2 participants

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
Target: Presenting problems of the youth decrease over time
Assessment Tool: Strengths and Difficulties Questionnaire (SDQ)
Source of Information: Caregiver report and youth self-report
Actual Result: 54% of participants (7 of 13) saw a decrease in the presenting problems, according to caregiver and/or youth self-report.

Outcome #2
Target: Trauma-informed caregiving skills strengthened
Assessment Tool: ARC Assessment
Source of Information: Caregiver self-report and staff observation
Actual Result: 67% of caregivers (4 of 6) saw an increase in trauma-informed caregiving skills.

Outcome #3
Target: Improve family's protective factors (social supports, concrete supports, family functioning, nurturing and attachment)
Assessment Tool: Protective Factors Survey, 2nd Edition (PFS-2)
Source of Information: Program staff assisted caregivers in completing the PFS-2
Actual Result: 92% of participants (11 of 12) saw an improvement in the family's protective factors.

CONSUMER PARTICIPATION IN DATA COLLECTION

1. How many total participants did the program have?

   199 (41 Treatment Plan Clients, 158 Non-Treatment Plan Clients). In addition to the total participants served, 36 family members of Treatment Plan Clients received support services.

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 was collected from participants who engaged as Treatment Plan Clients in the program.

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

   32 (total number of discharges for the year).

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

   13. Attempts were made to collect discharge data from all 32 discharges, but some were not collected due to the following circumstances: seven participants discharged due to lack of engagement, two entered DCFS care, one ran away, one moved out of the service area, five transferred to another service area or another service type, and three were moved to a more restrictive setting (residential treatment center). For these reasons, discharge data was only available from 13 of our discharged participants/families.

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

   Outcomes 1 and 3: Assessment were completed at intake and discharge.
   Outcome 2: Assessment was completed at 45 days after enrollment, at four months, at seven months, and at discharge. Note: The decision to implement completion of a baseline ARC assessment was determined during the 4th quarter of FY24. Prior to this time, the ARC assessment would have been completed for the first time at approximately 4 months (completion of the initial treatment plan review).

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.*

   The following results were calculated using the completed outcomes assessment data for 13 participants.

   Race: Positive outcomes were more likely to be reported for participants who identified as Mixed Race or Black than those who identified as White. Improvements in outcomes data were noted for 100% of mixed-race participants, 88% of black participants, and only 67% of white participants.

   There were no significant changes based on length of stay in the program, gender or age of 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.

   A typical case consists of weekly visits with the client. These visits are usually conducted in the home of the client in the community or at Cunningham. FST aims for both

participation from the caregiver and client each week, these can be sessions conducted together or separately. The first few sessions are set around building rapport, talking about expectations, and setting goals. Meeting in the clients home allows them to feel comfortable in a safe space, which helps strengthen client engagement.

Once a rapport has been established, additional sessions begin with a check-in to see how things have been since the last meeting, how the client and caregiver are feeling, and may include addressing any crisis situations that need immediate attention.

Each session begins with giving the client a brief introduction to the topic. The FST workers ask open-ended questions to allow the client to lead the session. After covering the "theory" portion of the lesson, practice of the skill takes place. For example, if the topic is deep breathing, the FST worker will explain the breathing technique, give them background information on where the technique derives from, what the technique can be used for (e.g. lowering anxiety, helping with sleep), then they will slowly walk through the steps together. The client will practice the technique at least 3 times and then share their feelings on the technique. The FST worker asks follow-up questions: Do you think this technique will be helpful? Is this something you will use? How can we change the technique to fit your individual needs? These individual or family sessions are meant to increase the youth and family's skills and tools to be able to regulate their emotions and move towards more stability within their home and other settings. FST also assists with assessing additional needs for other supports and services and is able to connect the family to these through referral or advocacy and encouragement.

The remainder of the session is utilized to play a game, discuss potential topics for the next meeting, or allow the client and caregiver to talk about anything they want to cover.

The FST worker is available to families throughout the week. If the family is involved with another program, (e.g. the Youth Assessment Center), the FST worker checks in weekly with their case worker to collaborate. The FST worker also checks in individually with the caregiver to provide support. FST workers have helped caregivers address food insecurities, worked on conflict management, provided support at IEP meetings, and assisted in the purchase of school supplies and cleaning items.

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?

The Families Stronger Together staff partnered with several area agencies to provide groups for Non-Treatment Plan Clients. These groups focused on… and partners included the Champaign County Juvenile Detention Center (JDC), LIFT program, and Don Moyer Boys and Girls Club.

The mission of the JDC is to supervise, educate and care for minors detained and to ensure the safety of offenders while in secure care. They also provide necessary

programming to address the special needs of the offender population. There were 67 total JDC groups held during FY24 for 62 total participants, who attended an average of six groups each.

LIFT focuses on African American youth in grades K-12, as well as their families, who are experiencing significant challenges academically and personally. The initiative provides trauma-informed care through intensive wraparound support and connections to both school-based and community resources. LIFT is designed to ensure students and families can succeed and thrive despite difficult circumstances or challenges in their scholastic or personal lives. 33 groups were held throughout FY24, and there were 18 student participants who attended an average of six groups each.

Don Moyer Boys and Girls Club has a mission to enable all young people to reach their full potential as productive, caring, responsible citizens. 37 groups were held throughout FY24, and there were 52 participants who attended an average of 11 groups each.

An FST therapist also held groups with Freedom School, an alternative education program through Urbana 116. There were ten total groups with 15 total participants.

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: Don Moyer Boys & Girls Club
Program Name: Community Coalition Summer Initiatives
Program Year: 2024

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. Participants in each program were provided a pre- and post- test to self-rate aspects of the program and the outcomes each participant experienced. The program plans provided, compared to the outcomes for each program (including the pre- and post-test results) indicate that the services provided to participants were properly administered, were goal-oriented, and were outcomes-focused in the areas deemed important for participants.

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.
   Each service partner used an individualized method for determining person-program fit by marketing services to at-risk and underserved populations.

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. Sub-awardees of the Summer Initiatives across several programs brought programming to neighborhoods, families, and youth who were identified as the target population for programming. Participants paid no fees to participate in programming, which created a match with participants of at-risk and under-served communities, and programming was conducted in spaces that were accessible to the intended populations (various locations).

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.
   Services were started in a timely manner. Programs targeting youth have different start dates based on the target audience and local school schedules. Nothing unexpected

regarding the timeline from assessment completion to start of services was discovered during programmatic review by DMBGC.

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

Participants will feel a sense of connection to community.

At least 50% of program participants completed a pre- and post-test survey to self-respond regarding their sense of connection to their community at the start of the program. The same population administered the pre-test were administered a post-test at the close of programming to assess their reported sense of connection to the community.

Overall, there was an increase in the self-reported sense of connection felt by participants. Respondents indicating they felt "Very Connected" increased between the pre-test (76%) and post-test (95%). The survey was ONLY completed by participants (not caregivers).

Outcome #2

Decrease number of violent incidents participants experience during the program period.

At least 50% of program participants completed a pre- and post-test survey to self-respond regarding their sense of connection to their community at the start of the program. The same population administered the pre-test were administered a post-test at the close of programming to determine whether the number of violent incidents participants experienced over the course of the program decreased.

Participants' exposure to violent incidents decreased by 50% during the program period, according to survey data.

Outcome #3
Participants will gain new skills or have novel experiences during the program or as a result of the program.

At least 50% of program participants completed a pre- and post-test survey to self-respond regarding their sense of connection to their community at the start of the program. The same population administered the pre-test were administered a post-test at the close of programming to identify intended skills/experience gains and compare to those actually reported gained by participants.

Participants across programs shared a variety of experiences and skills gained throughout the program. Many participants suggested that events presented as part of this programming could reduce instances of community violence and increased their sense of connection to their neighbors and community. Several participants stated they gained valuable leadership, employment, networking, and other professional skills. Youth reported gaining work experience, leadership, academic, and recreational skills that they would otherwise not have access to.

CONSUMER PARTICIPATION IN DATA COLLECTION

1. How many total participants did the program have? 700

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?
   Programs were required to administer pre- and post-tests to at least 50% of participants. Due to the nature of some of the events (specifically those not requiring formal registration or without formal eligibility requirements, specific networking and outreach events, jam sessions without formal arrival and departure times), it was not possible to administer pre- and post-tests to each participant.

3. How many people did you *attempt* to collect outcome information from? 350
4. How many people did you *actually* collect outcome information from? 324

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 start of the program and at the close of the program

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.*

   The actual impact of positive community events, particularly for youth, seemed evident from the pre- and post-tests administered, as well as the testimonials captured by service providers. Community member self-reported, particularly through testimonials, that outreach and engagement events are invaluable to fostering a sense of community togetherness (which several stated they believe can reduce instances of violence in our community).

   Youth participants largely stated that programming provided created opportunities which they would otherwise not have exposure to, and several highlighted the importance of having programming as an alternative to participation in risky behaviors.

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.

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?

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: Don Moyer Boys and Girls Club
Program Name: CU Change
Program Year: 2024

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 days from completed assessment to start of services identified within the application was 7 days. Throughout the course of the program year 7 business days was the average amount of time between completed assessment and start of services. Those who did not begin within this timeframe were based on the availability/schedule of the families when selecting the date for the first home visit.

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.

82% of eligible clients engaged in the program services within the above timeframe. For those who did not engage within the timeframe the documented cause was scheduling barriers/availability. Multiple families planned for their first home visit within the 7-day window and needed to reschedule outside of the window due to extenuating circumstances.

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 participate engagement identified within the application was 12 to 24 months. Due to transitions within the program at this time no clients have met the identified length of engagement. We do have 11 youth that are continuing with the program into the new fiscal year and are confident that they will stay engaged for the expected 12-23 months. 5 youth have disengaged throughout the program year due to no contact with client/families after multiple attempts or discontinuation of services based on family request. The 5 youth that disengaged were engaged for 6-8 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.

No demographic information was collected beyond the standard categories.

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 Target: 100% (20 of 20) of youth will complete full intake process and actively participate in the intervention strategies prescribed in comprehensive plan.

Outcome Result: 85% (17 of 20) youth completed the full intake process and actively participated in the intervention strategies prescribed in the comprehensive plan.

Assessment tool(s): IM+CANS Assessment, Case Notes, Goal Plan, Intake paperwork, Pre and Post

Program Surveys, Youth Questionnaire, and Family Needs Assessment.

Source of Information: IM+CANS- completed by Parent/Guardian, Case Notes- completed by CU Change case manager, Intake Paperwork- completed by Parent/Guardian, Family Needs Assessment- completed by Parent/Guardian, Pre and Post Surveys- Completed by Youth, Youth Questionnaire- completed by Youth, Goal Plan completed by Youth, Parent/Guardian, and CU Change Case Manager

Outcome #2

Outcome Target: 100% (20 of 20) Family Members/Parents/Guardians will participate in intake and actively participate in intervention strategies prescribed in the comprehensive plan.

Outcome Result: 100% (21 of 20) Family Members/Parents/Guardians participated in intake and actively participate in intervention strategies prescribed in the comprehensive plan.

Assessment tool(s): IM+CANS Assessment, Case Notes, Goal Plan, Intake paperwork, Pre and Post Program Surveys, Youth Questionnaire, and Family Needs Assessment.

Source of Information: IM+CANS- completed by Parent/Guardian, Case Notes- completed by CU Change case manager, Intake Paperwork- completed by Parent/Guardian, Family Needs Assessment- completed by Parent/Guardian, Pre and Post Surveys- Completed by Youth, Youth Questionnaire- completed by Youth, Goal Plan completed by Youth, Parent/Guardian, and CU Change Case Manager

Outcome #3

Outcome Target: 80% (17 of 20) Youth will remain engaged in school or take required steps towards re-engaging in school.

Outcome Result: 100% (17 of 17) Youth remained engaged in school or took required steps towards re-engaging in school.

Assessment Tool(s): Case Notes, Goal Plan, School Progress and Report Cards, Attendance Records

Source of Information: Case Notes- completed by CU Change case manager, Goal Plan completed by Youth, Parent/Guardian, and CU Change Case Manager, School Progress and Report Cards obtained from school by CU Change Case Manager with consent from Parent/Guardian, Attendance Records obtained from school by CU Change Case Manager with consent from Parent/Guardian.

Outcome #4

Outcome Target: 80% (16 of 20) Youth will demonstrate progress towards the goals listed in the comprehensive service plan.

Outcome Result: 100% (17 of 16) Youth will demonstrated progress towards the goals listed in the comprehensive service plan.

Assessment Tool(s): Case Notes, Goal Plan, School Progress and Report Cards, Attendance Records

Source of Information: Case Notes- completed by CU Change case manager, Goal Plan completed by Youth, Parent/Guardian, and CU Change Case Manager, School Progress and Report Cards obtained from school by CU Change Case Manager with consent from Parent/Guardian, Attendance Records obtained from school by CU Change Case Manager with consent from Parent/Guardian.

(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? 17

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 collected outcome information from all participants.

3. How many people did you *attempt* to collect outcome information from? 17
4. How many people did you *actually* collect outcome information from? 17
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 was regularly collected throughout the program year. Outcome information related to goal planning was updated quarterly or as progress/regression was observed with the documented goal. Outcome information related to pre and post surveys was completed within the first 30 days of engagement and at the end of the fiscal year. Outcome information related to assessments was collected within 30 days of beginning services and updated every 6 months. Outcome information related to case notes was collected after each service contact with families.

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.*

Fiscal Year 24 was marked with the overall transformation and strengthening of the CU Change program at DMBGC. We began the fiscal year with only two treatment plan clients continuing on from the previous fiscal year and the CU Change Case Manager position was open until the end of September. Once, the position was filled and training was completed, we decided that

the primary focus would be on community outreach to develop a pipeline for referrals, increase program awareness in the community, and increase the number of community partners to ensure we had a wide network of resources to connect our families too. We quickly saw a payoff in these efforts as referrals began to increase and the diversity of the referral sources steadily increased throughout the year. During the previous fiscal year, we received referrals from 4 community partners; in FY24 we received referrals from 6 community partners and received 4 "self" referrals from families. Community outreach is a noted strength and tactic that we will continue into next fiscal year to continue to increase engagement with the program and program awareness. Similar to the increase in referrals we saw an increase in the needs of the families and youth that were referred to CU Change, while the focus and emphasis of referrals was largely related to school functioning, during the intake process it was noted that the family unit as a whole had intensive needs that were being unmet that were contributing to their youth's negative interactions with school. It was quickly realized that in order to see the desired improvement of the youth's functioning we needed to holistically commit to meeting the needs of all members of the family. This led to an increase in resources shared with families and led to more engagement with the family unit as a whole in comparison to only engaging with the youth client. Another emphasis this year was connecting with the schools to ensure that we were strengthening the system of support and that we had all needed information regarding school functioning for all youth. This was noted as the largest barrier throughout the year and we have adapted multiple times to meet the expectations of each unique school in regards to obtaining releases from families. Through this process, we were able to build strong relationships with multiple area schools and are hopeful that this will carry into the next fiscal year as the information gathered in essential to tracking outcomes and evaluating the intervention strategies.

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.

We began engaging with "Robert" after receiving a referral from the school social worker. Robert is 13 years old and attends school in a rural community outside of Champaign. The school social worker reached out to the program as Robert was having behavioral issues at school and was at risk of being held back next year. The school social worker lamented that the behaviors noted were newly presenting but that their team was not able to connect with the youth or guardian in an impactful way specifically the school team noted that connecting with his father had been very challenging and that a relationship was yet to be built. The family was reluctant to engage with the program but ultimately made the decision to work with the CU Change Case Manager as they were able to recognize that they were having experiences that were unique to their specific identities and they wanted someone that had shared identities and could connect with their experiences. After completing the intake and creating the goal plan, the CU Change Case Manager reconnected with the school social worker and welcomed them into the home visits with consent from the family. As a team, they developed strategies and interventions that would be supportive of Robert catching up on missed assignments/tests and would ensure that Robert had a way to communicate if he was willing overwhelmed or if he was on the verge of withdrawing. The CU Change Case Manager also worked alongside the family and provided resources needed to support with the development of resources and a schedule at home that was supportive of Robert getting the rest and nutrition that he needed. In addition, one of the listed goals was to strengthen the bond between Robert and his father through regular communication and participating in activities

together. The CU Change Case Manager was able to print resources for activities to increase communication and also supported the family in obtaining event information, tickets, and supplies to support with the development and continued strengthening of the bond. Robert was also connected with a counseling services at our Park St location through our onsite mental health practitioner and throughout the summer engaged in a weekly life skills session which continued to support with his communication efforts and relationship building. The work that Robert and his support team engaged with proved to be successful and Robert was promoted to the next grade and improvement has been noted in the relationship between Robert and his father.

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?

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: _Don Moyers Boys & Girls Club________________________________

Program Name: _CUNC____

Program Year: 2023-2024____________

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.

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.

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

   Due to various reasons, we revised our outreach strategies, entrusting the responsibilities to the Wisdom Leaders and Peer Ambassadors. Additionally, we established a new position to coordinate our outreach efforts. Although we engaged in a greater number of activities, these efforts did not lead to an increase in connections, referrals, or program participants.

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.

