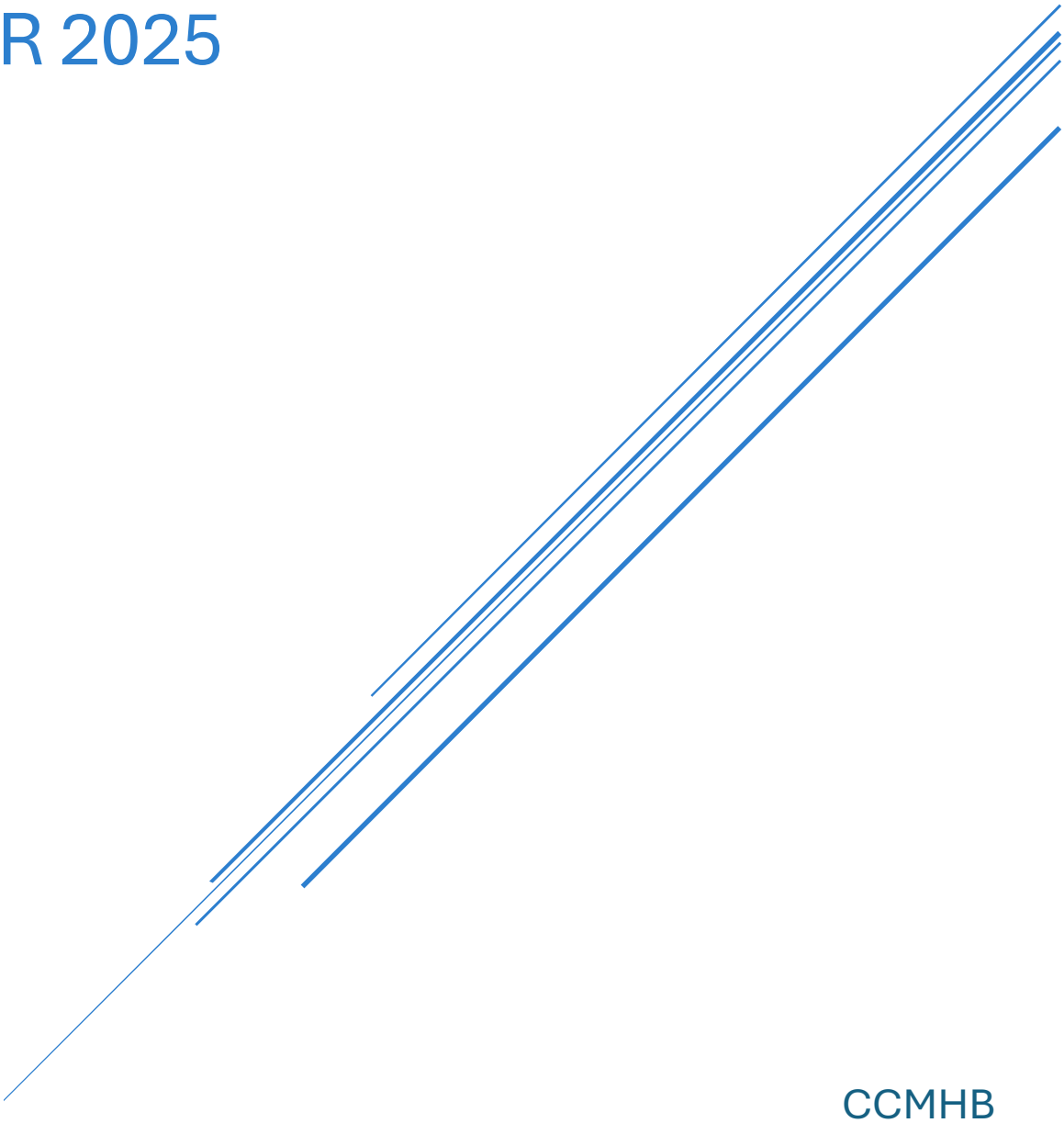
COMPILED ANNUAL PERFORMANCE OUTCOME REPORTS OF CCMHB FUNDED PROGRAMS FOR CONTRACT YEAR 2025



CCMHB
PY2025

Compiled Annual Performance Outcome Reports of CCMHB Funded Programs for Contract Year 2025

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

Don Moyer Boys & Girls Club	CU Change	$85,575	Pgs.95-99
DSC	Family Development	$656,174	Pgs.100-103
East Central IL Refugee Mutual Assistance Center	Family Support & Strengthening	$62,000	Pgs. 104-107
Family Service of Champaign County	Counseling	$30,000	Pgs.108-111
Family Service of Champaign County	Self-Help Center	$28,930	Pgs.112-116
Family Service of Champaign County	Senior Counseling & Advocacy	$178,386	Pgs.117-123
First Followers	First Steps Reentry House	$69,500	Pgs.124-126
First Followers	Peer Mentoring for Reentry	$95,000	Pgs.127-131
GCAP	Advocacy, Care, and Education (New)	$61,566	Pgs.132-140
GROW in Illinois	Peer-Support	$157,690	Pgs.141-151
Promise Healthcare	Mental Health Services	$330,000	Pgs.152-156
Promise Healthcare	PHC Wellness	$107,087	Pgs.157-160
Rape Advocacy, Counseling & Education Services	Sexual Trauma Therapy Services	$140,000	Pgs.161-165
Rape Advocacy, Counseling & Education Services	Sexual Violence Prevention Education	$75,000	Pgs.166-170
Rosecrance Central Illinois	Benefits Case Management	$84,625	Pgs.171-174
Rosecrance Central Illinois	Crisis Co-response Team (CCRT)	$310,000	Pgs.175-177
Rosecrance Central Illinois	Child and Family Services	$77,175	Pgs.178-181
Rosecrance Central Illinois	Criminal Justice PSC	$336,000	Pgs.182-184
Rosecrance Central Illinois	Recovery Home	$100,000	Pgs.185-187
Rosecrance Central Illinois	Specialty Courts	$186,900	Pgs.188-190

The UP Center of Champaign County	Children, Youth, & Families Program	$190,056	Pgs.191-198
WIN Recovery	Re-Entry & Recovery Home	$183,000	Pgs.199-204

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 Children's Advocacy Center
Program Name: Champaign County Children's Advocacy Center
Program Year: FY25

CONSUMER ACCESS

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

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

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.
   There are no unexpected findings. Clients consistently received services within 48 hours of the request.

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.

As expected, there were no significant delays to client services. A small number of clients declined 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.

Clients engaged in services longer than previous years. Because decreased personnel costs allowed for greater funding for counseling, some clients received extended counseling sessions at the request of their counselor.

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 data about referral sources – indicating whether cases were referred to our center by law enforcement, DCFS, or another agency. This data indicates a decreased number of referrals from DCFS. Because our local DCFS office has had significant changes in their supervisory staff, CAC staff are working to build relationships and recommit to service agreements with DCFS as a whole. This has resulted in an increased number of referrals from DCFS already – and the hope is that this will continue so that more children in need of our services will be identified and properly referred to services at the CAC.

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

According to OMS (Outcome Measurement System) survey results, 100% of caregivers agree that their child felt safe at the Center.

Outcome #2

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

Data tracked manually by spreadsheet indicates 73% of clients referred to counseling attended at least one session. This data is collected from counseling partners and logged in our case-tracking system, Collaborate.

Outcome #3

90% Information gathered in legally sound manner (based on 115-10 hearings).

100% of 115-10 hearings were successful. This data is gathered from forensic interviewers and tracking court cases manually from data in JANO and entered into a spreadsheet.

Outcome #4
100% of caregivers report that they know why they are at CAC.

According to OMS (Outcome Measurement System) surveys sent to caregivers, 100% answered 'Yes' to "The Center staff made sure I understood the reason for our visit to the center".

Outcome #5

95% child victims have a perceived feeling of being safe while at the CAC.

According to OMS survey results collected from Youth surveys (clients), 100% of child victims agreed that center staff were either 'helpful' or 'very helpful' in helping the child feel safe.

CONSUMER PARTICIPATION IN DATA COLLECTION

1. How many total participants did the program have? ___207_____

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?
   Surveys are offered twice to every caregiver, and once to every youth.

3. How many people did you *attempt* to collect outcome information from? ____207_____
4. How many people did you *actually* collect outcome information from? _____15_____
5. How often and when was this information collected? *(e.g. 1x a year in the spring; at client intake and discharge, etc)*

   This information is mailed to clients immediately after the interview, and a follow-up survey is sent approximately 1 month after their visit to the 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.*

One thing we noticed is that we are having very low rates of return of surveys. There is not even sufficient data to extrapolate to all participants or make the assumption that this data is statistically significant. Although most clients returned very positive surveys, this is clearly not an effective way to collect data from clients. Center staff have begun exploring new methods to administer surveys. The plan in FY26 is to administer surveys to caregivers while in the center, and to ensure staff reiterate the importance of collecting data to clients and caregivers upon their visit. Sadly, this issue was not addressed by previous administrative staff – but now that it is on our radar we are working urgently to collect better and more data.

Despite the lack of data, one concerning trend was an increase in caregivers reporting they are unsure of how best to keep their child safe in the future (up 10% compared to last year). To address this proactively, center staff have developed and begun including informational pamphlets on prevention, body-safety talks, and how to identify safe people.

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 Christian Health Center
Program Name: Mental Health Care Program
Program Year: July 1, 2024 to June 30, 2025

CONSUMER ACCESS

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

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

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.

   We were open at normal clinic hours during the grant period. While we did not quite meet the expected goals for the TPC due to inconsistent volunteer provider availability, CCCHC significantly surpassed the NTPC goals due to a robust outreach effort by CCCHC staff, namely Outreach and Wellness Director, Teddie Hill. CCCHC has established a partnership with Carle's psychiatric residency program and that has been very active in recent months.

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 percentage of eligible people were aligned with stated goals for the grant.

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 is not applicable for this service

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 health data from our patients. We use this data to identify health problems with the highest prevalence among our 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

500 paents will be screened to assess mental health needs

Since the number of patients were lower than anticipated, CCCHC did not reach the 500 goal for screening (strictly for mental health – other screening were conducted at events

Outcome #2
50 paents will receive ongoing mental health care

Achieved

Outcome #3
75 patients will have acute mental health issues treated/addressed

This number was closer to 50 for direct acute mental health issues that were addressed.

Outcome #4

	Annual Target	Actual Total for the Year
Events (CSE)	8	33
Call ins/not seen (SSC)	800	70
Health Ed/Outreach Contacts (NTPC)	500	1389

Seen by a provider (TPC)	**200**	**183**
Patients Referred elsewhere (other)	100	19

CCCHC did not achieve its TPC goal but greatly exceeded NTPC and CSE goals. SSC and Other are not as crucial as it relates to people calling in and not seen due to CCCHC not being the best place for requested services (SSC) and the number of referrals to other healthcare facilities (other). Most people that call CCCHC understand the scope of available services.

(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? 183 direct care, 1389 contact, approximately 200 offsite screenings or direct services provided (i.e. school and sports physicals)

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?

   Relevant data was collected as necessary from each patient/client

3. How many people did you *attempt* to collect outcome information from? 183
4. How many people did you *actually* collect outcome information from? 183
5. How often and when was this information collected? *(e.g. 1x a year in the spring; at client intake and discharge, etc)*
   Upon visiting the clinic

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.*

   There is a notable difference in how many people CCCHC was able to reach due to the dedication of staff and volunteers. In the future, these outreach efforts will lead to servicing

more people as more mental health volunteer practitioners are recruited and CCCHC hires a part time mental health provider

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

   This is more of general medical story.
   A patient walked in the clinic during off hours to get a medical refill. It was during the coldest days in December and the patient was dealing with having pneumonia. The patient wanted the prescription called in to the pharmacy at Meijer in Champaign (on Prospect Ave) which was going to take him about 1 ½ hours to get to and back home. Upon conversing with the patient, it became known that the patient lived near the clinic which had a Walgreens pharmacy a block away. When inquiring why the patient wanted to use the Meijer pharmacy, the response was that the Meijer pharmacy prescription costs $7 compared to Walgreen's $15 and the patient did not have the $8 to save him the trip. Thankfully, this information was gathered and the patient was given the additional funds needed to get the prescription at Walgreens. CCCHC patients who need free healthcare are high need individuals so every resource provided to CCCHC helps those who need it the most.

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 Health Care Consumers (CCHCC)_____

Program Name: CHW Outreach and Benefit Enrollment _____

Program Year: FY2025_____

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

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 120 new TPC clients and 40 continuing clients. We ended up serving 60 continuing clients; however, those do not always show up in Quarter 1, when we are asked to report on this number. In terms of new clients, we served 273 new clients. 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 for those who were seeking access to care or healthcare navigation services, we were successful in helping them gain those services. Approximately 91% of clients who required assistance were helped. The remaining 9% ended up not following through for a number of reasons, so they did not access the services they 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 3applications or more at one time. Our data show that, on average, these CHW clients required3.7 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? ___ 279 TPC and 19 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?

   N/A

3. How many people did you *attempt* to collect outcome information from? ___**279 TPC clients**__
4. How many people did you *actually* collect outcome information from? ___**279**_____
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 Medicaid, we document whether the application was successful and they are now receiving Medicaid. Likewise, if we apply someone for SNAP, we document the outcome of that 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 learned that people are having a much harder time now that Pandemic benefits have ended. 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 3.7 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.

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 Health Care Consumers (CCHCC)**_____

Program Name: _____ **Disability Application Services Program** _____

Program Year: ____**FY2025**_____

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. CCHCC has become 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 our application, we estimated 2 days from intake to assessment for eligibility for 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 begin the disability application, we work with them on those issues and we try to stabilize them as much as possible.

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 42 new clients and 27 continuing clients. In Q1, we ended up serving 17 continuing clients, and many more in the following quarters, due to delays with Social Security. We ended up serving a total of 139 TPC clients in this fiscal year! There is a huge demand for these services.

Outcome #2

We estimated that we would have the ability to take on 2 new clients per month, for starting new applications. However, we are actually taking on about 9 new clients per month, because the demand on us is so great. Fortunately, we have been able to streamline our services through various means, so that we can meet this demand.

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? _____

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? _____
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)*

RESULTS

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

2. 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 Health Care Consumers (CCHCC)_____

Program Name: ___Justice Involved CHW Services and Benefits_____

Program Year: __FY2025_____

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 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.

   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. The reason we estimated 80% is because some individuals in the jail end up getting

adjudicated to IL Dept. of Corrections prison, and in those cases, we cannot complete applications for Medicaid and SNAP, because if they are going to prison, they are no longer eligible for these benefits.

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 14% 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 "couchsurfing". 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 individuals through this program. Outcome data shows that we served 118 individuals in the TPC category. 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 2.7 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? __ **129 total, and 118 TPC, and 11 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?

   N/A

3. How many people did you *attempt* to collect outcome information from? **_118 TPC cases**_____
4. How many people did you *actually* collect outcome information from? ____**118**_____
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 tore-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. We also learned that there are many JI individuals among the homeless population in our 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 Regional Planning Commission
Program Name: Homeless Services System Coordination
Program Year: 2025

CONSUMER ACCESS

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

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

Yes. Agencies and organizations, community members, and businesses that have 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. Eligibility was determined by review of the participation of agencies/organizations, community members, and businesses in IL-503 Continuum of Service Providers to the Homeless (CSPH) meetings, committees, workgroups, or sponsored events. Member organizations of the CSPH must have an active Memorandum of Understanding (MOU) between the agency and the Continuum, attend a minimum of nine Continuum meetings in the most recent 12 months, and comply with the Code of Conduct as indicated on the MOU.

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, 2025, the CSPH currently has 45 members and 23 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 as well as establish re-engagement with existing member organizations: Champaign County Public Defender's Office, City of Champaign, Department of Equity and Engagement, Courage Connection, Restoration Urban Ministries, the University of Illinois,

College of Medicine, WIN Recovery, and Lived Experience representatives. The CoC Coordinator participated in meetings with downtown Champaign Businesses as a part of a collective effort to share information about local homeless services and problem solve concerns businesses were experiencing with regard to the unhoused population in downtown Champaign. The CoC Coordinator also participated in organizing the Summit on Homelessness: A Community Conversation event to share information about local homeless services with the public as well as discuss current services gaps and brainstorm next steps in addressing those gaps.

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 29 Community Service Events (CSE) (target was 30) 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 190 Service Contacts (SC) (target was 60) during the program year which is defined in the program application as:

- Number of persons participating in trainings organized by the CSPH.

The CSE target of 30 was nearly meant (29) 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 = 1 business day
   Actual (average) = 1 business 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
Downtown Champaign Businesses	6/20/2024	6/21/2024	1
Restoration Urban Ministries	7/2/2024	7/3/2024	1
Champaign County Public Defender's Office	9/4/2024	9/5/2024	1
WIN Recovery	9/13/2024	9/13/2024	Less than 1 day
Courage Connection	10/16/2024	10/17/2024	1
City of Champaign, Department of Equity and Engagement	11/15/2024	11/15/2024	Less than 1 day
University of Illinois, College of Medicine	12/5/2024	12/9/2024	2 business 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.

Estimate = 100%
Actual = 100%
Explanation: The CoC Coordinator engaged with 100% of organizations within 5 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 9 of 12 meetings each year (75 % of meetings).
Actual =

- 13 out of 45 member organizations (29%) participated in 75% or more CSPH meetings during the program year.
- 17 out of 45 member organizations (38%) participated in 70% or more CSPH meetings during the program year.
- 20 out of 45 member organizations (44%) participated in 60% ore more CSPH meetings during the program year.

*A total of 10 CSPH meetings were held in FY25 (no July 2024 meeting and no May 2024 meeting).

Explanation: Based on feedback from members, some monthly CSPH meetings have moved from virtual to in person; this has caused a decline in participation for some members. The CoC Coordinator continues to outreach to organizations that have not been attending CSPH meetings and working to establish reengagement.

CSPH Member Organization	# of CSPH Meetings Attended During Program Year (July 1, 2024 – June 30, 2025)
Carle Community Health Initiatives	8 out of 10
Center for Youth and Family Solutions	1 out of 10
Champaign County Emergency Management Agency	2 out of 10
Champaign County Healthcare Consumers	6 out of 10
Champaign County Mental Health and Developmental Disabilities Boards	2 out of 10
Champaign County Public Health District	3 out of 10
Champaign County Regional Planning Commission	10 out of 10
Champaign-Ford Regional Office of Education #9	0 out of 10
Champaign-Urbana Mass Transit District (MTD)	5 out of 10
Champaign Park District	0 out of 10
Child Care Resource Service	1 out of 10
City of Champaign	9 out of 10
City of Champaign Township and STRIDES	7 out of 10
City of Urbana	9 out of 10
Community Choices	0 out of 10
Community Service Center of Northern CC	7 out of 10
Courage Connection	8 out of 10
Crisis Nursery	3 out of 10
C-U at Home	8 out of 10
Cunningham Children's Home	9 out of 10
Cunningham Township	10 out of 10
Developmental Services Center	3 out of 10
Dimension-F	2 out of 10

Eastern Illinois Foodbank	4 out of 10
El-Roi House	0 out of 10
First Followers	0 out of 10
Greater Community AIDS Project	4 out of 10
Habitat for Humanity	6 out of 10
Housing Authority of Champaign County	6 out of 10
Land of Lincoln Legal Assistance	7 out of 10
LifeLinks	0 out of 10
Merci's Refuge	0 out of 10
OSF Community Resource Center	2 out of 10
The Pavilion	7 out of 10
Reintegration Haven Homes	0 out of 10
Rosecrance	3 out of 10
Salvation Army	8 out of 10
United Way	9 out of 10
Uniting Pride of Champaign County	0 out of 10
University of Illinois, Office of the Dean of Students	1 out of 10
Veterans' Affairs / Illiana Health Care System	4 out of 10
Village of Rantoul	0 out of 10
At-Large Member (Nathan Alexander)	8 out of 10
Lived Experience Representative (Damita Parsley)	4 out of 5 (joined January 2025)
Lived Experience Representative (Kintessa Redmon)	4 out of 5 (joined January 2025)

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
16 CSPH Members	26 CSPH Members	1 CSPH Member	2 CSPH Members

The CSPH Executive Committee now has two representatives with lived experience of homelessness on the committee.

