



An Evaluation of the Caring Community Initiative of the Leaders Roundtable

Prepared for

The Leaders Roundtable

Prepared by

Beth L. Green, Ph.D.

Northwest Professional Consortium, Inc.

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Beth L. Green, Ph.D.
Northwest Professional Consortium, Inc.
5200 SW Macadam Ave., Ste. 420
Portland, Oregon 97201
503/ 243-2436
503/ 243-2454 (fax)
green@npcresearch.com

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Executive Summary

The purpose of this evaluation was to describe the Caring Community Initiative, and to evaluate its accomplishments in terms of:

- *Organizational Effectiveness,*
- *Systems Integration, and*
- *Community Engagement.*

This report summarizes the evaluation of the Caring Community Initiative (CCI) conducted by the Northwest Professional Consortium through a contract with Multnomah County and the Leaders Roundtable. This is the first evaluation of the CCI since its inception in 1991. Data were

collected between November 1998 and July 1999 through a variety of qualitative and quantitative methods, including Key Stakeholder interviews, mail surveys, focus groups, and document review.

What is a Caring Community?

The definition below, taken from the Leaders Roundtable Caring Community Suggested Operating Guidelines (1997) highlights some of the key elements of the CCI:

- Community-based, multi-disciplinary teams,

"A Caring Community is....

.....a community-based team working within a specific geographic area (usually defined by school boundaries) whose objective is to engage families, schools, youth, human service and community agencies, governments, businesses, and other community support organizations in actions that lead to collaborative, interactive service delivery for individuals, children and families."

- Working on a variety of community issues and problems,
- With a shared philosophy of enhancing existing services and resources,
- Leading to enhanced outcomes for children and families.

Currently, eight individual Caring Communities are supported through the CCI: East County Caring Community; Grant-Madison Caring Community; Inner Southeast Caring Community; Jefferson Caring Community; Mid-County Caring Community; Caring Community of North Portland; Outer Southeast Caring Community; and West District Caring Community.

Goals of the Caring Community are listed below. In addition to these three overarching goals,

The three shared goals of the Caring Community Initiative are:

1. *Enhancing systems integration and coordination.*
2. *Helping communities achieve 100% school completion for all students.*
3. *Building and strengthening communities.*

there are a number of other goals that are held by individual Caring Communities. This diverse array of goals is both a strength and a challenge of the CCI. While community based goal-setting and decision-making support the goal of building and strengthening communities, it has also meant that there is tremendous variation between the eight Caring Communities in terms of specific activities and desired outcomes.

Funding for the infrastructure of the Caring Communities comes from a variety of sources. In 1998–99, Multnomah County provided \$268,000, which was evenly distributed between the eight Caring Communities. Two of the Caring Communities also received state Department of Human Resources funding totaling \$56,000. Additional sources of core funding include school districts, the City of Portland, the City of Gresham, and others. In-kind support from a variety of sources is also critically important to the Caring Communities. ***It is important to note that core funding, such as that provided by the county, has only been available for all eight of the Caring Communities since July 1, 1998.***

What Has the Caring Community Initiative Accomplished?

The evaluation focused on four primary outcomes: (1) Organizational Effectiveness; (2) Systems Integration; (3) Community Engagement; and (4) Other specific accomplishments.

Key Outcome #1: Organizational Effectiveness

Establishing an effective organizational structure is one of the keys to success for community collaborative groups (Kumpfer, 1993). Results suggest that the CCI has had considerable success in supporting the individual Caring Communities to become viable organizational entities. Four key indicators of organizational effectiveness that characterize the CCI are:

"Some of the Caring Communities have really been able to bring people to the table, and keep them there to work on social problem-solving....."

Key Stakeholder

- 1) *Engagement of a variety of community partners*, most notably the schools, social and health services providers, and public safety;
- 2) *Consistently high levels of member commitment* to the Caring Community and its work;
- 3) *Strong leadership*, including the coordinators, chairpersons, and action team/subcommittee leaders; and
- 4) *Effective communication with members*, especially in terms of responsiveness to individual requests.

All four of these indicators have been shown to be associated with improved productivity in community collaborative groups (Kegler, Steckler, Malek, & McLeroy, 1998).

Key Outcome #2: Systems Integration

Three types of systems integration can be distinguished: (1) *policy level systems integration*,

Evaluation findings suggest that Caring Communities have resulted in:

- *Significant improvements* in coordination and collaboration between providers;
- *Some improvements* in individual client-level service coordination; and
- *Fewer changes* in policy-level systems integration.

including changes in policy, service districts, and regulations to allow better integration of services; (2) *provider level systems integration*, which involves collaboration and coordination of an array of services within a community; and (3) *client level services integration*, which involves integrating services provided to a given client (Kusserow, 1991). Survey results suggest that there have been some significant

improvements in both individual and provider-level integration, such as the number of referrals, amount of joint planning, number of joint projects, and opportunities to share resources. Moreover, when asked to identify the most important accomplishments of the CCI, almost all Key Stakeholders mentioned improvements in provider-level systems integration and coordination. One of the major provider-level service integration successes of the Caring Communities has been their involvement in planning and establishing the Family Resource Centers. There have been fewer changes in policy-level systems integration, which has been found to be an extremely difficult outcome to achieve (Kusserow, 1991).

Key Outcome #3: Community Engagement

Evaluation results suggest that while the Caring Communities have made some progress in

Caring Communities were perceived by survey respondents to have:

- *High levels* of participation by social services and schools;
- *Moderate levels* of participation by recreational providers, the faith community, employment/business, public safety, youth, and government officials; and
- *Relatively low levels* of participation by transportation and housing providers, parents, and general residents.

reaching out to the non-service provider community, there still is room for improvement in this area. The specific non-provider groups who are absent differ depending on the specific Caring Community, although community residents and transportation providers were perceived as being absent from most Caring Communities. Many of the Caring Communities have only recently begun to shift towards a broader community focus. This shift will no doubt take time, and will require additional discussion and clarification of how this emphasis fits with existing Caring Community goals and activities. Progress

towards increasing community engagement has already occurred through some of the activities of the Caring Communities. Specifically, some of the Caring Communities have been involved in developing projects through the Community Building Initiative, and in convening community meetings to discuss issues such as county budgets, neighborhood violence prevention, and other topics.

The ability of Caring Communities to be responsive to neighborhood needs is another key indicator of how well Caring Communities are connected to the communities. Currently, there are many examples of Caring Communities acting in ways that are responsive to community input; however, more systematic ways of engaging the broader community in defining these needs and developing ways to respond will be increasingly important, given the new emphasis on community resident engagement.

Key Outcome #4: Other Accomplishments

Because each individual Caring Community is engaged in such a wide variety of activities, there are a number of other achievements that do not easily fit within any of the major categories defined by the Initiative as a whole. Examples of these accomplishments include:

- Facilitating the Take the Time Assets surveys and mini-grants;
- Planning and/or facilitating health fairs, health and immunization screenings and health clinics;
- Working to support the School Attendance Initiative; and
- Facilitating volunteer support to a variety of mentoring and tutoring programs for youth.

These project-specific accomplishments are a large part of the ongoing work of the Caring Communities.

What are the Remaining Issues for the Caring Community?

Results of this evaluation highlighted six key issues that need to be addressed in order to strengthen the CCI. These include: (1) Funding and Sustainability; (2) Organizational and Structural Issues; (3) Clarification of Goals; (4) Visibility; (5) Accountability; and (6) Support and Technical Assistance.

Key Issue #1: Funding and Sustainability

Without doubt, one of the biggest challenges facing the Caring Communities is how to ensure ongoing support for coordination. The role of the coordinator is central to Caring Community effectiveness; the importance of paid staff to collaborative efforts has been documented (Kegler et al., 1998). Core funding from Multnomah County helps to pay part of the coordinator's salary; however, many of the coordinators need to actively pursue other grants and funding sources to

support their work. In addition to funding for the coordinator, some of the Caring Communities lack a variety of other resources that could contribute to their productivity, such as support staff and hardware and software resources and support. Finally, additional funds for Caring Community-sponsored events and activities are generally in short supply, although many of the Caring Communities have had at least some success finding or leveraging resources.

Key Stakeholders agreed:

Sustained funding for coordination is one of the biggest challenges for the Caring Community Initiative.

Key Issue #2: Organizational and Structural Issues

Although the Caring Communities have many of the desired characteristics of effective organizations, there is some room for improvement. In particular, the individual Caring Communities need to work to:

- Develop clear and defined decision-making procedures.
- Develop and clarify a shared vision, goals and outcomes, and establish clear means for achieving them (see below).
- Enhance the timeliness and usefulness of coordinator communication regarding meetings and other general information.
- Develop mechanisms to ease problems associated with staff and member turnover.
- Develop ways to address the challenge of serving large, diverse, and often geographically defined “communities” rather than naturally existing “neighborhoods.”
- Ensure that discussion and planning moves efficiently towards action.

Future evaluation should make efforts to document that these organizational systems are in place for each Caring Community. Further, the CCI may want to consider including resident engagement in the Caring Communities as an important criteria for organizational effectiveness, given the new emphasis on community building.

Key Issue #3: Clarification of Goals

Several issues related to clarifying the goals and realistic expectations for the Caring Communities became apparent during the course of the evaluation. These issues, and possible strategies for resolving them, are discussed below.

3A. Merging of Systems Integration Goals with Community Building Goals

Further discussion and clarification of the underlying assumptions and expected outcomes for community engagement should occur before realistic outcomes can be established for this domain. Additionally, the implications of the shift towards a broader community focus for the

A process is needed for ensuring that the progress made in systems integration is not lost with the shift towards broader community engagement.

systems integration mission of the Caring Communities should be explored. The needs and interests of the service provider community in terms of information sharing, collaborative planning, etc., may be quite different than the needs, interests, and priorities of community residents.

3B. Appropriateness of School Completion Goal

Although a common goal uniting the different Caring Communities is 100 percent school completion, there is reason to question whether this is an appropriate or meaningful goal. Many of the Caring Communities are not engaged in activities that might be expected to have direct or

School completion is an extremely long-term goal for most Caring Community activities. It is unrealistic to expect any immediate changes in this outcome as a result of the Caring Community Initiative.

immediate effects on school completion. Instead, many of their activities are importantly *but indirectly* related to rates of school completion, such as early childhood prevention programs. Other programs, such as the School Attendance Initiative, are investing considerable resources in

activities designed to directly impact school completion outcomes; however, this outcome is difficult to impact even for these more focused programs. The goal of school completion is only appropriate if it is clearly understood that holding the CCI accountable for achieving this outcome is probably not realistic.

3C. Top-Down vs. Grass-Roots Goal Setting

In defining goals for the Caring Communities, one recurring issue is finding a balance between

The Caring Community Initiative may want to institute better systems for ensuring close, strong linkages between Initiative-wide goals and local objectives and activities.

goals that are established in a “top-down” fashion by policymakers and funders versus those goals that stem from grass roots community level concerns. While community level decision making is important, and in fact, having a high level of local ownership regarding

goals and activities has been found to be associated with the productivity of collaborative groups (Kegler et al., 1998), this does lead to diffusion and variability across the individual Caring Communities.

One compromise might be to work towards consensus about a set of parameters within which action teams can be developed and activities planned. Planned activities could then be evaluated by an Initiative-wide leadership group to determine whether the activities are adequately connected to Caring Community goals. Evaluation results suggest that some of the activities that are planned or currently ongoing bear only a tangential relationship to the Caring Communities short- and long-term goals.

Key Issue #4: Visibility of Caring Communities

Results from both Key Stakeholder interviews and Member Surveys suggest that the Caring Communities may need to increase their visibility as community organizations. Although some have

The Caring Communities should be recognized as a central part of the community services and events with which they are involved. This recognition would help to strengthen the visibility, influence, and support for the Initiative.

suggested that the Caring Communities should play a “behind the scenes” role in supporting community activities, and therefore that name recognition and visibility are not important, increased visibility may help to support the long-term sustainability of the Caring Communities.

Visibility would also be strengthened by greater involvement from key political leaders for ongoing support at the policy level.

Key Issue #5: Accountability and Documentation

Currently, each coordinator has her own idiosyncratic system for documenting and tracking

To improve accountability, the Caring Community Initiative may want to:

- *Develop a consistent way to report on the role of the Caring Communities in activities, as well as the type of activities and outputs generated;*
- *Streamline reporting systems;*
- *Consider closer monitoring of the types of activities and goals chosen by individual Caring Communities.*

information about their Caring Community. A common system for documenting and reporting activities would help to ensure accountability as well as ease the reporting burden on coordinators. One consistent aspect of the documentation process is the Caring Community workplan. During the past two years, the CCI has developed a common workplan format that is used by all Caring Communities. This workplan provides a well-organized format for reporting progress and outputs. A streamlined reporting system that is more closely linked to the workplans and which defines the types of activities to be documented might help to reduce unnecessary paperwork.

One of the challenges in documenting the Caring Communities' activities and outcomes is that the role of a Caring Community in a given project can vary considerably. A Caring Community might be centrally involved in planning, facilitating, and implementing a particular program, or they might be tangentially involved in a supportive role. Describing these different roles is important both for understanding the activities of the Caring Communities, and to make judgments about the level of accountability that is appropriate for a given program or event.

To address this, the CCI might consider developing a "typology" of activities that could be used for reporting. This approach has been used to evaluate community collaboratives of a variety of types (Mitchell, Stevenson, and Florin, 1996). Documenting the level of different kinds of collaborative group "outputs," such as the number of activities implemented, planning groups convened, or grants written, has been considered an important method for measuring their effectiveness (Kegler et al., 1998).

Key Issue #6: Support and Technical Assistance

The current system for supporting and supervising the coordinators is stretched extremely thin. Supervision for some coordinators is almost nonexistent, and organizational support is provided by

Caring Communities have significant needs for additional training and support in areas such as:

- *community organizing,*
- *public relations,*
- *documentation and reporting, and*
- *conflict resolution/mediation.*

a single person for all eight Caring Communities. With another Caring Community coming online in 1999–2000, the need for additional organizational support for the Caring Communities is particularly acute. Further, the complexity of the CCI continues to expand, further draining the existing support structure.

Centralized supervision might be a mechanism to enhance cross-community consistency; minimally, closer, ongoing supervision of the coordinators is needed.

Summary of Issues

In preparing this report, a decision was made by the Caring Communities Evaluation Team that the report would serve to raise issues for future action, rather than making concrete recommendations. It is the hope of the Evaluation Team that a subsequent working group will be developed that has responsibility for recommending concrete action steps for the Caring Communities. The following is a list of the key areas that are in need of action to support the continued improvement of the Caring Communities:

Organizational and Structural Issues

1. Systems for ensuring core funding and resources for the infrastructure of the Caring Communities.
2. Systems for ensuring high levels of organizational effectiveness (e.g., quality leadership, communication, member involvement) across all Caring Communities.
3. Improvements in the level of organizational support, accountability mechanisms, supervision, and technical assistance available to the Caring Communities.
4. Methods for increasing the visibility of the Caring Communities.

Issues Related to CCI Goals & Accountability

1. Clarification of the goals and expectations regarding community engagement and appropriate evaluation efforts to assess these goals.
2. A process for ensuring that the progress made by Caring Communities in regards to systems integration is not lost with the shift towards community engagement.
3. Consideration of the appropriateness of the school completion goal.
4. Consideration of a smaller set of Initiative-wide goals and parameters for appropriate activities, while maintaining the ability of the Caring Communities to respond to grassroots community issues.
5. Systems for ensuring that Caring Community activities are directly and appropriately related to expected outcomes.
6. Systems for improving accountability, especially in terms of understanding the Caring Communities' different roles in community events and ensuring high quality across all Caring Communities.

Conclusions

The CCI has grown and changed since its inception eight years ago. This evaluation was an attempt to describe the CCI and begin to evaluate its effectiveness. The evaluation highlights both the strengths of the CCI and areas that may need improvement. Participants in the evaluation shared both a commitment to the work of the Caring Communities as well as concerns about its future directions. The strengths of community-based action teams with strong local decision-making power were highlighted; at the same time, the need for increased consistency and quality across Caring Communities was apparent. Significant achievements in improving coordination and collaboration between community-based providers were documented, while other outcome areas, such as community engagement, need further definition before outcomes can be meaningfully established.

Additionally, the sometimes wide variation in the level of functioning on the major outcome domains (organizational effectiveness, systems integration, and community engagement) *between* individual Caring Communities makes it clear that **the success of the CCI rests upon maximizing the effectiveness of each individual Caring Community**. Efforts are needed to ensure a strong system of individualized technical and organizational support. This system should include clear, simple, measures for documenting the role of the Caring Communities in community-based projects, the links between activities and expected outcomes, and a clearly defined set of both individualized and shared outcomes.

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I. What is a Caring Community?

A. Definition

The following definition is taken from the “Suggested Caring Community Operating Guidelines” (The Leaders Roundtable, 1997). It was developed through a consensus procedure with input from the Caring Communities, Leaders Roundtable and other community partners.

Definition of a Caring Community

A Caring Community is a community-based team working within a specific geographic area (usually defined by school boundaries) whose objective is to engage families, schools, youth, human service and community agencies, governments, businesses and other community support organizations in actions that lead to collaborative, interactive service delivery for individuals, children and families. A Caring Community is committed to participating in the Leaders Roundtable Partners for a Caring Community Initiative (an effort throughout Multnomah County to help all children successfully complete their schooling with competencies for work and for post-secondary education), and to drawing upon the strengths of existing service integration efforts, with special emphasis given to addressing community and County benchmarks. **Caring Communities are open to all members of the community.** The basic premise of a Caring Community is that all sectors of the community can more effectively support individuals, children and families by collaborating, by implementing common strategies, and by utilizing existing resources in innovative ways.

B. History

The Caring Community Initiative (CCI) was started by the Leaders Roundtable in 1991 as a means to promote successful school completion. Community “roundtables” were held to bring together schools, families, human service agencies, policymakers, businesses, and other community representatives to begin a dialogue about how to accomplish 100 percent school completion. The original Caring Communities were: East County Caring Community, Outer Southeast Caring Community (formerly Marshall), the Caring Community of North Portland

(formerly Roosevelt), and the Jefferson Caring Community. Currently, there are four additional Caring Communities: Mid-County Caring Community, West District Caring Community, Inner Southeast Caring Community (formerly Cleveland), and Grant-Madison Caring Community. Although conceptualized as a single initiative, the CCI was designed to support local decision making about the nature, function, and goals of specific Caring Communities. There is, however, a shared philosophy, some shared goals, and other common elements that unite the eight different Caring Communities. Below we describe the elements common to the initiative as a whole. Following this, a brief profile of each individual Caring Community is provided. A map of the Caring Communities can be found in Appendix A, page 97.