   Since we had no treatment plan clients, we did not have a pre-established timeline for completing assessments for our group participants. For those programs where assessments were conducted, they took place during the second or third session, as allowed by the curriculum.

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 were no differences or variations from the plan outlined in our application.

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

Although we exceeded our program expectations despite holding fewer activities, this was our most challenging year in engaging our target population. Our model relied heavily on peer-to-peer recruitment, and the Peer Ambassadors and Wisdom Leaders struggled to conduct effective outreach. This difficulty was partly due to their involvement in other programs, which limited their capacity for outreach.

Additionally, changes in administration and leadership at some of our core partner organizations, such as Countrybrook and Restoration Urban Ministries, disrupted our established relationships. Consequently, we had to develop new partnerships, which slowed our performance during the first and second quarters.

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 do not collect additional demographic information.

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)."*

Educational Program and Group Based Outcome:

Education & Training Initiatives Outcomes:

Outcome Data:

1. **For individuals and families participating in group-based services who complete our survey:**

   (a) **Participation:** 75% will attend more than one session of a skill-building group.

   - We exceeded this goal due to changes in our design and programming. At Eden, we offered almost weekly programs, and similarly, at Tiger Academy and Freedom School, we expanded our offerings and reinforced skills in a more strategic manner.

   (b) **Referrals:** 75% will refer or invite a friend, family member, or colleague to participate.

   - We did not collect this data. We revised our evaluation process to better suit our audiences at Eden, JDC, and our Wisdom Leader activities, simplifying the evaluation to make it more user-friendly.

   (c) **Understanding and Skills:** 90% of participants will gain an increased understanding of trauma and adversity, along with information about wellness and resiliency, and will acquire skills they can use at home, school, or in the community.

2. **Resource Linkage:** 100% group/workshop participant received a resource or linkage to other needed supports and services.
3. **Trauma Group Intervention:** 75% of participants in a trauma group intervention for at least 4 weeks will report – respondents who completed an evaluation reported:
   - Feeling supported and reconnected to their community.
   - Acquiring new, useful coping skills and distress tolerance skills.
   - Identifying a natural or community resource.
   - Gaining a better understanding of trauma, toxic stress, and PTSD.

     28 individuals were connected to more intensive services and supports, with everyone receiving at least 2 referrals to community-based services, resources, or supports.

Respondents on the evaluations also reported:

1. 90% report that the training was helpful and useful.
2. 86% report acquiring skills they can use at home, school, and/or in the community.
3. 80% of those who complete the Psychological First Aid or Skills for Psychological Recovery feel equipped to use the skills acquired (to support someone who is experiencing emotional distress

Learning Collaborative (LC):

1. **Assessment and Training Impact:** 90% of participants in the LC organizational assessment/training process reported improvements in their understanding of trauma, gained more tools to respond to people impacted by trauma, and felt better equipped to avoid retraumatizing themselves and others.
2. **Change Plans:** All organizations participating in the learning collaboratives identified a change plan with 2-3 targeted goals, including clear implementation strategies and timelines.

Participating Organizations: Five organizations completed organizational assessments: CU @ Home, Mahomet Area Youth Club, Courage Connections, and the Trauma & Resilience Initiative. The organizational assessment is designed to measure policies, procedures, and practices aligned with trauma- and justice-informed values.

Survey Themes: Several themes emerged from the surveys:

- Most respondents had a basic understanding of trauma and its impact.
- There was a need for more provider support, including more space to discuss provider trauma embedded in the culture.
- There was a commitment to trauma-informed values, but few practices.
- Only two organizations had formal structures to meaningfully include the voices of program participants and individuals with lived experiences systematically.
- Increased discussions led to a better understanding of cultural competency beyond race/ethnicity, including ability, gender/sexual orientation, class, and aging.
- Few organizations had policies designed to address equity, formally discuss equity, or address structural barriers.

Data Collection: We did not collect final data because all organizations, except for Courage Connections, are still in the implementation phase. Courage Connections had initial baseline training but opted out of the process afterward.

Challenges and Continued Support: All organizations involved in the Learning Collaborative process faced challenging starts due to external factors such as staffing, funding, and organizational challenges. As a result, we have decided to continue our support for these organizations until January 2025.

CONSUMER PARTICIPATION IN DATA COLLECTION

1. How many total participants did the program have? __186 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?

This was a very individualized experience. When the facilitators became aware that there were literacy or other concerns that would require undue burden on participants, if the setting made it difficult and if we could not make the adaptations to meet the participants literacy, developmental we do oral assessments and evaluations. We found that our work with Youthbuild, Tiger Academy, Eden and Restoration our classical evaluation rarely could be completed. We completed a simplified the evaluation using colors and visual cues. It did not provide specific outcome data – but it did provide some overall participant satisfaction data.

3. How many people did you *attempt* to collect outcome information from? ___72________
4. How many people did you *actually* collect outcome information from? ___44_____________
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 second session and then when possible at the closing/final session as an evaluation*

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.*

See above

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.

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?

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: Don Moyer Boys & Girls Club

Program Name: Youth & Family Peer Support Alliance

Program Year: FY24

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.

   The intervention did not meet our expectations, as referrals are often driven by crisis situations for families by the time they connect with our organization. Due to the nature of these crises, it can take several days or even weeks to properly assess the appropriate fit, as our primary response focuses on helping families get stabilized during the immediate crisis. It's only after stabilization are we able to fully engage families in the systems navigation and peer support process. A potential improvement could be to designate all families as NTPC from the outset.

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.

   We estimated the time from referral/assistance to assessment of need to be approximately 14 days. Families often prioritized resolving their immediate needs or issues and were less engaged in completing the required paperwork. As progress was made in addressing their situation, it became increasingly difficult to maintain their engagement. Consequently, the assessment process took longer than estimated, if at all. We prioritized respecting the emotional and mental capacity of the families we serve, in alignment with our commitment being family-driven and youth-guided.

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.

   43% of the TPC families were assessed but not necessarily within 14 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 initially estimated the average duration of participant engagement in services to be between 9-18 months. By the end of the program year, we determined that the actual average was approximately 9 months, which is consistent with our experiences over the past few years. This aligns with the nature of the challenges our families face, which are often related to school-based mental health and behavioral issues.

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: Types of Support

- **Target:** 75% Parents/caregivers will report a greater breadth of types of supporters they have access to when facing the challenge of raising a youth with emotional behavioral needs.
- **Outcome:** All parents/caregivers (100%) who were assessed reported having at least one person (i.e. spouse/significant other, family friend, etc.) they could rely on for support in addressing their child's emotional and behavioral needs.
- **Assessment Tool:** FAST (Family Assessment Too)
- **Source of Information:** Caregiver

Outcome #2

Outcome: Coping with Stress

- **Target:** 75% of parents/caregivers will report greater coping with stress when they face challenges in their lives.
- **Outcome:** When assessed 71% of parents/caregivers "agreed they had the ability to deal with the things that happened to them", while 29% "disagreed."
- **Assessment Tool:** FAST (Family Assessment Too)
- **Source of Information:** Caregiver

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?

    For outcomes #1 and #2, no data was collected for certain participants due to their status as minors, as we do not conduct assessments on youth.

3. How many people did you *attempt* to collect outcome information from? **15**
4. How many people did you *actually* collect outcome information from? **7**
5. How often and when was this information collected? *(e.g. 1x a year in the spring; at client intake and discharge, etc)*

    Our goal is to collect data at intake and every 30 days thereafter, based on the family's needs. Since our approach is family-driven, it is up to the parent or caregiver to decide whether they wish to undergo additional assessments after the initial one.

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.*

While parents reported their ability to manage the stress they were experiencing, our interactions indicated that additional factors contributed to this stress beyond their child's mental and behavioral health issues. A significant portion of this stress appeared to arise from their difficulties in meeting basic needs. Accessing and maintaining affordable housing remains

a persistent challenge for many families in this community. According to a report from United Way's 211 helpline, the primary reason individuals in Champaign County seek assistance is housing, followed closely by requests for utility support and mental health and addiction services. In comparison to other counties in Illinois, Champaign County ranks among the most impoverished, with a food insecurity rate of 12.7%. It is estimated that 64% of those experiencing food insecurity fall below the Supplemental Nutrition Assistance Program (SNAP) threshold of 165%.

Additionally, we observed that parents often desired quick solutions for the challenges faced by their children with mental and behavioral health issues. During conversations with parents and caregivers, many expressed frustration and even resentment over the complexities of navigating the school system and other child-serving systems while also managing daily responsibilities for themselves and their other children.

The recent report from the U.S. Surgeon General highlights the urgent need for caregiver support, identifying caregiver stress as an escalating public health concern. Caregivers, particularly those in low-income households, are confronting increased mental health challenges due to the dual pressures of caregiving responsibilities and financial constraints.

In response to these challenges, we have actively worked to connect parents and caregivers with available community resources to alleviate these stressors. However, obstacles such as waiting lists and limited resources frequently hinder timely assistance. These barriers can impede family engagement, yet we remain committed to supporting our families in navigating these difficulties and accessing the essential support they require.

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.

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?

   If we had continued providing services and supports to families, it would have been necessary to restructure our service offerings and prioritize the identification of flexible funding to better assist parents with their basic and self-care needs. We would have implemented high-fidelity WRAPAround services, incorporating care coordination and peer support into our program. The intended outcomes of these efforts would have included enhanced parental mental health, increased family cohesion, and improved coping and problem-solving skills.

   With that being said, we would like to thank CCMHB for the opportunity and support to serve the great families of Champaign County.

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: **2024**

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. 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.

Forty-seven percent of children served were children of color. Forty-three percent live outside of Champaign-Urbana. Family Development continues to focus outreach efforts to include more marginalized populations with specific targeted efforts to engage in more diverse communities. Children are referred from Child and Family Connections, daycare centers and families as well as planned 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 90%.

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 90%.

Utilization targets and results:

- Treatment Plan Clients target of 655: **Exceeded with 832 receiving supports.**
- Service Contacts defined as the number of developmental screenings conducted with a target of 200: **Exceeded with 289 being completed.**
- Community Service Events with a target of 15: **Exceeded with 24.**

CONSUMER PARTICIPATION IN DATA COLLECTION

1. How many total participants did the program have? **832**

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 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 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?

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: __East Central Illinois Refugee Mutual Assistance Center ____________
Program Name: Family Support & Strengthening_____________________________
Program Year: __FY24__________

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.
   We have walk-in services Monday through Thursday from 9 am to 5 pm. Most clients receive same day service.

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 estimate that 90% or more of our clients are engaged in program services within 2 days of completion of intake and assessment.

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

We collect data on languages spoken by clients.

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

Applications for Social Service Public Benefits completed. In FY24, The Refugee Center completed 1,160 public benefit applications for our clients. This is almost twice the number we reported for FY23.

Outcome #2

If unemployed, Obtain Permanent employment. Due to increased client numbers and reduced staff capacity, we did not utilize the Change Insight survey this fiscal year. It was quite an extensive survey, and it took an enormous amount of staff time to translate and administer to clients. In addition, because our clients often have limited proficiency or are illiterate in their own language, none of the surveys were anonymous. We continued to assist clients with job applications. For our Refugee Resettlement clients, we have an Employment Specialist that assist them with finding jobs and developing a relationship between TRC and area employers. A huge barrier for our undocumented immigrant clients is lack of work authorization. While we advocate at the local, State and Federal level for Work Authorization for all immigrants, this is Federal law and will not change until Congress approves this change.

Outcome #3

Improve Quality of Life. Without our advocacy for our clients, many would not have received public benefits like SNAP and Temporary Assistance for Needy Families (TANF) benefits. Some applications were improperly denied and others delayed. The large number of applications completed does not begin to reflect the amount of time spent by our staff advocating for our clients with the Illinois Department of Human Services. Our services improve the quality of life of our clients.

Outcome #4

Improve Outlook on Life. We did not measure this outcome in FY24 due to limited staff capacity to administer the Change Insight survey and the ARISE grant program did not administer a survey in FY24. We will continue to explore other ways to receive anonymous client feedback from our clients, potentially through WhatsApp.

Outcome #5

Improve Relationships with Others & Improve Connections to the Community. We were not able to measure this outcome in FY24 due to limited staff capacity to administer the Change Insight survey and the ARISE grant program did not administer a survey in FY24.

(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? __3,528__________

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?
   Case note feedback was the primary source of information in FY24.
3. How many people did you *attempt* to collect outcome information from? _unknown_____
4. How many people did you *actually* collect outcome information from? __Unknown______
5. How often and when was this information collected? *(e.g. 1x a year in the spring; at client intake and discharge, etc)*
   Randomly through casenotes.

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.*

   We learned that more clients than ever need public benefit application assistance. The Illinois Department of Human Services public benefits system is backlogged with thousands of applications. As a result, our clients benefits are delayed, or improperly denied in some cases. Even our Refugee clients, who by law are entitled to public benefits and arrive with no income, have waited 90 days or more for benefits. This puts even more stress on our clients. Our staff works tirelessly at the local and State level to troubleshoot these problems and obtain positive resolutions for our clients.

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.

A typical service delivery case will involve someone who brings us a letter from a government agency or local school to translate. Our staff then determines what services are needed. If the person is a new client, an intake and assessment is taken. If the clients need assistance applying for public benefits, staff will create a case in ABE, the online Illinois Department of Human Services public benefit system. Sometimes, staff must accompany the client to the local Illinois Department of Human Service Family and Community Resource Center in order to file for or renew their benefits. Staff will often make referrals to other resources, such as food pantries, legal providers and medical clinics. They will inform the clients about the hours and where they are located. If clients need assistance accessing these resources, transportation may be provided within Champaign County. If the client has children that need immunizations or other medical needs, staff will make those appointments for them and inquire about transportation needed. If the client does not have a car or a bus pass, our office has car seats that can be used to transport the clients and children when needed. We can offer our clients reduced price bus passes through the Community Foundation of East Central Illinois. All clients are offered wrap around case management 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?

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: Family Service of Champaign County
Program Name: Counseling
Program Year: FY24

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.

   We estimated that clients would begin services within 5 days of completing an assessment. In FY24, 66% of clients began services within 5 days of completing an assessment. 19% of clients began services more than 5 days after completing an assessment because that is what worked best for the client. 15% of potential clients did not engage in services. The average number of days from completed assessment to beginning services was 5 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.

   We estimated that 85% of clients would begin services within 5 days of completing an assessment. In FY24, 66% of clients began services within 5 days of completing an assessment. 19% of clients began services more than 5 days after completing an assessment because that is what worked best for the client. 15% of clients who completed the assessment chose to not engage in services.

6. Compare year-end result with the application estimate of length of participant engagement. Especially if the result was unexpected, comment on this finding.
   Not applicable

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.
   Not applicable

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

Individuals receiving our services will report improvement in four areas of functioning: individual, relational, social and overall.

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

RESULT: As assessed at the end of FY24: 88% of the treatment plan clients who had both an initial and subsequent ORS score showed at least some improvement in their score during their treatment and 12% showed a decrease in their score. One client reached the benchmark score of 35 – 40. One treatment plan client is developmentally disabled and two treatment plan clients are minors and clients who are developmentally disabled and/or minors are not asked to complete the ORS.

Outcome #2

Individuals receiving our services who have a treatment plan will meet the treatment goals that they established with their therapist.

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

RESULT: Looking cumulatively at all objectives for treatment plan clients whose case was closed during FY24, 10% of objectives were fully met, there was improvement on 83% of objectives but they were not fully met, and there was no progress or the clients were unable/unwilling to address 7% of objectives at the time the case was closed. For treatment plan clients whose case was still open as of 6/30/24 progress has been made on 80% of their objectives and goals. The remaining 20% of objectives and goals are for treatment plan clients whose case was still open as of 6/30/24 and will have their first treatment plan review during the first quarter of FY23 to evaluate their progress with their objectives and goals.

Outcome #3

Individuals receiving our services who have a treatment plan will have improvement in their functioning over the course of treatment.

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

RESULT: As assessed at the end of the fiscal year based on the most current or final (if cased closed) GAF score for treatment plan clients: 44% of clients increased their GAF score by 5 or more points, 25% of clients increased their GAF score by less than 5 points, and 31% of clients had no change in the GAF scores. No clients reached the GAF benchmark score of 91 – 100 when their case was closed. In the third quarter of FY24 new clients were given the WHODAS instead of the GAF. Clients who began with the GAF will continue to use the GAF while all new clients will be assessed using the WHODAS. The WHODAS is the replacement for the GAF.

Outcome #4

Individuals who are Drug Court clients will complete a relationship assessment with the therapist. The therapist will make recommendations for additional services if appropriate.

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

RESULT: 100% of Drug Court clients who called to schedule an appointment for a Relationship Assessment completed their appointment.

(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? 51

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 collected outcome information on 37 clients. We were unable to collect this information on 14 clients: eleven clients did not continue counseling past one or two sessions so they did not complete a treatment plan and three clients have not had a treatment plan review yet. It is scheduled for the beginning of FY25.

3. How many people did you *attempt* to collect outcome information from? 51
4. How many people did you *actually* collect outcome information from? 43
5. How often and when was this information collected? *(e.g. 1x a year in the spring; at client intake and discharge, etc)*

    For Outcomes #1 - #3, this information is collected when a treatment plan is completed and every 6 months following.