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 replace the VI-SPDAT as the assessment tool utilized for the Coordinated Entry System.
Specific Outcome Goals: By the end of FY25, the CSPH will implement the use of a new, evidence-based assessment tool in its Coordinated Entry System.
Description: The VI-SPDAT is used to assist with prioritizing participants for homeless-specific resources. In 2021, the VI-SPDAT's developer discontinued the product, citing concerns for racial equity. The Coordinator will work with other Continuums to implement the use of an equitable tool for use in the CSPH.
Survey/Assessment Tool: The Place Value or the Matching to Appropriate Placement (MAP) assessment tools will be used to replace the VI-SPDAT.
Result: This outcome was achieved. 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. The Place Value developer and the CoC Coordinator conducted training with the Coordinated Entry System Committee members on the Place Value tool on 9/26/25. The tool was fully in use with the CSPH's Coordinated Entry System by 11/25/2025.

Outcome #2: Next Steps of the Racial Equity Assessment will be conducted within the CSPH.
Specific Outcome Goals: The Coordinator completed the initial steps of a Racial Equity Analysis in FY24. 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 to solicit feedback to improve CSPH systems.
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.
*Under new leadership with the federal administration, the aforementioned tools are no longer available on HUD's website.
Result: On 4/23/25, the CoC Coordinator presented data to the CSPH Executive Committee on the breakdown of race and ethnicity of clients served in the individual HMIS reporting projects during the last two fiscal years. Additionally, a Racial Equity Committee of the CSPH was established in late 2024 and continues to meet monthly.

Outcome #3: The CSPH will receive ongoing feedback and recommendations from people with lived experience of homelessness.
Specific Outcome Goals: The Coordinator will facilitate obtaining feedback from people with lived experience through the following means: establishment of a CSPH subcommittee for people with lived experience, hosting bi-annual focus groups, and satisfaction surveys.
Description: Lived experience is a crucial part of system planning and a key priority area identified in the CSPH Strategic Plan approved by the CSPH in late 2023. It is a priority area of HUD for CoC's to implement practices to regularly obtain feedback from people with lived experience in order to improve local services.
Survey/Assessment Tool: Minutes from the Lived Experience Subcommittee meetings, minutes and summary reports from the focus groups, and satisfaction surveys.
Result: The CSPH hosted a focus group with Strides Shelter guests on 7/30/24 and a focus group with just the women staying at Strides Shelter on 4/24/2025. Summaries and key takeaways from these focus groups are in the results section of this report. Additionally, as of December 2024, the two seats on the CSPH Executive Committee for individuals with lived experience of homelessness have been filled. In March 2025, the CSPH formed a standing committee for people with lived experience of homelessness which meets monthly.

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 12 treatment plan clients (goal of 10). Treatment plan clients are defined as: individuals with current or recent lived experience of homelessness will participate in CSPH efforts to receive ongoing feedback and recommendations from people with lived experience of homelessness.

During the program year, the Homeless Services System Coordination Program had a total of 41 non-treatment plan clients (goal of 45). Non-treatment plan clients are defined as: MOU member agencies engaged in CSPH Strategic Plan implementation 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 three identified outcomes.

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

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

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

   Outcome Data was collected for each of the three 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 monthly 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 FY25 are below.

Summary of CSPH Focus Group – July 2024

The Continuum of Service Providers to the Homeless (CSPH) conducted a focus group in July 2024 in partnership with City of Champaign Township, Strides Shelter. The focus group was held at Strides at 8pm on Tuesday, July 30th and the group was facilitated by Charlene Murray, Director of Operations and Community Relations with Strides; CSPH Chair, John Ruffin, Neighborhood Relations Manager, with the City of Champaign was also in attendance. All participants were provided with a $25 Visa Gift Card for their participation. 12 adults who were currently staying at Strides attended the event. Eight of the participants identified as male and four identified as female. Nine of the participants identified as Black and three identified as white. Ages of participants ranged from 24 to 71 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 Strides staff for their recruitment efforts and facilitation of the event.

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

- Various resources need to be more easily accessible (obtaining a State ID; SNAP applications, etc.) for individuals who don't have transportation and may require assistance.
- Finding housing opportunities is difficult and many individuals "give up" because of the daunting process and lack of availability of affordable, permanent housing.
- Finding a job can be very difficult and there are often many setbacks along the way.
- There is a need for job training programs to assist people in gaining skills and having more structure in their schedules until they can obtain permanent, steady employment. People expressed CU at Work being a valuable program because each worker learned about timecards, work ethic, and schedules, and were also paired with a case manager to work on interview skills, resume building and job searches.
- Participants want more organizations to come to Strides to present on their services so they can learn directly about programs they may be eligible for in the community.

Summary of CSPH Focus Group – April 2025

The Lived Experience Committee of the Continuum of Service Providers to the Homeless (CSPH) conducted a focus group in April 2025 in partnership with City of Champaign Township, Strides

Shelter. The focus group was held at Strides Shelter at 7pm on Thursday, April 24th and the target population was female identifying residents currently staying at Strides Shelter. The group was facilitated by members of the CSPH Lived Experience Committee including Kintessa Redmon, Chair of the Lived Experience Committee, Damita Parsley, Artrena Joseph, Angela Worthey, Karmyn Doughty, and Katie Harmon. All participants were provided with a $25 Visa Gift Card for their participation. Seven women ages 20-50 who were currently residing at Strides Shelter attended the event. Three of the participants identified as Black and 4 identified as white.

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 establish a system for eliciting direct feedback from people with lived experience
- To develop improvements for the CSPH systems

A special thank you to City of Champaign Township, Strides Shelter staff for assisting with organizing the event and providing participants with a meal.

Facilitated conversations covered four key areas:

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

Key Takeaways

- Participants expressed not knowing about all the resources, specifically for people experiencing homelessness, available in the community. This feedback was consistent with feedback obtained during a 2024 CSPH focus group.
- A recommendation was made to establish a "flow-chart" of available resources based on your current housing situation.
- Participants recommended establishing a list of landlords in the community who will rent to people experiencing homelessness who may also have poor credit and an eviction history.
- Consistent with feedback from prior focus groups in 2022, 2023, and 2024 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.
- There is a lack of safe and secure storage available for people's belongings, particularly if you are unhoused.
- Having a strong support system whether that be family, friends, and/or staff at agencies is extremely helpful in working toward goals.

- Participants would like the opportunity to give anonymous feedback to service providers for ongoing suggestions for improvement on their services.

Participants Homeless Situation and Contributing Factors to Homelessness

When asked about what factors led to their homeless situation, participants shared the following circumstances which impacted their stable housing:

- Loss of employment
- Domestic violence
- Aging out of the foster care system
- Addiction

Some participants shared difficulty in finding employment and obtaining a steady income, impacting their ability to move out of Strides and into permanent housing. Another participant shared they are currently working full-time and was recently approved for assistance through City of Champaign Township's Rapid Rehousing program. Prior to their Case Manager bringing this program up, they were not aware of what Rapid Rehousing programs were.

Experiences With Local Homeless Systems in Champaign County

Overall, participants shared it can be overwhelming and confusing to understand the different types of services and programs that may be available to them. Most participants identified peers as the main source of learning about available homeless services.

Suggested Improvements of Local Homeless Systems

Participants shared ideas for suggested improvements to local homeless service programs. The following suggestions were discussed:

- Increased availability of secure storage space of belongings.
- Training and education for staff on contributing factors to homelessness and engaging with clients in an empathic manner.
- Training for staff on how to manage situations with people who have a trauma history.
- Having a list of landlords that rent to individuals with lower credit scores and eviction history would be very helpful. Including landlords that homeless service organizations have a positive experience in working with. Participants also shared that this list needs to be updated regularly.

Annual Performance Outcome Report Form

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

Agency Name: Champaign County Regional Planning Commission
Program Name: RPC Early Childhood Education Program- Head Start
Program Year: 24-25

CONSUMER ACCESS

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

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

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

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

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

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

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

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

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

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

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

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

CONSUMER OUTCOMES

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

- Use (and expand) the space below to copy each numbered **Outcome** (expected program impact on participants) from your Program Plan. Include the specific **target** and add the **actual result**.
- For each outcome, list the specific **assessment tool** used to collect information. *If different from the tool indicated in the application, include a note explaining the change.*
- For each outcome, indicate the **source of information**, e.g. participant, participant's guardian(s), clinician/service provider, other program staff (indicate their role). Please report all sources of information that apply for each assessment tool, *e.g. "the XYZ survey may be completed by both a youth client and their caregiver(s)."*

Outcome #1

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

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

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

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

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

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

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

Outcome #2

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

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

Outcome #3

Parenting Stress Index; and Adult DECA

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

Outcome #4

TPOT/TPITOS - classroom management

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

CONSUMER PARTICIPATION IN DATA COLLECTION

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

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

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

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

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

   4 times per year.

RESULTS

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

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

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

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

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

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

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

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

Annual Performance Outcome Report Form

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

Agency Name: Champaign County Regional Planning Commission
Program Name: Youth Assessment Center
Program Year: FY25

CONSUMER ACCESS

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

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

   Yes. The stated criteria effectively ensured that individuals received the services and supports they were seeking.

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, and there is room for growth. Youth who are at risk or at the front door of involvement with the criminal justice system are referred to the Youth Assessment Center. We find these referrals generally align well with program services. At times, YAC doesn't know the youth's trauma history, or they may not exhibit symptoms at the start of their engagement with services; however, often as they build trust with their assigned Case Manager, trauma-specific needs are more fully identified. Additionally, YAC is noticing trends in higher level of offenses, increasing repeat referrals, and higher levels of risk at intake, while engagement with services has trended down, indicating that some youth may need more intense services than YAC 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.

Yes. Staff regularly participate in outreach events and continue to strengthen partnerships with community agencies, helping to ensure appropriate matches between participants and available services. Outreach, including advisory committee engagement, has supported engagement with referrals and group programming.

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.

On average, youth begin receiving services within 14 days of referral, ahead of the projected 21-day timeframe.

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

Of all eligible youth who engaged in program services, 80% (NTPC & TPC) were engaged in services within the 21-day timeframe. Of all eligible youth who engaged in program services and were identified as TPC, 77% were engaged within the 21-day timeframe. Both numbers are above the 70% 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.

From time of intake to close, the average number of days for youth to be involved in the program is 87 days (just under 3 months), and the median length is 93 days. The shortest time was 8 days (failed service completion), and the longest time of engagement was 225 days (a re-referral). This shows that youth are typically engaged for 3-6 months 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.

   In addition to race, ethnicity, age, gender, and zip code, data collection included household composition and referral sources. Findings show that 82% of referrals and 87% of TPCs live in households led by a female head of household. The majority of referrals (82%) and TPCs (88%) are between 13 and 18 years old. Racial demographics for referrals include 75% identifying as Black/African American, 22% as White, and 3% as Hispanic, Asian, Pacific Islander, Multiracial, or other. Racial demographics for TPCs include 70% identifying as Black/African American, 27% as White, and 3% as Hispanic, Asian, Pacific Islander, Multiracial, or other. Most referrals (73%) and TPCs are male (80%), while 27% of referrals and 20% of TPCs 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 is unable to report on the percentage of youth successfully diverted from juvenile court adjudication within one year of their services, as YAC does not currently have access to the court records of youth adjudicated. This resource was formerly available to the YAC.

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, 15% percent of TPC youth assessed at exit decreased from moderate or high risk to low risk to reoffend. These numbers do not include referrals received in quarter 4 that are still open due to youth currently being engaged in services.

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 service linkage form 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 information on and referrals to community resources at intake. It has been challenging to ensure successful linkage and utilization of recommended services due to the services being voluntary and not receiving reports from partner providers, so we do not currently have a percentage to report on. Based on the data we collect, 30% of all TPCs improved their Protective Factor level at exit compared to their level at intake.

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? 130 (99 TPC & 31 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?

   The Youth Assessment Center collects outcome information from every youth.

3. How many people did you *attempt* to collect outcome information from? 369 Referrals; 130 Participants
4. How many people did you *actually* collect outcome information from? 130 participants
5. How often and when was this information collected? *(e.g. 1x a year in the spring; at client intake and discharge, etc)*

   Information that is used to evaluate outcomes are collected from clients at the beginning of their engagement with the program, as well as at the end of their engagement with the program when possible.

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 updated outcome data provides a view of both participant engagement and program effectiveness at the Youth Assessment Center. Demographic trends remain consistent as most participants are Black male teenagers from female-headed households. This highlights the importance of YAC providing culturally responsive programming and the potential opportunity to focus outreach on potentially underrepresented groups, including racial and ethnic groups, such as Hispanic and Asian youth, and female youth.

Program efficiency in service delivery remains a strength, with an average 14-day turnaround from referral to service start, well below the 21-day benchmark. Diversion outcomes are currently unknown; however, the YASI scores of 15% of TPCs indicate a reduction in risk to reoffend from moderate or high at intake to low at exit, and nearly 18% of TPCs and NTPCs YASI scores lowered by at least one level from intake to exit.

Over the last year, 42% of eligible referrals participated in YAC services by completing at least an intake, indicating that engaging youth has been challenging. This has inspired staff to be creative and prepares us to focus on building staff skills in areas such as enhanced follow-up, motivational interviewing, focused outreach, and addressing participation barriers. Service linkage issues also persist, as coordination with partner agencies remains inconsistent, limiting the ability to confirm youth are accessing recommended resources and benefiting from their partnership to reduce the risk of youth re-offense.

Strengths of the program over the last year included outreach events, Youth Advisory Committee Engagement, and group programming. Youth reported positive experiences, learning, and appreciation for the dedicated group programming space. The YAC team regularly updates program materials to respond to evolving needs, and focuses on opportunities for continuous quality improvement, such as adding referral tracking via the Sierra database. YAC appreciates partner collaboration and seeks to streamline service connections next year.

Overall, the YAC continues to deliver timely services with strong outcomes in reducing the risk of re-offense and increasing protective factors for many youth. The YAC can enhance its impact by improving engagement rates and resource linkage through capacity building and continuous quality improvement.

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 success story demonstrates the effectiveness of YAC services.

The youth was referred to YAC due to a battery involving another youth at the school, where this youth was the aggressor in an interrupted sexual encounter with another youth. Before the sexual encounter could occur, the SRO interrupted it and referred this youth to YAC.

Using a Spanish-speaking interpreter, YAC staff contacted this youth's family on 11/7/24 and after explaining the program and the police report, they agreed to an intake on 11/18/24. Both parents came to the intake and were provided a Spanish interpreter to meet their needs; however, the youth participated without an interpreter as they preferred to speak to YAC staff in English. During the intake, it was clear there were some language barriers with this youth and that they preferred to nod and agree, so this was something YAC staff were attentive to and regularly made sure the youth fully understood the information. At the time of intake, the YASI assessment indicated an OVERALL moderate risk to reoffend and a moderate-high strengths.

This youth did not initially understand the effects of his actions, and that was the main discussion in his beginning check ins. They changed schools during the opening of their YAC case, and at their new school, Central High School, was bullied relentlessly. The YAC Case Manager engaged the youth on why this was happening and coached them on how to handle bullies by creating supports within the school and making plans to not retaliate against the bullies. The youth began to define what kinds of support they needed and developed supports in the school accordingly. Additionally, they were able to end the bullying situation by not responding to them and utilizing their school supports. This helped the youth greatly, including that they were able to bring their failing grades up to passing.

During the case, the youth became so secure in their supports and ability to handle classes at school independently, that they voluntarily gave up their one-on-one assistant and successfully completed their work in class, on their own, or through study groups.

The case manager assessed that they needed to address some cultural barriers to fully engage this youth and help them understand culturally and legally appropriate ways to act in the US and in the school to be successful and stay out of trouble. The YAC Case Manager approached this with cultural responsiveness, in an effort to enhance the youth's resilience, responsibility, resourcefulness, and restoration to community involvement. In addition to dealing with the stress on their family from this case, Federal political changes impacting immigrants also weighed heavy for this family. At one point, the family were afraid to bring the youth to YAC as they weren't sure if it was safe. Thankfully, trust developed between the case manager and the family, allowing the check-ins to be a source of reassurance and support. The YAC Case Manager referred the family to the Refugee Center for immigration-specific assistance, which provided support and relief for the family.

Several of the youth's check ins focused on exploring their beliefs regarding the sexual behavior that led to their referral, and the impact of it on the community in which they belong. YAC staff saw a significant change in this youth and their ideas of what is acceptable, safe, and legal through these check-ins.

This youth made a lot of progress and at their closing, their YASI assessment indicated a low risk to reoffend and very high strengths due to the wide-ranging work they did in the YAC program. As the youth successfully completed their station adjustment, and were closed out, the YAC Case Manager recommended they continue to develop supports in the school, church, and community to assist them with their future goals.

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 provided insight into what is working well and where improvements are needed. It reinforced effective practices already in place, while also highlighting areas for growth. Based on the findings, adjustments are being made to strengthen service delivery, improve communication, and address identified gaps. Planned changes include refining processes, enhancing staff training, and implementing new strategies to better meet participant needs.

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: DV Services

Program Year: FY25

CONSUMER ACCESS

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

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

   We provide services to all victims of domestic violence regardless of gender, immigration status, race, national origin, age, sexuality, or any other identifying factor. Eligibility is established based on self-report of domestic violence; there are no other barriers to receiving access to our services. We primarily serve clients in our particular target area of Champaign County with the majority of our clients coming out of Champaign, Urbana, and Rantoul.

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.

   Our criteria for eligibility has remained the same due to its success in ensuring the person and program are right for each other. Individual success is based on client participation in wraparound services, but baseline eligibility is maintained.

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

   Our outreach activities have increased in FY25 and are specifically targeted to support appropriate matches between the community and our services. We utilize community partnerships to ensure we're connecting with as many members of the community as possible, in many different demographic groups.

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 number of days from the date a person calls the hotline and is deemed eligible for services was 0 days, as indicated. Once eligibility is established, client has immediate access to any/all services desired.

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 people who engaged with program services through our hotline received an immediate screening for eligibility.

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 95% because, again, all our services are self-selective. Approximately 5% of clients were deemed eligible but then declined services. All clients are eligible to call the hotline for a rescreening and reentry to our program at their discretion.

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 related to languages spoken and we have seen a lesser number of English as a Second Language (ESL) clients. Our outreach and community engagement in this area suggests it is a direct response to the national tensions around ICE and their presence in our local community. Other demographic data collected (such as Veteran Status, Sexual Orientation, Noncash Benefits and Health Insurance Status) was used to ensure safety and comprehensive care, as anticipated.

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, 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 exits (60%) will meet this goal.

We were very close to our estimate on this outcome. We measured 55% of clients left under the positive indicators outlined in our Program Plan. We identified a gap in data reporting where "unknown" and "disappeared" clients were being reported in duplicate, which we have now corrected via internal procedure updates. We are confident this process improvement will result in meeting the higher percentage projected in future.

Outcome #2

We will also measure a survivor's skills and confidence to move to a more positive situation (or a more rapid removal from 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 covers all programs within the agency, and we expect 90% of responses to be positive. While we attempt to survey every client upon termination of services, due to restrictions, the base number of surveyed clients is lower, approximately 100. (90% of 100 = 90)

We were able to achieve this goal, with an overwhelming majority of our survey responses indicating a positive response for our survey questions regarding safety planning, community resources, legal rights, the effects of abuse, and sense of safety and knowledge the abuse is not their fault.

CONSUMER PARTICIPATION IN DATA COLLECTION

1. How many total participants did the program have? 216

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

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

   We attempted to collect all data from all clients. All data is self-identified and self-select.

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)*

   Information was collected at client intake and exit, as well as during the engagement with any and all wraparound services (counseling, legal advocacy, housing stabilization, 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.*

   FY25 was a growth year for Courage Connection, marked by significant turnover in grants and reporting staff. The previous Grants Manager departed the organization in late June, and a new candidate did not start until July 1. There were gaps in information and procedures left by the outgoing staff, and it took time for the new staff to fully onboard. We know we were under-reporting for the first half of the year as we worked to address these gaps and as our new Director of Grants worked with staff to reestablish best practices and work to ensure complete data was being collected. We are proud of the growth in this area and feel more confident in the accuracy of our data and procedures moving forward. We look forward to a more complete picture of our

services in FY26 and beyond. We appreciate CCMHB's support during this period of growth and we are excited for our continued partnership moving forward.

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 who is interested in accessing Courage Connection services calls our 24/7/365 hotline and speaks with a trained Client Advocate regarding their specific situation. Eligibility is determined immediately at the time of contact and the client is advised of all services available to them, possibly including shelter, counseling, legal advocacy, housing support, etc. The client is immediately able to connect with whichever services they self-select to engage with. They are assigned a Client Advocate to provide case management and support throughout their time as a client of Courage Connection. We have a formal intake that is conducted at their first visit with a staff/program and a brief outgoing departure meeting where exit data is collected. All data is documented in InfoNet throughout the course of their time in the program. All clients who depart the program are eligible for re-entry, if required. All entry into our program is coordinated through the hotline.

