City of Cambridge Community Benefits Fund

Family Level Evaluation Findings Implementation Years 1 –3

Submitted by: Health Resources in Action

October 2023

Health Resources in Action
Advancing Public Health and Medical Research

Contents

Introduction

The City of Cambridge Community Benefits Advisory Committee (CBAC or the Committee) engaged Health Resources in Action (HRiA) to conduct a comprehensive evaluation of the Community Benefits Fund Implementation Phase grants that were allocated in Spring 2020. The overarching evaluation was co-designed with the Committee and funded partnerships during the Planning Phase to provide answers to a set of questions set forth by the Committee for the Implementation Phase (**Appendix A**). Over the course of the 3-year Implementation, the evaluation sought to document implementation activities, understand program reach, and assess the progress achieved towards outputs and overarching outcomes at the system, partnership, and individual family levels.

This report describes the findings from the overarching family-level evaluation undertaken during Years 1 through 3 of the funded implementation (April 2020 through March 2023). It represents the final culminating findings related to impact among participating families and includes a summary of key themes and a set of recommendations, based on the family-level findings, that the Committee and funded partnerships can consider for future funding or implementation efforts.

Summary of Key Findings

Partnerships designed and implemented programs that addressed the top-tier needs and reached the priority population[1].

- Across the four funded partnerships an average of 400 individuals were engaged each quarter over the course of the Implementation Phase. The final evaluation sample included 101 participants who had complete Family Survey data at baseline and at least one follow-up timepoint.
- Among those included in the evaluation, there was a median of 1 adult and 2 children in each household and 70% of respondents were unmarried, separated, or divorced.
- Through interviews and focus groups, all partnerships shared that there were many more families and individuals in need of their services than they had the capacity to serve during implementation, demonstrating a high need for the services in the community. For many partnerships, this meant that families were put on a waitlist or turned away from participation in the funded programs.

Partnerships worked with participants on a range of needs with a particular focus on the top-tier needs of housing stability, economic security, and behavioral health.

- As partnerships worked with participants to identify and address their needs, administrative data showed that in any given quarter across the Implementation Phase, between 5% and 28% of participants had a housing need addressed; between 8% and 19% had an economic need addressed; and between 3% and 21% had a behavioral health need addressed.
- While these quarterly ranges were wide, they reflect the time intensive work that case managers were investing in participants in any given quarter. Partnerships each described how important it was to invest the time with participating families to build solid relationships and trust. This was essential to fully understand the complexity and interconnectedness of their needs and was described as foundational to program success.
- At the same time, as reflected by Family Survey data in Year 1 and Year 2, the needs of participants were greatly impacted by COVID-19, with the top-tier needs often being exacerbated and additional areas of need arising (i.e., food security, basic household needs, childcare, etc.).

[1] In the original RFP "Target Population" was used to describe the intended participants, throughout this report the term has been updated to be "Priority Population."

While overall participants' housing situations did not materially change, there was evidence that the perceived stability of their housing was improving, and some participants described substantial improvements in their housing situation.

- No significant changes were observed in the type of housing (e.g., own, rent, staying with others, etc.) or type of rent paid (e.g., market rate, affordable, etc.). However, based on the Family Survey, respondents' *perceptions* of their housing stability increased. The percentage who reported their housing to be 'somewhat' or 'extremely stable' increased significantly from 64% to 81% between baseline and endpoint.
- While this improved *perception* of housing stability may not align with the lack of tangible change in housing type or rent paid, it may reflect improvements related to the other top-tier needs which are known to be related to housing stability as well as the emotional support of the program staff who participants often referred to as ***"advocates"*** who were patient, understanding, and ***"good helpers"*** pushing participants to stay engaged and continue their commitment to improving their lives. One participant noted that their life had ***"completely changed"*** for the better thanks to program staff sorting out their housing challenges.
- Housing appeared to be the most challenging top-tier need for partnerships to directly address for most families. Partnerships and participants alike brought up major system limitations, including limited housing stock and limited affordable housing in Cambridge. Partnerships discussed being hindered in what they were able to accomplish when working on a family's housing situation. Generally, this was limited to assisting with applications that got them on a waitlist. Many participants discussed ongoing challenges and barriers related to Section 8 housing vouchers and power dynamics between tenant and landlords which greatly impact their stability and wellbeing.

Participants found that while their economic stability had improved in some ways, the assistance had not resolved their long-term economic concerns and many participants felt they were on the cusp of a financial *"hole"* that would put them into unstable financial positions.