    For Outcome #4, this information is collected when a Drug Court client schedules and completes a Relationship Assessment.

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.*

    We noted that we are not meeting our goal of assessing clients and having them enter into services as quickly as we planned. We began using an EHR system which has aided in

decreasing the time it takes to contact clients to have them complete paperwork in order to begin services. However, 16% of clients either did not complete the intake paperwork within 5 days of receiving it and/or requested to begin services at a later date for their convenience. We still believe this goal is valid and continue to schedule clients at their earliest convenience.

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.

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?

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: Family Service of Champaign County
Program Name: SHC
Program Year: FY24

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.
   Not Applicable

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.
   Not Applicable

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

6. Compare year-end result with the application estimate of length of participant engagement. Especially if the result was unexpected, comment on this finding.
   Not Applicable

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.
   Not Applicable

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

Through the Self-Help Center, individuals and families will be made aware of the existence of self-help groups and will be provided information and/or referral to a group(s) appropriate to address their needs (when one is available).

- *Participation in public awareness activities, which include informational fairs, conferences, public education presentations, media events, and publications.*
- *Continual update of the on-line version of the Support Group Directory, the Specialized Lists and the website.*
- *The rural libraries and places of worship in Champaign County will receive hard copies of the directory and other meeting notices.*

Assessment Tool used: individuals will be connected to a support/self-help group that will adequately address their needs. The Coordinator maintains a log of all contacts and tracks distribution of the directories. Also tracked are the number of phone calls received with responses provided by the Coordinator, number of emails, number of consultations, and the topic and number of community events in which the Coordinator participates.

Result: In FY24, the SHC Coordinator and/or a Program Director participated in 6 community fairs. Information was maintained on 159 support groups, 169 printed directories were distributed, 146 information and referral calls were addressed, there were 1,061 website views, responses were provided to 1,943 email contacts, and 2 editions of the newsletter were distributed.

Outcome #2

Through the Self-Help Center, individuals wanting to start a group and group leaders experiencing difficulties will be able to effectively start and lead groups and group visibility will increase.

- *Consultation services will be available to individuals wanting to start a group or to group leaders experiencing difficulties.*
- *Training opportunities will be provided through the biennial Self-Help Conference and the workshops.*
- *Resources are available through the Self-Help Center lending library to help with group development and understanding of group dynamics.*

Assessment Tool used: The Coordinator will provide consultations that assist an individual to start a group or help a current group leader overcome difficulties with their group. The workshop and conference topics will be relevant to address group leader needs. The SHC Coordinator developed an evaluation tool for conference and workshop attendees. Areas evaluated include skills acquisition, knowledge, satisfaction, and implementation of information.

Result: In FY 24, the Coordinator was not asked to provide any consultations. One workshop was held. Twenty-six people attended the Mental Health First Aid Class, and all participants completed at least part of the evaluation (not all participants answered every question). The workshop and the presenter received above 90% in all categories. Below are some of the comments from the evaluations:

-“Thank you for this! I will use it in my personal life and with my clients in need.”

-“The presenter did an awesome job!”

-“I feel I’m now educated enough to approach a person in crisis.”

-“Excellent! Wonderful info and resources.”

-“The presenter was really great. She kept everyone engaged and the information interesting. I will be able to help individuals experiencing a mental health challenge.”

Outcome #3

Through the Self-Help Center, professionals will be able to locate self-help groups to which they can refer their clients and will know how to work effectively with groups.

***Distribution of the printed Support Group Directories, Specialized Lists, quarterly newsletter and website information to group leaders and professionals.*

Assessment Tool used: Professionals will be successful in locating and referring their clients to appropriate groups. Professionals will receive printed copies of the Support Group directories.

Result: In FY24, 169 support group directories were distributed to libraries, businesses, and individuals in Champaign County. At least 146 callers received information regarding self-help groups which interest them. Specialized lists were distributed at all of the information and health fairs attended by Family Service.

Outcome #4

Through the Self-Help Center, the coordinator will monitor and track the existence of the support groups in Champaign County to better know and understand the demographics of the groups and maintain relationships with group leaders.

Assessment Tool used: The SHC Coordinator will survey all known self-help and support groups once/year to collect information about group demographics and allow group leaders to share concerns or training needs that they have.

Result: A survey was sent to all known self-help and support group leaders. No responses were received within 2 weeks so the survey was sent again to all known self-help and support group leaders. No responses were received again. In the past, we sent the surveys through from the SHC Coordinator's email. Due to changes in security among various email services, we were unable to send the surveys to group leaders through our email. We used Microsoft Forms to create and send the surveys which received no responses. We do not know if there was a problem with Microsoft Forms or if the leaders chose to not respond to the surveys. We will be investing in a service like Vertical Response or MailChimp for future mass emails.

(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?
   In FY24, there were 146 information and referral calls, 1,061 website views, 1,943 emails, 169 printed directories distributed, 6 information and health fairs at which the FSCC staff participated, 2 newsletters distributed to the SHC mailing list, the Mental Health First Aid Class with 26 attendees. The SHC staff served as members on several different service organizations or committees including the Human Services Council, Aging Services Task Force, the disability Expo committee, and AIR/Ebertfest. The SHC Maintained information on approximately 159 support groups available to Champaign County residents. The 19th edition of the Support Group Directory was distributed to therapists, libraries, and doctors around Champaign County. It was also distributed at information and health fairs, conferences, and presentations to organizations such as Champaign Kiwanis.

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?
   Due to confidentiality and anonymity issues, limited information is collected on the information and referral calls except for the topic. Data is usually requested from participants of the workshop on the registration form as it applies to gender, ethnicity, age group, and zip code.

3. How many people did you *attempt* to collect outcome information from?
   The registration for the Mental Health First Aid Class was handled by an outside entity so we were unable to gather the data we usually request from participants.
4. How many people did you *actually* collect outcome information from? 0
5. How often and when was this information collected? *(e.g. 1x a year in the spring; at client intake and discharge, etc)*

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.*

   From this outcome information we learned that the SHC is not fully functional without a SHC Coordinator. Due to not having a SHC Coordinator for more than 6 months, we only had one workshop in FY24 instead of two. We learned the importance of the SHC Coordinator as someone who networks, supports, and encourages the work of support groups in Champaign County.

   A new SHC Coordinator began in July 2024 (FY25) and has been reaching out to support groups and those interested in forming support groups. She began using MailChimp and has received excellent responses from group leaders. You'll learn more about her work in FY25 reports.

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.

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?

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: ___Family Service of Champaign County___

Program Name: ___Senior Counseling and Advocacy___

Program Year: 2024

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.

    In the application, our estimated number of days from referral to completion of assessment was 14, and we completed almost every assessment at the first point of contact, day zero. If we determined a client needed a home visit during the last fiscal year, we accomplished all of those within a window of 7 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.

    The goal was 90%, and the true percentage was close to 100, as this assessment is our Care Plan, which we typically complete at the first contact and provision of services.

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 estimate reflected the differing lengths of engagement between our TPCs and NTPCs. This trend did hold as most TPCs open and very rarely close without moving or passing away, and NTPCs may be engaged with us for just one task. For example, some NTPCs engage for a Medicare enrollment, Medicaid recertification, or LIHEAP application. Those engagements are completed within hours to days. That said, a small segment of those clients are "repeat customers" who revisit our services multiple times. They will come to us with multiple needs over a window of time, and we will keep such clients open in our reporting system.

Longer-term clients (TPCs) remain open for much longer. For example, someone struggling with mild depression symptoms who enrolls in our PEARLS programs will be engaged for at least 5-6 months. Clients who elect to take one of our free educational classes, such as Stress Busters or Matter of Balance, will be enrolled for 2-3 months. Clients who need social interaction can join our Friendly Caller program and receive phone calls in predictable intervals -- some clients receive calls more than once a week. Long-term TPC clients usually remain enrolled until they either move to a facility or pass 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.

We track a variety of demographic data, including:
- Rural address
- 75+ years old
- Living alone
- Race / ethnicity
- Limited English-speaking
- Income (above or below poverty level)
-Gender

Nearly half of our clients are 75 or older.
Over half of our clients live alone.
Approximately 100 of our clients are in rural areas.
About one-third of our clients consider themselves low income.

This information illustrates how aware we need to be of the potentially frail and vulnerable nature of our clientele. To respond to this, we are currently including messaging in our outreach about offering home visits. This has the dual purpose of being more convenient for our clients (who then do not need to drive or push the limits of their mobility, which are showstoppers for some) and also allowing case workers to visually make note of their home environment so we can help avoid future issues. A case worker might note signs of food insecurity, trip/fall risks, or caregiver stress, for example. Appropriate referrals are given. For example, we can also refer clients to HomeCare or other Care Coordination Unit (at Care Horizons) services to get help with personal or household tasks.

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

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

> ***Assessment Tool Used: Review of case notes***
>
> **RESULT: Family Service has several programs for anxiety, depression, and social isolation. For example, we provide PEARLS counseling for qualifying older adults who exhibit mild depression symptoms. We also can refer clients for more intensive talk therapy to the Family Service Counseling Center or to other psychiatric services local to the client (e.g., Carle, OSF Heart of Mary). For clients enduring social isolation, we enroll them in one of our Reducing Social Isolation programs, including Friendly Callers and Creativity Box deliveries. We also use Food for Seniors and Meals on Wheels deliveries to help reduce social isolation. This past fiscal year, we have been able to offer services to all clients in need of mental health services related to anxiety, depression, and social isolation.**

Outcome #2

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

> *Assessment Tool Used: UCLA-3 survey*
>
> **RESULT: From October 1, 2023 to May 31, 2024, our 6-month UCLA scores dropped from an average of 6.32 to 4.94, an improvement of 1.38 points.**

Outcome #3
PEARLS clients will have reduced PHQ9 scores.

Assessment Tool Used: PHQ9 survey

RESULT: All case workers were recently trained in PEARLS. We are working on building our PEARLS clientele base. Of the 6 PEARLS clients in FY24, all have given us positive feedback about the program, saying that they felt reduced signs of depression, anxiety, and isolation. All 6 have lower PHQ9 scores, though some had their final PHQ9 recorded after the end of FY2024. In FY2025, we have a designated staff member who will be reaching out to older adults, identifying partners, screening and enrolling participants, and providing PEARLS counseling. Therefore, we anticipate that reduced PHQ9 scores will continue to be an outcome in FY2025 for more participants as the program ramps up.

Outcome #4
People beginning healthy-aging classes will complete the series.

Assessment tool used: Report by our Director of Evidence-Based Programming.

RESULT: Family Service hosted a Chronic Disease Self-Management Program class beginning in May. Of the 11 who enrolled, 10 attended through the entire class. We also hosted a Matter of Balance Class in June. Of the 7 who enrolled, 6 attended for the duration of the class.
We also trained 2 Family Service casework staff (our HomeCare manager and Caregiver Advisor) in Stress Busters, a program to help those caring for a loved one with dementia to manage stress related to caregiving.

It is worth noting that we also trained 4 new CDSMP community leaders (not Family Service employees) in a professionals-training class; we also trained 2 new Matter of Balance leaders (also not Family Service employees).

CONSUMER PARTICIPATION IN DATA COLLECTION

1. How many total participants did the program have?

   We had a total of 1,051 participants who shared demographic information in FY2024.

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?

   Some of our I&R clients (Information and Referral) call for quick questions and referrals, but they may not choose to give us their personal information. We will give quick referrals without expecting all their information. For TPCs and NTPCs, information is collected about the person's demographics and case notes are journaled.

3. How many people did you *attempt* to collect outcome information from? 1,051
4. How many people did you *actually* collect outcome information from? 954
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: Referrals for those with symptoms of depression, anxiety, and isolation happen regularly, and we collect information on those clients immediately upon incident.

   Outcome 2: We collect UCLA scores from clients approximately every other month, so, 6 times per year.

   Outcome 3: PEARLS clients are evaluated with the PHQ-9 instrument before each of the 9 sessions.

   Outcome 4: Attendance is taken in every evidence-based healthy-aging 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 Service Counseling and Advocacy clients are almost exclusively over 60 and of modest financial means. Their interactions with our staff and our services hinge most strongly on their level of poverty. Differences in enrollment, demeanor, or other measure do not, in our experience, correlate to race, ethnicity, or other demographic characteristic. People with most economic need are more likely to ask for more help, whereas those who are unsure whether they would qualify for various programs are more reticent to ask for help. We have a diverse staff with variety in races, ages, linguistic competencies, etc.; they are visible in public and interact with clients on the phone and in our offices. Some clients hesitate to share information with caseworkers they judge to be too young, but that barrier is relatively easy to overcome through gentle, cheerful verbal persuasion plus demonstrated competence.

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.

Here is an example of the type of out-of-the-box thinking that our caseworkers perform to meet the needs of our clients. Our caseworker Elaine had a client who needed a particular kind of lift chair to sit and stand safely. Medicare would pay for 80% of the lift device and 0% of the chair. Elaine had to do two key things: (1) Find an agency that would pay the balance left after Medicare; and (2) find a furniture vendor who would accept third-party payments. Elaine had to visit 7 vendors to find one that would accept payment from both Medicare and Empty Tomb. This huge success was only accomplished because of Elaine's tenacity and persistence. The client has his chair and is thrilled.

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?

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: FirstFollowers____

Program Name: FirstSteps____

Program Year: 2024___

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 results are about the same. This is difficult to answer since we do the initial assessment while the person is still incarcerated and the date of start of services depends on date of release from prison. We have no control over release date.

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. This year we had more applicants than past years but we also had residents remaining in the house for a longer period of time, so this is difficult to determine.

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 have had a number of

people stay longer than anticipated. This has largely been due to their limited resources beyond FirstFollowers.

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 did not.

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

Provide a stable living situation- We had some conflict among residents early in the year but once that was resolved we have had the longest period of full occupancy of the house with now real challenges. All the residents have been gainfully employed and have set goals which they are working toward.

Outcome #2

Enhance employment opportunities- All our residents this year have had steady employment. In some cases they secured their own employment, in other cases we facilitated their connection with employers.

Outcome #3

Connect to social service agencies- We provided important connections for our residents in terms of access to these agencies, especially mental health supports and gaining the documents required to get an ID. Due to some changes in the IDOC more people are arriving at our house with most of their required paperwork intact in terms of what is required for those agencies.

Outcome #4

Build connections to the community- This has been uneven. One of our residents has been very active in many community activities of FirstFollowers and beyond. Two have been active in faith-based organizations and that has been their vehicle for connecting.

Outcome #5

Provide economic security-we have added new supports for people in terms of facilitating a higher credit rating and enabling them to use credit effectively. One person from our house left FirstSteps to buy his own house. Two have saved money to buy cars from careful planning provided by our drop-in staff.

(Add as many Outcomes as were included in the Program Plan Narrative)

Outcome #6

Access to long term housing opportunities-This has worked well. As noted above, one of our ex-residents bought a house, another used the housing voucher provided by HACC to help secure an apartment. Everyone who has moved out has landed a safe, well-located residential site.

CONSUMER PARTICIPATION IN DATA COLLECTION

1. How many total participants did the program have? ____5_________

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?
   Delivered from all residents
3. How many people did you *attempt* to collect outcome information from? __3___________
4. How many people did you *actually* collect outcome information from? _____3__________
5. How often and when was this information collected? *(e.g. 1x a year in the spring; at client intake and discharge, etc)* we primarily collect this information when the person moves out.

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.*

The statistical sample is very small. We have accepted one younger person into the house this year, a practice we have avoided in the past in favor of individuals who are older and have served a long period of time in prison. So far, this young man has done well, so that might help us to expand our potential recruitment pool.

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.
   A person came to us after serving 29 years in prison. From Day One he was very interested in FirstFollowers. He attended all of our meetings and events. He made personal friends with some of our staff. He also built strong ties with a local church which has been the source of considerable support both employment-wise and psychologically.

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? Although we have no faith basis for our program the evaluation has helped us to see how these connections can be important for our residents and for the community

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: FirstFollowers____
Program Name: Peer Mentoring____
Program Year: 2024____

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. We do not have a specific program that people go through. Our service relies on needs assessments and provision of appropriate services on a case by case basis.

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 remains about the same as in past years. However, we have decreased our pool of clients in order to make sure we are staying on our mission and not becoming excessively involved personally with clients, especially when their problems extend beyond our professional capacity.

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 have consciously reduced the length of our engagement due to factors noted in point 5 above.

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 did not.

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)."*

Note: we do not use assessment tools since the majority of our clients at drop-in visit us only once. We do some follow up with them but given our clientele it is often difficult to track them. The GoMAD participants, however, do fill out periodic evaluations and self-assessment forms which are designed in house.

Outcome #1 - Access to employment, education and housing (80%)

We gather information through intake forms and via personal relationship building. We do not follow up with each individual from the drop-in channel but we do gather data on those who are part of GoMAD and those who continue to connect to the drop-in staff. With regard to GoMAD we do monthly progress evaluations as well as performance assessment of their work on our constructions projects.