C. Structure

The Caring Communities share a similar structure, as most hold a monthly or bimonthly meeting attended primarily by local service providers (including health, mental health, education, criminal justice, etc) that is typically focused on information sharing. These meetings are one of the primary vehicles for coordination between service providers, and are typically chaired by a volunteer member of the Caring Community. In addition to this general membership, each of the Caring Communities has a steering committee or some other executive planning group, and “action teams” or other subcommittees focused on specific activities, programs, or goals. See the Community Fact Sheets for complete listings of each Caring Community’s current action teams. Some Caring Communities have had functioning action teams for many years; others have only recently adopted an action team structure.

Action teams appear to be a useful vehicle for ensuring that activities are developed and implemented, and those Caring Communities with longstanding action teams appear to have had more success in implementing large, ongoing projects. For example, the Early Childhood Action Team has been a functioning component of the East County Caring Community since its inception in 1991. This action team is responsible for a number of large and successful initiatives, such as the collaborative health screening. Another strong action team is the Jefferson Peace Action team, which has been engaged in promoting and supporting violence prevention activities for several years. Both of these action teams are also characterized by strong, active volunteer leadership. This allows the Caring

Caring Communities with long-standing, active action teams have had more success in implementing large, ongoing projects.

Communities to engage in considerably more programs and activities than would be possible if the paid coordinators had sole responsibility for all planning and implementation.

D. Funding

Funding for to support the infrastructure of the Caring Communities comes from a variety of sources. In 1998–99, \$268,000 was provided by Multnomah County to be evenly distributed between the eight Caring Communities. Two of the Caring Communities also receive state Department of Human Resources funding totaling \$56,000. Additional sources of monetary funding include school districts, the City of Portland, the City of Gresham, and others. In-kind support from a variety of sources is also critically important to the Caring Communities. It is important to note that core funding, such as that provided by the county, has only been available for all the Caring Communities since 1998.

Key Stakeholders who were interviewed about the challenges facing the Caring Communities agreed: **sustained funding for coordination is one of the biggest challenges.**

Initially, the Caring Communities were unfunded, and operated primarily on a volunteer basis. The East County Caring Community was able to leverage funds from a variety of sources to hire a coordinator relatively early in its development. Other Caring Communities have struggled with the issue of funding, although as of 1999 all are receiving some degree of core support from Multnomah County. Currently, all of the Caring Communities are staffed by a paid coordinator. However, sustaining funding for the coordinator is an ongoing challenge for most Caring Communities. For many, a significant amount of the coordinator's effort is expended towards ensuring ongoing support for that position.

E. Activities

Each Caring Community is engaged in a wide variety of programs and activities. The Caring Communities generally do not provide direct services or programs, although there are cases in which the coordinators are directly involved in service delivery (e.g., Inner Southeast's school-based programs and Mid-County's Family Nights). More typically, the Caring Communities are engaged in collaborative planning, facilitating resources (volunteers, space, etc), fostering new collaborative efforts, and information dissemination. Caring Communities also sometimes play a pivotal role in grant-writing and obtaining resources to start new programs, even though they typically do not act as the fiscal agent for such funds. Thus, their role is to support existing

programs, help to “kick off” new programs, and to provide a forum for coordinated program development. The role of the coordinator may be to lead these efforts, or to provide a support staff function to agencies or other community groups who are taking the lead.

F. Goals

The goals of the CCI have evolved over time. Originally, there were two primary goals: successful high school completion and systems integration. The focus on systems integration began in earnest about 1992, and was further reflected in the merging of the Caring

The primary goal of the Caring Community Initiative is “to change the human services delivery system in a way that will make things better for children and families.”

Communities with the Multnomah County District Coordinating Teams in 1994-1995. Key stakeholders interviewed for the evaluation described the original intention of the CCI as being a vehicle to promote systems change: “to change the human services delivery system in a way that will make things better for children and families.” Throughout the 1990s both state and county governments in the state of Oregon have

moved increasingly towards attempts to reduce service duplication and enhance integration, and the CCI is recognized by state and county employees as a positive model for supporting these efforts. More recently, the focus of the CCI has begun to explicitly emphasize the importance of community building and resident involvement in addition to systems integration. Six of the eight Caring Communities received grants from Multnomah County in 1998 to support community-building activities.

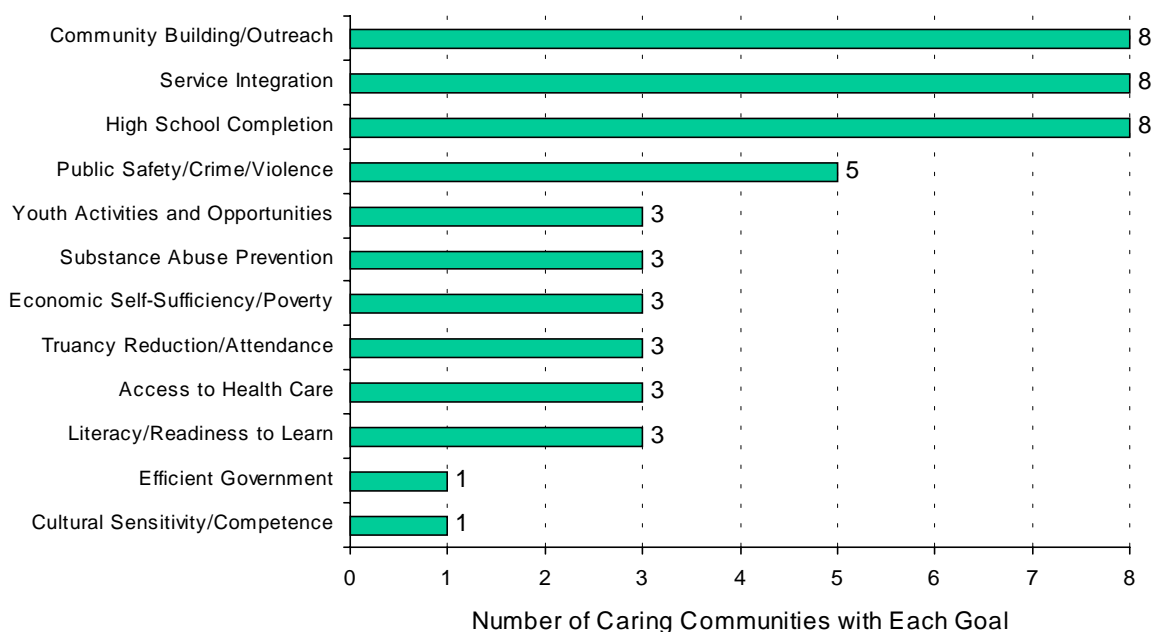
From the outset, the CCI also emphasized the importance of local-level decision making and goal-setting. Each Caring Community is encouraged to engage in community level needs assessments and planning, and to develop strategies and activities to meet the needs of each individual community. This has been both a strength and a challenge for the CCI. While community-based decision making directly supports the goal of community empowerment and allows each Caring Community to be responsive to community-specific issues, it also means that there are tremendous variations between the eight different Caring Communities in terms of specific activities and goals. Thus, defining common goals and objectives for the Initiative as a whole is difficult.

The lack of common goals and activities makes evaluation of the outcomes of the Caring Community as a whole particularly difficult. Figure 1 below shows the number of Caring Communities who hold each of a variety of stated goals. However, it is important to note that some goals, such as school completion, are quite broad, and many different activities can be implemented as a means of reaching them. Thus, holding a particular shared goal does not imply a common set of activities directed towards achieving the goal. As can be seen, other than the unifying goals of systems integration, school completion, and community building, there is considerable diversity of stated goals.

The common link between Caring Communities is one of philosophy: a shared belief in the importance of coordination, collaboration, and partnership. How this philosophy is implemented, however, varies considerably across the eight Caring Communities.

Figure 1

Caring Community Stated Goals



II. Purpose and Scope of the Evaluation

The purpose of this evaluation was to address four primary areas identified during the Phase I Caring Community evaluation process. These are:

1. The **profile** of each Caring Community, including descriptive information such as its duration, primary activities, goals, accomplishments, and challenges;
2. The **organizational effectiveness** of the Caring Communities, including engagement of community partners, communication, facilitation of new or enhanced projects, and general efficacy of the Caring Communities as organizations;
3. The other **outcomes** of the Caring Communities, including systems and resident outcomes; and
4. The level of **community engagement** in the Caring Communities.

In the course of conducting this evaluation, choices were made by the Caring Community Evaluation Team in terms of how to allocate resources to these various components. In particular, the degree to which it was appropriate for the evaluation to focus on resident-level outcomes and community engagement was discussed extensively. Because there are few common resident-level outcomes (due to the differing specific goals and activities of the eight Caring Communities) and because of the multiple potential influences on the goal of 100 percent school completion, the decision was made to focus evaluation activities primarily on organizational effectiveness and systems outcomes/systems integration. These outcomes were deemed feasible and realistic for all eight Caring Communities, and are consistent with key goals of the Initiative. Because community engagement is a relatively new emphasis of the CCI, a decision was made to develop and pilot test an instrument that could be used by the Caring Communities for future evaluation of community engagement outcomes. Pilot data from three communities was collected and is included in this report.

A mixed method design was used to collect information to address the evaluation goals. Both qualitative and quantitative methods were employed, and data were collected from persons with a wide range of different levels of knowledge and involvement in the Caring Communities. Decisions about methods and instruments were made in collaboration with the Evaluation

Team. Copies of the instruments and protocols used are included in Appendix D, page 133. In brief, there were five primary methods used to collect information:

1. **Document review and synthesis.** Existing work-plans, meeting minutes, reports, and other key documents were collected and reviewed by the evaluators. Additionally, documents were used to develop logic models for each Caring Community, specifying their long-term and short-term outcomes and their current activities and strategies for reaching these goals. Copies of the logic models for 1999–2000 can be found in Appendix B, page 101.
2. **Key Stakeholder interviews.** Qualitative, open-ended interviews were conducted with a total of 49 persons. Each Caring Community coordinator was asked to nominate the names of 3–5 people who were knowledgeable about their Caring Community, for a total of 35 persons. These are referred to as “community-specific” Key Stakeholders. Each coordinator was also interviewed. Additionally, the Evaluation Team identified 14 people who were involved with either the CCI as a whole, or with three or more different Caring Communities. These are referred to as “initiative wide” Key Stakeholders. Interviews were done either on the phone or in person, and lasted between 40–90 minutes.
3. **Focus groups.** One focus group was conducted with each Caring Community during one of their regular monthly meetings. The focus groups involved between 8 and 23 people, and lasted between one and two hours. Focus groups discussed the history, accomplishments, challenges, and areas in need of improvement for their Caring Community.
4. **Caring Community Member Surveys.** Surveys were distributed by mail to a total of 1135 persons on the mailing lists for the Caring Communities. A total of 335 surveys were returned, for an overall response rate of 29 percent. Response rates for individual Caring Communities are presented in Table 1, below. Member surveys contained an extensive battery of questions focused primarily on assessing organizational effectiveness and systems integration outcomes. The target response rate was 30 percent, which was achieved or exceeded in all of the Caring Communities except Jefferson. The Jefferson Caring Community, however, has an extremely large mailing list, which includes a number of individuals who are not necessarily involved in the Caring Community (e.g., it contains information about all individuals who attended the community budget forum). Because the absolute number of surveys was equivalent to

the numbers received from other Caring Communities, and because there were no statistically significant differences in terms of length of time involved in the Caring Community or level of participation in the Caring Community between Jefferson and other Caring Communities, this data was used in analysis despite the somewhat low response rate.

Table 1

Caring Community Member Survey Response Rates

Caring Community	Surveys Mailed	Surveys Received	Response Rate
East County	113	48	42%
Grant Madison	138	45	33%
Inner Southeast	111	33	30%
Jefferson	314	47	15%
Mid-County	125	55	44%
North Portland	87	27	31%
Outer Southeast	163	55	34%
West District	79	25	32%
Total	1135	335	29%

5. ***Caring Community Resident Surveys.*** To pilot a process for collecting information about community engagement in the Caring Communities, two different methods were used. First, 27 face to face interviews were conducted during a community event co-sponsored by two Caring Communities. Second, a mail survey was completed using a resident mailing list compiled by Multnomah County. A nominal incentive procedure was tested as a means to increase the response rate for this survey. This process will be discussed more completely below (see “Community Engagement Outcomes”).

This report will focus primarily on understanding the key themes and outcomes across the CCI as a whole, drawing from each of the types of information as appropriate. Results from

individual Caring Communities will generally not be presented, because of the difficulty in comparing results across the eight unique Caring Communities. Individual survey and focus group results will be shared with the Caring Community Coordinators and their Steering Committees for use in their ongoing program development and improvement. Additionally, this report will draw on the existing research literature regarding community coalitions and systems integration to provide a context for clarifying expectations and outcomes, where appropriate.

III. Individual Caring Community Fact Sheets

The following sections contain brief descriptions of the eight Caring Communities. The matrix on the following page shows a variety of key characteristics of each of the Caring Communities. Additionally, a supplemental report is being prepared that will include a detailed descriptive history and profile of each Caring Community. Documenting the historical development of the Caring Communities in the process of this evaluation proved exceedingly difficult, given the diverse array of stakeholders, their many different perspectives, and the lack of systematic record-keeping by many coordinators.

**For more information about the individual
Caring Communities, please see:**

- | | |
|------------------------------------|--|
| <i>Appendix A, pg. 97:</i> | A map of the Caring Communities. |
| <i>Appendix B, pg. 101:</i> | Individual logic models for each Caring Community for 1999-2000. |
| <i>Appendix C, pg. 123:</i> | Levels of community partner engagement in each Caring Community. |

Table 2

Matrix of Caring Community Characteristics

Caring Community Name	Year Started	First Year Coordinator Hired (pt/ft)	Number of Paid Coordinators Over Caring Community Lifetime	Approximate Number of Members on Mailing List	Number of Current Action Teams (including Steering Committee)	Number of Activities & Programs in 1998–1999 (primary role)
East County	1991	1992 (pt) 1995 (ft)	1	220	9	11
Grant-Madison	1994	1997 (pt) 1998 (ft)	1	160	6	6
Inner Southeast	1993	1996 (ft)	1	130	7, plus 3 task forces	7
Jefferson	1991	1996 (pt) 1998 (ft)	3	550	2, plus eight “community interface groups”	7
Mid-County	1995	1995 (ft)	1	125	6	7
North Portland	1991	1994 (pt) 1998 (ft)	2	90	7	5
Outer Southeast	1991	1997 (pt) 1998 (ft)	4	200	5	6
West	1996	1997 (pt)	1	90	5	5



East County Caring Community Fact Sheet

Mission Statement

To encourage and assist the families of East Multnomah County by promoting individual and family self-sufficiency through a stronger sense of community.

Benchmarks and Goals

- 100% high school completion
- Reduce the incidence of domestic violence
- Increase the percentage of Oregonians with access to health care
- Increase the percentage of Oregonians with access to government
- Increase the number of children moving from foster care to safe, stable homes

Geographic Area Served

Centennial, Reynolds, and Gresham Barlow school districts (east Multnomah County).

Current Working Groups & Action Teams

1. Operations Committee
2. Family Resource Center Steering Committee
3. Family Resource Center Action Team
 - Centennial Family Resource Center
 - Reynolds Family Resource Team
 - Gresham-Barlow Family Resource Team
4. The Early Childhood Action Team
5. Summer Lunch Program
6. Connecting Generations
7. East County Domestic Violence Roundtable
8. Rockwood Community Building Initiative
9. Greater Area Prevention Partnership

Contact Information: Lorena Campbell is the ECCC coordinator. She can be contacted at:



Lorena Campbell
ECCC/GAPP
18135 SE Brooklyn St.
Portland, Or 97236
Phone: (503) 760-7990
Fax: (503) 762-3689
Email: lorena_campbell@centennial.k12.or.us



Grant-Madison Caring Community Fact Sheet

Mission Statement

To foster school success for all children in the region by providing a network of support to children and their families and by promoting equity. In doing so, the Grant-Madison Caring Community shall create a strong supportive community for all children and families.

Benchmarks and Goals

- Increase high school graduation rates
- Increase readiness to learn
- Increase the efficiency of government
- Support a livable community
- Support nurturing families and a stable home life
- Increase citizen satisfaction with government
- Increase County government accountability and responsiveness

Geographic Area Served

Grant and Madison attendance areas of Portland Public Schools (outer northeast Portland).

Current Working Groups & Action Teams

1. Steering Committee
2. Whitaker /Rigler SUN (Schools Uniting Neighborhoods) Planning Team
3. Faith in Youth Action Team
4. A Grant Community Conversation
5. Oregon Together!
6. Madison Area Hispanic Youth Action Team

Contact Information: Vicky Martell is the GMCC Coordinator. She can be contacted at:



Vicky Martell
Grant-Madison Caring Community
8020 N.E. Tillamook Street
Portland, OR 97213
Phone: (503) 916-3697
Fax: (503) 916-2474
Email: vmartell@pps.k12.or.us



Inner Southeast Caring Community Fact Sheet

Mission Statement

The Inner Southeast Caring Community is about reducing the risk that keeps kids from graduating from high school, about coordinating resources, about bringing together businesses, schools, churches, families, and communities to build assets in youth that will build resiliency to carry them to becoming productive members of our community.

“To encourage youth to live healthy lifestyles and achieve 100 percent high school completion with employable skills”

Benchmarks and Goals

- 100% High school completion
- Promote nurturing families and stable home life for children
- Promote children's readiness to learn
- Increase access to health care
- Reduce student alcohol and drug use
- Reach the Department of Human Resource's integrated services project benchmarks

Geographic Area Served

Cleveland attendance area of Portland Public Schools (inner southeast Portland).

Current Working Groups & Action Teams

1. Interim Steering Committee
2. Operations Committee
3. The Care Team
4. Before and After School Activities Action Team
5. Volcanic Rumbles Action Team
6. Cleveland High School Action Team
7. Buckman Community Partnership

Additionally, there are three task forces:

1. Trends Task Force
2. Parent Education Task Force
3. Prevention/Intervention Strategy Task Force

Contact Information: Kathy Stromvig is the ISECC Coordinator. She can be contacted at:





Jefferson Caring Community Fact Sheet

Mission Statement

To foster a healthy, educated, and prosperous community.

Benchmarks and Goals

- Increase the rates of high school completion: Prepare children to participate successfully in school and achieve high school completion.
- Reduction of children in poverty: Secure access to employment, healthcare, housing, and social services.
- Reduction of Crime: Achieve a sense of neighborhood safety through the promotion of peace and community involvement in violence prevention activities.

Geographic Area Served

Jefferson attendance area of Portland Public Schools (inner north/northeast Portland).