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 indicated above, our Director of Grants reviews all data regularly and works with staff to consider improvements or changes in practice to ensure the best data is being collected, recorded, and reported at all times.

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: FY2025

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 FY25 was 15 days. Contributing factors to this included 3 attempts by our Family Specialists to reach families in order to schedule their enrollment visit, as well as changes in scheduling whether that be from the family or Family Specialist, due to illness or other 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.

57% of those who were identified as eligible for services engaged in program services within the identified period 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 4.5 months, with the longest participant engagement being 11months. 1 participant enrolled at the end of quarter 4 and was only enrolled for the last month of the fiscal year. 8 participants had their children turn 1 during the fiscal year which impacted their length of enrollment, 5 of which had been enrolled in the previous fiscal year as well.

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

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

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

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? __21____

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? ____21_____
4. How many people did you *actually* collect outcome information from? _____
    a. ASQ: 18
    b. EPDS: 21
    c. ARCH CR-1: 19
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. 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 FY25:

- 80% showed a decrease in their level of stress after using services.
- 90% felt there was an improvement in their parenting skills.
- 90% believed that our services reduced the risk of harm to children.

Our Strong Families Coordinator facilitated 3 parent support groups this fiscal year, open to the community for families who had children under the age of 2. However, 2 of the groups, hosted in rural communities, were not successful. Despite consistent advertising through flyer

distribution and social media, only one session was attended. The 3rd group which was held at the Nursery had 5 complete sessions, with 3 participants being new to the Nursery. For crisis care/respite hours, those enrolled in the Beyond Blue program were provided 790 hours of care.

We had an increase in our enrollment compared to FY24, serving 21 mothers compared to 14 in FY24. 9 of our 21 mothers resided in rural communities. Our Family Specialists spent the early months of FY25 focused on rural outreach too, traveling to community organizations that worked directly with families and included childcare centers, healthcare centers and counseling agencies to discuss Beyond Blue programming and how families can get connected to us. Our team also participated in numerous resource fairs and outreach events to recruit and educate families on the program.

The Edinburgh Postnatal Depression Scale 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, 57% of enrolled families showed improvement in their level and intensity of their depressive symptoms or experienced lower levels of depressive symptoms between their initial assessment and their most recent assessment. Family Specialist have reported that the level of engagement from families as well as the topics learned from the Mothers and Babies curriculum have assisted in this decrease. Of the curriculum, families especially appreciated learning about pleasant activities and engaging in tasks that bring them joy or elevate their moods. Some of the Mothers reported to their Family Specialists during check-ins that they have picked up activities that they enjoyed in the past but had not engaged in for quite some time. This along with learning about how negative thought patterns affect behaviors has provided knowledge to mothers on how to manage these symptoms when they occur. Improvements in mood have been evidence by verbal statements from mothers stating how their bond with their babies has increased, and example from one of our enrolled mothers being that when she first enrolled, she stated “it’s been hard to bond with my baby or do anything” and as baby continued to grow and learn new things, as well as mom engaging in therapy consistently, she stated “watching him learn new things has been exciting” and her moods are visibly better. Other evidence has been increased physical interactions between moms and their babies, progress in goals and the ability to identify and implement new coping skills they did not have before.

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 started working with a family who was in severe crisis when they reached out to the Nursery for support. They have a two-year-old and just had a new baby a few weeks prior to enrolling into Beyond Blue. Mom had experienced severe post-partum depression with her first

born and was hoping that this time would be different. Right after the baby was born, they experienced the unexpected deaths of two very close family members. One was mom's sister, who was a huge support for the parents for childcare and emotional support. Mom was experiencing PTSD from witnessing these deaths. Dad was also temporarily laid off and had been diagnosed with a physical health condition. A month into working with the family, dad had a mental breakdown and was admitted to a psychiatric stay.

When her and her Family Specialist first started working together, mom was very honest that she "could not do this," and "didn't feel an attachment for her baby." She did not feel that she could care for him and had extreme post-partum depression and post-partum anxiety. No one in her family would listen to her, and kept telling her she could do it, and she just had to push through. Her Family Specialist listened to her and they both came up with a plan of who she can call, and who can help care for the baby when these feelings become too overwhelming. Safety had to come first, and now mom is seeing a psychiatrist and therapist, has a solid plan, and a great support system that allows her to have time to decompress, so that she can feel able to build attachment and bond with her baby. She left her emotionally damaging job to get one with less stress and better hours. Dad received a mental health diagnosis and is now taking medication. Mom's medications are starting to work, and her anxiety and depression are much better. She now has improved insight into her feelings and we can talk about her thoughts, what they mean, and how to change them into more healthy and positive thoughts about herself as a mother. She has now been able to have meaningful interactions with both of her children and increased her attachment to baby.

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 facilitate 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. 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: CSCNCC

Program Name: Resource Connection

Program Year: PY25

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.

   It is not often, given the nature of our services, that people are not served in some way or other, but we do not track that data. Our PY25 Unmet Needs count, based on our count of information and referral inquiries, only about .56% are classified as unmet needs. This is a very slight increase of .37% from 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.

   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 August-September last year, where we completed 151 responses. 61.5% of respondents said they used 2 or more services from our program or others offered by agencies in our facility. 15+ agencies see clients in our building. Our staff conducted over 3,200 information and referrals to area agencies in PY25.

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 61.5% of our clients used two or more of our services or others offered in the building, and daily intake statistics show an overall increase in our food pantry usage.

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 69.8, which was up 4% from last year, and shows very 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. Our PY25 cultural competency score was 4.17, 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 survey mean is 4.7, which is very high on the (1-5 scale).

(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? _____1,460_____

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? ____151_____
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.)*

   We began the survey in August and finished in September.

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 4.70 (Score from 1-5) and a standard deviation of .77. 61.5% of our clients use two or more of our services or other programs available in our building. 4.17 is our average cultural competency score, which is high on a 1-5 scale and the PWI score was 69.8. We continually consider the survey results to retrieve 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, assistance paying rent and utilities. They also ask about SNAP applications. In the intake we find out they need to have a need for mental health counseling for someone in their family. We give immediate help with the food and information on our pantries (i.e. how often they come, hours, etc.). We give them CCRPC's rental application and information on any other programs providing rental assistance. We discuss the help we can give with utilities and the LIHEAP program and any other agency providing utility assistance. We give them a SNAP application. The client is given information regarding mental health counseling in our facility with Rosecrance and Hope Springs and in Rantoul with Promise Healthcare, 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. The client returns monthly to get assistance with food, due to underemployment. They 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?

   The high scores in all areas on the evaluation soundly support our current practices.

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 Case Management Program

Program Year: 25

CONSUMER ACCESS

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

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

Yes

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, with areas identified for improvement.
C-U at Home has primarily provided outreach through partnerships and referrals with Drug Court, Rosecrance, and Promise Healthcare. While these partnerships have led to appropriate service matches, we have noted a limited number of racial minorities entering through this referral process. As we expand beyond the initial 16 Mid-Barrier beds, we are actively rethinking our outreach strategy to ensure broader community access. While continuing to prioritize our existing referral partners in FY26, we are exploring the development of a street outreach system to connect with individuals who may not currently be reached through our traditional referral sources.

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.

C-U at Home estimated an average wait time of 3 days between a completed assessment and the start of services. Our year-end data shows that in most cases, the actual wait time fell within 1–3 days, aligning well with our initial estimate. The primary factor that occasionally extends the wait period beyond 3 days is when an individual is completing

treatment at another facility. In these cases, we often conduct the assessment in advance of their discharge to ensure a smooth transition. This proactive approach can result in a wait time of up to 7 days between the assessment and program entry. Overall, the findings are consistent with our expectations, with slightly longer wait times occurring only in circumstances where advance assessments are intentionally scheduled to support client success.

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 projected that 90% of eligible clients would engage in program services within the estimated timeframe. At year-end, 97% of clients engaged, exceeding our original estimate.
Only a small number of individuals moved into the house but later chose not to participate in services or left the program. We attribute the higher-than-expected engagement rate to strong case management support, a welcoming and structured living environment, and efforts to reduce barriers to participation (such as flexible scheduling and proactive communication). These factors have helped build trust with clients and encourage consistent follow-through with 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.

C-U at Home initially estimated that the average time a client would remain in the program would be 12–18 months. This projection proved accurate, with many clients choosing to participate for the full 18 months. Additionally, four clients elected to transition into our Advanced Shelter after completing their initial 12–18 months.
We believe the trend toward longer stays, including the move into Advanced Shelter, reflects clients' desire to continue working on long-term goals in a stable, supportive environment.

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.

C-U at Home collected data on average client income in addition to the metrics required by the MHB. At program entry, the average income of C-U at Home clients ranges from $0 to $10,000 annually. Beginning in FY26, we plan to also collect and analyze client income data at program exit to better assess changes in financial stability during participation.

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

C-U at Home saw a decreased graduation rate this year.
C-U at Home set a goal for 60% of program participants to graduate. This year, the graduation rate was 25%. An additional 12.5% of clients exited without graduating, with most of these departures occurring within the first two weeks of enrollment. The remaining 62.5% of clients are still active in the program and on track to graduate. We anticipate that, given the 18-month average length of stay, graduation rates will naturally fluctuate from year to year.

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

100% of client were tracked through the HMIS system.

Outcome #3 100% of program clients will have an initial screening for mental health and addiction issues and referred to resources when needed
C-U at Home's goal was for 100% of program clients to receive an initial screening for mental health and substance use issues, with referrals provided as needed. This year, 97% of clients received a screening. Some clients had already completed a screening prior to entry. Those who did not receive a screening either declined to participate or left the program shortly after entry.

Outcome #4 90% of clients will be will develop goals and action steps from seven areas of instability-mental health, physical health, substance abuse, income/financial, housing, life skills and spiritual.
C-U at Home's goal was for 90% of clients to develop goals and action steps in the seven key areas of instability: mental health, physical health, substance use, income/financial, housing, life skills, and spiritual well-being. This year, 97% of clients met this objective.

5) 100% of program clients will receive monthly goal evaluations.
Result: 100% of clients who remained in the program for 30 days or more received monthly goal evaluations.

6) 100% of mid-barrier clients will be assigned a case manager and receive intensive case management averaging 3 hours per week, with a maximum case manager-to-client ratio of 20:1.
Result: 100% of program clients were assigned a case manager. Case management ratios have remained

low; however, we anticipate an increase in caseloads with the expansion of the Mid-Barrier program into the Mattis Street property.

7) 100% of clients in the Advanced Shelter Program will receive case management services.

100% of Advanced Shelter clients received case management services.

Clients completed pre- and post-program surveys rating their mental health, living skills, stress levels, substance use, and physical health. Target outcomes and actual results were as follows:

Outcome Measure	Target	Actual
Improved overall mental health	70%	85%
Improved independent living skills	80%	75%
Reduced stress	70%	50%
Reduced substance use	60%	97%
Improved overall physical health	60%	75%

(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?

3. How many people did you *attempt* to collect outcome information from? _____40_____
4. How many people did you *actually* collect outcome information from? _____34_____
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 90-days and at program completion. We are working on implementing quarterly evaluations. These evaluations happen in the form of surveys, group meetings and assessments are at times occurring in 1:1 meetings.

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 found that overall client-reported stress increased during program participation, with only 50% of clients reporting a decrease in stress—below our target of 70%. As a staff we felt this prompted further investigation. As part of a discussion, many clients attributed this increase to taking on additional responsibilities while abstaining from their primary maladaptive coping strategy: substance use. This is consistent with our finding that 97% of clients reported reduced substance use. While this demonstrates

significant progress in recovery, it also underscores how the loss of previous coping mechanisms can initially heighten stress. These findings highlight the need for enhanced stress management supports earlier in the program.

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

Nicole

Nicole's journey reflects remarkable resilience in the face of significant challenges, including overcoming substance use, surviving domestic violence, and managing ongoing mental health struggles. After multiple treatment attempts and navigating a strained relationship with her adult son, Nicole entered the program and steadily progressed through Phases 1–3. When she experienced a setback, staff responded quickly with targeted support to help her stabilize and regain momentum. Today, Nicole is maintaining her goals, living in a Phase 4 house, and actively working toward reinstating her cosmetology license—a milestone that will increase her financial independence and long-term stability. Nicole's progress illustrates the importance of consistent case management, flexible program phases, and timely intervention when challenges arise.

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

The evaluation impacted our design concept for our new property on Mattis St. The space includes more de-escalation space, a reading room and an exercise room per our clients request. We have also worked to increase the peer support meeting frequency, which allows our clients to offer support and feedback to each other.

Client feedback also provided valuable insight into how phase requirements affect both experience and progression. Clients suggested adjustments to the sequencing of steps to improve clarity and alignment with long-term goals. This feedback will guide refinements to program phases, ensuring they remain both challenging and supportive.

We also incorporated client feedback to modify specific programs. For example, based on participant input, the Busey Bank program was restructured from six one-hour sessions into a single half-day session. We also adjusted the session content in response to client suggestions, ensuring the information presented was relevant, clear, and aligned with their needs.

Furthermore, we are looking into ways that we will be able to assist clients in reducing their stress levels as they move throughout the program; however, we acknowledge that some stress is inevitable.

Annual Performance Outcome Report Form

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

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

CONSUMER ACCESS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CONSUMER OUTCOMES

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

- Use (and expand) the space below to copy each numbered **Outcome** (expected program impact on participants) from your Program Plan. Include the specific **target** and add the **actual result**.
- For each outcome, list the specific **assessment tool** used to collect information. *If different from the tool indicated in the application, include a note explaining the change.*
- For each outcome, indicate the **source of information**, e.g. participant, participant's guardian(s), clinician/service provider, other program staff (indicate their role). Please report all sources of information that apply for each assessment tool, *e.g. "the XYZ survey may be completed by both a youth client and their caregiver(s)."*

Outcome #1

Outcome – Improvement of Parenting Skill and Knowledge

Target-95% in each area of the tool

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

Assessment Tool- Piccolo Parenting Interactions with Children observational tool

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

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

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

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

100 % of families consistently displayed affection to their child.

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

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

85% of caregivers consistently displayed encouragement to their child.

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

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

Outcome #2

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

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

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

Outcome #3
Target- 95%
Actual result 100 %

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

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

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

CONSUMER PARTICIPATION IN DATA COLLECTION

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

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

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

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

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

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

RESULTS

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

This program year was very busy and very productive. The CU Early home visitor maintained full enrollment and as soon as children aged out she was able to enroll new families quickly. Overall, we were pleased with the program data that we reviewed. The CU Early home visitor **worked hard to connect with families at the beginning of the program year to ensure that all of the children were connected to a physician and immunizations were tracked throughout the program year.**

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

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

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

Annual Performance Outcome Report Form

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

Agency Name: Cunningham Children's Home

Program Name: ECHO (Empowering Connections through Hope and Opportunities

Program Year: FY25

CONSUMER ACCESS

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

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

   YES: ECHO served participants who were lacking permanent housing, living on the streets, considered "doubled up," (individuals who are unable to maintain housing and 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: 89 Community Service Events were completed during FY25. 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, Austin's Place, and Trauma & Resilience Initiative. Program staff also participated in events such as 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: 53% (8 of 15) participants that enrolled in FY25 were assessed for eligibility and completed an Individualized Care Plan 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: 80%.
   Actual result: 47% (8 of 17) participants that enrolled in ECHO during FY25 were Treatment Plan Clients (TPC) within 30 days. The average length of time from program enrollment to engagement in services was 30.5 days (range was 1 – 63 days). Two clients were NTPC at the close of FY25 (06/30/25).

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 30-60 days post discharge. Participants with PSH vouchers may exceed that timeframe.
   Actual result: Average length of participant engagement among all ECHO clients discharged in FY25 was 28.0 months. 54% (7 of 13) of those participants had a PSH voucher. Clients with a PSH voucher had an average length of engagement of 46.6 months due to extended case management services available with this voucher. The average length of stay for clients without a PSH voucher (6 of 13) was 6.3 months.
   Note: Some discharged clients had other types of housing vouchers during program admission (e.g., Youth in Care, Housing Authority).

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.

   Grade Level Completed
   Less than High School/Drop Out: 10 participants
   GED/HS Diploma: 14 participants

Some College: 5 participants
Bachelor's Degree: 1 participant

Marital Status
Single: 25 participants
Married: 2 participants
Divorced: 2 participants
Widowed: 1 participant

Language
English: 28 participants

Disability Type (if applicable)
None: 6 participants
Mental: 15 participants
Physical: 7 participants
Mental and Physical: 2 participants

Other System Involvement (as noted by participants)
Adult Protective Services: 1 participant
ALLSUP: 1 participant
Courage Connections: 2 participants
Department of Human Services: 1 participant
HACC: 5 participants
Medicaid: 6 participants
Regional Planning Commission: 9 participants
Rosecrance: 2 participants
SNAP: 4 participants
Social Security: 3 participants
Urbana School District: 1 participant
WIC: 2 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 75% 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. 80% of participants (24 of 30) obtained permanent housing. Of those with permanent housing, 92% (22 of 24) obtained permanent housing in less than 120 days of program enrollment.
Note: One client maintained permanent housing (had PSH voucher) but was evicted after almost 5 years due to failure to pay their portion of rent. This client is counted in permanent housing statistics. If removed, the percentage is 77% (outcomes still met).

Outcome #2: Housing Stability
Target: At least 80% 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. 100% of participants (23 of 23) who obtained permanent housing and remained in the program longer than 90 days maintained their housing for 90 days. One participant is excluded from these statistics as they chose to discharge prior to reaching 90-day mark.

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. 83% of participants (25 of 30) obtained employment (n = 15) and/or secured social security benefits (n = 10).

Outcome #4: Life Skills Mastery
Target: At least 80% 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 13 discharges during FY25. Nine participants (69%) completed a pre- and post-measure: Results were as follows:

- 4 of 9 (44%) increased life skills as measured by the assessment tool
- 2 of 9 (22%) had the maximum score at both pre- and post-measure (no improvement was possible)
- 1 of 9 (11%) clients had no change between admission and discharge (pre-test score was 99%)
- 2 of 9 (22%) clients decreased in score between admission and discharge. Both clients had the maximum score at admission and a lower score at discharge.

Outcome #5: Participant Surveys
Target: At least 80% 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 2025 (20 of 20) during annual survey distribution completed a survey. The average overall score on the survey was a 4.72 (out of 5.00). The range of item ratings was 4.30 – 4.85.

(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? ____30 TPC_____

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 all participants who enrolled in the ECHO program, including Treatment Plan Clients (TPC) and Non-Treatment Plan Clients (NTPC). Some outcomes information may not have been available for some clients depending upon their outcome status (e.g., a client that moved out of the area and did not complete the discharge Life Skills Assessment or a client who was not enrolled at the time we offered the client survey). Most outcome information (housing status, employment/SSI status, etc.) is available for all clients.

3. How many people did you *attempt* to collect outcome information from? _____30_____

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

   Outcome 1, 2, and 3: 30
   Outcome 4: 9 (of 13 total discharges)
   Outcome 5: 20 (all clients enrolled at point-in-time survey, May 2025)

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 enrollment in the ECHO program
   Outcome 4: At client intake and discharge
   Outcome 5: Annual (May 2025)

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
   Met. 80% of participants (24 of 30) obtained permanent housing. Of those with permanent housing, 92% (22 of 24) obtained permanent housing in less than 120 days of program enrollment.
   19 of 30 participants (63%) were recipients of Permanent Supportive Housing vouchers, which helped them obtain and maintain housing.

Outcome #2: Housing Stability
100% of participants (23 of 23) who obtained permanent housing and remained in the program longer than 90 days maintained their housing for 90 days.

The ECHO program staff work with participants to understand the importance of following their lease as well as proactively identifying and overcoming 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
83% of participants (25 of 30) obtained employment (n = 15) and/or secured social security benefits (n = 10). The status of the 5 remaining clients is as follows:

- One client had applied for SSI but was denied. This client has not pursued an appeal, but is also not seeking employment;
- One client has recently had a baby and is anticipated to be seeking employment soon;
- One client relocated to live with family in hopes of finding a community with more housing and employment options;
- One client is volunteering as part of benefit requirements
- One client reports she is not seeking employment due to pregnancy.