Outcome #2. Access to services (80%)

Virtually everyone who comes to the drop-in wants access to some kind of services. We track their needs and our provision through weekly reports from staff on their clients. This data is in a data base on our drive. We do not however, do extensive follow up unless the

person returns for a follow up visit. We encourage follow ups but they do not always happen

Outcome #3. Provide enhanced self-esteem (90%)

Given the difficulty of measuring this, we rely largely on the weekly case reports from our staff and from informal interactions with clients. However, we know from our interactions with the community, family members and community leaders that we are having a positive impact on self-esteem.

Outcome #4. For workforce development: basic building skills, public speaking, critical thinking, basic math (80%)

For this component, the GoMAD class, we do group sessions where people either fill out an inhouse survey, do a focus group with a consultant, or have a class discussion where they assess their performance and progress. We also assess them on the basis of their on the job performance on our construction projects and in our pre-apprenticeship curriculum.

CONSUMER PARTICIPATION IN DATA COLLECTION

1. How many total participants did the program have? ___75_________

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?
3. How many people did you *attempt* to collect outcome information from? ____65_________
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)* It varies. With the workforce development (GoMAD) monthly with the drop-in clients it depends on their needs and the extent of their presence in the drop-in center.

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.

We realized that placing people onto an on the job training program too soon brought very mixed results with high rates of absenteeism and poor performance. Instead, we put their through a three month class,, four days a week which would acquaint them with the basics of construction as well as provide them with certification. This was a way of screening them for appropriateness as part of the regular, paid workforce in our construction project and served as a vehicle for quality control in our construction work. This has helped us to access more construction job opportunities and lay the ground work for a possible social enterprise in the future.

In terms of the drop-in services, we have put in place a better division of labor and made sure our service offerings were in line with our skill set and resources. Due to the lack of professional services for our constituency in our county, we have often taken on more than we have the capacity to execute, leading to burnout and loss of focus.

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.

A person comes to us and says he just got out of prison three months ago and he needs housing. He says he has been staying with a girl friend, but it is not working out. On the surface he presents us with a primary problem of housing but deeper discussions reveal a host of other issues. He has no driver's license due to a twelve year old traffic violation. He "lost" his link card but a deeper probe make us suspicious that he has sold his Link to get some cash. He also smells of marijuana when he comes to our center. We review his housing history and he has no rental history, apart from an eviction seven years ago before he went to prison. Nonetheless, he keeps coming back and works diligently with one of our staff to look for housing online. In the middle of our housing hunt, he tells us he has lost his job because someone told his boss that he had a criminal record. We have to do some triage here, identify the main issues, assess whether his present housing situation is untenable and if he has any family or friends he can stay with temporarily, and help him look for a job since a landlord will not rent to him if he is unemployed.

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?

Annual Performance Outcome Report Form FY23/24

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: GROW in Illinois________________________________

Program Name: GROW_____________________________________

Program Year: FY 23/24_________

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**

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 had 314 New non treatment Plan clients. We had 84 continuing non-treatment plan clients for a total of 398. I projected 150 for FY24. This was almost 248 more than my projections. I need to get better with these projections.

.

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 Some come for a short time and some stay for years. Actual average length of time participants engages in services.**
From the survey: greater than 10 years was (FY23 20%) (FY24 13%) 2 to 3 months (FY23 24%) (FY24 10%) 1to 2 months (FY23 16%) (FY24 23%) 3 to 6 months (FY24 8%)

2 years (FY23 8%) (FY24 13%)

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. demographic information beyond standard categories was collected. **We ask GROW'ers these questions and here are some of the responses. (From the Survey)**

What keeps them coming back to the GROW? Survey FY24

Education and purpose
Friendship, self-improvement, helps us build confidence and stability.
Because life is continuously challenging and changing, I continuously need to learn to grow and mature.
This is not a one and done thing, GROW is not only about recovery/rehabilitation but also a wonderful resource for prevention of the downward spiral of decline and maladjustment. It is a guideline for how to navigate life with its ever-changing landscape.
GROW is teaching me many tools/personal resources that I need to grow to my personal maturity throughout the different stages of my life. GROW Offers a multi-dimensional understanding, insight, guidance, and learning life as a whole. Not only does it help me to grow and mature mentally but also spiritually (my Belief in GOD and my personal relationship with him), emotionally (balanced development of my thoughts, feelings, and actions), and personally (Personal value and self-activation).
Plain and simple GROW works.
You get out exactly as much as you put into the program of life, GROW offers.
Friendships, deal with life problems
The environment.
The support of GROW when me and my family were in need.
It is a great place, and I love it.
Friendships and helps my mental health.
The positiveness and the thought from others keep my mind "moving"
Love
The aura of the volunteers and the encouragement that they give.
Learning
Comradery
The people who come to the group and run the group.
The leaders are amazing at keeping people engaged and calling the group out on their maladjustments, in order to help them.
It creates a positive group atmosphere and puts the group in an honest mindset.
Constructive criticism is so helpful to people here and I enjoy it.
Damon and Keysa support
To have a good behavior
I started back because I needed a meeting.
The volunteers
I like the atmosphere of GROW

The people
Talk to people
Spending time out of my cell.
Read and Growing
Very open and honest.
My commitment to things.
Grow is a group where I feel safe about sharing my life issues with others. I'm always able to get constructive criticism and support of my feelings.
For advice and experience personal growth and receive personal recourses.
The family feelings and the ability to express myself.
The contents of the conversation
Trying to better myself and learn to deal with situations and problems when they surface.

What would you change about how groups are run? FY24
We value our GROWer's and we take their suggestions very seriously. GROW is a grass roots organization, and it is important to address the issues that we face in today's world. I have listed the follow up from FY23 survey and the things we put into place to address the issues that the GROWer's would like to see improvement. We followed up with forming teams and addressing each of their concerns.

35 responses
Nothing
More pizza
I wouldn't change anything.
No change
more structured
Update the Group Method for Virtual/Zoom meeting.
make the program modern

What suggestions do you have to improvements our program? FY23 survey

I would suggest that we remove some parts of the group method.
FY24 Follow up formed a team to address this.

I would like to see more updated reading.
FY24 Follow up we created a team to update the program.

The GROW program literature can be updated and more opportunities in the overall GROW community not just leadership. Engage and motivate others in such a way that.
it's exciting to attend those other activities.
FY24 We formed a team to address much needed program updates. We have worked with new leadership to get idea's and way's to improve program.
Our leaders write papers on new topics 6 times a year.

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)."*

All Outcomes were gathered by the Assessment took used Survey the(2 way social scale and NIH Toolbox Emotional Support Survey) participants in Survey where GROW groups meet some did it on line most needed help from Organizer or Fieldworker of the group.

-

Outcome

1. Decreased hospitalization frequency **(**from participant survey)
2. Decreased medication (from participant survey)
3. Increased use of social resources (from participant survey)
4. Increased personal growth. (From participant survey)
5. Increased wellbeing: (from the survey NIH toolbox Emotional support participant survey)
6. Increased number of participants in leadership roles (from participant survey and internal reports)
7. Satisfaction with GROW program: (from the participant survey)

(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? _____314_______unduplicated

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 collect outcomes throughout the year for internal GROW guidelines from attendance and CCMHB quarterly reports. At the end of**

the FY23/24 fiscal year we have a participant **survey. We choose to collect from all our participants. Some do not want to participate. We also collect outcome information from our weekly attendance including Race, gender, age, demographics, organizers, recorders, Recovered or Recoveries. Also, number of times attended in a month, committed grower [attended 3 or more meetings], Community observers.**

3. How many people did you *attempt* to collect outcome information from? **From the** participant **survey during the last quarter. All**

4. How many people did you *collect* outcome information from? **All from weekly internal reports and participant survey from GROW attendance/leadership, social and O&R meetings. We had 38 participated in the survey.**

5. How often and when was this information collected? *(e.g. 1x a year in the spring; at client intake and discharge, etc.)* ***Every group does weekly attendance age, race, gender, demographics, First timers, LGBTQ+ (New none treatment plan),Attendance in groups, socials, leadership meetings Organizer and Recorders meetings. We also do our survey the last quarter of the FY23/24 year, April, May, June. From the survey we collect Military Service, Spirituality, diagnosed illness and if ever attempted suicide, were they ever Incarcerated, if they are retired, If they sought or gained employment.***

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.*

    1. Decreased hospitalization: **From the survey (FY23 85%) (FY24 81%) had not been hospitalized. in the (FY24 5%) was hospitalized 2 times (FY23 4.1%) (FY24 4.8%) hospitalized once**. **We had (FY23 13) (FY24 30) that had never been hospitalized in a lifetime. We had (FY23 2) (FY24 1) that had been hospitalized over 10 times in a lifetime. We had (FY23 4) (FY24 4) that had been hospitalized 1 time in a lifetime. We had (FY23 18) (FY24 5) that did have a diagnosis of some sort of mental illness.**

    2. Decreased medication [for mental illness]: **From the survey FY23 we had 56% (FY24 52.6%) who are on no medication (FY23 24%) (FY24 48%) that were on two or three**

medications. We had (FY23 22) (FY24 28) people that worked with their doctor to reduce medication.

3. Increased use of social resources**: From the survey: (FY23 18) (FY24 29) people have increased their knowledge of social resources. We try very hard to help anyone in the program to know their resources.**

4. Increased personal growth: **From the survey (FY23 16) (FY24 28) strongly agreed with increased personal growth. (FY23 3) (FY24 12) agreed they had an increase in personal growth; (FY23 1) (FY24 3) both agreed and disagreed.**

5. Increased wellbeing: Survey (personal wellbeing index) **From the survey (FY23 15) (FY24 32 have an increased sense of wellbeing. (FY23 5 most of the time and (FY23 6 sometimes. (FY23 56%) (FY24 32 are very satisfied with the help they have received from GROW friendship. (FY23 30%) (FY24 10) were satisfied. (FY23 13%) (FY24 2) had no opinion.**

GROW'ers were asked to rate their life on a scale of 1 to 10.

How satisfied are you with life as a whole? Means=(FY23 4.2 /10) (FY24 5.3/10)

How satisfied are you with your standard of living? Means=(FY23 4.1/10) (FY24 5.8/10)

How satisfied are you with your health? Means=(FY23 4.1/10) (FY24.8/10)

How satisfied are you with what you are achieving in life? Means=(FY23 4.1/10)

(FY24 3.5/10)

How satisfied are you with your personal relationships? Means=(FY23 6/10)

(FY24 3.8/10)

How satisfied are you with how safe you feel? Means=(FY23 6/10) (FY24 4.1/10)

How satisfied are you with feeling part of your community? Means=(FY23 5.9/10)

(FY24 3.8/10)

How satisfied are you with your future security? Means=(FY23 5.9/10) (FY24 3.7/10)

Comparable to last years the Highest satisfaction was with personal safety.

FY22Means =(FY23 9.15/10) (FY24 4.1/10)

FY23 Average over all Means=(FY23 7.3/10) (FY24 4.26/10)

I noticed on this survey and the results that people do not feel as secure and safe. I found that to be a little concerning coming out of a pandemic. I think this is a universal problem that is a result of uncertainty and fear. I hope to see this improve next year. It is important for people to feel safe in the community they live in.

6. Increased number of participants in leadership roles: **From the survey (FY23 52%) (FY24 55%) have been involved in some kind of leadership role. (FY23 48%) (FY24 44%) had not been involved in the leadership role. FY22, we had 58% involved in leadership roles. We have a slight decrease in this FY. We had 314 duplicated attendance x 3 hours for each activity, with this does not include planning time = 4230 hours in support activities such as GROW groups, Organizers & Recorders Meetings, Leader's meetings, and social events, this is a monthly activity that requires leadership to organize and plan.**
   Participation in GROW leadership fosters personal work in recovery and wellness. Leadership activities promote positive attitude and community involvement that raises self-esteem and reduces isolation. This is an essential part of the GROW program of growth to maturity.

7. Satisfaction with GROW program: **From the survey: (FY23 56%) (FY24 57.9%) very satisfied with the program. (FY23 30.4%) (FY24 28%) were satisfied and (FY23 13%) (FY24 7.9%) were satisfied or not satisfied. (FY23 12) (FY24 32) people believed that GROW helped them recover from mental illness. (FY23 15) (FY24 29) developed their own personal resources. (FY23 16) (FY24 34) experienced?? improvement in personal growth and increased maturity. (FY23 15) (FY24 32) experienced better relationships and friendships.**

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.

It is the goal of GROW for participants to 'GROW' out of the program and 'get on' with their lives. We have had just that. We had one GROW'er that is looking for work we have another GROW'er that is supporting us with some of the Groups in the homeless shelter.

We have worked hard on the updates to the program over the past year. We have had several team meetings to make sure that the changes that we make to the program are in line with GROW's philosophy. This has given seasoned leadership an opportunity to work on much needed growth for us as well as the program. GROW cannot be stagnant it has to be constantly GROWing.
We are pleased with the product and are prepared to move forward on the type setting and the revised culturally competency program.
We have also worked with the Data Capacity building group. Learning new ways of collecting Data and how to use Google sheets to our advantage. I am very appreciative of this group. I have learned and grown from the experience and enjoy the connection that we have made along the way. I think the micro trainings are an excellent idea. They're basic, simple and easy to understand.
We are constantly updating our website. We have come up with new tools to help people to join groups easier and will be adding more orientations in this fiscal year. This gives the person the opportunity to join and learn about the program. It also makes them more comfortable with joining a group. It helps to meet someone from the group and give them an opportunity to decide if GROW is for them. We can also help them with the Technology.
We still have many people that come to our groups that struggle greatly with Technology.

We have had great success working with the inmates in our Champaign County jail groups. The program is very well attended, and we have helped them improve their lives.

One thing GROW does not have is a graduation type structure like other programs. We believe that you do OUTGROW the need for GROW then you give back. To fill that purpose we write letters to the court on an individual basis describing how they used the program in their lives and weather they showed leadership in helping others. Participation in GROW has helped with reduced sentences and is pleasing to the judge and for this the inmates are grateful. Each letter is designed to high light the individual's participation in the Program and is truthful. Keysa and Damon take the time to put these letters together and submit them to Celeste for approval. We are so happy to see that the facility is pleased with the results and the Judge takes into consideration all that the individual is doing to change and GROW.

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 made great progress building capacity in the area and are serving a wide variety of people with problems of living. We have two community groups that are doing well, we have one that is just getting started and it has yet to have a quorum. We are getting the word and doing PR in the community. One meets in the Presbyterian church and the

pastor of the church has supported the group for over a year. We have also resumed the groups in the jail.

We have also partnered with Restoration Urban Ministries. We had great success with Restoration it was a rough start because of the amount of people that attended the group. We tried to do a 50 minute class that just didn't work but about 2 months into doing the best we could the director phoned and ask if we would like a two hour time slot. That made all the difference in the group and we were able to follow the GROW structure and leadership model that works. We had a variety of people that stepped up and lead meetings and enjoyed the group and its growth to maturity.

We also have the Monday night virtual group that is a community group. It has good leadership in it. I still think people struggle with technology and are intimidated by the processes. This is why it helps to have the welcome to GROW meeting because you can ease the frustration.

The Illinois Coordinator continues to do the Welcome to GROW group as a weekly informational/orientation meeting. We are considering doing this a few times a week if time permits. Our leadership is capable of doing this orientation and I have had a few volunteers that would like to start working in to there schedule. This helps to meet the person for the first time. We are able to have a conversation with them before they attend a group. It also give's the professionals in the field a place to ask questions and to see if GROW can meet the need of their clients.

We also were advised to have a presence on social media. We have updated the website, and we have a very nice web page. We also started doing more group listing and activities on Facebook. We have updated our Facebook information to promote GROW every week and have gained many followers since we implemented the student's recommendations. I personally attended a workshop on how to make social media a priority that has made a difference.

We are a part of a Data capacity building work group. I joined the team is a blessing. I am not much for Data but this team has a way of making it interesting. I have learned how google sheets can be a great tool for our organization and plan to learn more about it in the future. I love the idea of the micro trainings and think that GROW could do a few of them our selves. Thank you for the opportunity to be part of this team.

We have also Partnered with Champaign County Free Christian services. We are working closely with Teddie, she is the Director, and she has been volunteering and supporting us in our Jail groups. This has been a big help. We were having some issues in the Women's groups, so we spoke with Teddie she has been coming into the group and supporting us and

The groups are doing well, it is now well attended, and the problems have been corrected.

Damon is also supporting Honors in the Jail this is a trade off for supporting the women's group. It has worked for both organizations because of the need for two people. Working Together is always the solution. I hope we can continue to have good working relationships with all the organizations.

We are also on re-entry that has improved and helped us to connect inmates to some of the re-entry services.

We continue to seek a bilingual person to help come into to some of our groups and interpret when needed. We have a few inmates that only speak Spanish. We have the blue book printed in Spanish so that is helpful.

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: Immigrant Services of Champaign Urbana____________________________

Program Name: Immigrant Mental Health Program________________________________

Program Year: 2024______

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.
   Application estimate of days was accurate. We estimated 5 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.
   We estimated 90%. The end result was 100%. Our clients' needs are multi-faceted, and due to the fact that we offer a holistic approach. All of our clients engage with several of our services at one. Mental health services were seen as complementary to case management.

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 projections were accurate. We estimated 5-6 sessions. The average client participated in the program for a duration of 6 sessions with the option to continue on for another 6 sessions.

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.