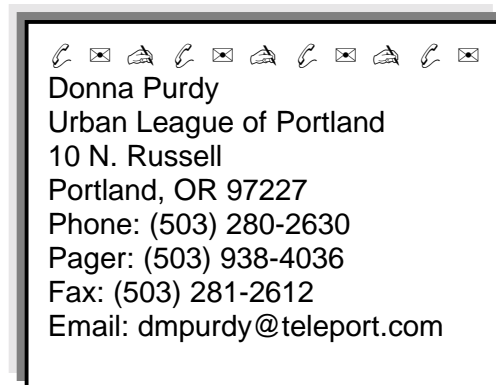
Current Working Groups & Action Teams

1. JCC Steering Team
2. JCC Peace Action Team

Additional “community interface groups” include:

1. Portland Mayor’s Gang / Truancy Task Force
2. Humboldt Neighborhood Target Area Grant
3. Legacy Emanuel’s Project Network KUUMBA Project
4. Humboldt Elementary Parent Teacher Student Association
5. Jefferson High School Parent Teacher Student Association
6. Jefferson Community Youth Development Initiative
7. Weed and Seed Committee North East
8. Educational Crisis Team

Contact Information: Donna Purdy is the JCC coordinator. She can be contacted at:





Mid-County Caring Community Fact Sheet

Mission Statement

Working together to promote the wellness and strengths of our community.

Benchmarks and Goals

- Increase the high school graduation rate
- Increase the percentage of people with access to health care
- Decrease the teen pregnancy rate
- Reduce juvenile crime
- Increase the percentage of healthy babies
- Increase the percentage of people who receive long-term care in community settings
- Increase the sense of community in neighborhoods

Geographic Area Served

David Douglas and Parkrose school districts (mid-Multnomah County)

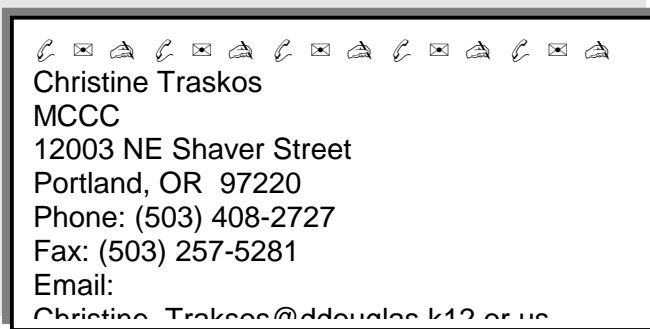
Current Working Groups and Action Teams

1. Early Childhood Action Team
2. Partners for Peace Action Team
3. Parkrose Family Resource Center
4. Performance Trends Action Team
5. Community Building Action Team

In addition to these Action Teams, there are five working groups:

- VIP Mentor Program
- Senior Partner Program
- David Douglas Newsletter Team
- Operations Committee
- STEP Summer Program

Contact Information: Christine Traskos is the MCCC Coordinator. She can be contacted at:





Caring Community of North Portland Fact Sheet

Mission Statement

To promote healthy children, families, and communities in the North Portland Peninsula.

Benchmarks and Goals

1. To increase the high school completion rate by:
 - Providing North Portland families with accessible services and opportunities through partnerships with schools, agencies, and community organizations.
 - Assessing, coordinating and developing before/after school and summer activities for children and youth.
 - Supporting and facilitating school initiatives such as literacy and truancy.
2. To address public safety concerns including livability, crime prevention, vandalism, speeding, and violence (family, community, domestic)
3. To expand membership to include North Portland residents, businesses, and faith communities.

Geographic Area Served

Roosevelt attendance area of Portland Public schools, and the area west of Interstate 5 in the Jefferson attendance area.

Current Working Groups & Action Teams

1. Steering Committee
2. Peace Action Zone Team
3. Before and After School Action Team
4. Community Building Action Team
5. School Initiatives Action Team
6. The Family Strengths Action Team
7. Special Projects Action Team

Contact Information: Pam Arden is the CCNP Coordinator. She can be reached at:



Pam Arden
Caring Community of North
Portland
6941 N. Central
Portland, OR 97203
Phone: (503) 735-9623
Fax: (503) 736-6253
Email: pam_arden@hotmail.com



Outer Southeast County Caring Community Fact Sheet

Mission Statement

Through effective community engagement, the Outer Southeast Caring Community's (OSECC) mission is to cultivate and economically secure a sustainable and healthy community by empowering individuals and families.

Benchmarks and Goals

- 100% high school completion
- Enhance youth opportunities and life skills
- Increase community involvement and capacity

Geographic Area Served

Marshall attendance area of Portland Public schools (outer southeast Portland).

Current Working Groups and Action Teams:

1. Steering Committee
2. Health Action Team
3. Family Involvement Action Team
4. Outer Southeast Weed & Seed Committee
5. Outer Southeast Community Schools Group

Contact Information: Anne Peterson is the OSECC coordinator. She can be reached at:



Anne Peterson
Outer Southeast Caring
Community
7211 SE 62nd
Portland, OR 97206
Phone: (503) 306-5961 ext. 224
Fax: (503) 306-5946
Email: not available



West District Caring Community Fact Sheet

Mission Statement

To support, enhance and contribute to the system of supportive services that promote the health and well being of individuals and families in the West Side Communities of Multnomah County.

Benchmarks and Goals

- Increase school success and life skills of young people
- Increase access to employment services and work force development
- Increase citizen involvement
- Decrease homeless youth population
- Increase children's readiness to learn
- Establish an effective structure and process for operations of the WDCC


Geographic Area Served

Lincoln and Wilson attendance areas of the Portland Public schools (downtown Portland and Multnomah County west of the Willamette River).

Current Working Groups & Action Teams

1. Coordinating Team
2. Employment and Workforce Action Team
3. Homeless Youth Issue Team
4. Wilson Action Team
5. Attendance Action Team

Contact Information: Anne Stone is the WDCC coordinator. She can be contacted at:



Anne Stone
WDCC
Robert Gray Middle School
5505 SW 23rd Avenue
Portland, OR 97214
Phone: (503) 916-5679
Fax: (503) 916-2629

IV. Organizational Effectiveness Outcomes

A. Agency Partners in the Caring Communities

One of the key indicators of a successful community collaboration is its ability to bring key partners “to the table” (Kegler et al., 1998). The Leaders Roundtable originally conceptualized the CCI as a means to bring key community partners to the table for systems integration and collaboration. The key partners identified were:

- Schools
- Recreational Services
- Faith Community
- Employment and Business
- Housing
- Public Safety
- Transportation
- Health and Social Services
- Youth
- Parents
- Community Residents¹

For purposes of this evaluation, the levels of involvement of two additional categories of community partner were also assessed:

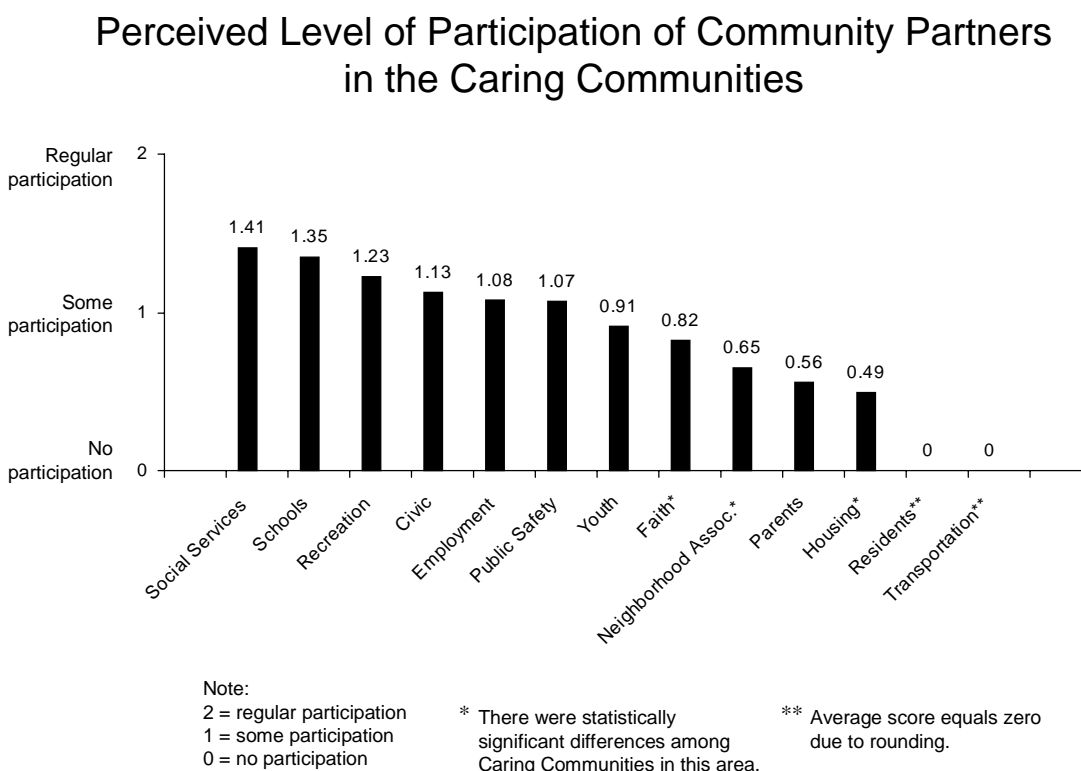
- Government, elected officials, and civic groups
- Neighborhood associations

Baseline data were collected through the Caring Community Member Survey (see Appendix D, page 133) to measure the extent to which these key partners are currently involved in Caring Community activities. Each Caring Community was asked to provide a list of specific key community partners (i.e., agency and program names). This method has been found to yield more accurate data than general ratings of categories of providers. Survey respondents were

¹ It should be noted, however, that members of the other community partner categories may also be community residents. In fact, some of the members of the Caring Communities play a dual role as both a provider and a community resident. Eighteen percent of

asked to rate the extent to which each agency/provider "regularly participates" in Caring Community meetings and activities. Response categories were: "Yes," "Sometimes," and "No." Higher scores indicate higher levels of participation. Figure 2 shows the average level of participation for each category of community partner. Figures showing the levels of participation of community partners within each individual Caring Community can be found in Appendix C, page 123. **It is important to note, however, that these reported levels of engagement are based on the perceptions of survey respondents. These may not reflect the full range of community partners who participate in Caring Community activities.** Also, some of the Caring Communities **do have** reported involvement by residents and transportation providers (e.g., Outer Southeast, North Portland, West District). However, because these figures are rounded averages across all survey responses, the average across the CCI is close to zero.

Figure 2



survey respondents indicated that their role in the Caring Community was related both to their paid work and to their resident status.

As can be seen, respondents rated social service/health agencies and schools/educational service providers as most involved, with an average rating between "sometimes" and "yes" for regular participation. Recreational providers, the faith community, employment/business, public safety, youth, and government/civic groups had average ratings closer to 1.0, or "sometimes." Housing providers, parents, and neighborhood associations were rated between "sometimes" and "no" for their participation and transportation and general residents were generally seen as not participating. It is important to note, however, that at least some of the service providers have a dual status as both a resident and a provider within the Caring Community. The structure of the survey required respondents to base their judgements on individuals' primary role, which in most cases was the provider role.

It is also important to note that levels of participation by these groups vary among the individual Caring Communities. Most notably, levels of involvement for the faith community were perceived as ranging from zero (no involvement) to an average of 1.6 (between "sometimes" and "yes"). Involvement by housing and neighborhood associations also varied considerably; in some communities these partners were rated as quite involved, and in others not at all involved. All Caring Communities were perceived by survey respondents as having consistently high levels of participation by social services and schools; moderate levels of involvement by

Caring Communities were perceived by survey respondents to have:

High levels of participation by social services and schools;

Moderate levels of involvement by recreational providers, the faith community; employment/business, public safety, youth, and government officials; and

Relatively low levels of involvement by transportation providers, housing, parents, and general residents.

recreational providers, employment/business, public safety, youth, the faith community, and government/civic groups; and relatively low levels of involvement by transportation providers, housing, parents, and general residents.

In terms of the number of different sectors involved, respondents indicated that about 7 of these 13 categories of providers participated "sometimes" or "regularly" in Caring Community activities, ranging from a low of 5.0 in one Caring Community to a high of 8.1 in another.

Other sources of information about community partner involvement in the Caring Communities

are the agency affiliations of survey respondents. Although respondents represented a variety of levels of involvement in the Caring Community, the proportion of surveys returned by each type of community partner is illustrative of the makeup of the Caring Communities. Survey respondents were primarily health/social service providers (51% of respondents). The remainder included:

- Schools, 21%
- Public Safety, 5%
- Faith Community, 4%
- Recreational Services, 3%
- Neighborhood Associations, 3%
- Employment and Business, 2%
- Residents (youth, parents, etc.), 1%
- Elected Officials, 1%

Again, however, it is important to keep in mind that respondents were asked only about their primary role; about 18 percent indicated that they are both working and living in their Caring Community.

The survey results indicate that the Caring Communities have been successful in bringing many of the key community partners to the table: Social/health services, education, recreational providers, the faith community, employment/business, public safety, youth, and government/civic groups are all at least moderately involved in regular Caring Community activities. **Additional efforts to involve housing, neighborhood associations, transportation providers, general community residents, parents, and the faith communities may be needed in at least some of the Caring Communities.**

B. Key Indicators of Organizational Effectiveness

Research conducted to examine the effectiveness of community collaborative groups similar to the Caring Communities has begun to identify some key factors that contribute to the productivity of such groups (Kegler et al., 1998; Goodman, Wandersman, Chinman, Imm, and Morrissey, 1996). The Caring Community Member survey included a number of questions

related to these areas, many of which were adapted from prior research on this topic (e.g., Kumpfer, Turner, Hopkins, and Librett, 1993). Key variables measured were:

- leadership quality,
- clarity of decision-making,
- level and consistency of participation,
- quality of communication,
- member commitment, *and*
- level of shared vision.

Groups in which there is better leadership, less turnover, clear decision-making procedures, and high levels of member commitment are generally *more effective*.

Additionally, questions regarding each working group's efficiency and outcomes were included. For example, respondents were asked whether "Timely progress is being made on this group's projects" and whether "This group is effective at getting things done." For most questions, respondents indicated "yes," "no," or "sometimes" (exceptions are noted).

The indicators of organizational effectiveness were positively associated with perceptions of effectiveness and outcomes. For example, the higher the perceived quality of leadership, the more likely respondents were to rate the group as effective and making progress. This suggests that groups in which there is perceived to be better leadership, less turnover, clear decision-making procedures, and high levels of member commitment may be more effective at achieving their goals. This is consistent with research that has shown that the productivity of community coalitions (e.g., number of activities implemented, etc.) is associated with these variables (Goodman et al., 1996).

Leadership Quality. Three questions assessed quality of leadership among Caring Community working groups:

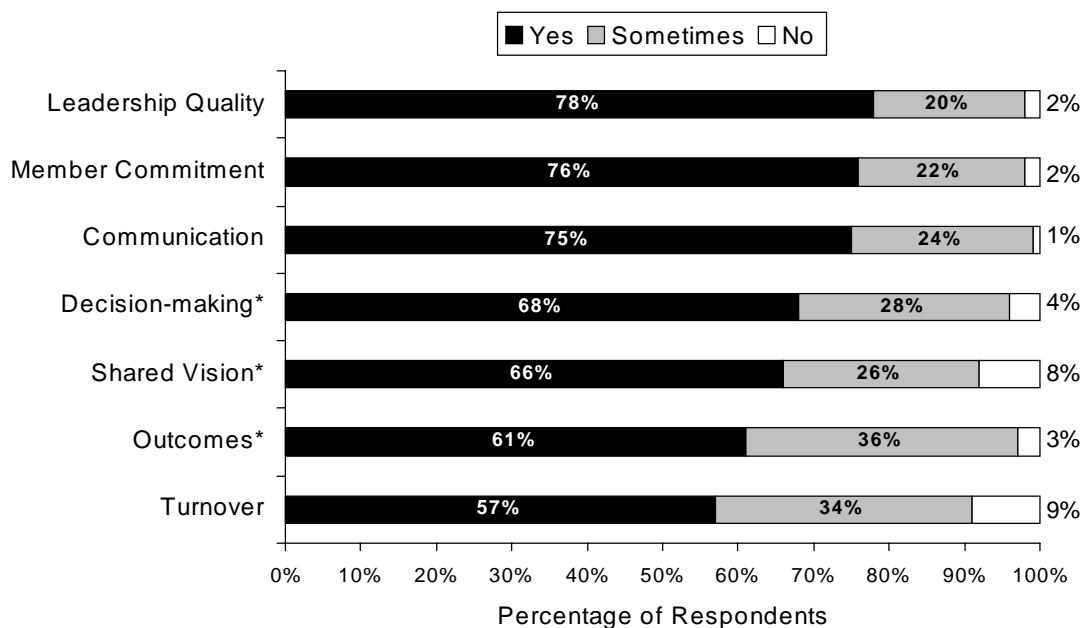
1. "This group's leaders do a good job of soliciting input from other members."
2. "This group has strong and effective leaders."
3. "This group's leaders are good at facilitating compromise when needed."

Answers to these questions were averaged to form an index of leadership quality, as shown in Figure 3 below. As can be seen, respondents generally perceived the leadership quality to be quite high, with an average score of 1.77 (out of a possible maximum of 2.0). Leadership quality

was the highest-rated of all the indicators of organizational effectiveness. Leadership includes Caring Community coordinators, Caring Community chairpersons, and action team and subcommittee leaders.

Figure 3

Indicators of Organizational Effectiveness Within Caring Community Working Groups



* There were statistically significant differences among Caring Communities in this area.

Clarity of Decision-Making. Two questions related to the clarity of decision-making and members' satisfaction with decision-making. The first asked respondents to indicate which of the following decision-making procedures was utilized by their group:

1. consensus
2. voting (majority rules)
3. leaders make decisions
4. no formal procedure

Results indicated that consensus was the most frequent method (65% of respondents), followed by no formal procedure (24%). A small percent of respondents indicated that a voting procedure was used (8%) or that leadership made decisions (2%). Interestingly, there was variation within each Caring Community in terms of which process respondents believed was used. For example, in East County and Mid-County, 75 percent of respondents agreed that consensus procedures were used. In other Caring Communities, such as Inner Southeast Caring Community and Outer Southeast Caring Community, there was less agreement: In Inner Southeast Caring Community, 47 percent indicated that consensus was used, while 20 percent indicated that the chair or leader makes decisions, and 33 percent indicated that there was no formal procedure. In Outer Southeast Caring Community, 60 percent indicated a consensus process, 17 percent a voting process, and 23 percent no formal procedure.

Research suggests that groups that have a clearly defined decision-making process that group members understand and utilize are likely to be more effective (Kumpfer et al., 1993). These results suggest that at least some Caring Communities may need to establish a decision-making process that is clearly communicated to group members. It should also be noted, however, that this question asked respondents to identify the decision-making process used in their specific workgroup or action team. It is possible that different procedures are used by different subgroups within the Caring Communities, thus explaining the variation in responses.