- Overall, no significant change in employment status or monthly household income was observed between baseline and endpoint. However, participants in the two cohort model programs were given stipends, and access to these funds was perceived as instrumental in giving them the ability to meet basic needs or have some economic freedom beyond just making ends meet.
- Despite this, there was an improvement in respondents' *perception* of their financial situation. Based on Family Survey data, the percentage who reported their financial situation to be 'somewhat' or 'extremely stable' increased significantly from 52% to 64% between baseline and endpoint.
- Importantly, participants' economic status was likely to have been greatly impacted by the COVID-19 pandemic which may have persisted throughout the Implementation Phase. As described by one program participant from Year 2, ***"I still have a lot of bills to pay. Sometimes I worry about how I'll pay them. I don't work as many hours because of COVID."***

Participants experienced significant reductions in depression and anxiety symptoms over the course of the program.

- Based on the *Patient Health Questionnaire (PHQ-2)* screening, which identifies clinically relevant symptoms of depression, the percentage of respondents that screened positive for depression symptoms decreased significantly from 26% to 16% between baseline and endpoint.
- Similarly, based on the *Generalized Anxiety Disorder-2 (GAD-2)* screening, which identifies clinically relevant symptoms of anxiety experienced in the prior 2 weeks, the percentage of respondents that screened positive for anxiety symptoms declined significantly from 29% to 18% between baseline and endpoint.

- It is possible that these findings are linked to the socioemotional support participants and their families received through their program. Despite limited improvement in families housing status, employment status, or household income, the consistent, one-on-one relationship building with case managers was named as a helpful method of stress/life management for participants Such support during time of crisis and instability may be instrumental in supporting good mental health and wellbeing.

Participants significantly increased their knowledge of where to go within Cambridge for support related to urgent mental or behavioral health problems, though the process of finding help remained challenging for many families.

- Family Survey respondents were significantly more likely to report that they knew where to go in Cambridge for urgent mental or behavioral health problems at endpoint compared to baseline, increasing from 30% to 46% between the timepoints. While the percentage of respondents who reported that they knew where to go in Cambridge for economic-related issues also increased, from 23% to 35% between baseline and endpoint, the change was only marginally significant.
- However, improved knowledge did not necessarily translate into how easy or hard the process of finding help was perceived to be. While trends were positive across each of the top-tier needs, the percentage of families reporting that it was 'easy' or 'very easy' to find help only increased marginally for housing-related problems, from 39% to 49% between baseline and endpoint.
- For participants that shared specific challenges experienced while accessing services, they were reflective of the larger economic and/or service delivery system issues such as long waiting lists for affordable housing, long wait times to see mental/behavioral health providers, frequent changes in providers, and inflation.

While programs aimed to address the interconnectedness of the top-tier needs through case management and referral, participants did not outwardly recognize the interconnectedness; but they did experience improvements in these areas that led them to improvement in overall well-being.

- Program staff described increased resiliency among their program participants as the complexity of their needs began to be addressed. However, they also discussed the struggles participants faced in getting to a more stable footing. Some commented that the changes they and their staff have witnessed in participants have been "intangible" improvements to their quality of life (i.e., increased happiness, engagement, hope, sense of self, and confidence in making changes to their lives), while most were continuing to struggle with each of the top-tier needs and not moving much beyond survival mode.
- Family Survey data showed that respondents' perceived understanding of their own housing, economic, or behavioral health needs remained unchanged and relatively low between baseline to endpoint. Despite this, there was a significant increase in respondent's *perception* of their family's overall wellbeing. The percentage that reported their wellbeing as either 'good' or 'excellent' increased from 46% to 60% between baseline and endpoint.,
- Based on qualitative data, program participants did not perceive a distinction between their overall well-being and their specific top-tier or related needs. Rather, in describing the impact of program participation on their improved well-being, they naturally segued into conversations around the top-tier needs and other services they and their families could access.

Background

The Community Benefits Funds (CBF) refer to monies offered to and received by the City of Cambridge, from developers from zoning-related activities or agreements entered, to be expended for community benefits or related purposes. Between 2010 and 2018, mitigation funds designated for community benefits purposes were pledged to the City through these amendments and agreements. While over $20 million has been pledged to this fund, approximately $7.5 million was received by the City and was available for distributions benefiting the community. Upon completion of various stages of development, additional monies will be deposited into the Fund to further assist in the expansion of services to better meet the needs of Cambridge residents.