Based on the data collected, we found that all clients served fell well below the federal poverty line. Approximately 80% of clients were either unemployed or engaged in informal employment, earning minimal wages without formal work protections. A significant portion of the population we served was also experiencing or at risk of homelessness. Additionally, the majority of clients were asylum seekers, many of whom had either not yet begun the asylum process or were still in the midst of navigating it. This data highlights the ongoing economic and housing instability faced by our client population, compounded by their uncertain immigration status.

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

Refer to explanatory notes at the end of page.

Outcome #2

Refer to explanatory notes at the end of page.

Outcome #3

Refer to explanatory notes at the end of page.

Outcome #4

Refer to explanatory notes at the end of page.

CONSUMER PARTICIPATION IN DATA COLLECTION

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

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?

Refer to explanatory notes at the end of page.

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

Refer to explanatory notes at the end of page.

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.*

Refer to explanatory notes at the end of page.

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.

Refer to explanatory notes at the end of page.

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?

Refer to explanatory notes at the end of page.

Explanation: In the Program Plan Narrative, we predicted several positive outcomes for participants in our program, including increased access to mental health counseling and social services, reductions in substance abuse, domestic violence, and child abuse, improved relationship satisfaction, decreased depression, and enhanced resilience and coping capacity.

Although we faced significant challenges in implementing the planned measurement tools, we observed notable successes in the program. For example, there was a significant increase in immigrants receiving mental health counseling, with one month seeing as many as 15 referrals from new arrivals alone. This surge in engagement highlights our program's success in connecting vulnerable individuals with the services they need.

Clients also reported higher satisfaction in their relationships, ranging from mother-child dynamics to partner-partner connections. Several women who had suffered from domestic violence were able to access therapy, making meaningful progress in their recovery. These women expressed that the therapy provided crucial support in rebuilding their lives.

Additionally, we saw a reported decrease in depression among clients and an increase in their capacity to cope with daily life. Many clients, who had never before had the opportunity to speak with a professional about their traumas, were able to do so for the first time through our program. This access to mental health services was transformative for many, fostering newfound resilience and improved mental health.

However, infrastructure issues, staff turnover, and difficulties in securing provider collaboration, even with client consent, posed significant obstacles. Additionally, we lacked the technological capacity and staff needed to collect, manage, and report data systematically. Although the original application included various outcome measurement tools, we found that implementing these tools would be very time-consuming and require significant staff effort. This would have taken away from other essential services we provide. These outcomes measurement tools included:

Outcome #1: Data on the number of clients receiving services was to be gathered at each step of the process—assessment input, counseling session attendance, and post-counseling meetings.

Outcome #2: The Risk Behavior Survey was to be administered pre- and post-counseling.

Outcomes #3 and #4: The Patient Stress questionnaire, along with a qualitative survey on domestic violence and child abuse, was to be administered pre- and post-counseling.

Outcome #5: The Patient Stress questionnaire and the Social Competence Scale for children and teenagers were to be used pre- and post-counseling.

Outcome #6: The Adult Needs and Strengths Assessment, focusing on Need/Stability measures, was planned for pre- and post-counseling.

Outcomes #7, #8, and #10: Quality of Life and Wellness Assessments were to be conducted pre-counseling, at 6 months, and 12 months later, along with a qualitative survey on housing, employment, and food security.

Outcome #9: The Social Competence Scale was to be administered both pre- and post-counseling.

The extensive time and complexity involved in using these measurement tools posed challenges for individuals who face language barriers and often have limited education. Focusing on crisis intervention was often a priority. In conclusion, there were many in house deficits as well as accessibility for clients, that hindered our ability to quantitatively track the progress and outcomes as initially intended.

Despite these limitations in formal data collection, the qualitative feedback from clients strongly indicates the positive impact of our program. Moving forward, we are committed to addressing these challenges to enhance our data collection and reporting processes, ensuring a more comprehensive evaluation of our program's effectiveness.

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: Promise Healthcare

Program Name: Mental Health, Psychiatry and Counseling

Program Year: 2024

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.

   Target 14 days. Target met for psychiatry. For counseling occasionally through out the year new patient appointments were scheduled within 21 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.

   Target 50%. During PY 2024, out of the 865 patients identified as in need for BH services based on PHQ-9 score, 402 received assessment by Counseling or Psychiatry (46%).

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

   Not applicable. All patients seeking services are eligible to receive services without limitations on length of 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.

   Not applicable.

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

1. Promise Healthcare will serve 800 treatment plan and nontreatment plan clients with Counseling services and at least 1,900 treatment plan and nontreatment plan clients with Psychiatry services by the end of Q4 2024. There were 1282 TPC and NTPC patients for counseling. Target met. There were 3278 TPC and NTPC patients for psychiatry. Target met.

Outcome #2

2. Promise Healthcare primary care and dental patients will be screened using the PHQ-9 behavioral health assessment tool and if identified to have moderate depression will be appropriately referred for further assessment. Promise expects 80% of medical patients will be screened and appropriately referred, and 20% of dental patients will be screened and appropriately referred by the end of Q4 2024. During PY 2024, 89% of medical patients 12 years of age and older were screened with a standardized tool and had follow-up documented if positive (UDS measure). Target met. Dental target not met. Turn over in program management has delayed implementation of behavioral health integrated services with dental.

Outcome #3

3. Promise Healthcare will see an increase in patients identified with depression and referred for further assessment and treatment. The percentage of patients 12 years of age and older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event will increase by 5% by the end of Q4 2024. Baseline: 1%; End of PY 2024: 8%. Target met.

Outcome #4

4. By the end of the grant time period, the Behavioral Health Case Manager will reach out to 100% of patients who scored 10 or higher on the PHQ-9 and offer case management services. During PY 2024, 865 patients were identified as in need for BH services based on PHQ-9 score. BH Case Manager reached out to 320 of these patients (37%) Not all patient meeting criteria were referred to the BH Case Manager. Internal education and training has been implemented to improve the number of patients meeting criteria that are referred.

(Add as many Outcomes as were included in the Program Plan Narrative)

5. By the end of the grant time period, 100 patients will be identified as in need of counseling or Psychiatry based on PHQ-9 scores of 10 or more. Of these individuals, it is estimated that at least 50 people will receive an assessment by Counseling or Psychiatry. During PY 2024, out of the 865 patients identified as in need for BH services based on PHQ-9 score, 402 received assessment by Counseling or Psychiatry (46%). 50 out of 100 target partially met.

CONSUMER PARTICIPATION IN DATA COLLECTION

1. How many total participants did the program have? 4560

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?
3. How many people did you *attempt* to collect outcome information from? 4560
4. How many people did you *actually* collect outcome information from? 4560
5. How often and when was this information collected? *(e.g. 1x a year in the spring; at client intake and discharge, etc)*

   Data collected monthly during collection for uniformed data system.

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.*

   23% of the mental health services patient served in PY24 were African American. African Americans make up about 15% of the Champaign population. The majority of patients fall between the ages of 19 to 59. Approximately 23% of the mental health patients served we adolescents or children 18 years of age or younger.

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.

   Wellness staff receive referral from external partner. Wellness staff meet with the patient assess the patient for needed services including psychiatry, counseling, mental health case management, medical and dental. Wellness staff then schedule appointments with the appropriate 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?

   The structure of the Mental Health Wellness program has been a positive impact on the efficient processing of external and internal referrals.

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: Promise Healthcare ____

Program Name: PHC Wellness____

Program Year: 2024________

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.
   Target 3 days. The majority of patients referred were contacted within the target, frequently same day referral was received, triaged by phone and scheduled for appropriate services. Patients with chronic conditions that would benefit from mental health care management were scheduled to meet in person with Wellness Care Managers within 14 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.
   Promise estimates at least 40 people will receive a PRAPARE assessment, with each individual contributing to their plan of service once the assessment is completed. 111 patients were assessed in PY24 with the PRAPARE assessment of Social Determinants of Health. Target met. Mental Health Wellness staff provided 2029 patient assists in PY24.

6. Compare year-end result with the application estimate of length of participant engagement. Especially if the result was unexpected, comment on this finding.
   Not applicable. Patients are able to engage in services without limitations on length of 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.
   Not applicable.

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

Help a minimum of 600 patients remove barriers to accessing healthcare services and treatment plans.

Target: 600 patients. Actual: 2,029

Assessment Tool: Data from Nextgen EHR

Source of Information: Data is input by staff and providers and reported on by the Promise Informatics & Data Systems Manager/ Data & Workflow Analyst

Outcome #2

Develop a referral system for community partner organizations to refer community members for services. The referral system will be operational by Q2 and external referrals will be tracked via Nextgen data reports.

Target: We did not list a number but the outcome was to stand up external referral services by end of Q2 (December). The external process was in place beginning in November and fully functional in January.

Actual: 410 referrals from community partners. 1,167 including partner and personal referrals. These organizations had more than twenty referrals: Urbana Schools- 21, OSF - 128, Pavilion - 56, Rosencrance - 67

Assessment Tool: NextGen Reporting and Excel spreadsheet

Source of Information: Call logs for the Wellness Team reported on by the Promise Informatics & Data Systems Manager/ Data & Workflow Analyst

Outcome #3
Implement the use of the PRAPARE screening tool by the end of the project period and conduct a minimum of 40 patient assessments.

Target: 40 patients.

Actual: 111

Assessment Tool: Data from Nextgen EHR

Source of Information: Data is input by staff and providers and reported on by the Promise Informatics & Data Systems Manager/ Data & Workflow Analyst

Outcome #4

(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? ___2875_____

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?
3. How many people did you *attempt* to collect outcome information from? ___2875______
4. How many people did you *actually* collect outcome information from? ____2875_______
5. How often and when was this information collected? *(e.g. 1x a year in the spring; at client intake and discharge, etc)*
   Daily

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.*

   Patients who are engaged with more than one contact or assisted through several barriers are considered case management (TPC). Promise projects 200 patients served as TPC. NTPC patients are ones who are just helped once in a program year. A service contact may be a referral from their primary care provider, mental health provider, or referring partner. Promise projects 400 patients served as NTPC. Other- insurance enrollment clients- the target was 1900 and 846 were actually assisted as there was significant staff turnover.

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.

   Examples of a typical case of a client or patient being assisted through the Wellness Project Include:
   Promise Wellness staff attended a table event with a partner (Salt and Light). Staff met with a patient and assisted him/her with a Medicaid application.

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?

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: __Rape Advocacy, Counseling, & Education Services (RACES)___________

Program Name: __Sexual Trauma Therapy Services________________________________

Program Year: _2024________

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.

   RACES expected to be able to move clients off of the waiting list within 60 days of their initial screening for therapy services. However, due to staff turnover, multiple therapists having medical emergencies, and more existing clients continuing services for longer than expected, RACES still had clients waiting for up to six months to receive services. This is despite the agency increasing its therapy team from two to five over the past three years. RACES was able to maintain this larger team in large part because of support from this grant. While FY24 saw the continuation of a significant waiting list for much of the year, RACES is now on track to have a shorter wait for new clients. This is due to a return to the therapy department being fully staffed and the agency bringing on two graduate-level counseling interns for 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 agency was unable to meet the 80% goal described in the application due to staff turnover and continued high demand for services. However, as of August of 2024, RACES is now on track to meet this goal.

6. Compare year-end result with the application estimate of length of participant engagement. Especially if the result was unexpected, comment on this finding.
   RACES estimated clients would receive therapy at RACES for an average of one year. In FY24, the agency a lower level of clients exiting services than expected, with an average of clients receiving services for closer to two years. This decreased the number of new clients the agency was able to take on.

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.

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: Increased feelings of well-being

During fiscal year 2024, RACES expanded the use of the Impact of Event Scale (IES-R) assessment. Previously, only the agency's Community Outreach & Group Services Therapist had been using this tool. As an Illinois Coalition Against Sexual Assault (ICASA) certified center, RACES' Therapists are prohibited from providing a diagnosis. Therefore, assessment tools are limited to data that does not ascribe a diagnosis or progress related to a diagnosis. The agency's first, and now former, Community Outreach & Group Services Therapist identified the IES-R as a tool that could be used to gather client feedback on their perceptions regarding their feelings of well-being. Many of RACES' other therapists have found this tool more cumbersome and many clients have chosen not to utilize it. As a survivor-centered organization, RACES does not force clients to complete this assessment. This opt-in approach has resulted in to low utilization of

this tool and the agency is exploring options that will be more user-friendly for clients and their RACES therapists.

Outcome #2: Decreased trauma-related symptoms, such as PTSD.
Due to the limited number of clients who completed the IES-R scale at multiple points, there isn't enough usable data to draw conclusions from this tool. However, the feedback provided by clients at the conclusion of their time receiving therapy at RACES consistently shows increased abilities to cope and satisfaction with the service.

Outcome #3
NA

Outcome #4
NA

(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? ___80 (just therapy)______

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?

   RACES provided all of its therapy clients the option to utilize the ISE-R and closure evaluations. Clients had the option to decide if they wanted to utilize these tools or not.

3. How many people did you *attempt* to collect outcome information from? __115__________
4. How many people did you *actually* collect outcome information from? _____38____________
5. How often and when was this information collected? *(e.g. 1x a year in the spring; at client intake and discharge, etc)*

   Therapists offered their clients the option of completing the ISE-R every six months and the satisfaction survey at the end of their time at RACES. Due to the low return rates, RACES is exploring additional options for evaluation in FY25.

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.

As noted above, the small number of individuals who completed the IES-R scale at multiple points makes the available data unusable. Only five adults and one child completed this scale at multiple points. Due to the nature of the process of healing from trauma, it is expected that some people will have harder and easier times throughout their healing journey, so fluctuations in responses from such a small group of individuals do not provide a large enough sample to draw any statistical conclusions. However, the written feedback provided by clients at the end of services consistently shows clients feeling more equipped and satisfied with the services they received.

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 following is a hypothetical case:

Aaliya is three years old and she’s started acting out in ways that are unusual for her. Aaliya’s mother, Jasmine, notices that Aaliya is always the most upset after she stays with her dad. After Aaliya screams and says that she doesn’t want to stay with her dad the next time she’s scheduled for a visit and recently told her mother that when she has to stay at her dad’s, Jasmine asks Aaliya again what is going on. Aaliya has been quiet when Jasmine has asked before, but this time she tells Jasmine that her dad touches her in her private areas and tells her that she has to keep it a secret. Aaliya’s mother, Jasmine, is horrified and also afraid of what Aaliya’s father, Zach, will do. Jasmine’s friend told her about RACES a long time ago when Jasmine was having a particularly hard time dealing with her trauma from her own experiences of sexual violence. Jasmine decides to reach out for help. Jasmine and Aaliya are both able to receive therapy services at RACES and Jasmine receives support from a RACES Advocate to secure an order of protection against Zach. As they both start to feel a bit safer, Aaliya’s outbursts subside and Jasmine is able to process her past experiences and her fears related to Aaliya’s abuse. They still have a long way to go as DCFS investigates but they know that they are not alone and Aaliya loves coming to see her therapist.

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?

   This was RACES first year implementing the IES-R scale broadly. It is clear that this tool is generally not one that clients want to engage with, so RACES plans to utilize other assessment options in FY25.

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: ___Rape Advocacy, Counseling, & Education Services (RACES)_________

Program Name: ____Sexual Violence Prevention Education________________________

Program Year: ___2024________

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.
   100% - As anticipated, RACES' staff reviewed all requests for prevention services within three days to ensure that the requesting entity was eligible for the agency's services.

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.
   RACES' Prevention Education Coordinator left the agency in February 2024 and some data regarding the amount of time that it took to schedule schools following their request for services is unavailable. However, the agency can confidently say that all schools that were scheduled for programming in the 2023-2034 school year did still receive the services that they requested. Some schools had to be rescheduled due to this staff turnover but the agency's other two Educators worked hard to ensure that they still met the need for programming.

6. Compare year-end result with the application estimate of length of participant engagement. Especially if the result was unexpected, comment on this finding.
   All schools received at least three sessions, with most receiving four. This is in keeping with expectations.

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 Knowledge Gained (increased knowledge of topics related to sexual violence)

All RACES programs are expected to address this outcome. RACES planned to use two empirically validated assessments created and developed by curriculum providers and four assessments that were created with the previous CCMHB Evaluation Consultation Bank. Data was collected from participants for each of these programs.

Second Step – Child Protection Unit and Darkness to Light Stewards of Children are nationally recognized programs with their own assessment tools. Boundaries Matter, Safer Relationships, Dating without Violence, and I <3 (heart) Consent are programs that were developed by RACES and the assessment tools were developed with support from the previous evaluation consulting group contracted with CCMHB.

The results of the agency's analysis of the proportion of students who answered knowledge-related questions correctly on the pre-test compared to the post-test showed the positive effect of the agency's curricula. See the "Results" section for more information.

Outcome #2 Attitude change related to risk factors (decreased acceptance of measures related to risk factors)

RACES programs for middle school, high school, and adults are expected to show changes related to this outcome. RACES planned to use two empirically validated assessments created and developed by curriculum providers and four assessments that were created with the previous CCMHB Evaluation Consultation Bank. Data was collected from participants for each of these programs.