Some Caring Communities need to clarify their decision-making process, and ensure that this process is communicated to group members.

Respondents were also asked about their satisfaction with the decision-making process in their working group. These results are shown in Figure 3 above. As can be seen, respondents were generally satisfied with decision-making, although this indicator was somewhat more negative than other indicators of organizational effectiveness. Further, there were significant differences between the Caring Community groups in terms of members' satisfaction with decision-making. Some groups were rated extremely positively, while others were not seen as positively, with a low score of 1.46 and a high score of 1.93, out of a maximum score of 2.0.

Level and Consistency of Participation and Turnover. Respondents were asked whether:

1. "Turnover among members is a problem for this group."
2. "Low participation/involvement is a problem for this group."

These results are shown in Figure 3, with responses coded so that higher scores indicate fewer problems with turnover. On average, scores on this indicator were the most negative of all the indicators of organizational effectiveness, with an mean score of 1.49, out of a possible maximum of 2.0. However, it should be noted that there were significant differences among the Caring Communities in terms of perceived problems with turnover. Some Caring Communities had very little problem with participation and/or turnover, while others appeared to have a larger problem with this issue. Scores for the individual Caring Communities ranged from .833, indicating that turnover was a significant problem, to a high of 1.73. Collaborative groups with greater member participation have been found to be more effective than groups with low attendance and participation (Wandersman, 1979).

Quality of Communication. Caring Community coordinators hold the primary responsibility for communication with their membership about Caring Community activities and meetings. This is

Efforts by Coordinators to establish membership databases and processes for updating them should be strongly encouraged.

done through both regular mailings and through email in some Caring Communities. All of the Caring Community coordinators are currently in the process of setting up membership databases that can be used as the basis for communication with members. This effort should be strongly encouraged. In the process of conducting this evaluation, coordinators were asked to provide mailing lists to the evaluators for the Member survey. Some coordinators had significant difficulties with this, for a variety of reasons. This process also revealed that a number of Caring Communities had outdated membership information and incomplete contact information. In some Caring Communities this was due to a lack of a well-coordinated membership database.

Efforts to support coordinators to develop and maintain databases are needed (including basic computer hardware/software support and training, as well as secretarial support for data entry and updating). Further, it would be helpful for coordinators to develop and implement a process for systematically updating and reviewing membership information to ensure up-to-date contact information about active members. A good example of a membership database is that of the

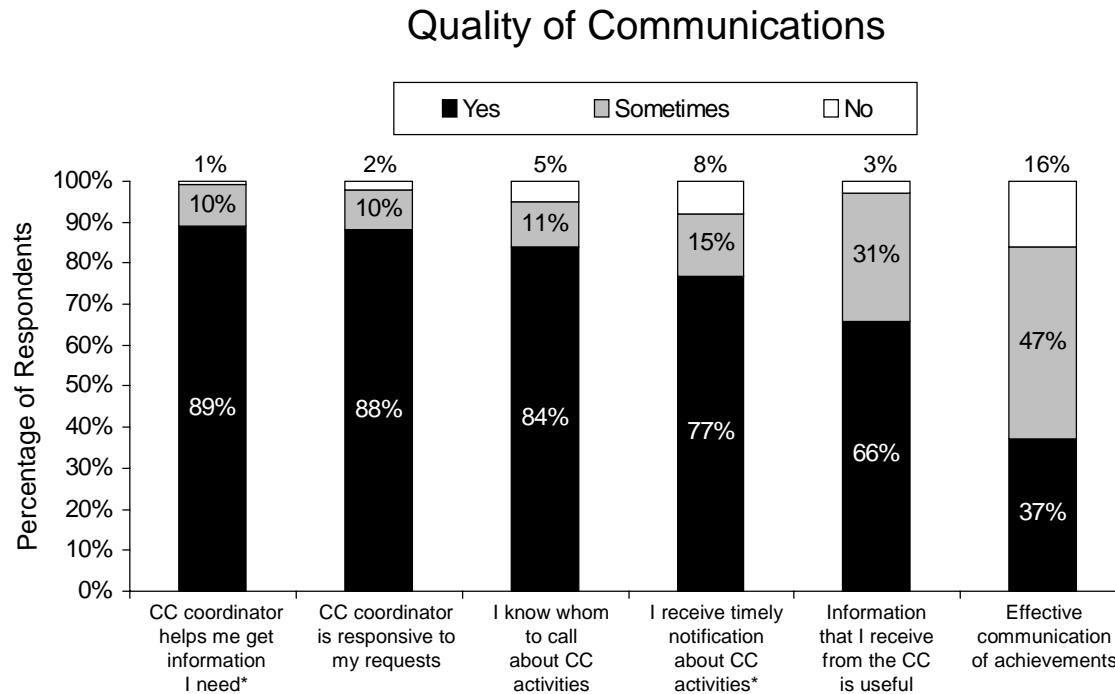
Grant-Madison Caring Community. This database contains contact information (address, phone number, and email) about each member, as well as information about their affiliation, interests, attendance, and involvement in particular action teams. This database allows the coordinator to monitor member participation as well as to have an efficient means of communication to members.

Information about the effectiveness of Caring Community communication was collected through the Member Survey. Respondents were asked to indicate whether:

1. "The Caring Community coordinator is responsive to my requests."
2. "The Caring Community coordinator helps me to get information I need."
3. "I know who to call to find out about Caring Community activities."
4. "I receive timely notice about Caring Community activities."
5. "The information I receive from the Caring Community is useful."
6. "The Caring Community is effective in communicating its achievements."

For each of these statements, respondents indicated "yes," "sometimes," or "no."

Figure 4



* There were statistically significant differences among Caring Communities in this area.

As can be seen in Figure 4 above, most respondents perceived the various aspects of Caring Community communication to be working effectively: communication was timely and useful, and the coordinators were perceived as being responsive and helpful. Most respondents also indicated that they knew who to call for information about the Caring Community. Ratings of the extent to which Caring Communities were effective at communicating their achievements were somewhat less positive; most respondents (46%) indicated that this was true only some of the time.

Caring Communities may need to improve their ability to communicate their achievements.

Additionally, there were statistically significant differences between the Caring Communities in terms of timeliness of information and helpfulness of the coordinator in providing needed information: some Caring Communities scored higher in these areas than others.

The survey also contained information about the quality of communication within Caring Community working groups and action teams. Open and honest communication has been identified as a key factor in effective community collaborations. Three survey questions were included to assess this domain:

1. "Differences of opinion are a problem for this group."
2. "When members of this group disagree with each other, they usually say so."
3. "Members of this group are encouraged to speak their minds even if it means disagreeing with the majority."

The three items were averaged together to define an index of communication quality, with an average score of 1.74, with a possible maximum of two, indicating highest quality communication. These results are presented in Figure 3 above. As can be seen, respondents were generally positive in their perceptions of the quality of communication within Caring Community groups. There were no significant differences between the Caring Communities in terms of overall level of communication quality.

Level of Member Commitment. An individual's level of commitment and feelings of belonging to a collaborative group has been found to be extremely important to the longevity and productivity of these efforts (Kegler et al., 1998). Four questions were used to assess member commitment:

About 75% of survey respondents said yes to these questions.



1. "There is a strong feeling of belonging in this group."
2. "It is worth my time to be involved with this group."
3. "Working with this group supports the other work that I do."
4. "I feel committed to this group."

Two additional questions assessed positive attitudes towards the Caring Community:

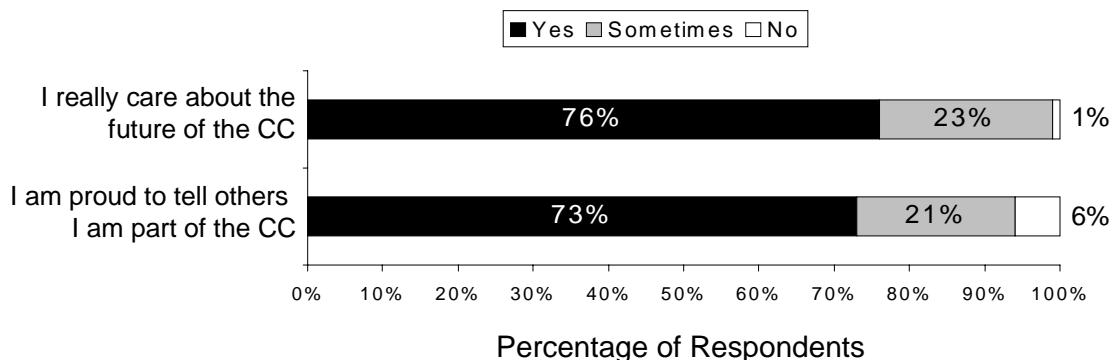
5. "I really care about the future of the Caring Community."
6. "I am proud to tell others that I am part of the Caring Community."

The four member commitment questions were averaged to define an index, shown in Figure 3. The results indicate relatively high levels of commitment, with an average score of 1.73, and a possible maximum score of 2.0. Approximately 75 percent of respondents also answered

positively in regards to their attitudes towards the Caring Community. These results are presented in Figure 5, below.

Figure 5

Member Commitment to the Caring Communities



Extent of Shared Vision. The extent to which groups share a common vision and goals may be important to group effectiveness (Kegler et al., 1998). A lack of shared vision can be an indicator either that differences of opinion about the group's goals exist, or that the group's goals have not been clearly defined and stated. Clear, consistent goals are important to focus a group's effort on key tasks and activities aimed at achieving these goals (Kegler et al.). Two questions assessed this factor:

1. "I have a clear understanding of the goals of this group."
2. "There is agreement among group members about the goals of this group."

As can be seen in Figure 3 above, it appears that respondents generally felt that members of their group did, in fact, share common goals. However, the average score for shared vision was somewhat lower than some of the other variables related to organizational effectiveness. About

55% of survey respondents were at least somewhat unclear about the role of the Caring Community in creating change.

two-thirds of the respondents agreed that there was a shared vision among Caring Community members. However, it is important to note that there were significant differences between Caring Communities on this variable, with groups within some Caring Communities having more agreement on goals than within other Caring

Communities. Scores for the different Caring Communities ranged from a low of 1.07 to a high of 1.86, with a maximum score of 2.0.

Respondents were also asked to indicate whether they understood the role of the overall Caring Community in creating change. Thirteen percent of respondents indicated "no" to this question, and 42 percent indicated "somewhat," indicating that there may be a significant proportion of individuals who are not fully informed or knowledgeable about the Caring Community efforts as a whole. Less than half of the respondents indicated that they did have a clear understanding of the overall role of the Caring Community.

Group Efficiency and Outcomes. Several questions were included in the survey to assess the extent to which working groups and each individual Caring Community as a whole were efficient in reaching their goals. For the working groups, respondents were asked to indicate "yes" "no" or "sometimes" to the following:

1. "This group is effective at getting things done."
2. "Timely progress is being made on this group's projects."
3. "This group regularly reviews and evaluates its progress."

These results are shown in Figure 3 above. Survey responses indicate that members generally perceive their working groups as being efficient in making progress, with an average score of 1.68 out of 2.0. This indicates a fairly high level of perceived effectiveness of the Caring Community working groups. There were no significant differences between Caring Communities on this variable.

To assess overall organizational effectiveness of the Caring Communities, respondents were asked:

1. "The Caring Community has done a lot to help this community make progress."
2. "Overall, the Caring Community is a strong force in this community."
3. "The Caring Community is effective in developing capacity to sustain its efforts."

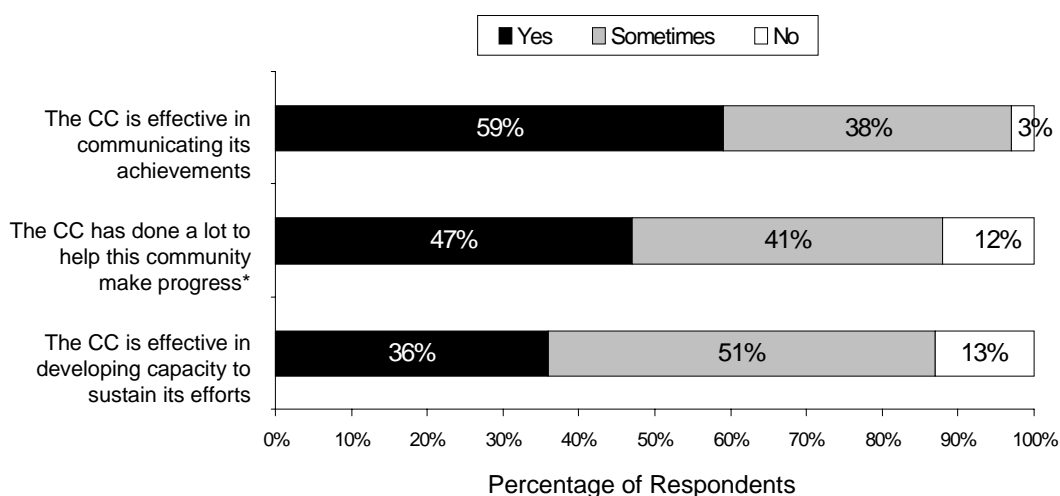
These results are presented in Figure 6, below. As can be seen, respondents were generally positive in terms of whether they believed that the Caring Community had helped the community to make progress, with 59 percent indicating "yes" to this question.

Respondents were less certain that the Caring Communities were successful in developing capacity to sustain their efforts, or that the Caring Communities were a strong presence in the communities. These results are consistent with information collected from qualitative Key Stakeholder interviews that suggests both that developing and sustaining an infrastructure for the Caring Communities has been an ongoing challenge, and that many of the Caring Communities are not widely recognized by the general community.

Over half of survey respondents believed that the Caring Community had helped their community to make progress.

Finally, it should be noted that there were significant differences between the Caring Communities in the extent to which respondents perceive that the Caring Community had helped the community to make progress: some were rated more positively on this dimension, possibly reflecting the varying progress that Caring Communities have made in terms of community building and outreach.

Figure 6
Overall Organizational Effectiveness
of the Caring Communities



* There were statistically significant differences among Caring Communities in this area.

C. Summary: Organizational Effectiveness

In sum, results from the Caring Community Member Survey suggest that:

- Overall, the Caring Community has been successful in engaging a significant number of community partners, especially schools, social/health services, recreational providers, the faith community, and government/civic groups.
- Additional work is needed to consistently engage parents, housing officials, transportation providers, and other community residents, at least in some of the Caring Communities.
- Caring Communities generally have strong group leadership, within-group communication, and a high level of member commitment
- Areas in need of improvement in at least some of the Caring Communities include: clarity of decision-making, consistency of participation, extent of shared vision, and coordinator communication (timeliness and helpfulness).
- Caring Communities could improve in terms of their visibility and recognition within the general communities.
- Caring Communities need to increase their capacity to sustain their ongoing efforts.

Additionally, focus groups and Key Stakeholder interviews suggest that individual Caring Communities may have specific organizational challenges that should be addressed. Some, like North Portland, Outer Southeast, and West District, mentioned struggles with turnover, in terms of staff (the coordinator), general membership, and/or leadership (superintendents, principals, and/or other key stakeholders). As one member stated, “When there are changes in who the people are, this is a real challenge. [We] have to get replacements up to speed, but this takes away the momentum.” East County, on the other hand, has had such little turnover among its core membership group that new members sometimes struggle to become oriented to the group’s philosophy and activities. Others, such as Inner Southeast have struggled with member commitment, especially getting people to be involved at an active level.

Another issue that several Caring Communities have struggled with is having a large and/or extremely diverse service area. West District includes both Southwest Portland and the downtown area, which have significantly different populations and needs. Other Caring Communities, such as East County, Grant-Madison, Outer Southeast, and Mid-County serve communities that are increasingly culturally diverse. Defining “community” within these large and diverse areas is difficult. Finally, virtually all of the Caring Communities have struggled with financial issues and the challenge of securing funding for the coordinator.

D. Realistic Expectations for Organizational Effectiveness

There is very little empirical information that can help to inform expectations or standards for the appropriate levels of the key indicators of organizational effectiveness. One recent study (Kegler et al., 1998) described organizational effectiveness variables for ten different community coalitions focused on community health promotion. This study found a range of three to seven different service sectors were represented in coalition planning groups that ranged in size from 13 to 76 persons. The primary outcome measure for this study was the number of activities implemented by each coalition, which ranged from two to twelve in a two-year period. These coalitions, like the Caring Communities, were staffed by a paid coordinator, although the amount of time dedicated by this staff to the coalition varied. Kegler et al. identified a number of characteristics, detailed below.

Key Factors Associated with Effective Collaborative Groups

(from Kegler et al., 1998)

- Having a shared, locally developed vision.
- The percentage of staff time devoted to the group: The most productive coalitions had a full-time coordinator who was skilled in community organizing.
- The perceived role of the coordinator: Coalitions whose coordinators perceived themselves as linking agents, coaches, or coordinators were more productive than coalitions in which the coordinator saw him/herself as "responsible for everything."
- Sense of cohesiveness and belonging to the coalition.
- Extent to which the coalitions focused on developing and implementing specific activities.
- Effective subcommittee structures.
- Ability to manage conflict.

In combination with the data collected for the CCI evaluation, Kegler's findings suggest the following as reasonable expectations for organizational effectiveness outcomes for the Caring Communities. Note, however, that the coalitions in this study had also engaged in a planning year, during which organizational structures, membership, etc. were established. Outcomes must be considered in the context of the developmental stage of the group.

**To Improve Organizational Effectiveness,
Each Caring Community should have:**

1. A shared, locally developed vision.
2. A full-time paid coordinator, and possibly additional paid staff support.
3. Coordinators who are skilled in community organization, and who are able to delegate work and responsibility to workgroups and volunteers.
4. Specific, well-defined goals and activities, with subcommittees that are responsible for their implementation.
5. Members who feel committed to their workgroup.
6. Members or staff with conflict resolution skills.
7. Mechanisms to help ease problems associated with turnover, such as orientation materials for new members and well-organized documentation of membership, member interests, group structure, goals, decision-making procedures, and group process.
8. Regular participation by at least half of the identified community sectors.

While these will not ensure success for all of the goals of the Caring Communities, these organizational characteristics may contribute to their overall productivity. These variables represent a set of concrete, measurable variables that could be easily assessed for each Caring Community. Additionally, as will be discussed further below, the Caring Communities may want to establish community resident involvement as a criteria for future assessment of organizational effectiveness, given the new emphasis on community engagement.