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 96.2%, and the average score upon discharge was 97.8%.

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.

As noted in the outcomes section, we occasionally see a decrease in reported knowledge and skills between admission and discharge. Because the assessment involves self-assessment on skills and knowledge related to several independent living areas, it's hypothesized that clients who reported less knowledge/skill at discharge may simply have felt more comfortable reporting skill deficits/vulnerabilities after working with program staff.

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 four years (as

compared to efforts to administer at 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, FY24 and FY25 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.

This is from a recent appeal letter involving one of our former ECHO clients.

Shantel's Journey of Strength, Faith and Friendship

By the time most college students reach their junior year, they've faced the usual challenges—late nights, juggling work and school and future planning. But for Shantel, the path has been anything but typical.

A lifelong Champaign-Urbana resident and proud hard worker, Shantel found herself in unfamiliar territory in late 2018—homeless, jobless and unsure where to turn. A near-fatal heart condition and emergency surgery left her physically limited. She lost her job and was denied disability benefits. With no income and drained savings, she lost her home.

Hope returned in early 2019 when Shantel connected with ECHO Housing and Employment Support at Cunningham.

Now in her third year pursuing a Business Administration degree at Strayer University, Shantel's story is one of perseverance, growth and unshakable faith.

Shantel's childhood was difficult. With parents unable to care for her, her Auntie Norrise and grandfather rose to the occasion. At 16, she became legally emancipated and moved into her first apartment.

"God allowed others to step in when I needed them," Shantel said. "Even in the darkest times, God showed me—'I'm still here.'"

One of those people brought into her life was Mike, a Cunningham case manager with the ECHO program, which helps adults and families secure stable housing and employment through personalized support.

Mike's steady presence helped Shantel through some of her hardest moments, and over time, he became a trusted friend.

"We've been through some battles," Shantel shared. "But what I love about Mike is his heart. He never let me go. I've had to fight for everything I have, and I don't give up."

When Mike began supporting her, Shantel was prepared. She stayed actively involved, believing faith had to be matched with effort.

In April, Shantel graduated from the ECHO program. While it's designed to last four years, she needed a fifth—something Mike made sure she received before retiring.

"She's a true success story," Mike said. "Even when things got tough, she never gave up."

Shantel's journey shows that everyone's path is different. For two years, she lived on just $310–$325 a month, never taking help for granted. Today, with stable income-based housing, she no longer carries the constant stress of securing a safe place to live.

Shantel is focused on finishing her degree, staying healthy and launching her own business. After 26 years in the service industry, she understands operations and sees how the economy is shifting.

"It's a service and goods economy now," she said. "Capitalism is changing. I've got ideas and I'm ready to brand out."

Her business goals aren't just about income—they're about impact.

"I know my life won't be easy—it's going to be a fight. But that fight has purpose. And if my story helps even one person, then it's worth it."

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: Families Stronger Together
Program Year: FY25

CONSUMER ACCESS

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

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

   YES: The Families Stronger Together program offered/provided services to youth, age 8 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 19 treatment plan clients and 109 non-treatment plan clients, approximately 20 family members (includes data from discharged clients only) received services. Some siblings received services and family members who received services are only counted once. Note: While we expanded our program criteria in FY25 to serve youth as young as 8 (eligibility had previously been 10), we only served one youth in this younger age range.

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 31 referrals from community partners, and no clients were declined for services. The program admitted 11 (35%) 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 were no longer available for services (e.g., client detained). 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: 3 *(down from 12 in FY24)*
   Champaign County Mental Health Board: 1 *(new referral source in FY25)*
   Other Cunningham Children's Home Programs: 4 *(up from 1 in FY24)*
   Parent Self-Referrals: 0 *(down from 6 in FY24)*

READY School: 11 *(down from 15 in FY24 – Note: Some individual services (NTPC) are being provided by our therapist in the READY program)*
Youth Assessment Center: 6 *(down from 13 in FY24)*

As noted in our grant report, in addition to attending 9 community service events this year, we also conducted outreach with 21 community agencies (e.g., police departments, libraries, schools, health care providers, etc.) to provide program flyers and determine interest in a more formal presentation about program services. These outreach efforts occurred in the 4th quarter of FY25.

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: Nine (9) Community Service Events were completed during FY25. Presentations were provided to a variety of community partners, including National Youth Advocate Program, Youth Assessment Center Advisory Meeting, Rantoul Provider Meeting (twice), Champaign County Mental Health & Developmental Disabilities Advisory Council, etc.

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: 41% of eligible participants (7 of 17) had a mental health assessment completed within 45 days. This excludes:
   - **Two clients were admitted in the program in June of 2025 and had not yet reached the 45-day mark (i.e., MHA was not yet due).**

   The average timeframe for completion of an assessment across all clients was 50 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: 41% of participants (7 of 17) engaged in program services by the 45-day timeline as measured by completion of a Mental Health Assessment by the program therapist which requires client/caregiver engagement. For those that did not meet the 45-day timeframe, the average length of time for engagement in services was 67 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 – 12 months
   Actual Result: Average length of stay in the program for discharged TPCs was 10.5 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.

Grade Level Completed

2nd: 1 participant
6th: 2 participants
8th: 2 participants
9th: 7 participants
10th: 6 participants
11th: 1 participant

Language

English: 19 participants

Other System Involvement (as noted by participants)

Better Tomorrows Counseling: 1 participant
Carle Psychiatry/Carle Counseling: 2 participants
Center for Youth and Family Services: 1 participant
Department of Children and Family Services: 1 participant
Lurie Children's Hospital: 1 participant
Mahomet School Behavior Coach: 1 participant
Rantoul Police Department: 1 participant
READY program: 1 participant
Rosecrance: 1 participant
Youth Assessment Center: 3 participants
Other Cunningham Children's Home Program: 2 participants
Note: Nine (9) clients did not note any other system involvement.

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: Presenting problems of the youth decrease over time

Target: Decreased scores on the "Total Difficulties" scale and increased scores on the "Strengths" scale.

Assessment Tool: Strengths and Difficulties Questionnaire (SDQ)

Source of Information: Youth self-report

Actual Result:
Thirteen (13) youth were discharged from the Families Stronger Together program in FY25. The disposition of these outcomes on the SDQ were as follows:

- Three (3) youth had brief admissions (less than 75 days). We did not have both pre- and post-measures for these youth.
- Two (2) youth did not complete closing measures (youth did not respond to attempts by staff to engage and maintain contact with youth).
- Eight (8) of 8 youth who completed pre- and post-measures on the SDQ had a net positive gain.
    - All 8 youth demonstrated a decrease on the "Total Difficulties" score. On average, scores on this scale decreased by 8.4 points. The average starting score was 19.4 (in the 95th percentile for normed populations).
    - Five (5) of 8 youth (63%) showed small increases on the "Strengths" score. The overall average change in score was negligible (+0.75). The average starting score was 7.4.

Outcome #2: Trauma-informed caregiver skills strengthened

Target: Trauma-informed caregiving skills strengthened in the following ARC areas:

- Foundational Strategies (engagement, education, routines and rhythms)
- Attachment Integrative Strategies (affect management, attunement and effective response)
- Regulation Integrative Strategies (identification and modulation)
- Competency Integrative Strategies (executive functions, self-development and identity; and relational connection)

Assessment Tool: ARC Assessment Tool

Source of Information: Caregiver self-report and staff observation (FST therapist completes the ARC tool)

Actual Result: Thirteen (13) youth were discharged from the Families Stronger Together program in FY25. The therapist completes the ARC tool based on the caregiver's competencies in the skills noted above. The disposition of these outcomes on the ARC tool were as follows:

- We did not have pre- and post- measures on the ARC tool for 3 caregivers due to the youth's/family's brief enrollment in the program.
- One caregiver did not have an admission measure on the ARC tool.
- In nine discharges, the family therapist completed the ARC tool to evaluate caregiver outcomes:
    - Six of nine (67%) of caregivers demonstrated a net improvement on skills measured by the ARC tool;
    - Three of nine (33%) of caregivers had a decrease in overall skills as measured by the ARC tool.

For caregivers whose skills were assessed to have improved, they demonstrated improvement in multiple (not necessarily all) skill areas measured by the ARC tool.

For caregivers who showed a decrease in skills measured by the ARC tool, the decrease was primarily in foundational skills with little or no change in any other area.

Outcome #3: Improve family's protective factors (social supports, concrete supports, family functioning, nurturing and attachment)

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: The disposition of these outcomes on the PFS-2 were as follows:

- Three (3) youth had brief admissions (less than 75 days). A pre- and post-measure was not completed by (or requested from) the youth's caregiver.
- One (1) caregiver did not complete closing measure (family disengaged from program/no contact)
- Nine (9) caregivers completed a pre- and post-test of the PFS-2:
    - Four (4) caregivers (44%) reported ratings that demonstrated an increase in protective factors during program enrollment.
    - Five (5) caregivers (56%) reported ratings that demonstrated a decrease in protective factors.

Outcome #4

Not applicable

(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? ____19 TPC / 109 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?

   Our goal was to collect outcome information from all participants who engaged as Treatment Plan Clients in the program. We were not able to collect data from some short-term clients and/or clients who failed to maintain contact with program staff.

3. How many people did you *attempt* to collect outcome information from? ____13_____
4. How many people did you *actually* collect outcome information from? _8 clients and 9 caregivers_____
5. How often and when was this information collected? *(e.g. 1x a year in the spring; at client intake and discharge, etc)*

   Arc Tool – collected at admission (within first 45 days), quarterly and at discharge.

   SDQ – collected from youth at admission and discharge.

   PFS-2 – collected from caregivers at admission 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.*

   One of the changes we are planning in the next grant period is to discontinue use of the ARC tool. While we value the ARC framework, many of our caregivers require extensive support in skills that are considered Foundation Strategies (e.g., developing rhythms and routines). In some cases, depending on the family's situation, this is a significant challenge. We are not able to address some of the higher level ARC building blocks; hence, the ARC model may not be a suitable fit for this population.

   Changes on the SDQ as reported by 8 discharged youth:

- All 8 youth demonstrated a decrease on the "Total Difficulties" score. On average, scores on this scale decreased by 8.4 points. The average starting score was 19.4. Using normative data cited by the University of Kansas, 18-19 is considered a "high") and clients, on average, tended to move into a more "normal" range (0 – 14).
- Five (5) of 8 youth (63%) showed small increases on the "Strengths" (or prosocial) scale. The overall average change in score was +0.75. The average starting score was 7.4 (which is in the average range).

There was interesting data connected to the Protective Factors Survey (PFS-2). It is noted that we saw less positive impact for caregivers in FY25 than we did on measures completed for discharged clients in FY24. Below is breakdown of changes reported by caregivers.

Resilience/Family Functioning (score range 0 – 4):

- Four caregivers reported positive outcomes on this scale - the average increase was +0.8
- Three caregivers reported no change.
- Two caregivers reported negative outcomes on this measure – average decrease was -1.4

Nurturing and Attachment (score range 0 – 4):

- Five caregivers reported positive outcomes on this scale – the average increase was +1.0
- Four caregivers reported negative outcomes on this scale – the average decrease was -0.8

Social Supports (score range 0 – 4):

- Four caregivers reported a positive change in social supports – the average increase was +0.6
- One caregiver reported no change on this measure
- Four caregivers reported fewer social supports at discharge – average decrease of -0.8

Concrete Supports (score range 0 – 4):

- Only one caregiver reported a small positive change (+0.3) in concrete supports
- Two caregivers reported no change in concrete supports
- Six caregivers reported negative outcomes with concrete supports – average decrease of -0.6

We worked with many families that were experiencing crises and instability. Many caregivers were looking for much more intensive support (e.g., residential programs) than is available through Families Stronger Together. In some cases, helping families access

services post-discharge was a significant challenge (e.g., insurance limitations, waitlists and transportation 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.

   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 practices the technique at least 3 times and is then asked to share their thoughts on the technique (e.g., is it helpful, is it something you will use, do we need to adapt the technique). 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 and/or advocacy.

   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 group and individual services for Non-Treatment Plan Clients. Services focus on skill development as well as helping youth process emotions and experiences. Services are provided at the Champaign County Juvenile Detention Center (JDC) and READY program.

   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 51 total JDC groups held during FY25 involving 70 unique participants, who attended an average of 4 groups each.

   The READY program is an alternative school serving youth with behavioral and emotional needs. A total of 39 READY students participated in individual sessions with the FST therapist. These services were initiated in October, 2024. The average NTPC in the READY program participated in approximately 2 sessions.

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: CU Change
Program Year: 2025

CONSUMER ACCESS

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

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

   Yes

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

   Yes

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

   Yes

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

The estimated timeframe from the youth's referral to the completion of the intake and assessment process was projected at five days post-referral. Upon receiving a referral, the Youth and Family Case Manager promptly contacts the parent or guardian within 24 to 48 hours to schedule an initial intake session. During this session, the Case Manager provides an overview of the program, conducts assessments with the youth and their parent/guardian, and gathers background information to collaboratively develop a goal plan tailored to the youth's needs.
The year-end actual results align closely with the projections outlined in the application. Specifically, 19 out of 20 referred youth successfully completed the process within the expected timeframe, demonstrating consistency with the estimated 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.

The projected percentage of youth referred and/or seeking assistance who would complete an assessment within the designated timeframe was set at 100%. For FY25, 95% of the referred youth successfully engaged with the program. Among those who participated, we ensured they were provided with comprehensive resources and support tailored to their needs, whether at home or in school, to help them stay on a positive trajectory and achieve their goals.

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 projected length of participant engagement for youth in the program was estimated to be between 12 to 24 months. By the end of FY25, six youth exited the program after six months due to lack of contact and insufficient participation, including not meeting the twice-monthly home visit requirement. However, the remaining 13 youth successfully met the projected engagement timeline, aligning with the program's 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.

No additional demographic information is 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- 100% (20 of 20) Youth will complete full intake and actively participate in intervention strategies prescribed in comprehensive plan.

Actual Result- 95% (19 of 20) Youth completed intake and participated in service delivery

Assessment Tool- Case Notes, Goal Plan, Intake Paperwork, Pre/Post Youth Surveys, Family Assessment/Questionnaire

Source of Information- Case Manager, Youth, Parent/Caregiver, School Personnel

Outcome #2- 100% (20 of 20) Family Members/Parents/Guardians will participate in intake and actively participate in intervention strategies prescribed in the comprehensive plan.

Actual Result- 100% (21 of 20) Family Members participated intake and service delivery

Assessment Tool- Case Notes, Goal Plan, Intake Paperwork, Family Assessment/Questionnaire

Source of Information- Case Manager, Parent/Caregiver, Additional Providers on Care Team

Outcome #3- 95% of the Youth will remain engaged in school or take required steps towards re-engaging in school.

Actual Result- 100% of Youth remain engaged in school/took required steps towards re-engaging in school

Assessment Tool- Case Notes, Goal Plan, Pre/Post Youth Surveys, School Progress Reports, Reports Cards, Attendance/Behavior Records
Source of Information- Case Manager, Youth, School Social Workers, School Personnel, Parent/Caregiver

Outcome #4- Outcome 100% of (20 of 20) Youth will demonstrate progress towards the goals listed in their comprehensive service plan

Actual Result- 100% of Youth demonstrated progress towards goals

Assessment Tool- Case Notes, Goal Plan, Pre/Post Surveys

Source of Information- Case Manager, Youth, Parent/Caregiver, School Personnel, Additional Providers on Care Team

CONSUMER PARTICIPATION IN DATA COLLECTION

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

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

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

NA Outcome information gathered for all participants

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

Outcome information is first collected during the client intake process where all participants complete demographic information, pre-surveys (both youth and family focused), needs assessment, and academic information collection. After intake, youth complete outcome surveys every 6 months.

RESULTS

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

Throughout this process, we have learned the importance of maintaining an open mind, practicing patience and understanding, and demonstrating a genuine willingness to support the families we serve. The more the Youth and Family Case Manager engaged with families, the more impactful the outcomes became. It became evident that parental involvement and a shared commitment to change were critical factors in helping youth achieve success.
By working closely with each family to assess their unique challenges, we gained a deeper understanding of the complexities faced by youth and families in Champaign. These challenges highlighted the need for a holistic and responsive approach to address their needs effectively. The goal plans developed collaboratively during the initial intake sessions served as valuable tools, enabling youth and their parents/guardians to articulate their needs, set clear objectives, and outline desired outcomes.
To enhance the program's impact, the Youth and Family Case Manager identified and provided tailored resources to support each youth's unique circumstances. These goal plans also fostered open communication between youth and their parents/guardians, creating a shared vision for success.

While there were barriers along the way—such as disengagement from parents, which often led to youth withdrawing from the program, or youth resisting change within their social circles—the experience underscored the importance of individualized goal plans. These plans not only address immediate needs but also equip families with sustainable knowledge and skills to continue their progress independently after exiting the program.

The Youth and Family Case Manager remains committed to the program's success by embracing the challenges of today's diverse societal landscape. With an understanding of the various ethnic backgrounds and community dynamics, the Case Manager provides a safe and supportive environment where families served by the CU Change Program can access meaningful resources and opportunities for growth. This dedication ensures that the program continues to make a positive and lasting impact on the families it serves daily.

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 involves working with a youth experiencing family and behavioral challenges, coupled with low academic performance. The process begins with setting clear, actionable goals to help the youth overcome these challenges and get their education back on track.

The Youth and Family Case Manager initiates contact with the youth's school to gain a comprehensive understanding of their academic standing. This often involves collaborating with guidance counselors, school social workers, or other relevant personnel to gather insights into the youth's situation and identify areas of need.

From there, the Case Manager works closely with school district staff to identify and provide tailored resources to support the youth's academic and personal development. This may include connecting the youth with mentors, community partners, and service providers to address specific challenges. Interventions often involve counseling, introducing extracurricular activities to create a positive environment, and, when necessary, collaborating with probation officers to ensure a holistic approach to the youth's progress.

Throughout the process, the Youth and Family Case Manager fosters strong partnerships with schools, families, and community stakeholders to ensure a coordinated effort. The ultimate goal is to provide the youth with the tools, resources, and support needed to achieve meaningful and sustainable outcomes, ensuring all parties work together toward a positive resolution.

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: **DSC**
Program Name: **Family Development**
Program Year: **2025**

CONSUMER ACCESS

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

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

Yes. Eligibility criteria included:

- **Child/family were residents of Champaign County as shown by address**
- **Child has evidence of need for service based on screening/assessment**
- **Child, birth-age 5, with or at-risk for developmental delay or disability**

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

Yes

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

Yes

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

Year-end actual results align with application estimate. Mass screening opportunities and early intervention teaming assisted in achieving this goal.

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

Year-end actual results align with application estimate. Group therapy opportunities and consultative/coaching support assisted with large caseload numbers.

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

The duration of participant engagement differed, as indicated in the application. Some children were screened and assessed, and were determined to be age-appropriate with no risk for developmental delay or disability. Others have been receiving services for several years, having been identified at a young age and continuing to receive services since they are not yet six years old.

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

During FY25, 51% of children served were children of color, and 43% resided outside of Champaign-Urbana. The Family Development program remains committed to expanding outreach to marginalized populations. Referrals for services were received through multiple channels, including Child and Family Connections, local daycare centers, individual families, and organized developmental screening events.

CONSUMER OUTCOMES

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

- Use (and expand) the space below to copy each numbered Outcome (expected program impact on participants) from your Program Plan. Include the specific target and add the actual result.
- For each outcome, list the specific assessment tool used to collect information. *If different from the tool indicated in the application, include a note explaining the change.*
- For each outcome, indicate the source of information, e.g. participant, participant's guardian(s), clinician/service provider, other program staff (indicate their role). Please report all sources of information that apply for each assessment tool, *e.g. "the XYZ survey may be completed by both a youth client and their caregiver(s)."*

Outcome #1: 90% of caregivers will feel more competent/comfortable in meeting/supporting/advocating for their child's needs. Caregiver survey will be shared with random samples of families at the end of the fiscal year.
Results: Outcome met at 98% according to the FD Satisfaction Survey provided to a random sampling of families involved in services.

Outcome #2: 90% of children will progress in goals identified on their Individualized Family Service Plan (IFSP). File reviews analyze child's therapy session notes, six-month progress updates, and annual evaluation reports to determine progress towards IFSP goals.
Results: Outcome met at 91% according to file reviews completed each quarter.