Second Step – Child Protection Unit and Darkness to Light Stewards of Children are nationally recognized programs with their own assessment tools. Boundaries Matter, Safer Relationships, Dating without Violence, and I <3 (heart) Consent are programs that were developed by RACES and the assessment tools were developed with support from the previous evaluation consulting group contracted with CCMHB.

The results of the agency's analysis of the proportion of students who answered knowledge-related questions correctly on the pre-test compared to the post-test showed the positive effect of the agency's curricula. See the "Results" section for more information.

Outcome #3 Attitude change related to protective factors (increased acceptance of measures related to protective factors)

All RACES programs are expected to address this outcome. RACES planned to use two empirically validated assessments created and developed by curriculum providers and four assessments that were created with the previous CCMHB Evaluation Consultation Bank. Data was collected from participants for each of these programs.

Second Step – Child Protection Unit and Darkness to Light Stewards of Children are nationally recognized programs with their own assessment tools. Boundaries Matter, Safer Relationships, Dating without Violence, and I <3 (heart) Consent are programs that were developed by RACES and the assessment tools were developed with support from the previous evaluation consulting group contracted with CCMHB.

The results of the agency's analysis of the proportion of students who answered knowledge-related questions correctly on the pre-test compared to the post-test showed the positive effect of the agency's curricula. See the "Results" section for more information.

Outcome #4
NA

(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? 7,040

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?

   RACES attempted to gather outcome information from every participant. There is not a 1:1 return rate on pre/post evaluations, potentially due to self-selection ability, comfort with material, and presence in the classroom on the day of test administration. Each student was given both pre- and post-tests, with directions to provide anonymous responses. Students were allowed to self-select participation in this process; however, they were strongly encouraged to complete the tests. RACES' Educators have continued to find that many classrooms struggle to complete both the pre and post-tests. For FY25, RACES is moving to a single assessment that will ask students to reflect on their knowledge prior to the programming and afterward. This single assessment will allow for one-to-one comparisons for individual students and agency staff have built in time for its completion during the final session of each program to increase return rates. Recent guidance from field experts also recommends this evaluation approach.

3. How many people did you *attempt* to collect outcome information from? 7,040
4. How many people did you *actually* collect outcome information from? 4,089
5. How often and when was this information collected? *(e.g. 1x a year in the spring; at client intake and discharge, etc)*
   Information was collected once before RACES' programming was provided and once after the programming was provided.

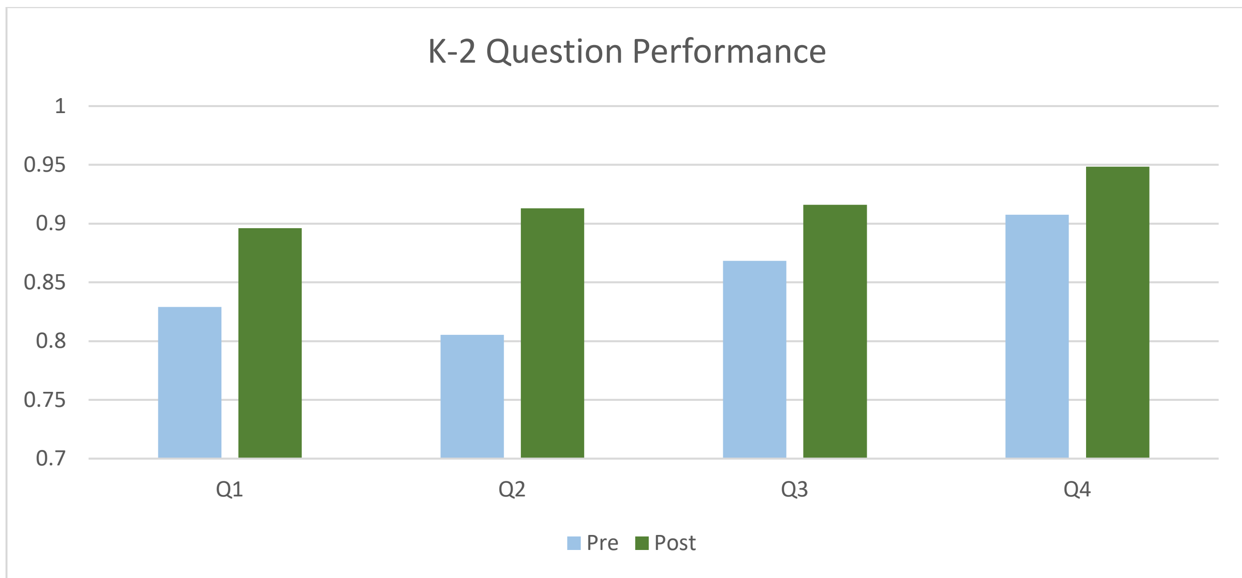
RESULTS

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.*

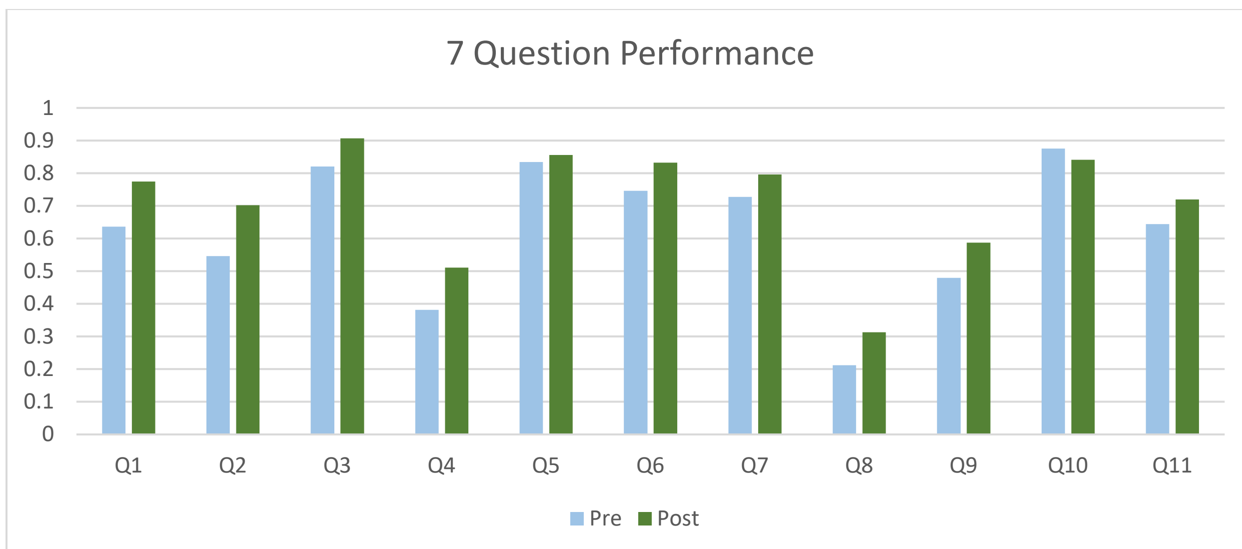
An analysis of the percent of correct responses on evaluation instruments implemented prior to the agency's programming compared to those after the agency's programming demonstrates meaningful, positive changes, many of which were statistically significant. Representative examples of the most significant changes are included below. While meaningful changes were present for all grade levels, the ones for the K-2, 7th grade, 8th grade, and high school curricula

were the most impactful. The blue bars in the chart below show the aggregate pre-test percent of correct answers and the green bars show the aggregate post-test percent of correct answers in each chart.

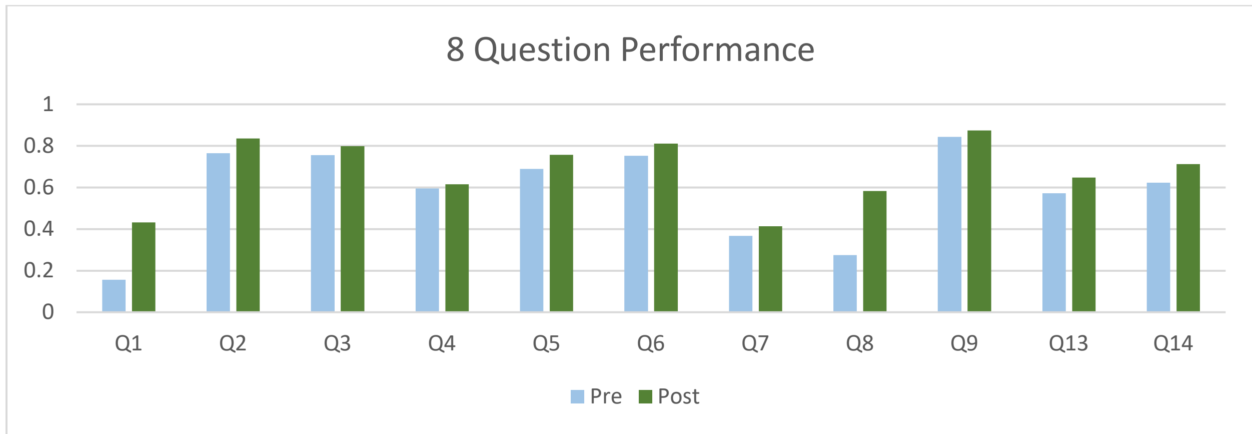
K-2 students' post-test scores were significantly higher (M = 3.63, SD = 0.76) than the mean of their pre-test scores, $t(920) = 11.11$, $p < .001$. The effect size, as measured by Cohen's d, was d = 0.31, indicating a small but significant effect.



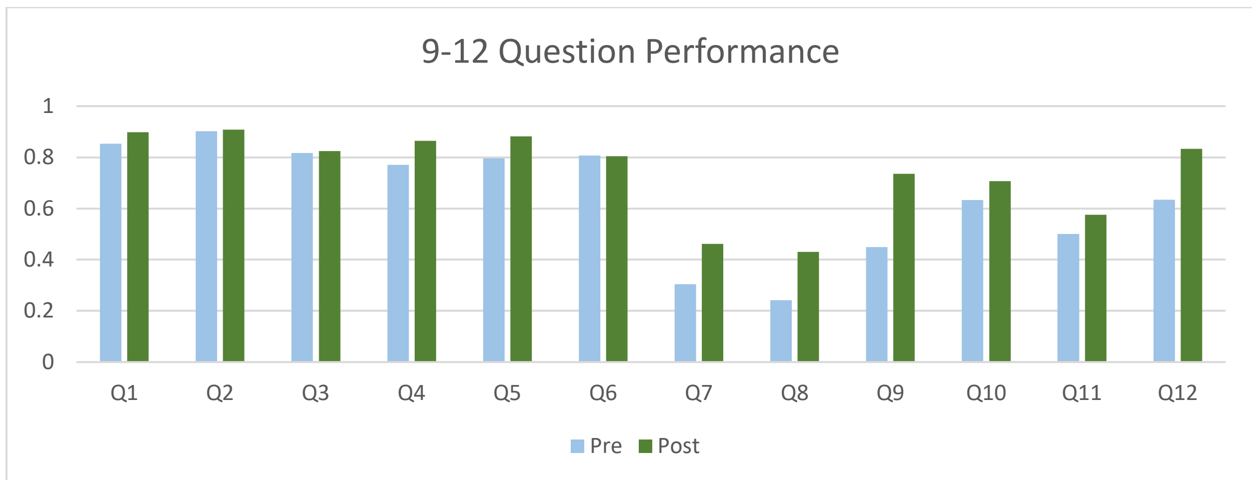
7th grade students' post-test scores were significantly higher (M = 7.62, SD = 2.48) than the mean of their pre-test scores, $t(562) = 7.74$, $p < .001$. The effect size, as measured by Cohen's d, was d = 0.33, indicating a small but significant effect.



8th grade students' post-test scores were significantly higher (M = 7.30, SD = 2.70) than the mean of their pre-test scores, $t(534) = 8.41$, $p < .001$. The effect size, as measured by Cohen's d, was d = 0.40, indicating a small to medium effect size.



9-12th grade students' post-test scores were significantly higher (M = 8.72, SD = 2.56) than the mean of their pre-test scores, $t(384) = 8.48$, $p < .001$. The effect size, as measured by Cohen's d, was d = 0.46, indicating a close to medium effect size.



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 following is a hypothetical case, based on RACES' Educators' experiences.

Max is a high school student at XYZ High School in Urbana. They've been in classes with Prevention Educators from RACES for as long as they can remember, and they feel confident that they know how to help a friend. This year, Miss Allison is talking about consent, and it makes them think about an experience that they had with their partner. At the time, they thought that they must have done something wrong for their partner to treat them that way, but they decide to ask to speak to Miss Allison after class. As they talk, Max realizes that their partner didn't have consent to do what they did. Max feels better talking to Miss Allison and gets information about starting therapy at RACES and information about how to have a conversation with their parents about what happened. They also discuss strategies for safely breaking up with their partner, which Max realizes they have wanted to do ever since the incident they were thinking about occurred.

Research has shown that the initial response to a disclosure has a significant impact on a survivor's healing. RACES Prevention Educators are trained to provide crisis intervention services and are often the first person to whom a child will disclose sexual assault or sexual abuse. They can also be an important link to connecting children and their families with resources, including others offered through RACES. RACES' staff will work with schools and families to provide therapy at school, explore options for increased safety, including protective orders or Title IX accommodations, and ensure that survivors of all ages know that they have options and are not alone.

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?

   RACES reviews survey results for each school year and uses this information to finetune the program for the following year, while maintaining their core components. Utilizing this data, RACES' Prevention Education team has spent the summer of 2024 working on revisions to curricula and evaluation tools. As noted above, related to the return rate, RACES is moving to a single assessment for FY25. While the process of attempting to administer pre and post-evaluations has provided meaningful and useful data, it has proven difficult to ensure that data from the thousands of students RACES serves each year is fully captured. The new process will make this important evaluation process simpler and also follow updated guidance regarding the most effective means of capturing and analyzing data regarding the efficacy of sexual violence prevention programming.

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: Rosecrance, Inc.
Program Name: Benefits Case Management
Program Year: PY2024

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.
   Estimate: 1. Actual: 1
   Since services start at time of program assessment, Benefits Case Management services begin on same day as assessment.

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.
   Estimate: 100%. Actual: 100%. Since services start at time of assessment, 100% of those seeking Benefits Case Management services met this.

6. Compare year-end result with the application estimate of length of participant engagement. Especially if the result was unexpected, comment on this finding.
   Estimate: 3-6 months. Actual: 12 to 18 months for SSI/SSDI due to SSA office delays/staffing shortages. 1 to 2 months for medical benefits.

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.
   None.

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

1. It is estimated that 100% of those seeking information, assistance with applications, or referral will receive an appointment for services. Actual: 100%

All clients seeking an appointment received an appointment for services. Outcomes 1 -4 are measured in the Rosecrance electronic health record. The Benefits Case Manager enters the data into the electronic record. The Benefits Case Manager also completes a Benefits Referral and Tracking Worksheet on each client, which tracks progress of the application(s) submitted.

Outcome #2

2. It is estimated that clients seeking services will be offered an appointment within 5 business days of referral, call, or walk-in.

Actual: 90% of clients were provided a service by the Benefits Case Manager within 5 days.

Outcomes 1 -4 are measured in the Rosecrance electronic health record. The Benefits Case Manager enters the data into the electronic record. The Benefits Case Manager also completes a Benefits Referral and Tracking Worksheet on each client, which tracks referral date as well as progress of the application(s) submitted.

Outcome #3

3. It is estimated that 100% of eligible clients will be assisted with benefits acquisition.

Actual: 100%

All clients who attended scheduled appointment with Benefits Case Manager received assistance. Outcomes 1 -4 are measured in the Rosecrance electronic health record. The Benefits Case Manager enters the data into the electronic record. The Benefits Case Manager also completes a Benefits Referral and Tracking Worksheet on each client, which tracks progress of the application(s) submitted.

Outcome #4
4. It is estimated that 600 contacts to assist clients with benefits acquisition will be completed annually.

Actual: 541 contacts to assist clients were made in PY24. Outcomes 1 -4 are measured in the Rosecrance electronic health record. The Benefits Case Manager enters this data into the electronic record.

(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? 129

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 was collected from Champaign County clients only.

3. How many people did you *attempt* to collect outcome information from? 129
4. How many people did you *actually* collect outcome information from? 129
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 tracked throughout the time of the client's engagement with the Benefits Case Manager. The frequency is dependent on each client's situation and which benefits the Case Manager is helping them understand and/or acquire.

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.*

The program is doing very well getting clients quick access to benefits case management services. The recruitment and retention rate for different ethnic or racial groups is reflective of our outpatient services, with 42% being black/African American, 56% being white, and roughly 2% being other or mixed race. Qualitative information from the Benefits Case Manager and quantitative information from the Benefits Referral and Tracking Worksheets show that the length of time it is taking for the State of Illinois to process disability claims continues to increase, with some clients waiting 12-18 months or more to hear whether a claim has been approved or denied.

Number of contacts has increased from PY23 since the COVID emergency automatic renewals/ "continuous coverage" for Medicaid eligibility ended on June 1, 2023 and Medicaid eligibility verification became required again.

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.

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?