V. Systems Integration and Systems Outcomes

As described previously, one of the original goals of the CCI was to support systems integration and systems change. Systems integration outcomes can be measured at both the individual client level and the systems level (Kusserow, 1991). Client level service integration has been described as the level at which providers are able to provide a seamless continuum of services to an individual client. Well-integrated services are perceived as seamless by the recipient; for example, there might be a single point of intake, absence of duplicative paperwork, and clear communication among providers about the client's needs, services, and progress. Mechanisms to achieve client-level systems integration typically involve joint case staffings or other types of cross-provider meetings in which individual clients' cases are discussed, such as the Care Team in the Inner Southeast Caring Community.

Systems level service integration implies coordination at a broader level. For example, a well-coordinated service system would be characterized by non-duplication of services provided within a community or service area, cooperative planning for service expansion or enhancement, and established systems for information sharing, referral, and communication. Systems level outcomes can also be assessed at two levels: the provider level, such as the level of coordination and communication between individual service providers, and the policy level, such as changes in service areas, regulations, or policies that support coordinated services.

Policy-level systems integration remains a formidable challenge:

One study found that 20 years of collaborative work yielded few, if any, changes at the policy level (Kusserow, 1991).

Key Stakeholders mentioned that supporters of the CCI have continued to work with policymakers to advocate for policy-level systems changes, such as the re-definition of county service areas. This type of systemic realignment has proved difficult, however, and those interviewed indicated that progress in this area has been slow. However,

results appear much more positive in terms of individual-level service integration. See “systems outcomes” below, for further discussion.

A. Individual Client Level Service Integration Outcomes

Although many of the Caring Communities are involved in client-level service coordination, especially through the activities of the Family Resource Centers, this has not been the primary focus of the Caring Community. Therefore, only a few questions were included in the surveys that related to this domain. Service providers responding to the Member Survey were asked to indicate the extent to which they believed that the following had either increased or decreased as a result of Caring Community activities:

1. The number of referrals between different organizations/groups.
2. The level of coordination of services to clients.
3. The amount of client information shared between agencies.
4. The amount of 'red tape' involved in sharing client information between agencies.
5. The willingness of other agencies to share client information with [respondent's] agency.

Possible responses were:

- 5="major increase"
- 4="moderate increase"
- 3="no change"
- 2="moderate decrease"
- 1="major decrease"

All responses were re-coded so higher scores indicated more positive changes in the levels of service integration. It is important to note that these results reflect respondents' *perceptions* of change.

While respondents indicated several positive changes in terms of client-level service integration, the amount of red tape was perceived as unchanged.

As can be seen in Figure 7 below, respondents indicated that there have been moderate positive changes, on average, in individual-level service integration. The only exception to this was in terms of the amount of "red tape": on average, respondents indicated that there had been no change in this

domain. It is also important to note that there were significant differences in the amount of reported change between Caring Communities in terms of the number of referrals. For some

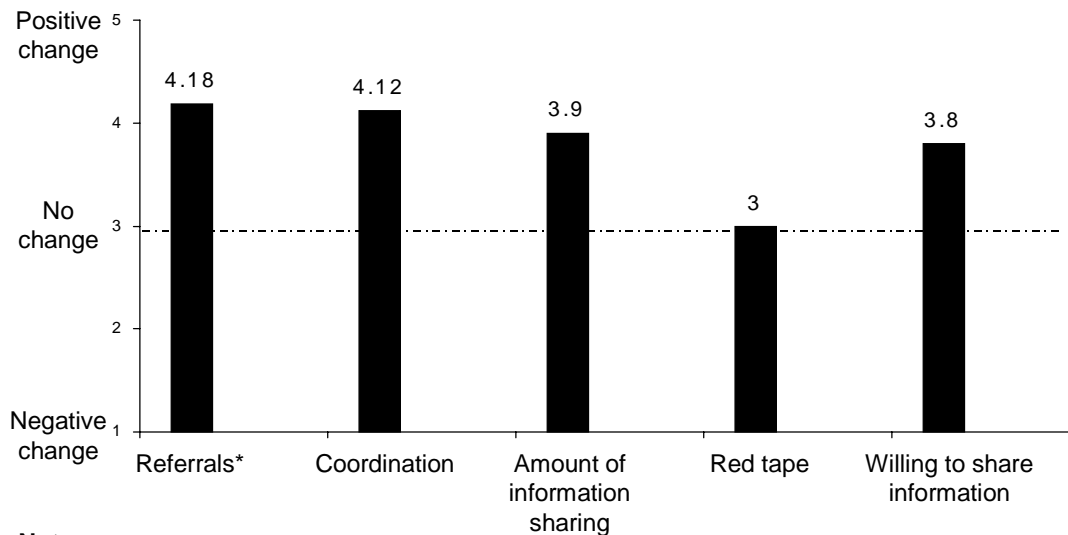
Caring Communities, respondents indicated a larger increase compared to others; however, the number of referrals within all communities was generally perceived as having increased. More referrals indicate that providers are knowledgeable about each other's services, and are working to access available resources for clients.

Results suggest that those who are more engaged in the Caring Communities may be more aware of the extent of coordination that occurs as a function of Caring Community activities.

Further, persons who reported attending more Caring Community meetings and activities tended to report a greater increase in both number of referrals and the general level of coordination of services. Although the causal effect can't be known with certainty, it may be that those who are more engaged are more aware of the extent of coordination that occurs as a function of Caring Community activities.

Figure 7

Changes in Individual Level Service Integration



Note:

5=major positive change
 4=moderate positive change
 3=no change
 2=moderate negative change
 1=major negative change

* There were statistically significant differences among Caring Communities in this area.

B. Policy-Level Systems Integration

Because of the difficulties in effecting change at the policy level, survey questions focused on providers' perceptions of systems change at the provider level. Several sets of questions were included to assess this key outcome. First, using the list of key community agencies and providers described above, respondents were asked to rate:

1. Their own level of understanding of the services provided by each of these organizations; and
2. The extent to which their own agency or organization had collaborated with each other agency to plan, provide, or coordinate services.

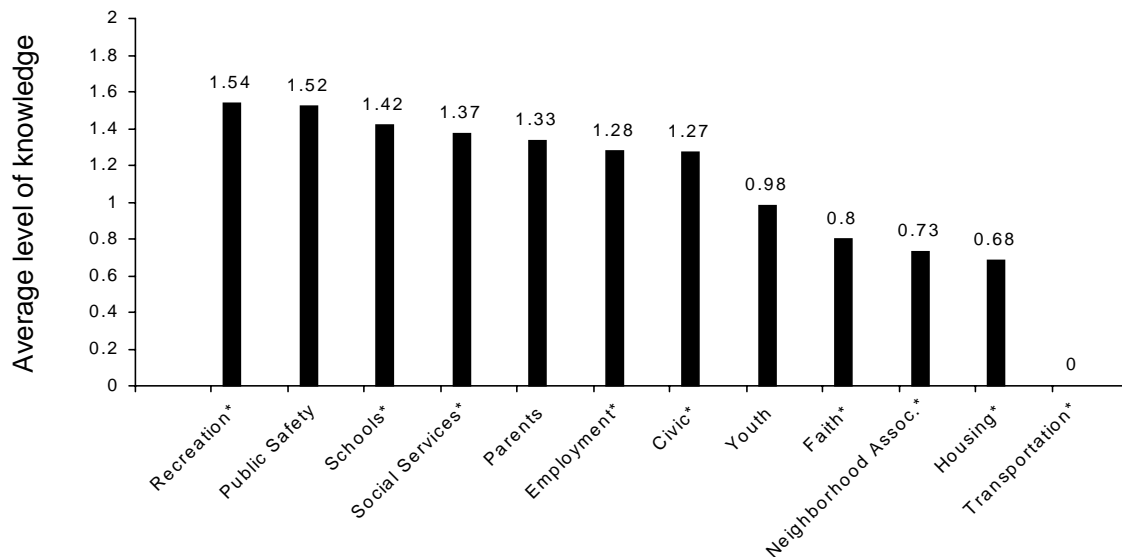
Results from these ratings were aggregated into the 13 key community partner domains: schools/education, recreation, faith, employment/business, housing, public safety, transportation, social/health services, youth organizations, parents/parent groups, other

residents, government/civic groups, and neighborhood associations. Knowledge and collaboration with “other residents” was omitted from further analysis because this category does not provide or organize services.

These data provide a baseline assessment of the level of shared understanding of community services and coordination for the Caring Communities. Figures 8 and 9 below show the average level of knowledge and collaboration for each type of community partner.

Figure 8

Respondents' Knowledge of Community Partner Services



Note:
 2 = high level of knowledge
 1 = some level of knowledge
 0 = no level knowledge

* There were statistically significant differences among Caring Communities in this area.

Caring Community service providers indicated the **highest** level of knowledge about school, recreational, and public safety services;

They had **much lower** levels of knowledge about activities provided by housing, transportation, youth groups, and neighborhood associations.

As shown above, respondents reported greatest knowledge of services provided by schools, recreational providers, and public safety. Relatively high levels of knowledge were also reported for employment/business groups, social/health services, parent organizations, and government/civic groups. Respondents were least knowledgeable about services or activities provided by faith organizations, housing services, transportation, youth groups, and neighborhood associations.

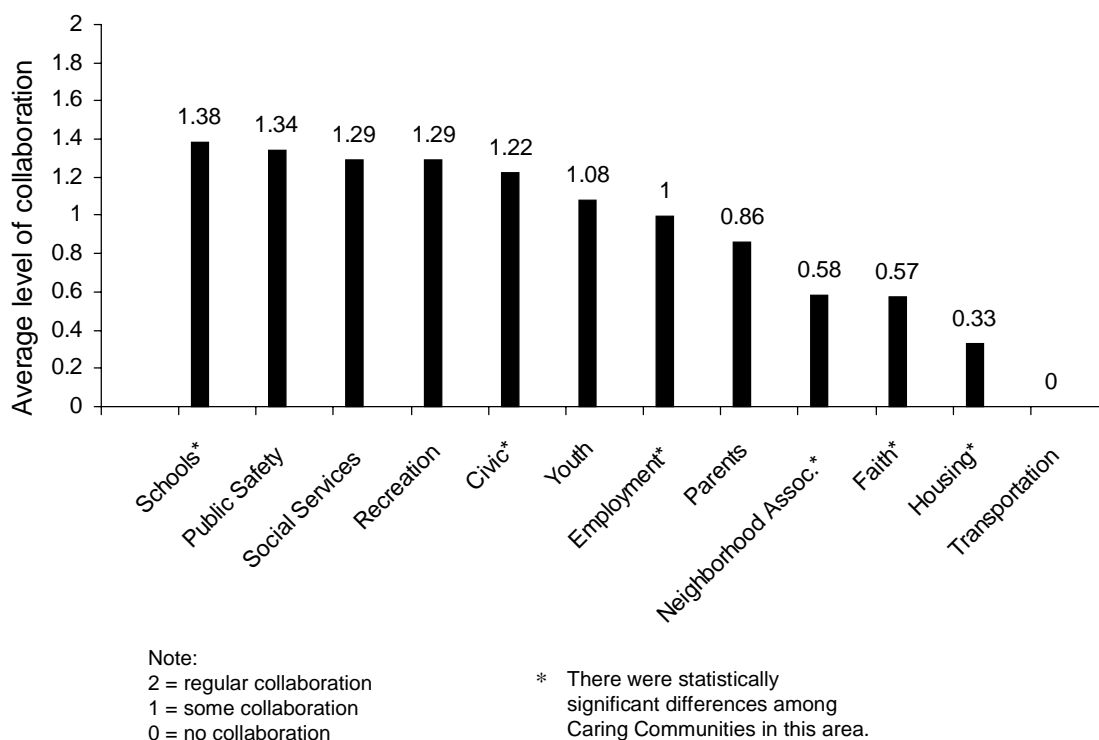
The levels of knowledge about different community services also differed depending on the type of service agency the respondent represented. In particular, educational providers were more knowledgeable about services provided in the schools than social service providers, "other" service providers, or non-providers. Non-service providers were most knowledgeable

about activities provided through the faith community and through neighborhood associations, and social service providers were most knowledgeable about social services. These results are not surprising; providers tend to know more about services within their own category.

There were also differences among Caring Communities for many domains. Specifically, knowledge of school services, recreation, faith community, employment/business, housing, transportation, social/health services, government/civic groups, and neighborhood associations differed significantly among the individual Caring Communities. Knowledge of community partner services was not associated with respondents' length of time in the Caring Community or with their level of involvement.

Figure 9

Extent of Collaboration Between Community Partners



As Figure 9 shows, the extent to which community partners have actually collaborated to plan, provide, and/or coordinate services is generally lower than their rated knowledge of each other's services (shown in Figure 8 above). Respondents indicated relatively high levels of collaboration with schools, recreational providers, public safety, social services, and government/civic groups. Lower levels of collaboration were indicated for the faith community, employment/business, housing, youth, parents, and neighborhood associations. Collaboration with transportation providers was almost zero.

There were, however, significant differences among the Caring Communities in the perceived level of collaboration with schools, faith communities, employment/business, housing, government/civic groups, and neighborhood associations. For some service domains, respondents from all Caring Communities showed at least moderate levels of collaboration. This was the case for schools, recreational providers, public safety, social services, and government/civic groups. However, for other categories, including faith communities, housing, and neighborhood associations, there was a high level of variability: for some Caring Communities, survey respondents reported very little collaboration with one or more of these entities, while in others the level of collaboration was moderate to high.

It was also the case that certain types of providers reported more collaboration than others. Typically, there was more collaboration between providers of the same type (e.g., educational providers tended to report more collaboration with other educational providers). In general, non-service provider groups reported less collaboration compared to social services, education, and other types of service providers. Length of time and level of participation in the Caring Community were not related to the extent of reported collaboration between community partners.

In addition to these ratings of specific providers, the survey also contained questions regarding general perceptions of changes in the levels of systems-level service coordination.

Respondents were asked to indicate the extent to which they believed the following had changed as a result of Caring Community activities:

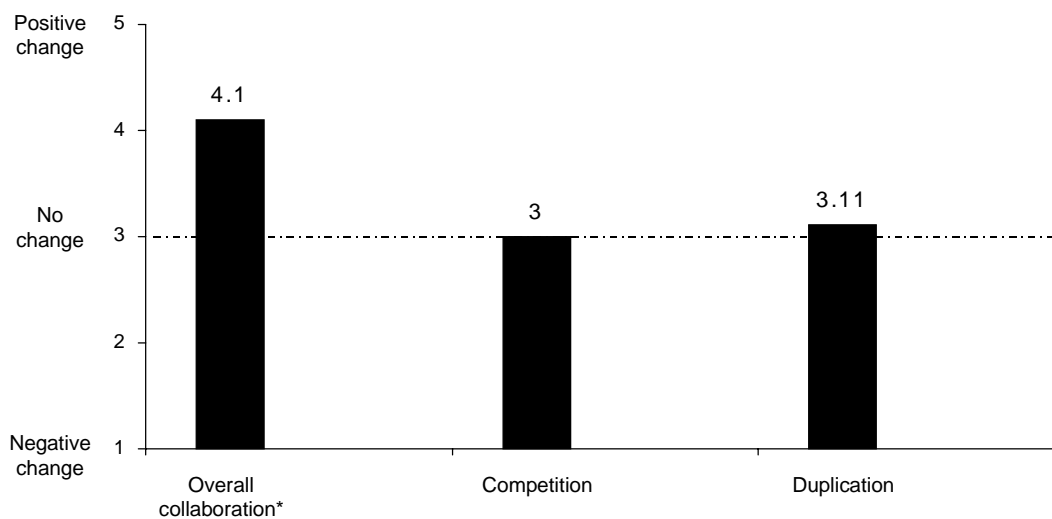
1. The amount of resources available in the community.
2. The number of new services or programs in the community.
3. The accessibility of services and programs in the community.
4. Respondent's own awareness of services and resources in the community.

5. The amount of information exchanged among groups/organizations.
6. The level of coordination of services in the community.
7. The number of joint projects undertaken.
8. The level of competition among service providers.
9. The level of duplication of services.

Responses to the first seven of these questions were highly correlated with each other; therefore, these items were combined to create an index of general provider-level systems integration. Internal consistency for this index was good, alpha=.83.

Figure 10

Changes in Provider-level Service Integration



Note:

5=major positive change
 4=moderate positive change
 3=no change
 2=moderate negative change
 1=major negative change

* There were statistically significant differences among Caring Communities in this area.

As shown in Figure 10, above, respondents indicated that there has been moderate positive change on the general index of provider-level systems coordination. For the two negative indicators of coordination, however, respondents indicated that there has been little or no change. This suggests that while progress has been made in terms of bringing providers together to coordinate and collaborate, eliminating duplication (possibly already existing) and

Survey respondents indicated positive changes in the level of coordination between service providers; however, the degree of competition and duplication has not been changed.

reducing competition between providers is more difficult to achieve. It should also be noted that responses varied considerably across the Caring Communities for overall collaboration but not for duplication or competition.

C. Summary: Systems integration Outcomes

The results of the Member survey suggest that there have been some significant improvements in the level of both individual and provider-level systems integration. This is consistent with the findings from the Key Stakeholder interviews, which suggested that improvements in provider-

Findings suggest that Caring Communities have resulted in:

Significant improvements in coordination and collaboration between providers

Some improvements in individual client-level service coordination; and

Few changes in policy-level systems integration.

level systems coordination and integration were the most significant accomplishments of the Caring Communities. As might be expected, however, **there was significantly more collaboration and coordination among those community partners who are more engaged in the Caring Communities:** social/health services, education, recreation, and public safety. Further, providers within any given category appeared to be both more knowledgeable about, and more likely to collaborate with, other providers within that same category. Expanding knowledge and collaboration about members of different community sectors may be

important to supporting continuing increases in systems integration. Finally, it is important to note that, not surprisingly, there are differences across the Caring Communities in terms of the extent of knowledge and collaboration between sectors. This is most likely due to the fact that

Caring Communities have been differentially successful in engaging various community sectors.

D. Realistic Expectations for Systems Integration Outcomes

Given the focus of the Caring Communities, it is most realistic to expect outcomes at the local provider level, along the dimensions outlined above. In particular, the longer an individual provider participates in the Caring Community, the more activities that are consistent with integrated services that provider should report (e.g., engaging in joint planning, sharing resources, sharing staff, etc). The survey used for the present study could be shortened and used as part of ongoing assessments of this outcome. Regular documentation could also incorporate relatively simple accounting of some indicators of systems integration, such as the number of different community sectors represented in a particular planning effort, or instances of sharing resources for a common program or event. Other variables that might be relatively easily measured, and which have been found to be important indicators of integrated service systems include:

- institutionalized linkages, such as co-location of service, sharing of staff, and written memoranda of agreement;
- systems for defining and communicating about service gaps, and commitment to filling these gaps; *and*
- financial incentives for interagency partnerships.