Utilization targets and results:

- Treatment Plan Clients target of 655: **Exceeded with 982 receiving supports.**
- Service Contacts defined as the number of developmental screenings conducted with a target of 200: **186 screenings for children in Champaign County completed in FY25**
- Community Service Events with a target of 15: **Met. 16 CSE in FY25**

CONSUMER PARTICIPATION IN DATA COLLECTION

1. How many total participants did the program have? **982**

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

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

Random sample of 15 files were reviewed each quarter for outcomes one and two.

3. How many people did you *attempt* to collect outcome information from? **60**
4. How many people did you *actually* collect outcome information from? **60**
5. How often and when was this information collected? *(e.g. 1x a year in the spring; at client intake and discharge, etc.)* **Quarterly**

RESULTS

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

Collaboration across the community has been instrumental in helping families access wrap around services. Specifically, Family Development works closely with the Champaign County Home Visiting Consortium, Salt & Light, CU Able, TAP, and Larkins Place in order to support young children and their families in accessing the resources and services they need. We are identifying additional gaps in service through our screenings and referrals, and thus better able to network with other entities to advocate for children and families' needs.

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

When screening requests come in, an FD provider completes The Ages and Stages Questionnaire (ASQ) with the family and makes referrals based on results. For children age birth-3 who are flagged for further evaluation, we make a referral to Early Intervention/Child & Family Connections. On occasion, families have struggled with getting EI evaluations completed in accordance with state mandates. Our providers work to help families advocate and understand their child's rights while also working with the EI system/CFC office to figure out barriers to referral linkage. While waiting on other services to start, these children are eligible to participate in playgroups which are open to the community. This helps bridge the gap in service delivery so that the child and family still have some supports while awaiting more formalized services.

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

Annual Performance Outcome Report Form

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

Agency Name: East Central Illinois Refugee Mutual Assistance Center

Program Name: Family Support & Strengthening

Program Year: FY25

CONSUMER ACCESS

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

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

YES

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

YES

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

YES

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

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. Our top 6 languages served were (in order of frequency), Spanish, Q'an'jobal, Vietnamese, French, Pashto & Lingala. This suggests that we should maintain our number of Spanish bilingual staff and encourage our Q'an'jobal speaking clients to make appointments so that we can have a Q'an'jobal interpreter present for their appointment. Some Guatelalan clients do speak Spanish, but it is best practice to deliver services in the primary language of the client. Our Vietnamese bilingual case manager is at capacity with a client waiting list. We will need additional funding to be able to hire a part time Vietnamese case worker or assistant to accommodate the Vietnamese client population. We will strive to translate more of our vital documents into the languages of our 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 FY25, The Refugee Center completed 1,149 public benefit applications for our clients.

Outcome #2

If unemployed, Obtain Permanent employment. The number of people assisted with employment activities was 71. We continue to assist clients with job applications. For our Refugee Resettlement clients who have work authorization, we have an Employment Specialist that assists 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 a matter of Federal law that seems unlikely to change in the near future.

Outcome #3

Improve Quality of Life. Through our efforts, 892 applications for public benefits were approved in FY25. 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 (1,149)

does not begin to reflect the amount of time spent by our staff advocating for our clients with the Illinois Department of Human Services local Family and Community Resource Center (FCRC) and the Special Units Division. Our services improve the quality of life of our clients.

Outcome #4

Improve Outlook on Life. 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 FY25 due to limited staff capacity.

(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? __**3,569**_____

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 FY25.
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.*

   Immigrant and Limited English Proficient (LEP) or Language Other Than English (LOTE) clients need public benefit application assistance, preferably in their primary language. The Illinois Department of Human Services public benefits system is complicated to navigate. Different immigrant status are entitled to different benefits. For example, a refugee is eligible for public benefits upon arrival into the U.S., but a person who gained their Legal Permanent Residency (LPR, or green card) through family immigration is not eligible for benefits until they have been a LPR for 5 years. The complicated rules and regulations for immigrant

eligibility for public benefits often result in improper benefit delays or denials. 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: FY25

CONSUMER ACCESS

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

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

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

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

4. Compare year-end actual result with the application estimate of days from completed assessment to start of services. Comment on findings, especially if unexpected.
   We estimated that clients would begin services within 5 days of completing an assessment. In FY25, the number of days from completed assessment to start of services ranged between 1 to 22, the average number of days for all clients from completed assessment to start of services was 7.6 business days. We have the availability for clients to begin services within 5 days; however, it is the client's availability and preferences which dictate when services begin.

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 FY25, 36% of clients began services within 5 days of completing an assessment. 64% of clients began services more than 5 days after completing an assessment because that is what worked best for the client.

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 FY25: 100% of the treatment plan clients who had both an initial and subsequent ORS score showed some improvement in their score during their treatment. Five clients reached the benchmark score of 35 – 40. Three treatment plan clients were minors and one had dementia so were 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: For treatment plan clients whose case was closed during FY25, 17% met their goals, 80% made progress on their goals, and 3% made no progress on their goals. For treatment plan clients whose case was still open as of 6.30.25, progress has been made on 100% of goals. Three clients will have a treatment plan review during the first quarter of FY26 so we have no data for them.

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). We are transitioning to the WHODAS, which is the updated GAF.

Result: As assessed at the end of FY25 based on the most current or final (if case is closed) GAF and WHODAS scores for treatment plan clients: 76% of treatment plan clients increased their GAF or WHODAS scores. 24% saw no improvement in their score.

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? ____43_____

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 are unable to collect outcome information from clients who complete less than 3 sessions.

3. How many people did you *attempt* to collect outcome information from? _____43_____
4. How many people did you *actually* collect outcome information from? ____34_____
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, information is collected when a treatment plan is completed and every 3 – 6 months following, depending on how often they see their therapist. A client who comes weekly or biweekly will have a treatment plan review at 3 months. A client who comes 1x/month will have a treatment plan review at 6 months.

For Outcome #4, 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 having clients begin services within 5 days of completing an assessment. We have the availability to meet this goal; however, we defer to the clients desires as to when to begin services. For several clients this FY, they chose to wait 2 - 3 weeks before beginning services.

We learned that our counseling program is being effective in that most clients have experienced improvement both subjectively and objectively.

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: Self-Help Center

Program Year: FY25

CONSUMER ACCESS

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

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

2. YES/NO - Did the stated process for determining that the person and program were right for each other work well? If NO, comment on causes and possible solutions.
   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 will maintain a log of all contacts and track 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 FY25, the SHC Coordinator and/or the Program Director participated in 5 community fairs. Information was maintained on over 200 support groups, 90 printed directories were distributed, 32 information and referral calls were addressed, there were 3,653 website views, responses were provided to 691 email contacts, and 3 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 FY25, the SHC coordinator met with individuals interested in forming a new support group; however, they did not follow through on their plan. New books were purchased for the SHC library. Four workshops were held. One in the fall, "Leading with Purpose: Empowering Support Group Leaders" Eight people attended and gave 100% score in all areas for both presenters and for the program itself. Three workshops were held in late winter and spring in partnership with Champaign Public Health District, "Mind, Body, and Coverage: A total guide to women's wellness". Much positive feedback was received from the participants. The difficult decision was made to cancel the conference, "Living Beyond Covid: Building Better Communities Together" scheduled for May 8. Dr. Kevin Tan was to be the key note speaker and all other speakers were lined up and everything was ready. It was cancelled due to a low number of sign-ups.

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 FY25, 90 support group directories were distributed to libraries, businesses, and individuals in Champaign County. At least 32 callers and 691 emailers received information regarding self-help groups and other SHC activities. Specialized lists are always available in our lobby and 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: In FY25, a survey was sent to all known self-help and support group leaders. Initially no responses were received. The survey was sent out two more times and three responses were received. The results of the survey were that none of the groups had professionals involved, all were peer-led. Topics addressed by the groups were Substance Use Disorder, Co-dependency, and Depression and Bi-polar disorder. The number of attendees ranged from 8 – 15. The SHC services used are the directory and specialized lists, workshops, and conferences. Challenges faced by the groups included limited outreach or visibility, low or inconsistent attendance, lack of funds or resources, burnout or leadership fatigue, member engagement or participation. They would like to continue to receive the directory and individual lists and appreciate the workshops and conference. They would like to see additional promotion of support groups, perhaps through WCIA and/or Facebook.

(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 number of participants is difficult to assess since the SHC is a clearinghouse for information. We know that 90 printed directories were distributed, at least 32 callers and 691 emailers received information regarding self-help groups and other SHC activities, there were 3,653 website views, responses were provided to 691 email contacts, and over 200 email addresses received the newsletters. At least 22 people attended the workshops. The SHC maintained information on at least 200 support groups available to Champaign County residents.

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 workshops 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?
   We attempted to collect specific information from over 200 support group leaders.
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)*
   This information is collected 1x/year in the spring.

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 more people are accessing information about support groups online; however, many people still appreciate having the paper directory and specialized lists. From the participants we talked with at health and community fairs, they continue to appreciate the specialized lists and having a smaller handout with QR codes which link to the lists online.
   We continue to see the importance of the outreach and network efforts of the SHC coordinator. We also continue to see the importance of the SHC advisory council and will continue to seek new members.
   While participants have expressed appreciation for the workshops and conference, we have seen a decrease in attendance. This year, we hosted the workshops and attempted to host the conference at times and days different from past workshops and conferences. We will continue to explore topics of interest preferred and preferred days and times for the workshops and conference in our outreach efforts.

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
Program Name: Counseling & Advocacy
Program Year: 2025

CONSUMER ACCESS

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

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

   YES

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

   YES

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

   YES

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

   We estimated 7 days in our application, and in almost every case, service was initiated on the same day the assessments were performed. Exceptions include scheduling home visits, which were all completed within 7 calendar days of first contact with the client. We offer home visits to all Counseling & Advocacy clients, and we always strive to accommodate their day of choice.

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.

Our goal was 95%, and, as in past years, we were at ~99%. Clients usually contact us with specific goals in mind, and we strive to provide the assessment, service, and/or referral at the first meeting.

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 services are designed such that NTPCs can typically be served in one day (usually day zero, the day they contact us). TPCs stay engaged for longer: TPCs in PEARLS engage in services for approximately 5-6 months, TPCs in healthy aging classes will participate over approximately 2-3 months, and those who need longer-term aging navigation counseling stay in contact with their case manager for months or years. It is not unusual for long-term TPCs to receive services until they enter an assisted living / skilled nursing facility, or they 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:
   -Rural address
   -Age, especially those aged 75+
   -Living alone
   -Race and ethnicity
   -Limited English speaking
   -Income level (above, at, or below poverty level)
   -Gender

   Almost half of our clients are 75 or older, and more than half of those we work with live alone. Over one-third of our Champaign County clients have rural addresses. Approximately one-third of our clients were of a race / ethnicity other than white / non-Hispanic. Similarly, about one-third of our clients consider themselves low-income. We had 18 clients who were limited English-speaking. We serve women to men at a ratio of about 3:1.

   These trends have been consistent over the last several years. They tell us that older adults have a rural address, live alone, are non-white, or experience poverty to some degree are served in our Counseling & Advocacy programming, but that we need to continue to find alternative methods of outreach to connect with the older adults who are most at-risk and who could most benefit from Counseling & Advocacy services.

   We continue to strategize ways to address these challenges. For example, in late fall 2025, we will be executing a postcard mailing campaign to all low-to-moderate-income seniors with rural addresses to communicate that we do home visits and/or will meet in a third

place of their choice. The bottom-line messaging is that access to Aging Navigation services (aka Counseling & Advocacy) is as simple as a phone call, no matter who the client is, where the client lives, or how big a challenge transportation is.

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: Case note reviews by our Aging Services Manager and Senior Resource Center Director

Result: Case managers (now called Aging Services Navigators) inquire about anxiety, "the blues," loneliness, and other symptoms of deteriorating mental health. For clients who show signs of such, we may refer them to PEARLS, a coaching program to help seniors regain their previous zest for lift and desire to get in action; we may also enroll them in Creativity on Wheels, which is an art box delivery that comes to the senior directly every other month. Seniors in the COW program receive follow-up phone calls to discuss the crafts and activities, to chat, and to gauge a senior's loneliness and isolation. COW is one extension of our Friendly Caller program, where seniors can receive regular phone calls to chat and check on them and their needs. We also invite seniors who could use some fellowship to activities at our newly opened Helen Stevick Senior Center at Family Service. There are a variety of activities, like BINGO, cards, knitting / crochet groups, and kaffeeklatsch groups.

For more severe symptoms, we may encourage a visit to the doctor, or more extreme interventions to keep a senior safe.

Outcome #2

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

Assessment tool used: UCLA-3 survey

Result: Our 9-month UCLA score reduction from Pre-Test was 6.00 to 4.00.

Outcome #3

PEARLS clients will have reduced PHQ-9 scores.

Assessment tool used: PHQ-9 survey

Result: All PEARLS clients are evaluated with the PHQ-9 instrument, and all saw improvements in their score. PEARLS is a program we continue to focus on growing since those in the program show remarkable improvement and give great feedback about the quality of the PEARLS curriculum (especially in PHQ-9 improvements). However, Family Service has found it difficult to persuade potential PEARLS participants to try the program. As a matter of interdisciplinary and interdepartmental approaches, Joy Jones, who oversees our Counseling and Self-Help departments, is also taking on PEARLS promotion and enrollment so we can expand the awareness and reach of this powerful tool for seniors.

Outcome #4

People beginning Healthy-Aging classes will complete the series.

Assessment tool used: Attendance as reported by Director of Evidence-Based Programming

Result: 56 clients completed Healthy-Aging classes during FY2025, and another 19 began a Healthy-Aging class, to be completed in Q1 of FY2026.

CONSUMER PARTICIPATION IN DATA COLLECTION

1. How many total participants did the program have? 1,119

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?

   Our information & referral clients rarely share demographic information. They call for a quick phone number or question, e.g., "When does Medicare Open Enrollment start?" They therefore do not expect to give a full demographic profile. We hope for a full name, phone number, and birthday. We give contact information and answer general questions without demanding excessive demographic information in the spirit of helpfulness.

   For clients with specific needs (e.g., license plate discounts, Medicare enrollment, referral to Meals on Wheels, Peace Meals, Food for Seniors), we collect comprehensive demographic information.

3. How many people did you *attempt* to collect outcome information from? 1,119
4. How many people did you *actually* collect outcome information from? 1,038
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 anxiety and depression, we collect complete information at time of first contact.

   OUTCOME #2: We collect UCLA scores on clients who participate in our Connectivity programming (formerly called Reducing Social Isolation), so that data is typically collected every other month when Creativity on Wheels boxes are delivered.

   OUTCOME #3: PEARLS clients are evaluated with the PHQ-9 before every session, so we collect each client's PHQ results approximately 9 times over the course of ~5 months.

   OUTCOME #4: Attendance is taken at 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.*

Our Counseling & Advocacy (aka Aging Navigation) serves seniors 60+, many of whom are near, at, or below poverty. We have many seniors in our programs who do not qualify for Medicaid, license plate discounts, or other programs for those with limited monthly funds, but who themselves are struggling to buy groceries, pay for gas, and meet medical and pharmaceutical copay obligations. We see differences in requests, demeanor, expectations, and goals along the income vector. We also observe differences in culture among those in more rural, isolated areas of the County vs their more urban counterparts. We need different strategies for attracting and engaging rural clients, sometimes because of their challenges with transportation, but also sometimes because of feelings of shame or an outsized desire to make things work "without help."

Our staff is diverse; we have aging navigators of a variety of ages, races, sexual orientations, backgrounds, and interests. Some clients are initially distrustful of young case managers, but we train staff to build rapport and explain the need to collect (and keep safe) personal information. By demonstrating competence, we can minimize barriers to trading personal information shared at intake for the services found appropriate as a result of that intake.

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

This is not a composite case, but a singular episode with a client during spring 2025. An older woman from Rantoul called saying she had been referred to us because she was in crisis. She lived alone in her home and was well past her 80th birthday. Home maintenance had long since become unmanageable, and the repairs now necessary had hit a critical state. She was also food-insecure and reported to her aging navigator that she was totally out of food to eat. Her aging navigator immediately went to the grocery store and brought the client emergency groceries to relieve this time-sensitive, pressing need. She did a full intake with the client and saw for herself the gravity of the home repairs. Upon returning to the office, she put in a referral to Food for Seniors (a senior-serving food bank that delivers) to assure regular grocery

deliveries, and to Empty Tomb for the home repairs. Empty Tomb agreed to repair her home and return it to its previous safe condition. This client now receives regular follow-up calls from an Aging Navigator to check on her and assure her that future assistance through Family Service is only a phone call away.

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:

___FirstStepw_____

Program Year: _25_____

CONSUMER ACCESS

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

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

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. We do not run a program that follows a set curriculum. Rather we provide appropriate resources and support.

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 number of people who engaged in the program was about the same as what we estimated.

6. Compare year-end result with the application estimate of length of participant engagement. Especially if the result was unexpected, comment on this finding. They are approximately equal. We had two residents who stayed for over a year, which is a longer time period than in previous years where we most residents stayed for less than a 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 did not collect demographic information of residents 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 -Provide a stable living situation. We have maintained a stable living situation for all residents throughout the year. They have been comfortable in the house and took advantage of drop-in and other services while preparing themselves for the next step.

Outcome#2- Enhance opportunities to find employment-all our residents have found employment that pays wage higher than the minimum and has some potential for advancement.

Outcome #3-Connect to social service agencies-Through our drop-in center our residents have been able to access Medicaid, Link Card, Psychological services and veteran benefits.

Outcome #4- Build connections to the community-This has been uneven. One of our residents has made those connections and others have not made much of an effort. Nonetheless, we have tried to engage them with community groups and social services but only one has established long-term connections.

Outcome #5-Provide economic security-we have partially accomplished this by helping residents to establish a bank account, increase their credit rating and save enough money to buy a car and pay rent on an apartment.

Outcome#6-Provide access to long-term housing opportunities-This has been a challenge as the housing market has become problematic. In the past our residents were able to save enough money from their work to even buy a house but the market has changed and even procuring apartments is more challenging, though our residents have been able to secure housing after leaving FirstSteps, the housing is not of a high caliber.

27. Assessment Tools-we are dealing with a small number of people in our house in a year, only three. We assess their success through personal interviews on a monthly basis with the case manager. We have a monthly report form that we use for this purpose.

28. Processes to measure outcome- Once again this information is gathered through interviews and through exit and follow up interviews for residents who leave FirstSteps. This will be done for every resident that leaves FirstSteps.

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: 25

CONSUMER ACCESS

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

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

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. We did complete the workforce development component, but we moved the course from an in-person, classroom-based format to an on-the-job process which we were able to enact due to funding from RPC and the City of Champaign. We suspended the family support work as it was not attracting sufficient clientele.

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 run a program that follows a set curriculum. Rather we provide appropriate resources and support.

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 finished with about the same number of people as anticipated but they arrived in waves, with the last six months of the two years drawing a lower number due to exhaustion of funding.

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

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. 100% of our clientele were impacted by incarceration. We collect employment and housing status. 50% of our clients are unhoused or housing insecure. Housing is becoming the primary need for people coming out of prison, especially since rents are increasing.

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 -Access to employment and housing (est. 80%)- For the first quarter of the year we were hitting about 80% of housing needs because we had a voucher program from the RPC. However, that money ran out in October and since then we have met about 15% of the housing target. This outcome has become even worse due to a large number of applicants who are on the sex offender registry and most landlords will not rent to them despite our advocacy. In terms of job access, this has also come in spurts, with about 60% positive rate for the first two quarters, then plummeting to about 25% for the next two, although finding jobs did become easier toward the end of the fiscal year when we rose to about 40% for the last month.

Outcome #2-Acccess to Services (est. 80%)-We were at 60% of this outcome, slightly less than our target due to the cutbacks in funding for services for the last quarter of the fiscal year. We gathered this data from our intake forms and follow ups surveys.

Outcome #3-Provide Enhanced Self-Esteem-We believe that this outcome happens when people come to our drop-in center and just converse with us, making connection with people who have also been impacted by the criminal legal system. Large parts of the lack of self-esteem experienced by out clients is the absence of connection with people who have been

through the lived experience of incarceration. Our peer mentors have the experience and the tools to work through this.

4. For workforce development: basic building skills, public speaking, critical thinking, basic math. Our workforce development team has been busy this year with their building. They have renovated five houses and acquired many new skills. On occasions they have done public speaking and had sessions on various critical thinking skills, along with basic math for construction.

27.

Outcome 1: We gathered this data from our intake survey and follow ups.