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: Rosecrance, Inc.
Program Name: Child and Family Services
Program Year: PY2024

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.
   Estimated: 7 days. Actual: 1.3 months. Due to the unexpected loss of a counselor who would see the overflow of youth participants, we had to waitlist participants temporarily until a new counselor was hired. If a participant was identified as high risk or high need, additional services were initiated in the meantime such as psychiatry, crisis stabilization, and care coordination. The new counselor started in July 2024 and will greatly reduce the wait time for PY25.

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.
   Estimated: 75%. Actual: 25% Due to the unexpected loss of a counselor who would see the overflow of youth participants, we had to waitlist some participants temporarily until a new counselor was hired. If a participant was identified as high risk or high need, additional services were initiated in the meantime such as psychiatry, crisis stabilization,

and care coordination. The new counselor started in July 2024 and will greatly reduce the wait time for PY25.

6. Compare year-end result with the application estimate of length of participant engagement. Especially if the result was unexpected, comment on this finding.
   Estimated: 120 days. Actual: 215 days. Typical outpatient counseling treatment plans are generated with a 180-day time frame before a reassessment for continued treatment is initiated. While some participants may successfully complete treatment under 180 days, the typical average LOS in outpatient counseling programs is 6 months to 1 year which is evident in the actual result. We also saw youth and families staying engaged in services longer than estimated, which typically means a better chance of success but leaves less availability for new participants.

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.
   None.

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 participant and their caregiver(s)."*

Outcome #1

The Child and Family Services program aims to help participants decrease emotional and behavioral issues and functional impairment. Treatment also aims to help the participant improve in social adjustment and school performance.

1) Participants will show improvement in Children's Global Assessment Score (CGAS). This is the clinician's rating of a child's overall functioning level.

Actual: 50% of the participants showed improvement in CGAS, 36% showed a decline, and 14% showed no decline nor improvement. Scores are based on a global measure of level of functioning in children and adolescents. The measure provides a single global rating only, on scale of 0-100. In making their rating, the clinician makes use of the glossary details to determine the meaning of the points on the scale. These scores are tracked in the electronic medical record.

Outcome #2

2) Participants will show improvement in Ohio Scale Problem/symptom severity. This scale is comprised of items covering common problems reported by youth who receive behavioral health services. Each item is rated for severity/frequency.

43% of the participants evaluated at 6-month and/or at discharge showed improvement on the Ohio Scale Problem/symptom severity. 43% showed a decline, and 14% showed no decline nor improvement. Scores are based on participant report (with participant guardian input as appropriate). These scores are tracked in the electronic medical record.

Outcome #3

3) Participants will show improvement in Ohio Scale Functioning scale. This scale rates the youth's level of functioning in a variety of areas of daily activity (for example, interpersonal relationships, recreation, self-direction, and motivation.

50% of the participants evaluated at 6-month and/or at discharge showed improvement on the Ohio Scale Problem/symptom severity. 36% showed a decline, and 14% showed no decline nor improvement. Scores are based on participant report (with participant guardian input as appropriate). These scores are tracked in the electronic medical record.

Outcome #4

4) Participants will show improvement or no decrease in Columbia Scale. This scale is used by the clinician to assess the severity and immediacy of suicide risk.

43% of the participants evaluated at 6-month and/or at discharge showed improvement on the Ohio Scale Problem/symptom severity. 36% showed a decline, and 21% showed no decline nor improvement. Scores are based on participant report (with participant guardian input as appropriate). These scores are tracked in the electronic medical record.

(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? 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?

3. How many people did you *attempt* to collect outcome information from? 34
4. How many people did you *actually* collect outcome information from? 14
5. How often and when was this information collected? *(e.g. 1x a year in the spring; at participant intake and discharge, etc)*

We were unable to collect outcome data from newer participants who did not yet reach their first 6 month reassessment period during PY24 and participants/families who refused to complete the scales or never returned the forms. We also discovered some instances in which the counselor was neglecting to issue scales at time of reassessment and discharge. With this discovery, we have initiated retraining for all counselors on how to properly complete the scales, how to improve engagement in completing scales with participants and family, and have put new safe guards in place to ensure the information is being gathered at the designated times.

Information is attempted to be collected at time of intake, 6-month reassessment, and at discharge.

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 participants of different ethnic or racial groups, or of characteristics of all participants engaged versus participants retained.*

Participants are staying in the program longer than anticipated, which is generally seen as positive (longer to moderate lengths of stay have traditionally meant better long-term outcomes in behavioral health). The sample size was much smaller than we had hoped due to various circumstances stated above but there is evidence of participants improving by being engaged in treatment. For those clients who showed no improvement or a decline, there are many factors that can impact the scoring such as timing of the scores (completing scores in

session after they just left school which can be stressful, life stressors/situations that arose after starting treatment, and any changes to the participants daily routine)

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.

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?

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: Rosecrance, Inc.
Program Name: Criminal Justice PSC
Program Year: PY2024

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.
   Estimated: 15 days. Actual: 9 days for TPC. NTPC clients immediately received linkage services following initial assessment.

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.
   Estimated: 70%. Actual: 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.
   Estimated: 5 months. Actual: 3.7 months. Much of the length of participant engagement is reliant upon criminal justice system processes such as sentencing, how long they remain in jail, reliable contact information once they are released, etc.

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.
   None.

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

Increase clients' access to resources: 676 successful linkages for TPC and NTPC were made by case managers to the following resources:

• MRT and Anger Management group services (197)
• Linkage to Housing (79)
• Linkage to Employment (75)
• Linkage to Education (23)
• Linkage to Insurance (92)
• Linkage to other benefits (85)
• Linkage to Primary Care (29)
• Linkage to behavioral health (mental health and substance use disorders treatment) (96)

Outcome #2

Data on the length of stay in the jail for people with MI/COD; by collecting the date of booking into the jail and the date of release for each client who engages in the program from the jail, length of stay data for the Mental Illness/Co-occurring Disorders population.

Average LOS for MI/COD: 84 days

Outcome #3

Outcome #4

(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? 28 TPC client/290 NTPC clients = 318 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?

3. How many people did you *attempt* to collect outcome information from? 318
4. How many people did you *actually* collect outcome information from? 318
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 collected at intake, discharge, and throughout the client's service episode.

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.*

   We were able to link 100% of clients who sought linkage to MRT, Anger Management, Insurance, Primary Care Provider, Benefits, Mental Health Treatment, Substance Use Disorders Treatment, Transportation, and Other services.

   100% of applicable Jail Request Slips were completed

   Persons who are referred to the program and interested in receiving linkage to resources are getting linked.

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.

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?

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: Rosecrance, Inc.

Program Name: Crisis Co-Response Team (CCRT)

Program Year: PY2024

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.

   Estimate: 0. Actual: 0 Services are immediately started once contact is made with the participant

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.

   Estimate: 100%. Actual: 100% Services are immediately started once contact is made with the participant.

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

   Estimate: 1-3 months. Actual: 2.5 months. Within estimated range.

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.
   None.

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

1. Increase individual's capacity to engage in treatment and/or access resources, as shown on improvement in score on Self-Sufficiency Matrix.

After the initial roll out of the Self-Sufficiency Matrix, we discovered the length of the survey was a barrier to the client's willingness to complete them considering the level of emotional stress the participants were experiencing. We quickly pivoted and created a much shorter survey called "Client Experience Survey" that rated the participant's perception of their emotional state before and after the interaction with CCRT responders.

The Client Experience Survey has the participants rate their perception of their emotional state on a scale of 1 to 5, 1 being the worst and 5 being the best. Average scores for FY24 showed overall improvement in the participants perception of their emotional state after the interaction with a CCRT responder from 1.7 to 3.3.

Outcome #2

2. Reduce number of repeat calls to law enforcement for social emotional behavioral needs. No more than 25% of the requests for law enforcement assistance for behavioral needs during the program year, will be repeat requests.

Actual: 10% were repeat requests

Outcome #3

Outcome #4

(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? 117

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?
3. How many people did you *attempt* to collect outcome information from? 117
4. How many people did you *actually* collect outcome information from? 117
5. How often and when was this information collected? *(e.g. 1x a year in the spring; at client intake and discharge, etc)*
   Information is collected at time of intake/first contact and discharge.

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 data shows an overall improvement in participant perception of their emotional state after an interaction with a CCRT responder which improves their ability and willingness to continue engagement in the program as well as consider further applicable treatment services

   Outcome data shows that Crisis Co-Response services are helping to limit repeat calls to law enforcement for behavioral health situations when a person is engaged with the CCRT services, reducing the burden of 911 dispatch and responding EMS workers.

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.

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?

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: Rosecrance, Inc.
Program Name: Recovery Home
Program Year: PY2024

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.
   Estimated: 3 days. Actual: 3 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.
   Estimated: 100%. Actual: 100% By setting the assessment time close to the client's projected discharge date from residential/higher level of care, we are able to help the clients stay motivated to engage in services immediately.

6. Compare year-end result with the application estimate of length of participant engagement. Especially if the result was unexpected, comment on this finding.
   Estimated length of stay is 3-6 months. Actual: 4 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.
   None.

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 of the foundational principles of lasting recovery is a strong support network and longer engagement in treatment. The recovery home setting provides on-going learning to help decrease the likelihood of relapse and a chance for residents to practice living their new lifestyle in a supportive environment where staff provide case management to help connect clients with resources.

Successful linkage to items in individualized plan such as: affordable housing, vocational/educational resources, medical, dental, psychiatric/counseling services; engagement in 12-step support groups.

100% of participants were successfully linked to at least one of the resources identified on their individualized service plans while in the program.

Outcome #2
Step down to less intensive services.

53% of clients stepped down to less intensive services. This is tracked in Rosecrance's electronic health record. Information is gathered from the client, their clinician, and other program staff.

Outcome #3
Secured housing.

41% clients were able to secure stable housing at time of discharge. This is tracked in Rosecrance's electronic health record. Information is gathered from the client, their clinician,

other program staff, and any other person the client wishes to include in their service plan. There is a widely known and documented lack of affordable housing in Champaign county for many residents and this especially impacts the participants in this program.

Outcome #4
Secured employment or engagement in education program.

76% of clients were employed or enrolled in an education program while in the recovery home. These are tracked in Rosecrance's electronic health record. Information is gathered from the client, other program staff, and any other person the client wishes to include in their service plan.

(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? 17 from Champaign County

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?

3. How many people did you *attempt* to collect outcome information from? 17
4. How many people did you *actually* collect outcome information from? 17
5. How often and when was this information collected? *(e.g. 1x a year in the spring; at client intake and discharge, etc)*

   Information is collected at intake, discharge, and throughout the client's stay in the recovery home.

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.*

We look at the change from admission to discharge, by regularly reviewing service plans with clients, behaviors in the recovery home, engagement in support groups, and employment. The clients who are engaged in support groups, remain employed, and have longer lengths of stay continue to have more favorable outcomes than those who have not.

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.

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?

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: Rosecrance, Inc.
Program Name: Specialty Courts
Program Year: PY2024

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.
   Estimated: 3 days. Actual: 14 days. Assessments are now done prior to client being sentenced which leads to the length of time varying greatly, depending upon the client's court case.

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.
   Estimated: 45%. Actual: 56%. Rosecrance and the drug court staff prioritized getting eligible participates into the program when their court case allowed for it.

6. Compare year-end result with the application estimate of length of participant engagement. Especially if the result was unexpected, comment on this finding.
   Estimated: Minimum 1 year, average 1.5 years. Actual: Minimum 1.5 years, average 1.75 years. While slightly above estimate, this is expected as individuals struggling with

addiction benefit from a longer stay in treatment and often are more likely to achieve longer term success.

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.
   None.

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

Specialty Courts aim to stop the abuse of alcohol and other drugs among Drug Court participants, decrease recidivism, help participants to achieve and maintain recovery, and decrease the costs of crimes associated with mental illness or substance abuse.

1) No. of Graduates: Target: 15 Actual: 8

Only 8 individuals qualified for graduation this year and there was no Fall graduation in PY24 due to no eligible candidates being ready for that deadline.

Outcome #2

2) % of Graduates who do not experience recidivism: Target: 65% Actual: 100%

While there were fewer graduates than anticipated, all of those graduates were successful in not experiencing recidivism which is a testament to the quality of individualized treatment being provided in the program and the level of support provided to each individual.

Outcome #3
2) Individuals with potential barriers who received Case Management services. Target: 100%
Actual: 100%

Rosecrance outreach workers track Case Management service needs in the client chart. Positive changes in substance use, employment/education, and 12-step group involvement are anticipated for those who engage in the program.

Outcome #4

(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? 37

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?
3. How many people did you *attempt* to collect outcome information from? 37
4. How many people did you *actually* collect outcome information from? 37
5. How often and when was this information collected? *(e.g. 1x a year in the spring; at client intake and discharge, etc)*

   Information is collected at intake, throughout treatment, and at discharge.

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.*

   According to Champaign County website, “Champaign County Drug Court graduates do not commit a new crime within four years of graduation.”….“ The cost to taxpayers for incarcerating a defendant is approximately $24,000 per year. The cost of treatment for a Drug Court participant is approximately $5,000 per year. Therefore, an individual's

participation in the program saves the community $19,000 per year. When all totaled, the citizens of Champaign County and the State of Illinois have saved hundreds of thousands of dollars because of the success of Drug Court."

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.

   A typical drug court client is referred to Champaign County Drug Court by their defense attorney in hopes of deferring a jail/prison sentence in exchange for participation in the drug court treatment program. The client is assessed typically in jail while awaiting court/sentencing, then the assessment is reviewed, and if accepted, the client is referred to drug court. The client is admitted into either residential or outpatient treatment services based on the results of the substance abuse assessment. If the client is assessed as needing residential treatment services, the client will complete residential treatment and then be transferred to intensive outpatient treatment services. The client will eventually step down to continuing care treatment services as they work through the Drug Court phases. The client typically is followed from admission to graduation by the same addiction counselor. The client will receive case management (transportation and referral services), individual and group sessions, as well as toxicology testing. Upon completion of all treatment program requirements and drug court phases, the client will participate in a graduation ceremony. Also, the client is required to have a sponsor, participate in AA/NA support groups, have a job, and return once a month to sit in on a treatment group for the first six months following graduation.

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?

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: ____Terrapin Station Sober Living___________________

Program Name: ___Recovery Home____

Program Year: __2024_________

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.

Findings were as expected, individuals were taken in a timely manor after the intake. Applicants are typically taken directly from rehab to us, or can come from a halfway house or otherwise the following day.

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 the individuals had the services available to them in that timeframe, but we work with individuals in rehab who come to us whenever they have completed treatment. Otherwise, they typically arrive within 3 days, although they are permitted to come the following day.

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

On average this estimate was consistent.

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 data shows that addiction is a nearly unstoppable force that only responds to militant discipline of the self.

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

Our data shows that addiction is a nearly unstoppable force that only responds to militant discipline of the self.

Outcome #2

Decrease Recidivism.

Outcome #3

Decrease homelessness and increase permanent housing.

Outcome #4

Decrease relapse and increase understanding of harm reduction.

(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? _____9________

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?

3. How many people did you *attempt* to collect outcome information from? ______9_______
4. How many people did you *actually* collect outcome information from? _______9________
5. How often and when was this information collected? *(e.g. 1x a year in the spring; at client intake and discharge, etc)*

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.*

Information is collected upon intake and discharge, information is also gathered throughout and added to recovery plans, which are gone over 6 months into stay/ when applicable. Other information is written down throughout stay but not in any formal capacity.

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.

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?

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: The UP Center of Champaign County ____________________________

Program Name: Children, Youth, & Families Program_______________________________

Program Year: FY24_________

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. People who self-identify as LGBTQ+, or people who are not LGBTQ+ but are in need of education and information as it relates to interacting with the LGBTQ+ population works well as our criteria for service.

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. As stated above, people self-identify as needing what our organization provides.

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

   Mostly yes. We continue to develop strategies to reach more deeply into populations that are underrepresented in our program and service participants. In particular, we were successful in securing a grant from United Way of Champaign County to create a position that has a focus on outreach and engagement with the BIPOC community. As this grant did not begin until Q3 of this year, we have only begun this work. That said, we did see an uptick in numbers within this population in Q4, which leads us to believe this could yield even more promising results from here on.

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.

   There is essentially no delay between when someone identifies as wanting to engage in our programs and services and then doing so. The only time between that might be if someone reaches out to us outside of work hours and we respond once the next workday begins. Or if someone wants to engage in a program that isn't happening until a future date, and then that person signs up and then participates when that program takes place.

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.
   See above. So this is 100%, or N/A for our programs and services.

6. Compare year-end result with the application estimate of length of participant engagement. Especially if the result was unexpected, comment on this finding.
   With our variety of programs and services, this becomes difficult to assess or report on in aggregate. Some are one-time programs, like an educational seminar. Others are support groups where someone might come every week, or every other week depending on the group's schedule. Where we have repeating programming, we see average participation length of one year, however we have several individuals who participate for multiple years in a row, some who come when they are in times of crisis and need time-limited support, and many who just participate in one-off programs one time or a few times over the course of 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 Sexual Identity, and more detailed and comprehensive data on Gender Identity than is asked for by CCMHB. This data aids us in ensuring program creation and execution meets the needs of our service population based on their unique LGBTQ+ status.