Policy level, institutionalized systems change is not a realistic outcome to expect. One review of twenty years of systems integration activities found that although much change was evident on the service provider and individual client level, the service system itself remained largely unchanged, and quite fragmented (Kusserow, 1991). Moreover, individual client-level outcomes are probably an unrealistic outcome for the Initiative as a whole, as only some of the Caring Communities have activities in place that can support this outcome. Although most of the Family Resource Centers engage in work to support client-level service coordination, it is probably not reasonable to hold the individual Caring Communities accountable for Family Resource Center outcomes.

VI. Community Engagement Outcomes

As described previously, there has been a relatively recent shift in emphasis beyond a focus on systems integration, and towards a broader definition of "community." Although community members who are not service providers have always participated in the Caring Communities, and Caring Communities are designed to be responsive to community-specific events, there is now a greater expectation regarding resident involvement. This has also entailed a shift towards more community-focused activities and events. However, it is important to note that the Caring Communities differ considerably in terms of the extent to which they have begun to shift towards a broader community focus. While some, such as Jefferson and Grant-Madison, have had this focus for several years, others are just beginning to move in this direction, and it has only recently been contractually required as a condition of funding from Multnomah County. For this reason, the evaluation did not have a primary focus on assessing community engagement. However, considerable evaluation effort was spent in developing an instrument that could be used for ongoing future assessment of community engagement by the Caring Communities. This is described further below (see "A Measure for Assessing Community Engagement," page 163).

A limited number of questions addressing community engagement were included on the Caring Community Member survey. First, we examined community engagement based on the community of service providers. Three questions assessed the extent to which the service provider community was knowledgeable and responsive to community issues. These questions asked respondents to indicate the extent to which the following had increased or decreased:

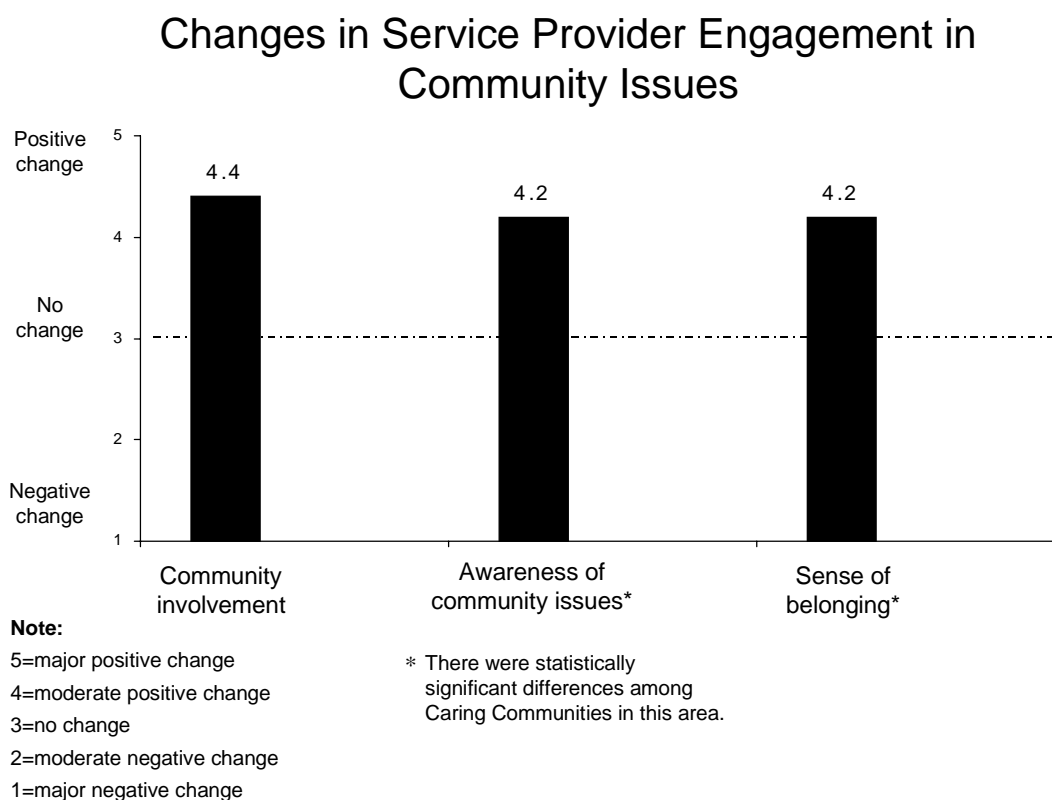
1. The number of community service providers actively involved in community issues.
2. The level of awareness in the service provider community about key community issues.
3. The sense of belonging to the service provider community.

As can be seen in Figure 11 below, respondents generally perceived a moderate level of positive change in the extent to which community service providers were aware of and engaged in community issues. Moreover, the longer respondents had been involved in the Caring Community, and the more engaged they were in Caring Community activities, the more positive change they reported in terms of feelings of "belonging" to the service provider community.

There were also significant differences among the Caring Communities in terms of reported awareness of key community issues, with scores ranging from a low of 4.0 to a high of 4.5. Note, however that across all Caring Communities, survey respondents reported at least a moderate positive change in awareness of community issues.

Figure 11

Using the same response format, three additional questions assessed the respondent's perception of change in the extent of **general** community engagement:



1. The number of community residents actively involved in community issues.
2. The level awareness in the general community about key issues.
3. The sense of belonging the respondent feels to the general community.

Figure 12 shows the results of respondents' perceptions of general community involvement. As can be seen, respondents reported consistent and moderate levels of change for each of these three items, although the most positive change was reported in respondents' feelings of belonging to the general community. As might be expected given the variability of the Caring Communities in addressing the community involvement issues, there were significant differences among Caring Communities for each of these questions.

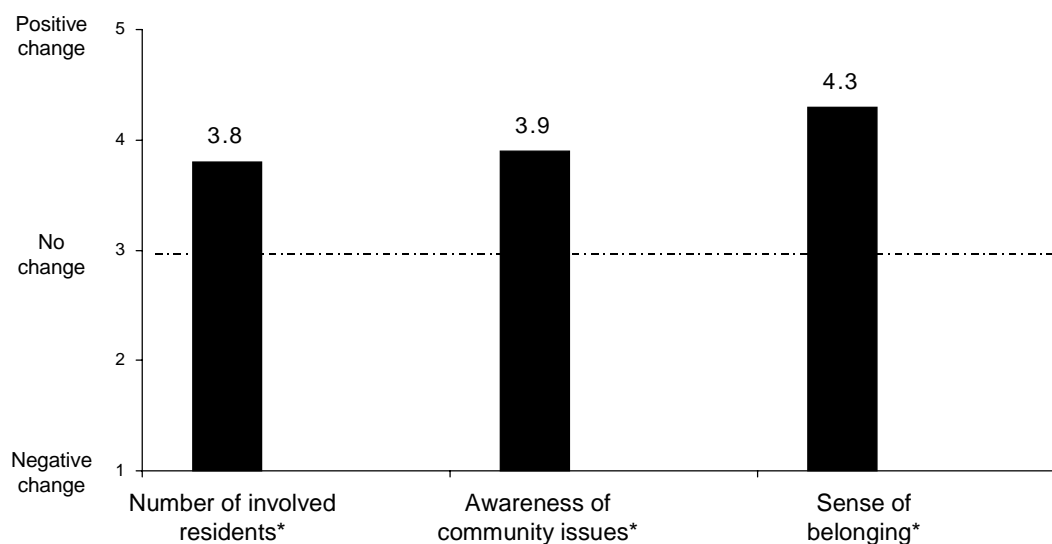
Respondents who were more actively involved in the Caring Community reported a greater increase in their sense of belonging to the general community.

For example, the reported change in the number of community residents involved in community issues ranged from a low of 3.5, indicating almost no change, to a high of 4.0, indicating moderate positive change.

Further, as was found for the sense of belonging to the provider community, the longer the respondent had been involved in the Caring Community and the more s/he was active in its activities, the higher the reported change in sense of belonging to the general community.

Figure 12

Changes in Perceived Community Involvement



Note:

5=major positive change
 4=moderate positive change
 3=no change
 2=moderate negative change
 1=major negative change

* There were statistically significant differences among Caring Communities in this area.

A. Involvement of Residents and Other Partners

As described in “Organizational Effectiveness” above, most of the Caring Communities have engaged at least some non-service provider partners in their activities. Many of the Caring Communities have been successful in engaging the faith community, youth, and the business sector, although some Caring Communities have been more successful than others. Parents and general community residents appear to be less involved, overall, although again, in some Caring Communities these groups are active. Those who have been most successful in reaching out to non-provider groups have been engaged for several years in these efforts, and have actively restructured their meeting times and locations to facilitate involvement from these sectors. For example, Jefferson holds meetings in the evenings at the local high school to encourage community involvement. Grant-Madison, which has been quite successful in engaging the faith community, actively partners with local churches to share resources and

engage in joint planning. Caring Communities may want to consider whether resident involvement in governance and leadership should be included in the future as a criterion for organizational effectiveness.

Despite the efforts of some of the Caring Communities, the primary participants at this time are social/health service programs and representatives from the education sector. It is important to note, however, that the current structure in most Caring Communities emphasizes services integration and coordination, a topic that is more directly relevant to the provider community. **As the focus of the Caring Communities shifts towards broader community participation, the extent to which this new goal fits with the existing goals of systems integration and school completion will need to be explored.**

Involving Community Residents

Caring Communities that have been most successful in reaching out to non-provider groups have been engaged for several years in these efforts, and have actively restructured their meeting times and locations to facilitate involvement from these sectors.

B. Responsiveness to Neighborhood Events

As described previously, the Caring Community was designed to support community-level decision making about goals and activities. This has allowed the Caring Communities to develop individualized events and activities that can be responsive to specific community needs. Many of the Caring Communities have current activities or programs that were developed in response to an identified community need. For example:

In East County, a large number of children were being excluded from school enrollment because they lacked proper immunizations. This finding led directly to the immunization programs and the community health screenings.

In Grant-Madison, the Grant Community Conversation developed in response to a series of armed robberies committed by Grant High School students.

In Inner Southeast, a variety of after-school activities were planned based on a community needs assessment that identified this as a significant service gap.

In Jefferson, the Caring Community helped to facilitate the Humboldt Neighborhood Association's Community Visioning Process (part of their Target Area Grant Project), engaging the community in planning the revitalization of the Humboldt Neighborhood.

In North Portland, the Caring Community evolved from efforts to deal with increases in gang-related violence in the Columbia Villa housing project.

In West District, there has been an action team devoted to dealing with emerging community issues.

However, although many of the Caring Communities have developed such community-

Caring Communities do not have a systematic method for identifying or selecting community issues or possible solutions.

responsive events, the mechanism for how new projects are initiated and sustained is somewhat unclear. Only one of the Caring Communities (Mid-County) has an action team that is focused on data-based needs assessment. In other Caring Communities the system for identifying and addressing community needs is much more informal.

C. Responsiveness to Community Diversity

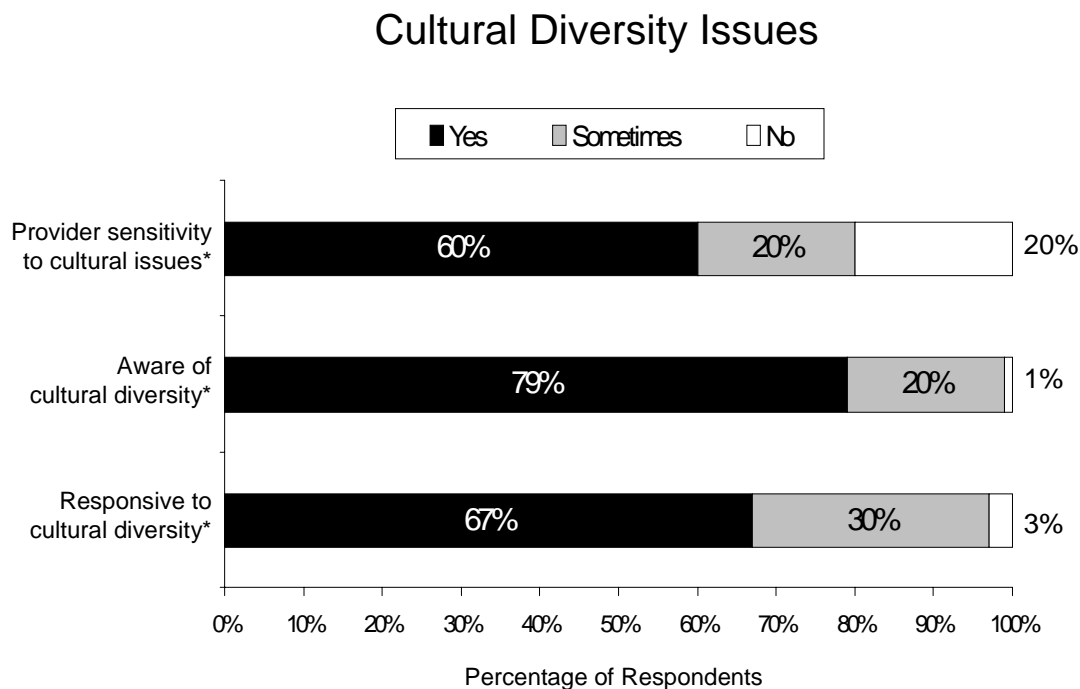
One unanticipated change that many Caring Communities have encountered is a major shift in the demographics of the resident population. While the nature of this shift differs depending on the community (e.g., East County and Mid-County have seen rapid increases in the Hispanic population, while Grant-Madison, Inner Southeast, and Outer Southeast have seen increases in Asian and Eastern European groups), this issue has become an important one across the Initiative. Caring Communities have begun to actively address issues of cultural diversity, especially in regards to the needs of non-English speaking residents. East County, Mid-County, Outer Southeast, and Grant have all had some Caring Community materials translated into other languages. Some Caring Communities have action teams to specifically address the needs of diverse cultural groups.

A few questions were included in the Member Survey to address the issue of how well the Caring Community is responding to cultural diversity issues. Respondents were asked whether:

1. "The Caring Community is aware of cultural diversity in this community."
2. "The Caring Community is responsive to the needs of culturally diverse groups in this community."

Additionally, respondents were asked to indicate the extent to which "the level of sensitivity of the provider community to issues of cultural diversity" had changed as a result of Caring Community activities.

Figure 13



* There were statistically significant differences among Caring Communities in this area.

As can be seen in Figure 13, most respondents indicated that their Caring Community was aware of cultural diversity in the community. However, the extent to which Caring Communities have been responsive to the needs of culturally diverse groups is somewhat lower: 79 percent indicated that the Caring Community is aware of cultural diversity, while only 67 percent indicated that they were responsive to the needs of these groups. This is consistent with the fact that many Caring Communities are still working to raise awareness among their constituencies of the needs of different cultural groups, and beginning to devote energy and resources to their needs. Most respondents (60%) indicated that there had been moderate increases in the level of provider sensitivity to cultural diversity issues, as well. Twenty percent indicated that there had been “no change” and another 20 percent indicated that there had been a major increase in sensitivity. Key informants also mentioned that Caring Communities need to improve their outreach to persons of color or other minorities.

It should be noted, however, that there were significant differences among Caring Communities for all three of these items. Some Caring Communities were perceived as more aware of and responsive to issues of cultural diversity than others. Caring Communities ranged in both awareness and responsiveness from a low of 1.3 to a high of 1.9, out of a maximum possible score of 2.0.

79% of survey respondents indicated that the Caring Communities are aware of cultural diversity;

67% indicated that the Caring Communities are responsive to this diversity.

D. Summary: Community Engagement Outcomes

Results from Key Stakeholder interviews, Member Surveys, and Resident Surveys suggest that while some progress has been made in engaging different community sectors, additional work is needed in this area. The specific non-provider groups who are absent differ depending on the specific Caring Community, although general residents and transportation providers are consistently absent from most Caring Communities. As previously mentioned, many of the Caring Communities have only recently begun to shift towards a broader community focus. This shift will no doubt take time, and require additional discussion and clarification of how this emphasis fits with existing group structures and activities.

The ability of Caring Communities to be responsive to neighborhood needs is another key indicator of how well-connected to the communities the Caring Communities are. **Currently,**

there are many examples of Caring Communities acting in ways that are responsive to community input; however, engaging the broader community to define these needs and develop ways to respond will be increasingly important. Finally, the measure developed to assess community engagement may provide a good tool for assessing ongoing changes in community engagement outcomes at the resident level (see below).

E. A Measure for Assessing Community Engagement

A measure of community engagement was developed and pilot tested as part of this evaluation. A copy of this measure can be found in Appendix F, page 163. The survey included five items from a previously developed measure of community engagement, the Sense of Community scale (Chavis, Florin, Rich and Wandersman, 1987). These items were:

1. I think my community is a good place for me to live.
2. I can recognize many of the people who live in my community.
3. I feel at home in this community.
4. If there is a problem in this community, people can get it solved.
5. I can have an influence on what this community is like.

For the purposes of the survey, the “community” was defined as the geographic area around the specific local high school that was most central in each Caring Community.

Three additional items were added to examine factors thought to be important to the Caring Community:

1. In this community, people, schools, agencies and other groups work together.
2. In the past year, I have been more involved in my community.
3. In the past year, there have been positive changes in my community.

Surveys also asked whether the respondent had ever heard of the Caring Communities, and if yes, whether they had ever participated in a Caring Community event or activity. Those respondents who had heard of the Caring Community were also asked to rate the following statements from strongly agree to strongly disagree:

1. “Overall, the Caring Community is a strong force in this community.”
2. “The Caring Community works on the most important community issues.”

3. “The Caring Community is responsive to the needs of culturally diverse groups in this community.”

Additionally, several open-ended questions asked respondents about the kinds of activities or events they would like to see in their communities, and what would help them to become more involved in the community.

Face to Face Interviews. The instrument was piloted as a face-to-face interview at two health screenings co-facilitated by the East County Caring Community and the Mid-County Caring Community. Persons attending these clinics often have to wait between appointments, and the coordinators felt that it would be a good opportunity to attempt this type of data collection. A pair of interviewers went to the screenings, which proved helpful in allowing parents to respond to the survey while one of the interviewers helped to supervise the children. At the second screening, a bilingual Spanish speaking interviewer served as an interpreter, allowing data to be collected from seven Spanish-speaking residents. The interviewers reported that Spanish-speaking parents were especially enthusiastic, and appreciated the presence of the interpreter.

Although the questionnaire was not re-formatted as an interview script, the format is simple enough that interviewers could readily convert the questions to interview style. Interviewers reported that some of the parents wanted to complete the survey “on their own,” rather than as an interview. In the face-to-face interview, it appeared that parents struggled more to respond to the open-ended questions. Interviewers reported that parents appeared to have no trouble responding to the closed-ended (quantitative) questions. They also reported that most parents were eager to participate in the survey process. Interviews took between 10–15 minutes to complete. A total of 27 persons were interviewed.