Outcome 2: Gathering data from our intake survey and follow ups

Outcome 3: No specific survey; assessment based on interview and debrief with workforce development participants

Outcome 4: We will evaluate the work done on the construction projects which will also be inspected by city officials. We will do debriefs after public speaking engagements. We conduct math review sessions and evaluate the participants ability to complete the calculations as needed on the job.

CONSUMER PARTICIPATION IN DATA COLLECTION

1. How many total participants did the program have? ____55_____

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

2. If outcome information was NOT gathered from every participant, how did you choose who to collect outcome information from? We gathered data from people who were available during our drop-in hours. Other clients were serviced by phone and the collection of data was often not possible. E.g. the person taking the call was not in the office or online.

3. How many people did you *attempt* to collect outcome information from? _____35_____
4. How many people did you *actually* collect outcome information from? __30_____
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*

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 noticed that there were more people than in previous years who identified as white using our services and more people who identify as women. We also noted that there was an increase in the demand for housing and the inability of people to afford housing prices.*

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 Black man of age 33 shows up at our drop-in center on a Tuesday. He is still wearing the grey sweatpants that people are given upon release from IDOC. He has been out of prison for 10 days after serving 11 years. He opens the discussion by asking if we can get him a phone. We say that we can arrange that but ask him to sit down and fill out an intake form and then we talk to him. He takes about 20 minutes to fill out the form though it is only 2 pages. He hands us the form and asks when he can get a phone. We tell him to go to the other room where two or our peer mentors talk with him. Not surprisingly, he needs more than a phone. He has been couch surfing for the last four nights after his sister kicked him out of her house, telling him he was too angry to deal with. We ask him where he will be staying that evening. "With a friend," he says. We ask him what job skills he has. "I an drive a forklift," he says, and "cook in fast food." We have a long discussion with him, finding out what he wants to do and what he needs at present. He says he can stay with his friend for "a minute" but would like his own place. He says he has the deposit for an apartment. We don't ask him where the money came from. Even though he has the money for an apartment, we tell him he will need a job before a landlord will rent to him.
   We make a few calls and get him to apply online for a fork lift driving position at Caterpillar and another one at Kraft. He says he has an uncle that works at Kraft and he will talk to him. He hangs out for a few minutes and one of our peer mentors shows up with a car and drives him to get his phone. He already has his ID. He is ready to hit the job market. He comes to the drop-in center two more times until he gets an interview at Caterpillar after we speak with one of our ex-clients who has worked there for two years. He goes to the interview, phones ue two days later to tell us he got the job. We follow up with him a week later by phone and text but he doesn't reply. A month later he shows up at the drop-in center, saying that he got fired from his job because someone checked his criminal background. We consoled him and started the job hunt again. This is a typical set of events with our constituency.

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: Greater Community AIDS Project of East Central Illinois
Program Name: Advocacy, Care, and Education (ACE) Program
Program Year: FY25

CONSUMER ACCESS

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

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

    - Year-end Actual Result: 100% of eligible clients received services within 3 days of completed assessment
    - Application Estimate: 90%
    - Comment: Our case manager consistently met with clients within 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.**

    - Year-end Actual Result: 89.5% of eligible people engaged in program services within 3 days.
    - Application Estimate: 90%
    - Comment: The actual engagement rate met the application estimate. This highlights the responsiveness of our team, and the critical community need for our 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.**

- Year-End Actual Result: 14 months (Average)
- Application Estimate: 12 months (+/- 6 months)
- Comment: The average engagement of 14 months falls within the estimated range. This duration indicates participants remain in the program long enough to make noticeable progress on their goals and achieve a stable level of self-sufficiency., as evidenced by the increase in SSM and GAS scores.

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

Beyond standard demographic data, our program tracks key socioeconomic factors including annual income, number of people in household, number of children in household, and housing status at intake.

The data suggests our target population faces profound, multi-layered systemic barriers related to poverty and housing:

- Housing Status:
  - 100% of the clients were considered Category 1 "Literally Homeless" at intake. This confirms that the program serves the most vulnerable individuals
- Income Source:
  - 80% of clients relied on SSI/SSDI.
  - 15% of clients had no source of income.
  - 5% of clients were employed.
  - This indicates a near-universal reliance on fixed disability income or a complete lack of income, necessitating intensive case management focused on maximizing benefits access, budgeting, and (for the small employed group) job retention support.
- Family Status:
  - Data regarding living children showed that the clients who had living children had either lost custody of them, the children had died at a young age, or they had a poor or non-existent relationship with the child. This suggests a significant history of trauma, loss, and familial isolation within the client population.

This data highlights the severe and complex barriers to care for individuals facing homelessness, extreme poverty, and social isolation. These findings validate the program's focus on comprehensive, supportive services—specifically, connecting clients to housing, maximizing income stability, and addressing the social/emotional components reflected in the strong outcomes for the RSES (self-esteem) and MSPSS (social support).

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 ability to meet basic needs securely and sustainably.

Targets

Target 1: 90% of clients will score 25% or higher than their score upon intake on the Rosenberg Self-Esteem Scale (RSES) at discharge.

Target 2: The average client score on the Self-Sufficiency Matrix (SSM) at discharge will be 15 or higher (scale 0-30).

Target 3 : Upon discharge, clients will have an average score of +0.5 or higher on GAS

Actual Results

Result 1 : 100% of participants scored 25% or higher on the RSES at discharge. 94% of clients scored 25% or higher on the RSES at end of Q4

Result 2: The average SSM score at discharge was 18.

Result 3 : Clients who were discharged from the program in FY25 had an average of +1 across all domains

Comment:

The program surpassed the confidence and self-sufficiency targets significantly. This shows a strong increase in both the psychological skills and practical skills needed for clients to meet their basic needs. Also, the average GAS score of +1.0 exceeded the target, showing that clients achieved "some progress toward goal" for their individualized needs and goals under this outcome

Assessment Tools:

Tool 1. Self-Sufficiency Matrix (SSM): Completed at intake and discharge.

Tool 2 The Rosenberg Self-Esteem Scale (RSES): Completed by client at intake, end of Q1, Q2, Q3, Q4, and discharge.

Tool 3. Goal Achievement Scaling (GAS): Individualized goals are tracked continuously via case-manager completed progress reports. Goal check-ins are quarterly on a -2 (Goal counter-productive) to +2 (Goal fully achieved) scale.

Source(s) of Information: Client (self-report) and Case Manager (perceived client self-sufficiency)

Outcome #2: Strong social connections and support networks.

Targets

Target 1: 90% of clients will score 25% or higher than their score upon intake on the Rosenberg Self-Esteem Scale (RSES) at discharge.

Target 2 : 90% of clients will score 25% or higher than their score upon intake on the Multidimensional Scale of Perceived Social Support (MSPSS) at discharge

Target 3 : The average total score on the Multidimensional Scale of Perceived Social Support (MSPSS) at discharge will be 15 or higher. 15 is chosen as scores 15-25 are considered to be within normal range.

Actual Results

Result 1: 100% of participants scored 25% or higher on the RSES at discharge. 94% of clients scored 25% or higher on the RSES at end of Q4

Result 2: 94% of participants scored 25% or higher on the MSPSS.

Result 3: The average MSPSS score was 20

Comment:

The program surpassed the confidence target significantly. The self-sufficiency target was nearly met, with a high degree of confidence achieved, suggesting strong psychological preparation for long-term stability.

Assessment Tool(s):

Tool 1 Multidimensional Scale of Perceived Social Support (MSPSS): Completed by client at intake, end of Q1, Q2, Q3, Q4, and discharge.

Tool 2 The Rosenberg Self-Esteem Scale (RSES): Completed by client at intake, end of Q1, Q2, Q3, Q4, and discharge.

Source(s) of Information: Client (self-report)

Outcome #3: Confidence and self-sufficiency for long-term success.
Targets

Targets

Target 1 : 90% of clients will score 25% or higher than their score upon intake on the Rosenberg Self-Esteem Scale (RSES) at discharge.

Target 2 : The average participant score on the Self-Sufficiency Matrix (SSM) at discharge be 15 or higher (scale 0-30).

Actual Results

Result 1: 100% of participants scored 25% or higher on the RSES at discharge.

Result 2: The average SSM score at discharge was 18.

Comment*:*

The program surpassed the confidence target and the self-sufficiency target. The high RSES result suggests that a strong psychological foundation supports this stability.

Assessment Tool(s)

Tool 1 The Rosenberg Self-Esteem Scale (RSES): Completed by client at intake, end of Q1, Q2, Q3, Q4, and discharge.

Tool 2 Self-Sufficiency Matrix (SSM): Completed at intake, end of Q1, Q2, Q3, Q4, and discharge.

Source(s) of Information

RSES: Participant (self-report).

SSM: Participant (self-report) AND Case Manager (perceived client self-sufficiency).

Outcome #4: Reduction in barriers that interfere with access to care
Targets

Target 1: 90% of clients will report a reduction in barriers related to access to nutrition support, healthcare, and medication within the first 90 days of the program.

Target 2: 90% of clients that identified as having a significant barrier (e.g., lack of transportation, childcare, insurance coverage) will report that this barrier has been fully or partially resolved at the point of discharge.

Actual Result

Result 1: 100% of clients reported significant reductions in barriers related to access to nutrition support, healthcare, and medication within the first 90 days of the program. This was attributed to case management and care coordination

Comments:

100% of participants reported a reduction in barriers upon discharge. However, only 60% reported full reduction of barriers. This indicates the need for long term support for highly vulnerable populations

Assessment Tool(s)

Tool 1: Case Management Progress Notes & Discharge Summary: Program staff documentation tracking the identification, referral for, and resolution of barriers (e.g., transportation vouchers issued, healthcare appointments scheduled, insurance enrollment completion).

Tool 2: Client Exit Survey/Interview: A brief survey assessing the barriers identified at intake.

Source(s) of Information:

Case Management Notes, Clinician/Service Provider reports and notes. Client Exit Survey/Interview, Client (self-report).

Outcome #5: Goal Achievement

Targets:

Target 1: 100% of clients will meet with their case manager to complete a motivational interviewing assessment to define goals, goal readiness, goal importance, and to create a goal achievement plan

Target 2: The average Goal Achievement Scaling (GAS) score across all participants at discharge will be +0.5 or higher.

Actual Results

Result 1: 100% of participants completed the motivational interviewing assessment and were involved in creation of their goal achievement plan

Result 2: Clients who were discharged from the program in FY25 had an average of +1 across all domains

Comments:

The program exceeded all targets for goal achievement. Target 1 was met at 100%, confirming effective client engagement and collaboration in service planning. The average discharge GAS score of +1 not only significantly surpassed the target of +0.5 but also provided the quantitative evidence required for Target 2, showing that participants, on average, achieved "some progress toward goal" or better across their individualized objectives. This validates the effectiveness of the case management approach and the goal-setting process.

Tool.

Goal Achievement Scaling (GAS): Individualized goals are tracked continuously via case-manager completed progress reports. Goal check-ins are quarterly on a -2 (Goal counter-productive) to +2 (Goal fully achieved) scale.

Source(s) of Information: Client (self-report) and Case Manager (progress notes)

CONSUMER PARTICIPATION IN DATA COLLECTION

1. **How many total participants did the program have?** ___19_____

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

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

3. **How many people did you *attempt* to collect outcome information from?** _19_____

4. **How many people did you *actually* collect outcome information from?** __19_____

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

   Outcome information was collected 6 times over the course of program participation: at client intake and at the end of Quarters 1, 2, 3, 4, and at discharge. Goal Achievement Scaling (GAS) was also tracked continuously via case-manager completed progress reports.

RESULTS

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

Overall, the program was highly successful in achieving its primary goals—the average Self-Sufficiency Matrix (SSM) score showed a significant improvement from 12.5 to 18 indicating a strong shift toward stability, the MSPSS score showed an average shift from 17 to 20, and the overall Goal Achievement Scaling (GAS) score was +1.0, confirming that clients made measurable progress on their individualized goals. However, the data highlighted demographic disparities, specifically revealing lower baseline and final confidence levels on the Rosenberg Self-Esteem Scale (RSES) for female and transgender clients. This may suggest a need for more focused psychosocial interventions for gender minorities. Conversely, retention rates remained consistently high (100%) across all ethnic and racial groups, shoeing the program's inclusive engagement strategies. Finally, an important and interesting trend was observed among the older white male demographic (65 years and older) who were engaged in services for over 18 months. For this group, goal progress plateaued and willingness to engage in services declined. This may indicate a lack of motivation over time, but it also warrants considering the impact of racial privilege—these long-term clients may have already resolved their most critical barriers (e.g., housing, income stability) due to historically greater access to community resources, leaving only deeply entrenched, quality-of-life goals that require more time or different interventions, or a lack of motivation due to a shift in client priority after reaching a stable baseline. In contrast, BIPOC clients, while equally retained, may see continued progress as they navigate persistent, systemic barriers that require longer, more intensive program support. Overall, the outcome data demonstrates that the ACE Program is highly effective in achieving its core targets related to stability, self-sufficiency, and goal progress. The specific demographic findings—particularly the lower baseline confidence among female and transgender clients and the plateauing goal progress for long-term, older white male clients—provide clear, actionable areas for program refinement in FY26.

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.**

Client A, a 60-year-old transgender female, was referred to GCAP from C-UPHD. Client A was identified as Literally Homeless by her C-UPHD case manager, and is needing immediate housing. GCAP case manager responds to the referral, completes intake assessment, and enrolls Client A into the program. Upon intake, her Self-Sufficiency Matrix score was 10 and she had a low Rosenberg Self-Esteem Scale score of 9. She states her most critical barriers are applying for benefits, finding an Infectious Disease provider and Primary Care provider,

obtaining transportation, and obtaining healthy food. Case Manager rapidly addresses these immediate barriers by providing Client A with a bus pass voucher and food voucher, coordinating immediate primary care appointments, and sending referral to local ID provider. The Case Manager then uses the Motivational Interviewing Assessment to collaboratively define short-term and long-term goals related to housing, income, social support, self-care, health, mental health, and employment/volunteering. Over 14 months (the average engagement period), the Case Manager meets with Client A weekly to check in on goal progress and assist with needs related to defined goals (ex: assisting with permanent supportive housing applications, transportation to medical appointments, referrals to mental health providers, benefit coordination, etc). Additionally, Client A attends monthly group meetings where motivational interviewing worksheets are used and goals are discussed in group setting. At the end of the first 90 days in the program, Client A has established Medicare/Medicaid benefits, SSI/SSDI, and SNAP, and has also completed permanent housing voucher applications and is on the waiting list for a voucher. Client A works with the Case Manager to find housing, and once the voucher is approved, Client A moves into permanent housing. Upon discharge, Client A reports full reduction in barriers and 100% medical compliance.

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 consistently high success rates across outcomes confirm the current individualized case management model and assessment tools are highly effective and should be maintained as core program practice. Also, given that Permanent Housing Stability was identified as the most persistent barrier, the ACE Program plans to provide Housing Counselor training for all Case Managers in FY26.

Annual Performance Outcome Report Form FY24/25

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 24/25

CONSUMER ACCESS

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

1. YES/NO - Did the stated criteria serve the purpose of providing people the services/ 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 248 New non treatment Plan clients. We had 51 continuing non-treatment plan clients for a total of 299. I projected 250 for FY25. This was just a little over what I projected. It would have been more if the jail groups had met consistently.**

.

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 (FY24 13%) (FY25 30.4%) 2 to 3 months (FY24 10%) (FY25 6.5% 1to 2 months (FY24 23%) (FY25 17.4%)3 to 6 months (FY24 8%) (FY25 8.7%) 2 to 5 years (FY24 13%) (FY25 6.5%)

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 FY25
The difference GROW has made in my dealings with life's challenges, by teaching me what tools I can use to mature and showing me I have personal value and the best in life and love and happiness is ahead of me.

Learning how to cope with and bring problems out in the open.

To help recover from mental illness. To develop my own personal resources. To reduce criminal habits and stop substance abuse. To experience personal growth and increase maturity. And to improve my relationships.

Good time credits

The GROWER's learning and helping others, working along side as friends.
I love it! I will keep coming back.

Friendly help in groups, developing healthy friendships in group, expand leadership
the caring and sharing, the friendships, and the Program that teaches me How to navigate life.

My friend that I knew, and the people that live close to me that I can see at meetings.
GROW has made an immense improvement in my life by reframing my perspective on mental health. By instead making mental illness something obtuse and difficult to pinpoint it places the responsibility on me to have the gift of recovery. I am the steward of my own life and can learn from others, GROW texts, and the broader GROW community tools to equip myself with becoming less maladjusted and more mature. I can and will recover from my mental illness.

The people

The blue Book

The things I learned and the conversations.

It's a great program that I enjoy. It helps me mentally as well.

Seeing how it has improved others and the relationships with others

Support in dealing with my mental illness

To get help.

Truth, friendship, and character.

Having Friendships

Having someone to talk to.

Friendly helpers, and friendly listeners who are kind and understanding.

Like the conversations we have, allows me to open up.

GROW is the best thing I have in my life!

Learning more about self discovery with the program and learning a lot about leadership in the GROW community and beyond.

The friendships and keeping on track.

Becoming a recorder for GROW and participation

Getting out of cell.

Positive experiences and advice given. The sense of security and community.

What would you change about how groups are run?
FY25
Nothing

Have them more frequently.

I would have more diverse help to teach with different backgrounds. To relate and teach many different people in the program. Have more acting and problem solving in group.

Nothing. Group Method helps stay on track.

have 10 minutes before meeting starts to welcome and ask volunteer to lead and volunteer testimony and to just say hi to everyone else. (We have been doing that it helps on the virtual groups just to connect rather than jumping straight into the group.)

I like the way it is.

Absolutely nothing. Sheila and Brenda could talk a little more. Love their insight and wisdom. Truly do.

More detailed workbooks to use when not in groups that structure program adherence when in group

To be the leader.

People not interrupting others and talking too much.

Need more people to step up in leadership.

No change

What suggestions do you have to improvements our program?

I would suggest that we remove some parts of the group method.
FY24/25 Follow up formed a team to address this. We have improved the group method and we plan to implement the new one as soon as it has approval from the governing leadership.

I would like to see more updated reading.
FY24/25 Follow up we created a team to update the program. Updates have been made to the program we will have final finished very soon.

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 /25 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? _____299_____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 FY25/25 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 47 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 FY24/25, 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 (FY24 81%) (FY25 52%) had not been hospitalized. in the (FY24 5%) (FY25 8,7%) was hospitalized 2 times (FY25 13%) were hospitalized once**. **We had (FY24 30) (FY25 24) that had never been hospitalized in a lifetime. We had (FY24 1)(FY25 1) that had been hospitalized over 10 times in a lifetime. We had (FY24 4) (FY25 6) that had been hospitalized 1 time in a lifetime. We had (FY24 5) (FY25 26) that did have a diagnosis of some sort of mental illness.**

2. Decreased medication [for mental illness]: **From the survey (FY24 52.6%) (FY 37%)who are on no medication (FY24 48%) (FY25 30%) that were on two or three medications. We had (FY24 28) (FY25 17) people that worked with their doctor to reduce medication.**

3. Increased use of social resources**: From the survey:(FY24 29) (FY25 31) 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 (FY24 28) (FY25 21) strongly agreed with increased personal growth. (FY24 12) (FY25 11)agreed they had an increase in personal growth; (FY24 3) (FY25 6) both agreed and disagreed.**

5. Increased wellbeing: Survey (personal wellbeing index) **From the survey (FY24 32) (FY25 31) have an increased sense of wellbeing. (FY24 5)(FY25 4) most of the time sometimes. (FY25 38) are very satisfied with the help they have received from GROW friendship.**

   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= (FY25 4.7/10)

   How satisfied are you with your standard of living? Means= (FY25 4.6/10)

   How satisfied are you with your health? Means= (FY25 4.6/10)

   How satisfied are you with what you are achieving in life? Means= (FY25 4.7/10)

   How satisfied are you with your personal relationships? Means= (FY25 4.7/10)

How satisfied are you with how safe you feel? Means= (FY25 4.7/10)

How satisfied are you with feeling part of your community? Means= (FY25 4.6/10

How satisfied are you with your future security? Means= (FY25 4.7/10)

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

FY25Means = (FY24 4.1/10) (FY25 4.7/10)

FY25 Average over all Means= (FY25 4.7/10)

I noticed on this survey and the results that people do not feel secure and safe.

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. I think the residual effect of the pandemic is still lingering yet people are finally starting to get out and do things with less fear.