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

For all programs besides our Education Program: *Improved social support. We anticipate that social support will increase by 25%.*

We request that all program participants fill out surveys, but some opt not to do so. Of those who chose to respond, we saw a 94% rate of improved social support. For our Youth Groups, we also added an interview component with our Youth & Family Coordinator in order to better

capture information from those who might be too young to self-report correctly through a survey tool. This proved to be very successful so we intend to continue with this additional tool for data collection with our youth groups.

For Trainings: *Improved knowledge about LGBTQ+ communities. We anticipate that knowledge will increase by 25%.*

We request that all training participants fill out surveys, but some opt not to do so. Of those who chose to respond, this year we received an incredible 100% response rate of improved knowledge about LGBTQ+ communities.

Outcome #2

For all programs besides our Education Program: *Improved self-worth. We anticipate that improved self worth will increase by 20%.*

We request that all program participants fill out surveys, but some opt not to do so. Of those who chose to respond, we saw an 85% increase in improved self-worth. For our Youth Groups, we also added an interview component with our Youth & Family Coordinator in order to better capture information from those who might be too young to self-report correctly through a survey tool. This proved to be very successful so we intend to continue with this additional tool for data collection with our youth groups.

For Trainings: *Improved confidence to create LGBTQ+ affirming environments. We anticipate confidence will increase by 20%.*

We request that all training participants fill out surveys, but some opt not to do so. Of those who chose to respond, this year we received an incredible 100% response rate of improved confidence to create LGBTQ+ affirming environments.

Outcome #3

NA

Outcome #4

NA

(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? __300____________

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 request that every participant fill out surveys, but some opt not to respond.

    Additional context relating to response rates: We have found increased resistance to filling out any kind of forms or materials within the last few years. As we've asked about the reasons behind this, we find that many in our community report being afraid to be tracked in any kind of a way, due to the massive shift in anti-LGBTQ+ rhetoric and legislation. There is serious concern about possible ramifications should identifying information of any kind be in our systems and those system get hacked. Despite assurances of anonymity and security, we find this reluctance to participate in written reporting is increasing. In particular, we find this within those who have moved into our community from states that are passing legislation that involves reporting people engaged in gender affirming care, be it on the receiving or delivering end. These fears are based in real world situations that community members have fled from, which makes them entirely reasonable and understandable. We find that trying to force reporting would result in lower participation in our programs, as people would simply opt out rather than report. Which would leave those in need without the resources that could help them. As a result, we have determined that it is in the best interest of our service population to make all reporting optional at all times.

3. How many people did you *attempt* to collect outcome information from? __300_________
4. How many people did you *actually* collect outcome information from? __101___________
5. How often and when was this information collected? *(e.g. 1x a year in the spring; at client intake and discharge, etc)*
    2 times per year for our groups, once after Pride Fest, and after each program for trainings.

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.*

Findings from this year's responses from UP's non-educational work include:

We find that our LGBTQ+ population in the Champaign County area have a low sense of community and/or belonging, but that this is beneficially impacted by engaging with our programs.

Through engagement in our programs, participants report a stronger sense of social support, while also reporting continued need for more. We've seen high participation in the additions we've made to our

program offerings, which supports statements about this continued need. We continue to hear the community would benefit from even more than we've been providing.

We have made great strides in increasing reach and visibility, but continue to have challenges getting information widely distributed, along with issues of mis/disinformation being spread.

One of the largest areas of growth for us is in people reaching out to us for affirming referrals for areas where we do not provide direct service work (housing, financial aid, healthcare, etc.), to get questions answered and grow their knowledge, or to find out about our programs and services. In FY23 that number was 604, and in FY24 that number grew to 871. We have also seen higher participation in our programs and services, but the number of people willing to participate in surveys and data collection has stayed essentially the same. The number of people we were able to gather survey responses and data collection from in PY23 was 342, and in PY24 it was 358. While this is a small increase, we have seen attendance and participation jump much higher than this.

In seeking clarity around low participation in surveys and data collection, we hear responses around fear of being tracked, and possibly having systems hacked and therefore people being outed and targeted. The massive uptick in violence, bigotry, and anti-LGBTQ+ rhetoric, even in a community that is fairly accepting like ours is, justifies these concerns. Additionally, with many people moving into our community from places where they are passing legislation that includes tracking and legal ramifications for those engaging in gender affirming care, many people participating in our programs and services have real examples of this taking place that leads to this reluctance.

Uniting Pride's decision is to not force survey and data collection, as we've heard from participants that this would result in people disengaging from programming and services, rather than comply. Instead of withholding support due to lack of response to collection attempts, we have chosen to allow people to opt out as feels right for them, such that they stay involved and get the help they need.

We anticipate this continuing to be a challenge unique to our service population that other agencies many not experience when they do surveying and data collection.

One consistent trend we are seeing again this year is an increased connection to the local LGBTQ+ community. This is the 3rd year in a row where we see this metric continuing in a positive direction. We feel this supports that our significant increase in the amount of programming we are producing is having a beneficial effect. Feedback around this mentions appreciation for more opportunities to gather and build a strong local LGBTQ+ community.

Notable Quotes from Survey Responses from all UP non-education programs:
"Mom says that I've gotten a lot more confidence in other things and when I'm hanging out with friends I seem more happy. So that's really good. I think it's been really good for me to just be myself."

"The local group has been a great resource for me. I am the parent of a successful older transgender child and I certainly wish this resource would have been available for me (I am from another state).

Things would have been much less stressful if I had any kind of education/knowledge about these issues sooner."

"Nothing is weird here and I can be myself and not feel bad about it. Actually, my mom came out to me because she knew that. She said she wanted me to have a more supportive space and to feel better about myself before she told me. But now we're, like, even closer."

"People at UP with whom we interacted made us feel useful and valued."

"You made my youth feel very supported in our community."

"I didn't have other spaces with queer and trans kids in them. That's kind of why I was looking for a group. I definitely made friends!"

"It's great to see community come together and feel good and be who they want to be without judgement."

"I have several children and several grandchildren who are LGBT+ and, although they are not local, I participate for them as an ally. I am very proud of the job UP is doing!"

"Thank you for all you do. It is so helpful to have the supports for my child. What do you guys do through support groups and the festival is truly life-saving work."

Findings from our LGBTQ+ Cultural Competency Education Program:

One of the most stark findings is that, of those who chose to respond, we had 100% report that they not only grew in their knowledge and awareness, but in their intention to do something to better the experiences of the LGBTQ+ population. These are striking statistics, and ones we did not achieve last year. We feel this shows we have listened to feedback from previous training work, increased quality of content and delivery, and have become very effective in achieving our goals for this program.

One of our only barriers with this program is getting more groups, businesses, organizations, and institutions to allow us to provide this training. We regularly reach out and get no response, or get flatly turned down, or there are statements about interest but no follow through to schedule and make the program happen.

With this in mind, we renew our offer that we made as part of our CLC plan when we applied for FY24 funding: we would welcome to the chance to formally partner with CCMHB/DDB staff and board to offer this training to all funded agencies. Sadly, we have heard about incidents with some of the funded agencies in which our LGBTQ+ community members did not receive affirming treatment. These situations left people feeling like they could not engage with those organizations and could not use their services. This is a very troubling situation that we would appreciate the opportunity to impact for the better. If this is something the CCMHB/DDB team would like to discuss, we welcome that chance.

Quotes from educational programming surveys:

“I learned that what I can do as an individual can literally be life-saving.”

“Honestly this was one of the best presentations/trainings that I think we’ve had. The added ‘real life’ examples make it all the more impactful and held my attention.”

“This made a big impact on me: ‘Children talk when they feel safe’.”

“The presenter gave excellent examples to ‘make it make sense’. It was helpful to start off with deeper explanation of terminology and I really liked how she broke apart which words could be offensive and which are ok and explained why.”

“I did not know about the direct relationship between the use of pronouns and other affirming practices and lowering suicide risk in trans youth.”

“The most impactful thing for me was how much the suicide rates dropped for youth who had one supportive/caring adult in their life. It closely aligns with the outcome from the ACEs study and youth who have experienced abuse in their childhood.”

“I like that everyone attended and had a safe space to ask questions in a non judgmental setting.”

“I had a lot of knowledge coming in, but knowing the *legal* requirements actually makes it much easier to take action. The stats on suicide were both alarming and encouraging (re: the impact of even one affirming adult).”

“This was my second time attending this training and I learned even more! I believe this training would be extremely beneficial to have either annually or bi-annually so people in the social work field can stay up to date on advocacy as well as using correct language for their clients.”

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.

People who participate in Uniting Pride programming have full freedom to opt in to the support groups, programs, training, and other opportunities we provide. UP’s goals include helping the LGBTQ+ community in Champaign County have access to affirming and knowledgeable resources, and have increased support and feelings of empowerment. We have seen people who choose to be involved and connect with resources build meaningful connections and a close community. Below are two examples. One is an example of services, supports, and potential outcomes for someone who is highly involved in our programming, and the other is someone with more limited involvement.

Highly Involved Participant

Teenager A recently disclosed to their parents and teacher at school that they are queer. Teenager A’s teacher connected them with the school GSA, who’s sponsor communicates regularly with Uniting Pride

staff. The GSA referred Teenager A to the Uniting Pride staff, who in turn connected Teenager A with Uniting Pride's Talk It UP facilitator. After talking with the group facilitator, Teenager A begins to attend Talk It UP and connects with LGBTQ+ teens from all over Champaign County. As Teenager A's self-esteem and empowerment grows, they attend Uniting Pride's Queer Prom, workshops, and the annual Pride Festival and Parade. Teenager A's parents are not sure how to be supportive of their queer child. So they ask to be referred to Uniting Pride's UParent group. At UParent, they connect with other parents who are learning how to best support their LGBTQ+ children at school, at home, and in the community. Because Teenager A and their parents are plugged into Uniting Pride, they learn about which healthcare professionals in Champaign County provide inclusive care, as well as community and state action that affects them.

Limited Involved Participant

Teenager B hasn't disclosed to their family or friends at school that they are questioning their gender identity. They came across Uniting Pride's Instagram page and sent a private message asking what kind of help was available for them. Uniting Pride staff responded with an offer to answer any questions, and provided information about the Talk It UP program. Teenager B talked to the group facilitator a few times and after a couple months, decided to attend the group. Teenager B has come once a month to group for the past 9 months, and engages with the other teens at group. They aren't ready to disclose anything to anyone outside of the group but feel like they have a safe place to ask questions and be themselves each month.

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?

   One of the largest changes this year was the addition of a United Way grant funded position that includes a deliberate focus on outreach and engagement within the BIPOC community. We have already made changes and have many plans for continued development, additions, and changes to both programming and operations, based on recommendations from this staff member.

   We also took community feedback on existing programs and determined we needed to end some that are no longer serving the need, while beginning some new ones to address new needs and interests. UP has always had a history of ending and starting our groups based on what the community reports they want, and based on what they attend and engage in. We intend to continue with this process, which will mean there will always be some level of change to what we do and how we do things.

   Also as previously mentioned, we have added an interview component to acquiring feedback from our youth programs and this has proven very effective. So we intend to continue on with this shift in data and feedback collection.

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: WIN Recovery

Program Name: Re-Entry & Recovery Homes

Program Year: 2024

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.

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.

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

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.

2 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.

100% of the eligible client were engaged in services within the time frame, unless they sought out assistance before their release or discharge date. The client received services immediately upon release or discharged from institution or facility.

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

Residents live in transitional housing from 275-365 days. Completion depends on each individual's mental and economic stability

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.

   WIN Recovery collects data on the required demographic data as well as; (a) obtaining Identification Documents, (b) Family Reunification, (c) Criminal History, (d) treatment, (e) Social Economic Status, (f) Income, (g) Employment Status, (h) Education, (i) Recovery Milestones, (j) Formerly incarcerated (h) number of children.

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

WIN treats these 12 benchmarks as shorter- and longer-term individual outcomes. In addition to these 12 individual outcomes, we also track family reunification outcomes for all relevant cases (i.e., women with children). These outcomes are 1) housing stability, (2) acquiring personal identification, (3) maintenance of sobriety, (4) development of self-identified goals, (5) progress toward achieving self-identified goals, (6) compliance with conditions of probation or parole, (7) no re-incarceration, (8) ability to access benefits or assistance, (9) regular attendance at recovery meetings, (10) enrollment in school, (11) access resources to employment, (12) sought employment, and (13) family reunification (if applicable).

All outcomes are tracked in Mission Tracker; data collection frequency/time frame varies depending on what is most relevant to a given outcome and is generally provided from case notes by a caseworker unless otherwise noted. 1) housing stability: referral and utilization of housing voucher ; (2) acquiring personal identification (tracked as current need or successfully acquired), (3) maintenance of sobriety (successful completion of relevant AA and/or NA sobriety milestones as reported by the individual) ; (4) development of self-identified goals (assessed after probationary period; i.e., 30-60 days; reported by the client and tracked by caseworker) (5) progress toward achieving self-identified goals (assessed at 3, 6, 9, and 12 months; reported by the client and tracked by caseworker); (6) successful completion of probation or parole (assessed continually and tracked once completed); (7) no re-incarceration (given the early stage of our program, we are still developing an appropriate timeframe for which to track this outcome). (8) ability to access benefits or assistance (tracked as current need or successfully acquired), (9) regular attendance at recovery meetings; (10) enrollment in school, (if applicable; tracked upon enrollment); (11) access resources for employment (assessed on an individual basis; generally, 3-6 months mark); (12) sought employment, and (13) family reunification (if applicable).

Outcome #2

Outcome:	Assessment Tool Used:	Information Source:
Maintain Sobriety	**Informal Checklist through Client Interviews during Case Management**	**Clients**
A decrease in Mental/Behavioral Health Services	**Informal Checklist and Client Interviews during Case Management & Certificates of Completion**	**Clients & Counselors**
Obtain Stable Housing	**Informal Checklist and Client Interviews during Case Management & MTW Program Requirement Assessment for Voucher Readiness conducted by the Champaign County Housing Authority**	**Clients & Case Management & Housing Authority**
Obtain Employment	**Informal Checklist and Client Interviews during Case Management**	**Client**
Assess to Education	**Informal Checklist and Client Interviews during Case Management**	**Client**
Family Reunification	**Informal Checklist through Case Management**	**Client**

Program Completion	Informal Checklist during Case Management	Case Management
No Recidivism	Developed Internal Tool to track & trend reoccurring criminal justice system involvement	IDOC Records Illinois State County Circuit Clerk Databases

Outcome #3

WIN Recovery employs a client-centered approach to assessing its program outcomes. Recognizing that conventional assessment tools might not capture the nuanced benchmarks they aim to measure; the program utilizes internal checklists and informal client interviews. This strategy allows them to track progress and changes that are not easily quantifiable. By tailoring their approach to individual needs through initial intake assessments, WIN Recovery creates personalized plans with relevant benchmarks for each client's journey. Divided into phases, the program continually assesses clients, spanning a 9 to 12-month period, to monitor progress over time. Notably, clients with mandated requirements and consequences for non-compliance exhibit longer participation, indicating heightened motivation. Additionally, clear communication of the program's comprehensive services fosters longer client engagement. The role of the client coordinator is pivotal in conducting interviews, tracking progress, and aligning plans with clients' needs. In sum, WIN Recovery's holistic and adaptable methodology acknowledges diverse client needs and effectively measures its impact on clients' lives.

(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? _____40________

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 was gathered from all participants who received services.

3. How many people did you *attempt* to collect outcome information from?
____100%_________

4. How many people did you *actually* collect outcome information from?
____100%_________

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

   During the first interaction with the client, we collect the initial information from the client. WIN Recovery continuously contains additional details throughout the 9 to 12-month period as the client navigates through the 3 phases of the program.

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.*

WIN Recovery has implemented a multifaceted approach to gauging client progress and evaluating program outcomes. The organization has recognized that the benchmarks they seek to measure are diverse and not universally applicable, leading to the adoption of an internal checklist and questionnaire method. This approach enables WIN Recovery to personalize assessments, aligning them with each client's unique circumstances.

Client progress is assessed through a thorough analysis of weekly achievements discussed during individual case management sessions. This dynamic process ensures that changes and developments are captured in real-time, facilitating an agile and responsive assessment mechanism.

The initial intake assessment serves as a foundational tool, enabling WIN Recovery to identify and document client needs. This information forms the basis for crafting individualized plans that outline specific benchmarks relevant to each client's situation. This tailored approach guides clients throughout their program participation, creating a roadmap for their journey.

Phased assessments are a key feature of WIN Recovery's evaluation strategy. At each phase of the program, clients are assessed to monitor their progress over the course of the 9 to 12-month program duration. This systematic approach provides valuable insights into the evolution of clients' situations over time.

Observations regarding referral sources have yielded interesting insights. Clients referred due to mandated requirements exhibit prolonged program engagement, likely driven by the

consequences associated with non-compliance. This underscores the significance of external pressures in influencing program commitment.

Furthermore, client comprehension of WIN Recovery's comprehensive service offerings correlates with extended program engagement. Clients who understand that the organization provides a broader spectrum of services beyond housing tend to remain in the program for longer durations. This underscores the importance of effective communication in establishing accurate expectations from the outset.

Incorporating these insights into their assessment methodology enables WIN Recovery to offer targeted support, tailored to individual needs, and to holistically evaluate the impact of their 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.

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?