Mail Survey. The same instrument was also piloted as a mail survey. A mailing list was obtained from Multnomah County, comprised of individuals who had attended a recent community forum or event. From this list, those residents from four zip codes within two Caring Communities (Jefferson and Grant-Madison) were selected. These communities were chosen because they have both been active in community outreach/involvement activities for a relatively long time. A total of 91 surveys were mailed in the Jefferson area and 77 in the Grant-Madison area (168 total). Of these, 14 were returned as undeliverable, and 69 were completed and returned for an average response rate of 45 percent. The response rate for Jefferson was

32 percent, and for Grant-Madison was 52 percent. A nominal incentive technique was tested as a means to increase response rates. This technique involves giving respondents a small incentive (in this case, a \$5 bill), which is sent with the survey itself. The incentive is expected to trigger “the norm of reciprocity,” and thus facilitate survey response. In this case, of 76 surveys successfully mailed with incentives, 46 were returned for an incentive response rate of 61 percent. This is an extremely high response rate for this type of mail survey. In contrast, of 78 surveys successfully mailed without incentives, only 28 percent were returned.

\$\$ Small Incentives Work! \$\$

Surveys with \$5: 61% completed and returned

Surveys without \$5: 28% completed and returned

Table 3, below describes the characteristics of persons responding to the community resident survey (both face to face and mail versions). As can be seen, the majority of respondents were female, Caucasian/White, between the ages of 21 and 55, and had children. The great majority (91%) lived in the specific Caring Community, while only 32 percent worked in the community. Only a small percentage had heard of the Caring Community (15%).

Table 3
**Demographic Characteristics of
Community Resident Survey Respondents**

Gender	
Female	63%
Race/Ethnicity	
Caucasian/White	75%
African American	9%
Hispanic/Latino	11%
Asian/Pacific Islander	1%
Native American	2%
Bi-racial	2%
Age Group	
Less than 21 years	0%
21–55 years	74%
Over 55 years	26%
Have Children?	
Yes	71%
Live in the Caring Community?	
Yes	91%
Work in the Caring Community?	
Yes	32%
Heard of the Caring Community?	
Yes	15%

One key question for the pilot study was whether the Sense of Community scale appeared to be a useful measure of residents' level of community engagement. To assess this, we examined: reliability, or the extent to which the survey items are related to each other; variability, or the extent to which answers vary across the items, and the average scores on the items. A reliable measure is one that seems to measure a single key construct. Variability is important for instruments used to measure change: if all respondents answer the same way, it

will be difficult to measure change. Similarly, the average score should be low enough that scores can increase (e.g., if scores are all extremely high at baseline, there is no room for improvement).

The scale proved to be statistically reliable², even though shortened from its original length of 10 items. Further, there was sufficient variability on the scale to indicate that the measure might be sensitive to change over time. The mean score was 3.88 on a 5-point scale, which although somewhat positive, does suggest there is room for increases in individuals' scores on this measure. The standard deviation was .61, indicating small but sufficient variance for the measure to be sensitive to change.

As can be seen in Figure 14 below, there was a slight tendency for respondents who had heard of the Caring Community to score higher on the measures of community engagement. Although the sample is small, and it not possible to know the direction of causality (e.g., people who become involved with the Caring Community may feel more positively about their community to begin with, rather than involvement in the Caring Community leading to more positive feelings about the community), the data at least suggest that this may be a good measure of differences in terms of perceptions of the community. Of those who had heard of the Caring Community, however, it is important to note that most of these (57%) had never attended a Caring Community meeting. The remaining 43 percent indicated that they attended one or two meetings per year.

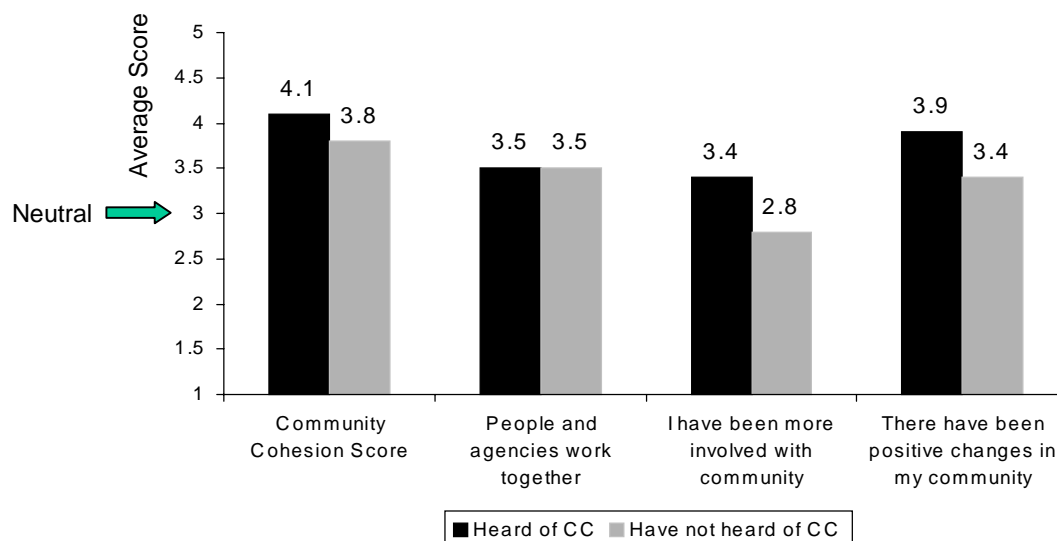
The measure of community engagement may prove to be a useful approach for measuring the success of community-building efforts.

² Coefficient alpha=.81.

Figure 14

Outcomes of the Community Resident Survey

Higher Scores=More Positive Community Outcomes



Resident surveys may also serve as a mechanism to facilitate community outreach. Of the 69 mail surveys returned, 27 persons (39%) completed a form in order to be added to the Caring Community's mailing list. Of the 27 face-to-face interviews, about 12 completed this form.

F. Recommendations for Future Evaluation of Community Engagement

The measure developed and pilot tested for this evaluation appears to be a useful, user-friendly instrument for assessing community engagement. The measure was reportedly easy to complete, and response rates (especially when incentives were used) were quite high, reducing the chances of response bias. While it was beyond the scope of the present work to assess the content validity of the measure, it is reassuring that the major component of the community engagement instrument was tested and developed through prior research on community collaboration (Chavis et al., 1987). The items appear to have face validity as indicators of community engagement and involvement. The measure did not show any "ceiling" or "floor" effects which would indicate that it would be inappropriate to use for assessing change.

If the Caring Communities continue to focus on and emphasize community engagement, it will be important to measure their outcomes on this dimension. A baseline measure taken relatively soon would be useful in order to assess change over time. It is important, however, to maintain realistic expectations for change on this dimension. It seems unlikely that a single organization or group, such as a Caring Community, will be able to influence large numbers of community residents without significant resources dedicated to outreach, public relations, and/or advertising. **However, it is more realistic to expect to see (1) increasing numbers of residents involved with or “touched by” a Caring Community, and (2) changes in levels of community engagement and/or cohesion among those actively participating in a Caring Community.** This issue is discussed further below.

G. Preliminary Findings from the Community Building Initiative

Concurrently with the Caring Community Evaluation, the Multnomah County Department of Community and Family Services (DCFS) undertook an evaluation of six projects funded by the Board of County Commissioners and administered by the Caring Communities as part of the County's Community Building Initiative (CBI). The purpose of the projects was to explore how initial seed money might be used to foster community development, community engagement and capacity building. Six Caring Communities submitted proposals, which were funded at \$10,000 each. The project period was March 1, 1998 through March 31, 1999. Because of the similarity between the two projects, the evaluators collaborated to ensure some consistency in the data collection across initiatives. Preliminary findings from the CBI are included below. These results underscore many of the issues highlighted by the Caring Community Evaluation.

Preliminary Findings from the Community Building Initiative Evaluation

By Ellen Konrad, Department of Community and Family Services

The three-fold purpose of the CBI evaluation was to describe the projects and the near-term outcomes achieved, assess the extent to which projects exemplified the key characteristics of successful community building efforts, and obtain informal feedback from community residents who participated in selected project activities. In a cooperative effort, the two evaluations jointly adopted five common questions from the Sense of Community scale (described above) and added on one additional question, to measure residents' level of community engagement.

The following early lessons from the CBI study may be useful in supplementing the results of the Caring Community evaluation in the area of community engagement:

1. The CBI grant projects provided an opportunity for the participating Caring Communities to further expand their focus beyond service integration and move toward the broader definition of "community." They did so in two ways: either through a specific activity or set of tasks, and/or by supporting the Caring Community Coordinator's role in facilitating a variety of community development and capacity-building efforts.
2. However, in order to assess the outcomes of these efforts in the proper context, it is important for stakeholders and participants to adopt realistic expectations about what can be accomplished—particularly with respect to the breadth of community sectors that are likely to become involved, the depth of penetration within any given sector, and the length of time it takes to achieve tangible, measurable results of community involvement.
3. As the individual Caring Communities increase their community building efforts they must address or reassess the scope of that role. A number of project stakeholders expressed the need for clearer identification and definition of goals for the community building portion of their activities. To what extent should goals, issues and strategies be externally driven versus community driven? Important considerations in that discussion are who should be involved in developing those goals, how it should be done, and what the Caring Communities' capacities are to pursue the community development path in light of their other goals.
4. Stability of resources to support a coordinator/facilitator role is critical so that community building efforts are not supplanted or diluted by the struggle for survival. While the development and contribution of resources from a variety of funding sources is to a certain extent a measure of the community's commitment to such activities, a minimum level of support is necessary to establish a core capacity and enable a basic, consistent level of community building activity.
5. ~~The Department of Community and Family Services supports efforts to measure various~~ aspects of community engagement, both during the early stages of community building work (i.e., at baseline) and over time. To the extent possible, it would be desirable to collect data on a standard set of community involvement variables, both across the community as a whole, and for participants in targeted community development activities.
6. In addition to their existing capabilities and expertise, Caring Communities might benefit from further technical assistance on a variety of community building techniques, including goal-setting, needs assessment, strategy development, leadership development, follow up, outcome measurement, etc.

CBI Results, Continued.

The CBI study also piloted a community resident survey, which targeted participants in the Mid County Caring Community grant project. The grant provided for several series of enhanced recreational evenings ("Family Nights") for families at the East Portland Community Center. A combination of in-person interviews and mail-return questionnaires was used to survey 23 attendees. Five of the same "sense of community" items used in the Caring Community evaluation's community engagement measure were also used in the CBI instrument. Although the small number of surveys and other methodological limitations make it difficult to draw any definitive conclusions, some of the findings may be helpful in guiding and assessing future community building efforts:

1. With respect to the common Sense of Community questions used in the two studies, a majority of respondents said they felt positively about their community, had been more involved in the past year, and felt they could influence what the community is like. They were ambivalent about the ability of the community to solve local problems and the extent to which they recognized other people in the community. Fewer than one-fourth said that they recognize community leaders (e.g., school principals, clergy, business owners, etc.).
2. In the short term, respondents' participation in Family Nights was not likely to result in their subsequent involvement in other community activities. However, most participants increased their social capital by enthusiastically encouraging their friends and neighbors to attend the Family Night events.
3. Responses highlighted the importance of having a strong community institution (i.e., the City of Portland's Community Center) as a focal point for attracting and sustaining community interest.
4. Responses to several open-ended CBI survey questions suggested, among other things, that community residents would be willing to become more involved if they received regular information about local events or if they were given specific, detailed information about how they could participate on an individual basis.

Obtaining this kind of feedback from community residents can be an important resource for Caring Communities in both planning for future community building efforts and assessing long-term progress towards those goals.

H. Realistic Expectations for Community Engagement

Both the CCI Evaluation and the Community Building Initiative highlight the need for additional work to clarify the expected goals and outcomes of community engagement. There are at least five, if not more, different possible goals for community engagement:

1. To involve residents in solving community-specific issues or problems, with the assumption that these efforts are strengthened by the development of grass-roots leadership;
2. To involve residents as a means for enhancing these individuals' feelings of competency, empowerment, and feelings of connection to the community;
3. To involve residents in planning and coordination of social services, with the assumption that the "consumer perspective" is critical to implementing a quality system;
4. To involve individual parents, children, and service recipients in efforts to plan and implement their own specific set of individualized wraparound services.
5. To involve residents as recipients of Caring Community services and activities that support community development and interaction (e.g., Family Nights).

Realistic expectations for outcomes related to community engagement differ depending on which of these models, or combination of models, the Caring Communities adopt.

Traditionally, community development activities are initiated in response to specific community events or issues. While many of the Caring Communities do have action teams that are focused on specific community goals or issues, these efforts do not typically stem from grass

Expectations regarding community engagement need to be clarified, while at the same time a balance should be found between community based goals and externally-driven ones.

roots community development. A unique aspect of the Caring Community is that these action teams primarily, although not exclusively, consist of neighborhood service providers of a variety of types. Thus, the focus is on working within existing service systems to create community change, rather than using a grass-roots (resident-based) approach. It remains to be seen whether

these approaches are mutually exclusive. The work in some of the Caring Communities, such as Jefferson and Grant-Madison, suggests that these two groups can be merged successfully. However, even within these two Communities, the majority of persons involved in planning and decision making are not residents, although significant numbers of residents may attend Caring

Community-sponsored events. This tension between locally-driven and externally-driven goals and activities was also highlighted in the Community Building Initiative evaluation.

Research has found that residents are most likely to participate in community groups focused on issues that directly impact them, or in which they have a personal interest (Wandersman, 1979). This suggests that efforts to engage and involve community residents will be more successful to the extent that the Caring Communities have action teams, projects, or activities that are important to the community residents. The information-sharing

Efforts to involve community residents are likely to be more successful if there are projects or activities that are *important to them*.

Services integration may not be centrally important to many residents.

that is the focus of many general Caring Community meetings may be of primary interest to the service provider community, but may not be a good mechanism for engaging community residents. Other groups, such as the Peace Action team in the Jefferson Caring Community, may be more likely to foster residents' interest. While measures such as the Sense of Community scale used in this evaluation as well as the Community-Building initiative may be useful to assess residents' sense of belonging and empowerment in the community, defining outcome measures is premature at this point. Additional work to clarify the goals, scope, and roles for the Caring Communities in relation to community engagement is necessary before specific recommendations regarding evaluation of this component can be made.

VII. Conclusions and Issues

A. Strengths

Key Outcome #1: Organizational Effectiveness

Establishing an effective organizational structure is one of the keys to success for community collaborative groups (Kumper, 1993). The CCI has been largely successful in many of the key indicators of organizational effectiveness (Kegler et al.). In particular, although not all key sectors are engaged in all of the Caring Communities, the number of partners currently “at the table” on a regular basis is quite large, and represents many different aspects of the community. A variety of service providers are regularly engaged, and in many Caring Communities, schools are an extremely strong partner. This alone is quite noteworthy, however, several of the Caring Communities have also successfully engaged other sectors, such as the faith community, elected officials, parents, youth, and the business community. Engaging community residents in organizational leadership may be an area for improvement in the future.

Further, although member and staff turnover has been a significant challenge in some Caring Communities, most members report a high level of commitment to their Caring Community and its work. Member commitment is a key to effective community development and collaborative group work.

Caring Communities have:

- *Engaged a variety of community partners*, most notably the schools, social and health services providers, and public safety;
- *Consistently high levels of member commitment* to the Caring Community and its work;
- *Strong leadership*, including the coordinators, Caring Community chairpersons, and action team/subcommittee leaders; and
- *Effective communication with members*, especially in terms of responsiveness to individual requests.

The Caring Communities are also characterized by strong leadership. Caring Community members perceived those in leadership positions, which includes coordinators and action

team/subcommittee chairpersons, to be strong and effective leaders. Leaders were seen as particularly skillful in their ability to solicit input from large groups and to facilitate compromise, key skills for the diverse membership of the Caring Communities.

At least some of the Caring Communities have an effective subcommittee or action team structure. Action teams serve a number of different functions, and are important mechanisms for Caring Community work. Communication between action teams is an area that may need additional attention in order to facilitate knowledge among all Caring Community members about the various projects and activities. This is especially important for those Caring Communities that have a large number of action teams and workgroups.

Key Outcome #2: Systems Integration

The CCI has been successful in supporting systems integration, especially at the service provider level, at least among those providers who participate in Caring Community activities. Monthly meetings appear to be a successful mechanism for supporting provider-level systems integration and information sharing. This finding is consistent across the various evaluation data sources. Caring Communities have helped to increase the number of collaborative activities, joint planning, and other key indicators of provider-level systems integration, according to members' reports. Caring Community members also reported some increases in client-level service integration, such as the number of referrals, although the mechanisms for this are less clear. The most obvious pathway to individual service integration is through the work of the Family Resource Centers, which are supported by the Caring Communities.

Evaluation findings suggest that Caring Communities have resulted in:

- *Significant improvements* in coordination and collaboration between providers
- *Some improvements* in individual client-level service coordination; and
- *Fewer changes* in policy-level systems integration.

One of the primary accomplishments of the CCI was its involvement in developing and supporting Family Resource Centers in six of the eight communities. Family Resource Centers actively support the service integration goals of the CCI by working to coordinate services for individual families and youth. While the Caring Communities do not directly operate the Family Resource Centers, they are closely involved with their planning, development, and

implementation. Some, for example, the Grant Madison Caring Community, have action teams that provide ongoing support to the Family Resource Centers. In other cases, the Caring Community coordinator is a Family Resource Center Board Member. In many cases, there continues to be a supportive, collaborative relationship between Family Resource Centers and Caring Communities.

Another major accomplishment in terms of systems integration was the merger of the Caring Communities with the District Coordinating Teams. This merger both helped to strengthen the Caring Communities as a systems integration entity, as well as to avoid potential duplication of efforts, the very thing the Caring Communities work to avoid. The process of completing this merger was not without problems, and raised a number of issues related to balancing local-level decision making with the goals of the funding agencies. That the merger was ultimately successful is a credit to the Caring Community partners.

Key Outcome #3: Community Engagement

Evaluation results suggest that while the Caring Communities have made some progress in reaching out to the non-service provider community, there is still room for improvement in this area. The specific non-provider groups who are not “at the table” differ depending on the specific Caring Community, although general community residents and transportation providers were consistently absent from most

Caring Communities. Many of the Caring Communities have only recently begun to shift towards a broader community focus. This shift will no doubt take time, and will require additional discussion and clarification of how this emphasis fits with existing Caring Community goals and activities. Progress towards increasing community engagement has already occurred through some of the activities of the Caring Communities. Specifically, some of the Caring Communities have been involved in developing projects

Caring Communities were perceived by survey respondents to have:

- *High levels* of participation by social services and schools;
- *Moderate levels* of participation by recreational providers, the faith community, employment/business, public safety, youth, and government officials; and
- *Relatively low levels* of participation by transportation providers, housing, parents, and general residents.

through the Community Building Initiative, and in convening community meetings to discuss issues such as county budgets, neighborhood violence prevention, and other topics.