6. Increased number of participants in leadership roles: **From the survey (FY24 55%) FY25 45%) have been involved in some kind of leadership role. (FY24 44%)(FY25 54.3%) had not been involved in the leadership role. FY25, we had 45% involved in leadership roles. We have a slight decrease in this FY. We had 299 duplicated attendance x 3 hours for each activity, with this does not include planning time = 3112 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: (FY24 57.9%) (FY25 65.2%) very satisfied with the program. (FY24 28%) (FY25 28.3%) were satisfied and (FY25 4.3%) were satisfied or not satisfied**. **(FY24 32) (FY25 45) people believed that GROW helped them recover from mental illness. (FY24 29) (FY25 41) developed their own personal resources. (FY24 34) (FY25 38) experienced improvement in personal growth and increased maturity. (FY24 32) (FY25 35) 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 have 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.

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 we had a few months that we could not meet because of remodeling. The program is very well attended, and we have helped them improve their lives. We have to male groups and we still have a waiting list at times to attend the groups. The women's group is well attended.

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 fulfil that purpose we write letters to the court on an individual basis describing how they used the program in their lives and whether 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. Damon has taken 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.

We also had one long term GROW'er in the area purchase a home. This was definitely a dream come true.

We had another GROW'er that went back to college. They had dropped out because of stress and decided that they could return.

We have new organizers and recorders of our community groups and since the Jail groups started back up we have many that are starting to lead meetings again.

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 are doing PR in the community. One meets in the Presbyterian church and attendance has improved for this year. Damon works with strides and brings some to the afternoon community group if there isn't enough attendance on sight. We have also resumed the groups in the jail.

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 do it twice a week on Tuesday 11:00am and 5:30pm. We are considering doing this a few times a week if time permits. 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 continued to update 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 these recommendations.

We are a part of a Data capacity building work group. I joined the team it 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 ourselves. Thank you for the opportunity to be part of this Team.

We are also on re-entry that has improved and helped us to connect inmates to some of the re-entry services. I have not gotten word on when the re-entry meetings might start again.

Now that the Jail groups have started back up and we got through a few rough patches. We have successfully gained members in the Jail and leadership is starting to come along. Anytime you have period with out the ordinary GROW group you almost start over when it comes to the understanding of leadership and why it is vital. We have a very understanding staff team that has their own personal testimony and are able to relate to the inmates. Celeste recommended Toni and she has been a blessing. She understands the ins and outs and how important it is to have guidance and understanding.

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_____
Program Year: ___PY25_____

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.
   Service began on the date of 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.
   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.
   Patient engagement was consistent with assessed need

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 was not colleected beyond 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

Promise Healthcare will serve 1,000 treatment plan and non-treatment plan clients with Counseling services and at least 1,900 treatment plan and non-treatment plan clients with Psychiatry services by the end of Q4 2025.

Counseling Target: 1000 Counseling Actual Result: 904

Psychiatry Target: 1900 Psychiatry Actual Result: 2011

Promise Healthcare will utilize Nextgen EMR data reports to identify the # of patients accessing counseling services and psychiatric services at the primary care clinics.

Source of Information: NextGen reporting.

Outcome #2

Increasing awareness of mental health issues to reduce stigma and increase public knowledge of services available by conducting at least 2 community service events on psychiatric topics as well as 4 community service events on mental health issues by end of Q4 2025.

Counseling Target: 4 Counseling Actual Result: 22

Psychiatry Target: 2 Psychiatry Actual Result: 0

Promise Healthcare will track the # of community service events hosted in the community by mental health and psychiatric staff to raise awareness around mental health issues.

Source of Information: Marketing tracking and calendar. Psychiatric providers did not do actual outreach. However, psychiatric services were discussed at all outreach events.

Outcome #3

By end of Q4 2025, Promise Healthcare will have provided 2,800 total encounters to low-income patients in need of counseling services as well as 3,200 encounters to low-income patients with psychiatric needs.

Counseling Target: 2800 Counseling Actual Result: 3246

Psychiatry Target: 3200 Psychiatry Actual Result: 9722

Promise Healthcare will utilize Nextgen EMR data reports to identify the # of counseling and psychiatric encounters each quarter.

Source of Information: NextGen reporting. The addition of providers and reformatting appointment time frames had an impact on the outcomes being higher than targeted.

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? ___15,883_____

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 collected from all patients.

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) At intake and at 1 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.*

   A significant portion of the Champaign County population are in needed of high level quality psychiatric and mental health services. A significant portion of Promise Healthcare patient population suffer severe symptoms.

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: __Promise Healthcare_____
Program Name: __Wellness_____
Program Year: ___PY25_____

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.
   Services began on the day of 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.
   100% of patients assessed engaged 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.

Patient engagement was appropriate to the level of assessed need.

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 other demographic information collected beyond 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

Assist a minimum of 1,600 patients with linkages to social services (transportation, health insurance enrollment, employment, housing, food, etc.) to remove barriers to accessing healthcare services and treatment plans.

Target: 1600 Actual Result: 1906

Assessment Tool: Provide enabling services to a minimum of 1,600 patients to remove barriers to accessing healthcare services by assisting with Medicaid enrollment and linkages to transportation, employment, housing food, etc.

Source of Information: NextGen reporting.

Outcome #2

Maintain a robust referral system with 35+ community partner organizations who provide at least 1,100 referrals from outside entities to Promise Healthcare to accept low-income patients in need of psychiatric, mental health, and case management services.

Target: 1100 Actual Result: 1853

Assessment Tool: Accept at least 1,100 referrals from outside entities for low-income patients in need of psychiatric, mental health, and case management services at PHC.

Source of Information: NextGen reporting.

Outcome #3
By the end of the project period, conduct a minimum of 150 patient assessments utilizing a Social Determinant of Health screening tool (PRAPARE).

Target: 150 Actual Result: 106

Assessment Tool: SDH screenings will be conducted on a minimum of 150 patients. Data will be collected quarterly. For all outcomes, the Data and Workflow Analyst will be responsible for pulling the data for reporting. The Behavioral Health Director will validate data.

Source of Information: NextGen reporting.

CONSUMER PARTICIPATION IN DATA COLLECTION

1. How many total participants did the program have? __2012_____

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 collected from 100% of patients.

3. How many people did you *attempt* to collect outcome information from? __100% _____
4. How many people did you *actually* collect outcome information from? ____2012 _____
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.*

   Social determinants of health have a negative impact on the overall health of patients served by Promise Healthcare. Reductions in negative economic impacts had a positive experience on patient's overall health.

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: Rape Advocacy, Counseling, and Education Services
Program Name: Sexual Trauma Therapy Services (2025)
Program Year: PY25, 4th quarter

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: 1 day; Year-end actual: Approximately 95% completed phone intake assessment within one day of contact. Application author used this phone intake process in response to this question. Due to a variety of factors, such as caseloads, staff vacancies, volume of requests generating a wait list, the period from phone intake to start of counseling services could be weeks or months. However, as of the start of FY/PY26, RACES has completely eliminated its waiting list.

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 80%; Year-end actual: As noted above, 95% of clients requesting services received the phone intake assessment within one day. Again, author used the phone intake period as the estimate of eligible people engaging in program services as the baseline. Client choice, as well as the factors listed in q.4, affects actual start of program services. For example, clients who want Spanish language only services must wait for an opening in the new bilingual therapist's caseload, unless they choose to use the agency's live interpretation options (LanguageLine, or earbuds that provide live interpretation).

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 1 year, if engaged in EMDR Therapy; Year-end actual: Our therapists use a variety of therapeutic modalities: IFS (Internal Family Systems), CPT (Cognitive Processing Therapy) Polyvagal Theory, Somatic Experiencing, EMDR, TF-CBT (Trauma focused Cognitive Behavioral Therapy). A few, like TF-CBT or CPT, suggest a limited number of sessions, however, per policy, RACES does not limit the number of sessions a client can have as they work through the program. Typically, therapy is once a week, approximately 50 sessions a year (assuming no cancellations). The client and therapist discuss when to end services. Therapists have a cap of 20 active cases at a time, with a maximum capacity of 100 caseloads at any given period. Therapists may carry a caseload of less than 20 depending on the complexity and frequency of visits for each case. In FY25, only three clients that were active during the fiscal year were discharged and their cases closed.

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.
   RACES requests data regarding the individual(s) who harmed our clients, the client's sexual orientation, the location where they were harmed, and income information. Providing any demographic data is optional for clients, assuming they meet the residency requirement and are appropriate for RACES' services. The data sets RACES requests are dictated by another funder that uses them and data from other centers throughout the state to gain an overall understanding of experiences of sexual violence and related forms of harm at a state level. No identifiable information is provided to any funder.

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

Therapy services through RACES are designed to *increase feelings of well-being*, *decrease PTSD and other trauma-related symptoms*, and *provide clients with tools that foster self-care and resilience*. The **Impact of Event Scale (IES-R), completed by the client and therapist,** is used to establish base levels of wellness and help guide the work with clients. All RACES' therapists work on service plans with their clients at intake and every six months thereafter and have incorporated the IES-R assessments into their service plans with the funding received from CCMHB. Trauma recovery is a process, and clients may have times when they feel like they have made more progress than others.

Table 1: Comparison of last two years of evaluation

	FY24	FY25
# Clients	37	62
Lowest Score	4	4
Highest Score	72	76
Avg. Q1	36.7	45.95
Avg. Q4	52.8	38.22
Avg. Inc/dec	43.87%	**16.82%**
# increase	2	5
# decrease	2	13
Only 1 score	33	44
% 1 score clients	89.19%	93.55%

In FY24, 37 clients completed the IES-R. Out of a possible score of 88, the lowest score recorded was 4, very low symptoms of PTSD, versus the highest recorded score of 72. Averaging the scores submitted in Q1 with Q4, FY24 clients indicated an average increase in symptoms, but only four clients completed more than one evaluation. Of those four, two showed an increase in symptoms and two showed a decrease in symptoms.
In FY25, 62 clients completed the evaluations, with the lowest score being 4 and the highest 76. Averaging Q1 with Q4, scores indicated a **16.82% decrease in symptoms** overall, with five clients scoring increased symptoms and 13 showing decreased symptoms.
Our interpretation of these data is that the IES-R is an effective measure of a client's symptoms and therapeutic services help reduce those symptoms over time. It is not atypical for symptoms to worsen as clients initially dive into experiences of trauma and then get better as they process this harm. RACES' data reflects this expectation.

RACES attempts to gather information from all therapy clients but recognizes that agency is important in the process of healing from sexual violence and, therefore, will not force clients to complete this tool if there is another trauma-informed option for assessing their progress, as determined by the client and their therapist.

Outcome #2

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? Est. 170; Year-end: 94 clients received 1,885 therapeutic sessions during FY25, counted as unduplicated participants, averaging 20.1 sessions for each client. Each participant may have as many appointments deemed therapeutic

between client and therapist. The lower total number of clients served is primarily related to the fact that clients stayed with the agency for longer than estimated, but staff turnover also was a contributing factor.

2. *For each of the following questions, if there are different responses per outcome, please identify the numbered outcome and the relevant detail.*
    3. If outcome information was NOT gathered from every participant, how did you choose who to collect outcome information from?
    Outcome 1: RACES' therapists attempt to gather outcome information from every participant, but by mandate do not force clients to complete this tool (IES-R assessment).

    4. How many people did you *attempt* to collect outcome information from? 9 4
    5. How many people did you *actually* collect outcome information from? 6 2
    6. How often and when was this information collected? *(e.g. 1x a year in the spring; at client intake and discharge, etc)*
    IES-Rs are implemented at six months after initiating therapy and every six months thereafter.

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.*

Please see assessment information under the Consumer Outcomes section.

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: Rape Advocacy, Counseling, and Education Services
Program Name: Sexual Violence Prevention Education
Program Year: FY25

CONSUMER ACCESS

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

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

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

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

4. Compare year-end actual result with the application estimate of days from completed assessment to start of services. Comment on findings, especially if unexpected.
   Estimated: 8.
   Year End result: 8. Educational programs can be scheduled up to a year in advance of students receiving programming. Most requests to schedule programming receive a response within three 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: 80%
   Result: 100%. During FY25, 15 schools in Champaign County received 515 presentations serving 2581 students.

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: School programs consist of 3-4 sessions, depending on the program and/or modality (synchronous, asynchronous). Adult programming is typically one session.

Year End Result: Sessions run 30 minutes to one hour. Presentations accounted for more than 600 hours of staff conduct hours, not including preparation hours or travel.

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. Application: Our data collection includes the zip code of the school or organization where the presentation takes place. Due to the fact that this service is provided to large groups often over multiple sessions, we cannot collect data on race, ethnicity, age, and gender. Response: We do collect town name and county, as well, to distinguish between the in-county and out-of-county services. Other grants RACES has received ask for town and county data.

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.

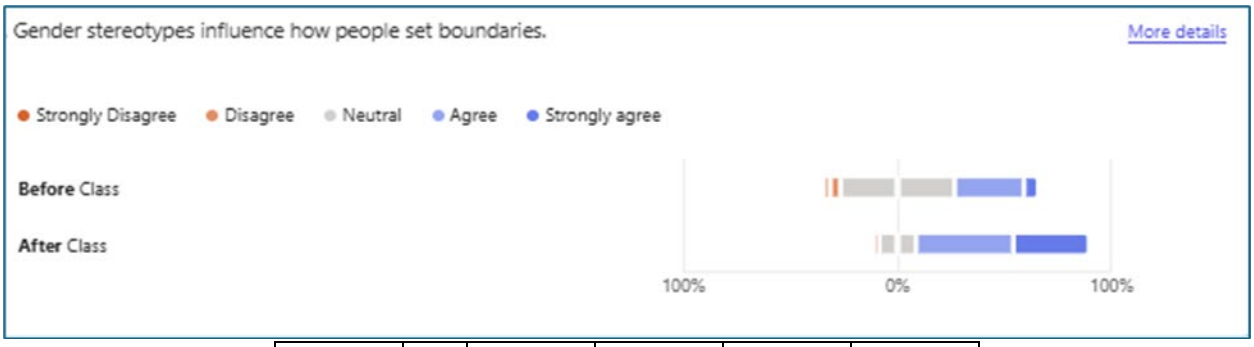
- Use (and expand) the space below to copy each numbered **Outcome** (expected program impact on participants) from your Program Plan. Include the specific **target** and add the **actual result**.
- For each outcome, list the specific **assessment tool** used to collect information. *If different from 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)."*
-

Application: RACES uses age appropriate pre- and post-tests to measure three key outcomes. Tools used for preschool and elementary school participants are designed to measure progress related to outcomes #1 and #3. Tools used for middle school and high school measure changes related to all three outcomes.

At the first session, students take a pre-test to gauge their knowledge or beliefs prior to receiving programming. At the last session, students take a post-test, assessing content knowledge gained or a change in attitude toward the subject, assessing absorption of the material presented.

For grades 6-12 pre- and post-tests, a Likert scale determined the change in attitude vs. content knowledge, indicating better understanding of concepts presented. Ex. 6.7% of 6th graders strongly agreed that gender stereotypes influence how people set boundaries

before the agency's programming. After four sessions, 35.4% strongly agreed, a 438% increase, demonstrating deeper understanding of the concept.

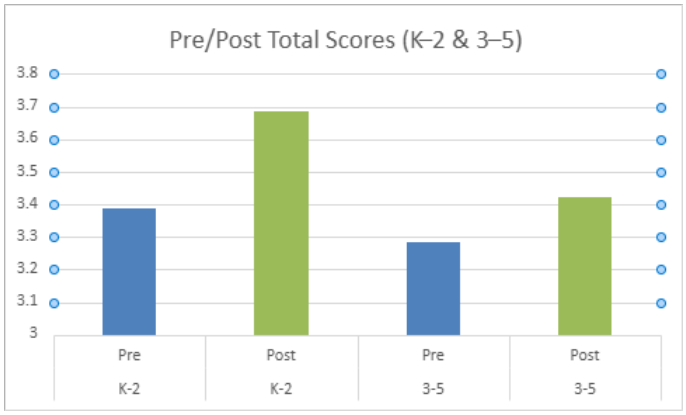


Before	SA	6.70%	After	SA	35.40%

Outcome #1

Knowledge gained. The goal is to increase knowledge.

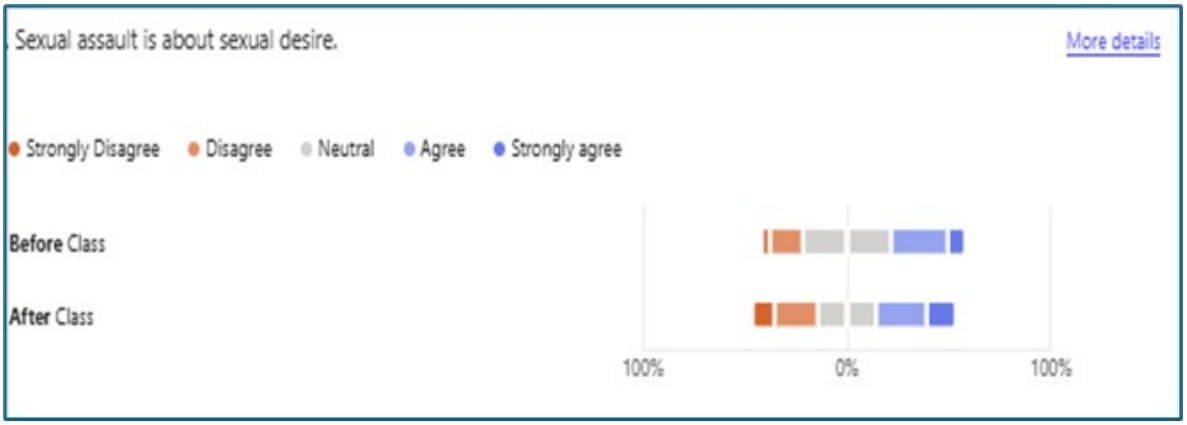
Grade	Type	Total Score	Increase %
K-2	Pre	3.387470998	
K-2	Post	3.683862434	8.75%
3-5	Pre	3.284153005	
3-5	Post	3.422222222	4.20%



For K-2 and 3-5 grades, pre- and post-tests showed an increase in comprehension (content knowledge) of 8.75% among K-2 and a lower 4.2% increase among the 3-5 grades, indicating retention of material presented to them as K-2 students.

Outcome #2

Attitude change related to risk factors. Goal: Decreased acceptance of measures related to risk factors.



Q9	Before		After
N	43.20%	N	28.50%
A	27.80%	A	24.80%

This question indicates the risk factor of assuming sexual desire leads to sexual assault. Studies show that sexual violence is not about desire, but rather, power and control. It is a difficult concept for teens to understand; however, while 43.20% of students responded neutral about the question in the pre-test, only 28.5% were neutral about it at the post-test, a 34.03% decrease, meaning that 34% more students understood that desire is **not** part of what drives sexual assault. And, of those who agreed with the statement in the beginning, 11% less agreed with it at the post-test.

Outcome #3

Attitude change related to protective factors. Goal: Increased acceptance of measures related to protective factors.

As noted in the chart and table below, only 25% of the students strongly agreed with the statement before the sessions. After the sessions, 41.4% of students strongly agreed that they knew of sources for supporting survivors, an increase of 65%.

Q9	Before		After
SA	25.00%	SA	41.40%

CONSUMER PARTICIPATION IN DATA COLLECTION

1. How many total participants did the program have? In Champaign County, 5439 students participated in FY25. We served 6039 in our service area.

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 from students present on the first day of programming and the last day of programming for each session presented. Because pre- and post-tests were anonymous, there is no way to determine who was present or absent on those days to correlate each pre-test with a post-test.

3. How many people did you *attempt* to collect outcome information from? 5439

4. How many people did you *actually* collect outcome information from? 5439

5. How often and when was this information collected? *(e.g. 1x a year in the spring; at client intake and discharge, etc)*
   Pre-tests were given at the beginning of each program session; post-tests were given following the conclusion of each program session. Two data collections were made for each program presented.

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 outcomes received from the pre- and post-tests indicate that through our programming, we are making a difference in general attitudes about sexual violence as unacceptable behavior. The questions in the pre/post-tests measure attitudes, so we look for an overall absorption of the concepts, rather than a certain percentage increase or decrease. Our efforts are to increase attitudes about protective factors and reduce those relating to risk factors in the overall goal of ending sexual violence.

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.
   RACES is unable to respond to this question due to our confidentiality policy.

3. OPTIONAL: In what ways has the evaluation supported the current practice or changes in practice? What changes were made or are planned, based on findings?
   Each year, we continue to refine the language of the evaluations to make it more understandable and less open to interpretation, helping to more clearly define the difference between a risk factor and a protective factor.

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: PY2025

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.
   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: Average 166 days, within the estimated time frame.

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

"100% of those seeking information, assistance with applications, or referral will receive an appointment for services." 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

"Clients seeking services will be offered an appointment within 5 business days of referral, call, or walk-in." Actual: 83% 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

"100% of eligible clients will be assisted with benefits acquisition." 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

"600 contacts to assist clients with benefits acquisition will be completed annually." 521 contacts to assist clients were made in PY25. 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? 167

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? 167
4. How many people did you *actually* collect outcome information from? 167
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 continues to successfully provide clients with timely access to benefits case management services. Recruitment and retention rates by racial and ethnic group remain consistent with outpatient service demographics, with 37% of clients identifying as Black/African American and 63% as White. Data from the Benefits Referral and Tracking Worksheets, supported by qualitative observations from the Benefits Case Manager, indicate that processing times for disability claims through the State of Illinois have continued to

lengthen, with many clients waiting 12 to 18 months or longer for a determination.Contact volume in PY25 has remained steady compared to PY24, reflecting the persistent need for accessible care regardless of financial status. These trends further underscore the importance of ongoing outreach and education to ensure that community members are aware of the benefits and services available to them.

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) & Diversion Center

Program Year: PY2025

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.
   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: 65%. Actual: Of those referrals received, 72% of individuals opted to continue beyond the assessment for further services deemed appropriate.

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: Average 45 days. 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

"Increase individual's capacity to engage in treatment and/or access resources, as shown on improvement in score on Self-Sufficiency Matrix." Rosecrance continued to collect data through their "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 FY25 showed overall improvement in the participants perception of their emotional state after the interaction with a CCRT responder from 1.4 to 3.2.

Outcome #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." Only 6% of encounters 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? 192

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? 192
4. How many people did you *actually* collect outcome information from? 192
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 indicates that participants report improved emotional well-being following interactions with CCRT responders, which supports ongoing program engagement and openness to additional treatment services. The data also shows that Crisis Co-Response services help reduce repeat law enforcement calls for behavioral health crises, easing the demand on 911 dispatch and EMS responders.

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 & Family

Program Year: PY2025

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.
   Estimate: 7 days. Actual: Average 26 days. Due to turnover among staff the average time from assessment to start of services was delayed. 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.

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: 75%. Actual: 100%. Data reported was over 6 months as the contract was discontinued following Q2 of 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.
   Estimate: 120 days. Actual: 211 days. Outpatient counseling plans are set for 180 days before reassessment, though the average length of stay is 6–12 months. Many youth

and families remained engaged longer than expected, which supports better outcomes but limits capacity 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.
   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

"Clients will show improvement in overall functioning level." Actual: 66% of the participants showed improvement in CGAS, 0% showed a decline, and 33% 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

"Clients will show improvement common problems reported by the client." 66% of the participants evaluated at 6-month and/or at discharge showed improvement on the Ohio Scale Problem/symptom severity. 0% showed a decline, and 33% 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

"Clients will show improvement in level of functioning in a variety of areas of daily activity (e.g., interpersonal relationships, recreation, self-direction, and motivation)." 66% of the participants evaluated at 6-month and/or at discharge showed improvement on the Ohio Scale Problem/symptom severity. 0% showed a decline, and 33% 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

"Clients will show improvement or no increase in the severity and immediacy of suicide risk." 66% of the participants evaluated at 6-month and/or at discharge showed improvement on the Ohio Scale Problem/symptom severity. 0% showed a decline, and 33% 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? 7 TPC_____

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? 7 TPC_____
4. How many people did you *actually* collect outcome information from? 3 TPC_____
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 could not be collected from newer participants who had not yet reached their first six-month reassessment during Q1&Q2 of PY25, as well as from participants or families who declined to complete the scales or did not return the forms. Furthermore, data could not be collected from those participants who discontinued services against medical advice or stopped engaging in services. Data collection is attempted at intake, six-month reassessment, 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.*

Participants are remaining in the program longer than expected, which is generally positive since moderate to longer stays are often linked to stronger long-term behavioral health outcomes. Although the sample size was smaller than anticipated due to the circumstances noted above, the data still shows evidence of participant improvement through engagement in treatment. Additionally, due to the small sample size to gather data from over the shortened program duration (6 months versus 1 year), the data shared may not be an accurate reflection of participant progress.

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: PY2025

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.

   Estimate: 20 days. Actual: Average of 12 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.

   Estimate: 70% . Actual: 81%

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: 5 months. Actual: Average 142 days. 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 client's access to: groups, housing, employment, education, insurance, other benefits, primary care, MH/SUD treatment, transportation, or other." All individuals engaged with the program were provided linkages to MRT and Anger Management group services, Housing, Employment, Education, Insurance, Primary Care, behavioral health (mental health and substance use disorders treatment), and other benefits.

Outcome #2

"Data on length of stay in jail for people with MI or cooccurring disorders." Average LOS for MI/COD: 93 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? 229

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 were unable to determine the number of jail slip requests completed during Q4 accurately as the staff member who was tracking this left the agency without leaving us the numbers.

3. How many people did you *attempt* to collect outcome information from? 229
4. How many people did you *actually* collect outcome information from? 229
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. We were unable to determine the number of jail slip requests completed in Quarter 4, as the staff member responsible for tracking this information left the agency without leaving corresponding records. As a result, the total number of program participants reported does not accurately reflect the number actually served. 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: Recovery Home

Program Year: PY2025

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.
   Estimate: 20 days. Actual: Average 17 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.
   Estimate: 70%. Actual: 70%

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: 124 days. Within 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

"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 linked with at least one resource identified on their individual service plans while in the program.

Outcome #2

"Step down to less intensive services" 73% of clients stepped down to less intensive services. This is tracked through our EHR records. Information is gathered from the client, the clinician working with them, and other program staff.

Outcome #3

"Secured housing" 44% 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" 74% 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? 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?

3. How many people did you *attempt* to collect outcome information from? 14
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 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 assess progress from admission to discharge by regularly reviewing service plans with clients, monitoring behaviors in the recovery home, tracking engagement in support groups, and evaluating employment status. Clients who actively participate in support groups, maintain employment, and remain in the program for longer periods consistently demonstrate more favorable outcomes than those who do 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: PY2025

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.
   Estimate: 3 days. Actual: 26 days. Data collected only across Q1 & Q2

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: 45%. Actual: 14%. Data collected only across Q1 & Q2

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: Avg 1.5 years. Actual: 58 days. Data collected only across Q1 & Q2

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

"15 graduates" Actual: 2. Data collected was only during Q1 & Q2, so fall graduation was the only data collected.

Outcome #2

"65% of graduates will not experience recidivism" Actual: No data could be gathered due to the shortened window of time.

Outcome #3

"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? 10

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

During Q1 and Q2, staff were able to provide 111 hours of case management for our 10 participants. This includes staff hours spent transporting clients, helping clients to access and engage with other community resources, and complete tasks relevant to treatment on the client's behalf. This increased linkage to resources contributes to the continued success in low recidivism rates over time. Additionally, the Champaign County website reports that Drug Court graduates remain crime-free for at least four years after completing the program. It also notes that while incarceration costs taxpayers about $24,000 per person annually, treatment through Drug Court costs roughly $5,000 per year—resulting in a community savings of approximately $19,000 per participant each year.

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: **Uniting Pride**
Program Name: **Children, Youth, and Families Programs**
Program Year: **PY2025**

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. Our eligibility framework—open to LGBTQ+ individuals as well as allies and professionals seeking education about LGBTQ+ communities—continues to function effectively. This approach ensures that services reach both those who directly identify within the community and those in positions to foster affirming environments around them.

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. Because participation is self-determined, individuals enter programming with clear awareness of what they seek and how it aligns with what we offer. This self-selection process has proven straightforward and highly effective.

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. While outreach strategies have broadly succeeded, we continue working to better engage populations historically underrepresented in our programs. The Youth and Family Manager outreach and engagement position completed its first full year in February and has

established a foundation for connecting with and supporting BIPOC youth. This work has included expanding education and resources centered on QPOC experiences, strengthening relationships with organizations that primarily serve BIPOC communities, and initiating a partnership with Don Moyer Boys and Girls Club. Through this partnership, we aim to provide affirming support for queer youth within their programs while also broadening the reach of our youth services. These efforts represent significant strides in building sustainable infrastructure for more equitable and inclusive outreach. Additionally, staff and Board have been reevaluating program outreach efforts and program infrastructure to adapt to growing need and support community members who may face increased barriers to accessing services due to increased attacks on our community.

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 waiting period between a person's expression of interest and their ability to participate. The only exceptions occur if inquiries come outside of business hours or if a program they wish to join is scheduled for a future date. In these instances, participants are connected as soon as feasible.

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.

Consistent with the above, engagement occurs immediately upon eligibility. As a result, we report a near-100% rate of eligible individuals accessing services without delay. Clients with delayed access to services are generally not delayed more than 48-72 hours (on weekends or periods of office closure for example).

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 length of participation varies widely depending on the type of program. Single-session events like workshops or seminars draw one-time attendance, while recurring groups sustain engagement for an average of one year. Some participants remain connected for multiple years, while others attend more intermittently, often during periods of personal crisis. This flexibility allows participants to engage at the level and duration most appropriate for their needs.

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

In addition to standard demographic categories, we collect more nuanced data on sexual orientation. These data points allow us to tailor program development and delivery to the specific needs of LGBTQ+ individuals, ensuring that offerings remain affirming, relevant, and reflective of the community we serve.

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%.*

Participants outside of our Education Program consistently report increases in social support, with 94% of surveyed individuals noting improvement. In youth groups, supplementary interviews conducted by staff provided richer data, particularly for participants too young to reliably self-report via surveys. This hybrid model has proven highly effective and will be continued.

Training participants also demonstrated clear gains, with 100% reporting increased knowledge of LGBTQ+ issues, surpassing our initial target of 25%.

While we request that all participants across programs fill out feedback surveys, like a demographic survey, we acknowledge that some participants opt to not participate this process for a myriad of reasons. We are committed to continuing to improve our data collection methods to capture as much feedback as possible from our program participants throughout the year. In PY26 we will be implementing new strategies to connect with participants and provide more holistic outcome data to evaluate program effectiveness.

Outcome #2

For all programs besides our Education Program: ***Improved self-worth. We anticipate that improved self worth will increase by 20%.***

Surveyed participants across non-education programs reported an 85% improvement in self-worth, exceeding our target of 20%. Youth group interviews again validated and deepened these findings. Training participants demonstrated exceptional outcomes, with 100% reporting improved confidence in creating LGBTQ+-affirming spaces, well above the projected increase.

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? **375**

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?

Feedback collection occurs biannually for groups, following Pride Fest, and after each training session.

Participation rates in surveys remain lower than desired. Many community members express concern about data security and potential misuse of identifying information, particularly given recent anti-LGBTQ+ legislation across the country. New residents who relocated here from states with restrictive laws shared particular hesitancy, citing lived experiences of surveillance and discrimination. For this reason, UP has chosen to maintain optional reporting, recognizing that mandatory data collection could create barriers to service access.

3. How many people did you *attempt* to collect outcome information from? **375**
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)*

2 times per year for our groups, once after Pride Fest, and after each program for training.

RESULTS

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

In FY25, Uniting Pride (UP) continued to expand its reach and deepen its impact across Champaign County and surrounding areas. Over the course of the year, 481 participants engaged with our programs—430 adults and 51 youth—representing a wide range of racial and ethnic backgrounds. 375 of those participants came from Champaign County with 232 adults and 143 youth participants engaging with our services. What stands out most from this year's data is the consistent feedback that UP programs provide a vital sense of belonging, affirmation, and peer support for LGBTQ+ community members who often report feeling isolated due to

external pressures, safety concerns, and limited access to LGBTQ+ spaces.

Participants regularly told us that involvement in UP programs strengthened their sense of community. Many described feeling “seen,” “heard,” and free to be themselves in ways they had not experienced elsewhere. New and expanded programs—including Camp Kaleidoscope, Queer Prom, the Clothing Closet, and the Binder & Waist Cincher program—saw significant increases in attendance, highlighting both growing visibility and ongoing unmet need in the community.

We also saw growth in requests for referrals and information about services outside of our direct offerings**.**

We saw positive community response through multiple testimonials from our youth and families served:

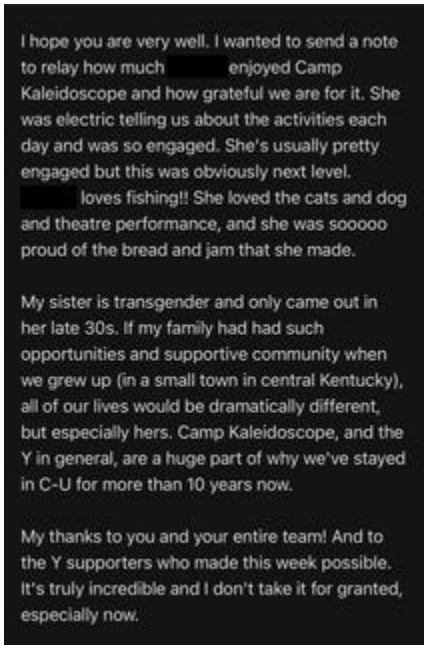
“Mom says that I’ve gotten a lot more confidence in other things… It’s been really good for me to just be myself.”

“Nothing is weird here and I can be myself… We’re, like, even closer now.”

“I didn’t have other spaces with queer and trans kids in them… I definitely made friends!”

“It’s great to see community come together and feel good and be who they want to be without judgment.”

One particular testimonial from our second year of Camp Kaleidoscope stood out to us as emblematic of why we do this work:



I hope you are very well. I wanted to send a note to relay how much [redacted] enjoyed Camp Kaleidoscope and how grateful we are for it. She was electric telling us about the activities each day and was so engaged. She's usually pretty engaged but this was obviously next level. [redacted] loves fishing!! She loved the cats and dog and theatre performance, and she was sooooo proud of the bread and jam that she made.

My sister is transgender and only came out in her late 30s. If my family had had such opportunities and supportive community when we grew up (in a small town in central Kentucky), all of our lives would be dramatically different, but especially hers. Camp Kaleidoscope, and the Y in general, are a huge part of why we've stayed in C-U for more than 10 years now.

My thanks to you and your entire team! And to the Y supporters who made this week possible. It's truly incredible and I don't take it for granted, especially now.

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.

Highly Engaged Participant

Participant A came out to their parents and a supportive teacher, who connected them with the school GSA and, subsequently, with Uniting Pride staff. Through conversations with the Talk It UP facilitator and guidance from the Youth and Family Manager, Participant A began attending the group regularly. These structured conversations provided a safe space to explore their identity, build confidence, and navigate challenges in school and at home.

Participant A's engagement deepened over time, expanding to participation in Queer Prom, workshops, and the annual Pride Festival and Parade. Their parents, seeking guidance on how to best support their child, were referred to UParent. Through conversations with the Family Manager and participation in UParent sessions, the parents learned strategies to provide affirming support, connected with other families, and accessed inclusive healthcare and community resources. The combined support for both Participant A and their family helped strengthen self-esteem, empowerment, and family cohesion.

Selectively Involved Participant

Participant B is questioning their gender identity but has not come out to family or peers. They reached out privately via Uniting Pride's social media and were connected with the Talk It UP facilitator and Youth and Family Manager. Through ongoing conversations, Participant B learned about available supports and began attending the group monthly.

While Participant B is not yet ready to disclose their identity outside of the group, these facilitated discussions have created a safe, structured space to ask questions, build peer connections, and explore their identity at their own pace. Participant B reports that knowing these supports are available has reduced isolation and provided a reliable touchpoint for navigating uncertainty around gender identity.

Parent-Focused Participant

Participant C came to Uniting Pride in the early stages of their child's coming out, experiencing significant grief and uncertainty. They did not know how to support their LGBTQ+ child and sought guidance on understanding LGBTQ+ identities, addressing internalized stereotypes, and creating a safe environment at home. Through conversations with the Youth and Family Manager and participation in UParent, Participant C received education, practical tools, and peer support for navigating these challenges.

Simultaneously, Participant C's child accessed Talk It UP and other youth-focused programs, providing both parent and child with parallel supportive spaces. Over time, the family has

maintained a strong relationship despite starting from very different places, with both parent and child gaining confidence, understanding, and strategies to communicate openly and affirm each other's identities. This case highlights the importance of dual access to family and youth support services in fostering resilience and connection.

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 year, UP continued to expand outreach to better serve BIPOC community members through our newest staff position. Community feedback also guided us in sunsetting less effective programs and launching new ones, keeping our offerings aligned with evolving needs.

Additionally, interview-based evaluation for youth programming has strengthened our data collection process, capturing perspectives that surveys alone often miss. This blended evaluation strategy will remain a core practice going forward.

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: Community Support ReEntry Homes

Program Year: 2025

CONSUMER ACCESS

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

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

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.

WIN Recovery ensured that 100% of eligible clients were engaged in services within the designated timeframe, unless they independently sought assistance prior to their release or discharge date. Clients received immediate support upon release or discharge from an institution or facility, guaranteeing timely access to essential services and a seamless transition into community-based care.

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 WIN Recovery's transitional housing for 275 to 365 days. The length of stay is determined by each individual's mental health stability, economic readiness, and overall progress toward independent living. This flexible approach ensures that clients receive the time and support needed to achieve long-term stability and self-sufficiency.

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

Objective:	Assessment Tool Used:	Information Source:	Outcome
Maintain Sobriety	**Informal Checklist through Client Interviews during Case Management**	**Clients**	**18**
Mental/Behavioral Health Services	**Informal Checklist and Client Interviews during Case Management & Certificates of Completion**	**Clients & Counselors**	**22**
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**	**8**
Obtain Employment	**Informal Checklist and Client Interviews during**	**Client**	**10**

	Case Management		
Assess to Education	**Informal Checklist and Client Interviews during Case Management**	**Client**	**15**
Family Reunification	**Informal Checklist through Case Management**	**Client**	**6**
Program Completion	**Informal Checklist during Case Management**	**Case Management**	**22 Continuum Services**
No Recidivism	**Developed Internal Tool to track & trend reoccurring criminal justice system involvement**	**IDOC Records Illinois State County Circuit Clerk Databases**	**22**

Outcome #3

WIN Recovery employs a client-centered approach to assess program outcomes, using intake assessments, internal checklists, and informal interviews to track progress. Staff create personalized plans and continuously monitor clients over a 9- to 12-month period. Through this approach, clients achieve housing stability, maintain sobriety, comply with probation or parole, make progress toward self-identified goals, and, when applicable, reunify with family**.** Clear communication and personalized support foster strong engagement, and the Client Coordinator ensures plans stay aligned with client needs. As a result, WIN Recovery successfully reaches its intended outcomes**,** demonstrating measurable and meaningful impact on clients' lives.

CONSUMER PARTICIPATION IN DATA COLLECTION

1. How many total participants did the program have? ___22_____

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 according to each participants self identified milestone plan

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. We also continue to take information from individuals that still receive program assistance from us even though they are no longer living in the Community Homes, due to our program being a continuum amount of services.

RESULTS

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

WIN Recovery takes a comprehensive and adaptable approach to evaluating client progress and program effectiveness. Because traditional benchmarks do not always capture the varied experiences of participants, the organization relies on customized tools—such as internal checklists and questionnaires—that allow assessments to reflect each client's specific situation.

Client growth is monitored consistently through weekly case management sessions, where accomplishments and challenges are reviewed. This ongoing process captures progress as it happens, giving staff the flexibility to respond quickly to shifting needs.

At the start of the program, an intake assessment establishes a baseline by identifying needs and priorities. From this foundation, individualized service plans are created, with clearly defined goals that serve as a guide throughout participation. To track development over time, WIN Recovery also uses phased assessments at different stages of the program's 9- to 12-month duration, offering a clear picture of each client's journey.

Patterns emerging from these evaluations have provided valuable insights. For example, clients who enter the program through mandated referrals often remain longer, likely due to the accountability built into their requirements. Similarly, clients who recognize that WIN Recovery offers more than housing—such as wraparound support and long-term stability planning—tend to engage more deeply and extend their stay. These findings highlight how both external motivators and effective communication influence commitment.

By applying these lessons, WIN Recovery has refined its evaluation process to be both client-centered and outcome-driven. The organization is able to deliver tailored support, track meaningful change, and demonstrate the full impact of its holistic model.

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?