The ability of Caring Communities to be responsive to neighborhood needs is another key indicator of how well Caring Communities are connected to the communities. Currently, there are many examples of Caring Communities acting in ways that are responsive to community input; however, more systematic ways of engaging the broader community in defining these needs and developing ways to respond will be increasingly important, given the new emphasis on community resident engagement.

Key Outcome #4: Other Accomplishments

Because each individual Caring Community is engaged in such a wide variety of activities, there are a number of other achievements that do not easily fit within any single category defined by the CCI. Examples of these accomplishments include:

- Facilitating the Take the Time Assets surveys and mini-grants;
- Planning and facilitating health fairs, health clinics, and health and immunization screenings;
- Facilitating volunteer support for a variety of mentoring and tutoring programs for youth;
- Working to support the School Attendance Initiative; and
- Convening community meetings to discuss issues such as the county budgets, neighborhood violence prevention, and other topics.

These project-specific accomplishments are a large part of the ongoing work of the Caring Communities.

B. Issues and Challenges

Key Issue #1: Funding and Sustainability

Without doubt, one of the biggest challenges facing the Caring Communities is how to ensure ongoing support for coordination. The role of the coordinator is clearly key to Caring Community effectiveness; the importance of paid staff to coalition efforts has been documented (Kegler et al., 1998). Core funding from Multnomah County helps to pay part of the coordinator's salary, however, many of the coordinators continue to need to actively pursue other grants and funding

sources to support their work. East County has a model funding mechanism for the coordinator. Multnomah County and Department of Human Resources funds are supplemented by dollars provided by the involved school districts and the City of Gresham. Thus, a number of key players are able to merge funding to support the coordinator. This prevents a large amount of the coordinator's time from being spent in pursuit of grants to support her salary. Grant funding is used, instead, to support specific projects. This model, or some other mechanism to ensure consistent core support, is needed for the other Caring Communities. In addition to funding for the coordinator, some of the Caring Communities lack a variety of other resources that could contribute to their productivity. Support staff assistance would help to ensure organized and well-maintained membership lists and databases. Computer resources are scarce in some Caring Communities, which is a significant barrier to communication. Finally, additional funds for Caring Community-sponsored events and activities are generally in short supply, although most of the Caring Communities have had at least some success finding or leveraging new resources or partnering with other providers to maximize the impact of available resources.

Key Issue #2: Organizational and Structural Issues

Although for the most part, the Caring Communities have many of the desired characteristics of effective organizations, there is room for improvement. In particular, additional work is needed to develop systems to ensure clarity of decision-making procedures within Caring Community workgroups, to clarify and define a shared vision, to enhance the timeliness and usefulness of coordinator communication (at least in some Caring Communities), and to develop mechanisms to ease problems associated with staff and member turnover. Many of the Caring Communities need to ensure that there is an organized member mailing list and systems for updating this information. Finally, Caring Communities may want to consider whether engaging residents in organizational leadership should be adopted as a criterion for organizational effectiveness, given the new emphasis on community engagement.

Key Issue #3: Clarification of Goals

3a. Merging of Systems Integration Goals with Community Building Goals.

Currently, the Caring Communities are experiencing a shift in emphasis towards broader community engagement. As discussed previously, further discussion and clarification of the underlying assumptions and expected outcomes for community engagement should occur before realistic outcomes can be established for this domain. Further, the implications for the shift on the systems integration mission of the Caring Communities should be explored. As one Key Stakeholder put it, “we may be trying to straddle the systems view and the grass-roots view” which may be difficult. The needs and interests of the service provider community in terms of information sharing, collaborative planning, etc., may be quite different than the needs, interests, and priorities of community residents. A well-thought-through structure for ensuring that the successes gained in working towards systems integration are not lost with the shift towards community engagement is needed.

Fully half of the Key Stakeholders interviewed for the initiative-wide survey indicated that a smaller set of clear, unifying goals and parameters would help to improve the Caring Communities.

3b. Appropriateness of School Completion Goal. Although a common goal uniting the different Caring Communities is 100% school completion, there is reason to question whether this is an appropriate or meaningful goal. As discussed previously, many of the Caring Communities are not engaged in activities that might be expected to have a direct and relatively immediate effect on school completion. Instead, many of the activities are related only in a very indirect way to rates of school completion. Other initiatives, such as the School Attendance Initiative, are investing considerable resources in activities designed to directly impact school completion outcomes; however, even for this type of program this remains a difficult outcome to effect. As one Leaders Roundtable member put it, “They [the Caring Communities] have a vague shared connection to school completion, but it is very oblique.” Consideration should be given to limiting stated outcomes and goals to those that are more realistically within the scope of Caring Community activities.

3c. Top-Down vs. Grass-Roots Goal-Setting. In defining goals for the Caring Communities, one recurring issue is finding a balance between goals established in a “top-down” fashion by policymakers and

funders, vs. those goals that stem from grass roots community level concerns with various issues. While community level decision-making is important, and in fact, having a high level of local ownership regarding goals and activities has been

The Caring Communities should be recognized as a central part of the community services and events with which they are involved. This recognition would help to strengthen the visibility, influence, and support for the Initiative.

found to be associated with coalition productivity (Kegler et al., 1998), it does lead to fragmentation and variability across the Caring Communities. Half of the Key Stakeholders interviewed for the initiative-wide survey indicated that a smaller set of clear, unifying goals and parameters would help to improve the CCI. These respondents indicated that although local control and decision making should be encouraged, there needed to be some common elements, activities and goals that would more closely link the eight Caring Communities. This was seen as important in order to strengthen the Initiative-wide impact of the Caring Communities.

However, the need for a smaller set of consistent goals must be weighed against the need for community-level individualized planning and development. One compromise might be to work towards consensus about a set of parameters within which action teams can be developed and activities planned. Planned activities could then be evaluated by an Initiative-wide leadership group to determine whether the activities have a close enough connection to Caring Community goals to warrant pursuing. Review of Caring Community logic models (see Appendix B, page 101) suggest that some of the activities that are planned or ongoing bear only a tangential relationship to the short and long term goals that they are perceived as related to. Defining a smaller set of acceptable goals, however, might be difficult. Another possibility would be to define characteristics of programs or activities that are appropriate for the Caring Communities. Examples of such criteria might be that Caring Community activities must involve more than three different providers, must be targeted at certain age groups, or must include an educational component.

Even if no new parameters are established, it would be helpful for the Caring Communities to create a better system for decision-making about how community needs are assessed, which

projects are pursued, and to ensure close, strong, linkages between Initiative-wide goals and local objectives and activities.

4. Visibility of Caring Communities

Results from both Key Stakeholder interviews and Member Surveys suggest that the Caring Communities may need to increase their visibility as community organizations. Although some have suggested that the Caring Communities should play a “behind the scenes” role in supporting community activities, and therefore that name recognition and visibility are not important, increased visibility may help to support the long-term sustainability of the Caring Communities. The Caring Communities should be recognized as a central part of the community services and events with which they are involved. This recognition would help to strengthen the visibility, and perhaps the popular and political support, of the initiative.

5. Support and Technical Assistance

The current system for supporting and supervising the coordinators is stretched extremely thin. Supervision for some coordinators is almost nonexistent, and organizational support is provided by a single person (the Leaders Roundtable Coordinator) for all eight communities. Given the fairly significant needs in some communities for additional support, especially in the areas of computer training, community organizing, public relations, documentation and reporting, and

Caring Communities have significant needs for additional training and support in areas such as:

- *community organizing,*
- *public relations,*
- *documentation and reporting, and*
- *conflict resolution/mediation.*

conflict resolution/mediation, the current system appears to have exceeded its capacity to meet the needs of the Caring Community. Further, the complexity of the CCIs continues to expand, further draining the existing support structure. Centralized supervision might be a mechanism to enhance cross-community consistency; minimally, closer, ongoing

supervision of most of the coordinators is needed.

C. Defining and Measuring Realistic Outcomes

1. Accountability and Documentation

As described previously, defining and measuring outcomes for the Caring Communities posed significant challenges to this evaluation. Specific recommendations for realistic expectations have been described for each of the major outcome domains studied in this project, and are summarized below. Another goal of the evaluation was to review current documentation systems and to provide recommendations about possible improvements to the system. Currently, each coordinator has her own system for documenting and tracking information about their Caring Community. Given the structural similarity of the Caring Communities, it might be beneficial to engage in cross-training and technical assistance to develop a common system for documenting activities. Currently, all Caring Communities provide reports to Multnomah County and the Leaders Roundtable; several others have additional reporting requirements. Reporting requirements from these different groups have been made consistent so that duplicative reporting efforts are not required. However, the formats used by the coordinators vary considerably, as does the level of detail provided.

One consistent aspect of the documentation process is the Caring Community work plan. During the past two years, the CCI has developed a common work plan format that is being used by all Caring Communities. This work plan specifies a Caring Community's goals, strategies, responsible persons and short-term outcomes, and provides a well-organized format for reporting progress and activities. A considerable amount of additional information appears to be required for some reports, however. Much of this information seems quite tangential to the actual functioning of the Caring Communities. A streamlined system that is closely linked to the work plans might help to reduce unnecessary paperwork.

One of the challenges in documenting Caring Community activity and outcomes is that the role of the Caring Community in a given project can vary considerably. The Caring Community might be centrally involved in planning, facilitating, and implementing a particular program, or they might be tangentially involved in a supportive role. Describing these different roles is

To improve accountability, Caring Communities may want to:

- *Develop a consistent way to report on the role of the Caring Communities in activities, as well as the type of activities and outputs generated;*
- *Streamline reporting systems;*
- *Consider closer monitoring of the types of activities and goals chosen by Individual Caring Communities.*

important both for understanding the activities of the Caring Community, and to make judgements about the level of accountability that is appropriate for a given program or event.

To address this, the CCI might also consider developing a “typology” of activities that could be used for reporting. This approach has been used to evaluate community coalitions of a variety of types (Mitchell et al., 1996). Such coalitions are similar to the Caring Community in that their role is typically to facilitate, plan, convene, and support various programs and activities through collaborative community efforts. Documenting the level of different kinds of “outputs” of these coalitions has been considered an important method to measure their effectiveness (Kegler et al., 1998). In the course of the evaluation, a variety of different activities were identified, including:

1. Planning community services or activities.
2. Helping to deliver/implement services or activities.
3. Convening meetings to foster information sharing.
4. Convening meetings to foster collaboration across programs/agencies/interest groups.
5. Attending meetings to learn about other programs and projects.
6. Providing a forum for responding to emergent community issues.
7. Educating community providers and members about community issues.
8. Disseminating information about community resources.

Within each of these activities, the Caring Communities could play a variety of different roles, including:

1. Fiscal agent or funder
2. Project director (in charge of implementation)
3. Project planner (not in charge of implementation)
4. Project facilitator or convener (bringing people together)
5. Project support staff (securing resources, supports, volunteers, etc.)
6. Project advisor/consultant

While these may not be exhaustive lists, they could form the basis for a simple system of categorizing roles and activities that would help to better characterize the work of the Caring Communities.

Another issue that is important to consider in defining outcomes and outcome measures is the varying developmental stages of the Caring Communities. Florin, Mitchell, & Stevenson (1993) identified seven developmental stages for community coalitions, and note that the expectations for outputs or outcomes are different depending on the coalition's status. The seven stages are:

- initial mobilization
- establishing organizational structure
- building capacity for action
- planning for action
- implementation
- refinement
- institutionalization

It might be useful to categorize each of the eight Caring Communities within these developmental stages in order to define realistic outcomes given their organizational status. It should be noted,

Outcome expectations should consider the developmental stage of the Caring Community:

It might be useful to categorize each of the eight Caring Communities according to their developmental stage in order to define realistic outcomes given their organizational status.

however, that progression through these developmental stages is not linear: A collaborative group could move from the implementation or refinement stage back to initial mobilization or establishing organizational structure, if, for example, key staff or members were to leave the group, or if the coalition decided to make a significant change in emphasis. This typology might also be useful for characterizing the developmental status of specific action teams.

2. Shared Outcomes for the Caring Community Initiative

Because of the varied goals and activities, it is extremely difficult to pinpoint a realistic set of shared outcomes for the CCI as a whole. One outcome that is promising in this regard is that of **systems integration**. All of the Caring Communities have regular, ongoing means for enhancing information sharing and collaboration between providers, via the monthly meetings. These monthly meetings can be realistically expected to lead to changes in some of the primary indicators of provider-level systems coordination, at least among the participating general membership. These indicators include: knowledge of other providers' services; increases in collaborative planning, information exchange, referrals, joint projects or grant-writing; and decreases in perceived competition, duplication of effort, and barriers to information sharing.

One realistic shared outcome is systems integration at the provider level, which could be measured by assessing changes among service providers in their perception of coordination, collaboration, and reduction in duplication of services.

It should be noted, however, that some Caring Communities are more involved with services integration at the *individual case level*, which might be expected to lead to changes in client outcomes, especially satisfaction with services received, while others are not at all engaged at service coordination at this level. Further, some have argued that systems integration is best thought of

as a means to an end, rather than a goal in and of itself. That is, systems integration should lead to better, more efficient and more effective services, and ultimately result in other positive outcomes for families and children. These client-level outcomes, however, are quite far-removed and are likely to require significant changes in service delivery systems at a number of levels, some of which may be beyond the scope of the Caring Communities (e.g., policy changes, changes in regulations, etc). Given these difficulties, it seems both feasible and reasonable to expect that Caring Communities would result in at least some changes among participating service provider representatives in the perception of coordination, collaboration, and reduction in duplication.

It could be argued that rates of school completion would be another reasonable outcome to expect and measure for the Caring Communities. The difficulty with this is that school completion is a complex outcome that is affected by many different factors, and, as discussed previously, the activities in which the Caring Communities are engaged are diffuse and often not directly focused on this issue. While work aimed at reducing neighborhood violence,

increasing early childhood immunizations, and building stronger communities is likely to have important long-term effects on school completion, it is unlikely to impact school completion outcomes for many years. In determining realistic expectations for programs, it is important to be able to specify close and direct links between program activities and desired outcomes. The more “distance” between activities and expected outcomes, the more other factors can contribute, either positively or negatively, to the outcome, making it difficult to pinpoint the cause of the effect. Additionally, Caring Community activities that might be expected to have a direct impact on school completion typically target a small number of youth (e.g., mentoring in East County, literacy and math programs in North Portland). Thus, while one might reasonably expect changes in the school completion levels for these small numbers of individual youth, it would not be reasonable to expect these programs to have a significant effect on community or school level outcome indicators.

Before a common set of community engagement outcomes can be recommended, there needs to be additional work to clarify:

- why resident involvement is important,
- how it is defined, and
- what is expected to achieve.

Another goal that is shared by all of the eight Caring Communities is community building and outreach. This reflects a relatively recent shift in emphasis among all the Caring Communities to involve more community residents in Caring Community activities. This shift is consistent with current efforts at the state and county levels. Thus, community involvement and participation might be a realistic outcome for all Caring Communities. The expected objective of increased community involvement, however, is

not always clearly articulated. Rather, there are several different implicit philosophies about the expected benefits of resident involvement. For example, one model of community involvement might emphasize developing programs and activities that are of interest to the general community, such as Mid-County’s Family Nights. Another model might focus on increasing resident involvement in Caring Community leadership and planning. Yet another might emphasize parent and youth involvement in individual service coordination.

Another difficulty in defining outcomes for the Caring Communities is that frequently neither the Caring Community itself nor the coordinator is directly responsible for directing and implementing programs or activities. As a facilitator and convener of activities, it seems unrealistic to hold the Caring Community coordinator responsible for specific program-level outcomes, *unless the program is directly provided by the Caring Community*. For example, in the Caring Community of North Portland, a number of school-based programs were initiated and planned by the Caring Community. However, these programs were managed and run by another agency. Outcomes for the project, therefore, should realistically be the responsibility of that agency. One option might be to have Caring Communities institute a procedure for following up with these “spin-off” programs to ensure some degree of accountability.

D. Summary and Conclusion

In preparing this report, a decision was made by the Caring Communities Evaluation Team that the report would serve to raise issues for future action, rather than making concrete recommendations. It is the hope of the Evaluation Team that a subsequent working group will be developed that has responsibility for recommending concrete action steps for the Caring Communities. The following is a list of the key areas that are in need of action to support the continued improvement of the Caring Communities:

Organizational and Structural Issues

1. Systems for ensuring core funding and resources for the infrastructure of the Caring Communities.
2. Systems for ensuring high levels of organizational effectiveness (e.g., quality leadership, communication, member involvement) across all Caring Communities.
3. Improvements in the level of organizational support, accountability mechanisms, supervision, and technical assistance available to the Caring Communities.
4. Methods for increasing the visibility of the Caring Communities.

Issues Related to CCI Goals & Accountability

1. Clarification of the goals and expectations regarding community engagement and appropriate evaluation efforts to assess these goals.
2. A process for ensuring that the progress made by Caring Communities in regards to systems integration is not lost with the shift towards community engagement.

3. Consideration of the appropriateness of the school completion goal.
4. Consideration of a smaller set of Initiative-wide goals and parameters for appropriate activities, while maintaining the ability of the Caring Communities to respond to grassroots community issues.
5. Systems for ensuring that Caring Community activities are directly and appropriately related to expected outcomes.
6. Systems for improving accountability, especially in terms of understanding the Caring Communities' different roles in community events and ensuring high quality across all Caring Communities.

The CCI has grown and changed since its inception eight years ago. This evaluation was an attempt to describe the CCI and begin to evaluate its effectiveness. The evaluation highlights both the strengths of the CCI and areas that may need improvement. Participants in the evaluation shared both a commitment to the work of the Caring Communities as well as concerns about its future directions. The strengths of community-based action teams with strong local decision-making power was highlighted; at the same time, the need for increased consistency and quality across Caring Communities was apparent. Significant achievements in improving coordination and collaboration between community-based providers were documented, while other outcome areas, such as community engagement, need further definition before outcomes can be meaningfully established.

Additionally, the sometimes wide variation in the major outcome domains (organizational effectiveness, services integration, and community engagement) between individual Caring Communities makes it clear that **the success of the CCI rests upon maximizing the effectiveness of each individual Caring Community**. Efforts are needed to ensure a strong system of individualized technical and organizational support. This system should include clear, simple, measures for documenting the role of the Caring Communities in community-based projects, the links between activities and expected outcomes, and a clearly defined set of both individualized and shared outcomes.

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