The Community Benefits Advisory Committee (CBAC, or the Committee) was charged with identifying needs of Cambridge residents based on the priorities established by the City Council, soliciting, and evaluating applications from local nonprofit organizations for the provision of services to residents, and establishing rules, regulations, and guidelines for the proper administration and implementation of the Fund. The City Manager appointed 13 members to form the Committee; members included representatives from the City, the nonprofit and business communities, and community residents. A sub-set of Committee members, called the Core Team, was comprised of members who were City staff as well as one supporting non-member City staff person. The Core team met on a regular basis to plan Committee meeting agendas, operationalize decisions made by the full Committee, and to streamline discussions and decisions for future Committee meetings.

The Committee developed a framework for distributing Community Benefits Funds to address the unmet needs of Cambridge residents and solicited proposals from nonprofit partnerships to disseminate the first round of funding from the Fund. In this first round of funding, the Committee sought to fund innovative approaches to the provision of services that prioritized partnership and coordination between two or more organizations, an integration of services to support all three top-tier needs (as identified and defined in the 2017 Community Needs Assessment), and a commitment to broader engagement of the community and available resources. The goals of the funding, as articulated in the planning grant RFP, are summarized in **Table 1**.

Table 1. Goals for First Round of Community Benefits Funding

Goals for Families of the Priority Population[1] in Cambridge	Goals for the Social Services System in Cambridge
• Enhance housing stability, including enhanced connections to appropriate services that provide housing support. • Enhance economic stability, including enhanced connections to appropriate services that provide financial support. • Enhance family well-being, including improved access to provision of mental and behavioral health supports and counseling services. • Increase family housing stability and family economic stability. • Enhance child and adult resiliency.	• Increase capacity to support families around Top-tier Needs. • Advance coordination and integration among nonprofits, service providers, and other partners to deliver services.

[1]*Priority population was defined as Cambridge families with children that are low-income or in poverty, particularly families headed by a single woman*

The City of Cambridge hired an external facilitator, Daniel Michaud Weinstock, to assist with planning and running Committee meetings. Additionally, the City hired an external evaluator, Health Resources in Action (HRiA), to conduct a comprehensive overarching evaluation of this first round of Community Benefits funding, including evaluations of the planning grant RFP, the funded Planning Phase, and the subsequent 3-year Implementation Phase. An evaluation sub-committee was staffed by two Committee members and one City staff member to discuss the evaluation work in detail and to monitor the scope and progress of the evaluation.

Funded Programs

The Committee held a competitive process to solicit proposals from nonprofit partnerships across Cambridge, with four partnerships receiving funding for the planning phase (May 2019 – December 2019). Committee members with direct or indirect relationships with applicants recused themselves from these funding decisions. The planning grants gave funding to partnerships to build and strengthen the partnership and hone their proposed approach, culminating in the development of a final implementation plan proposal that would be ready to launch at the start of the 3-year Implementation Phase in March 2020 (later modified to be 4-years). All four funded partnerships applied for and received subsequent funding for the Implementation Phase. Descriptions of the four funded partnerships can be found in **Table 2**.

Table 2. Overview of Funded Partnerships

Partnership Name and Partner Organizations	Program Model	Program Description
Families Moving Forward		
• Bridges Homeward • Cambridge Health Alliance • Cambridge Housing Authority • Community Action Agency of Somerville • Institute for Health and Recovery • **Just-a-Start**	Cohort	One-on-one coaching model, cohort of 25 families participate over 3 years to achieve individualized goals, improve self-sufficiency, health, housing stability, and economic independence. Partners in this program will operate more seamlessly, better integrating services, warm referrals will improve access and reduce barriers around service navigation. "Front-door" approach.
Family Stability Project		
• Cambridge Economic Opportunity Committee • **De Novo** • Transition House	Ongoing/rolling	Comprehensive, wraparound direct services and targeted training to improve housing stability, financial security, and overall well-being of families. Partners have a broader goal to coordinate, expand, and integrate direct services and outreach with co-location and inter-partnership referrals; will also leverage networks of partners to expand the depth and breadth of support available to families. "No wrong door" approach.

Port Arise		
• **Community Art Center** • Margaret Fuller Neighborhood House • Tutoring Plus of Cambridge	Cohort	Multi-year training and community building program in the Port neighborhood to provide case management support, referrals, coaching, and training to families. Focus is on social capital, early childhood development, postsecondary/employment pathways, economic assets, and health/well-being. Partnership will streamline services and provide a stronger safety net for families by providing both proactive and responsive support.
Strengthening Families Together		
• Agassiz Baldwin Community • **Cambridge Community Center** • East End House	Ongoing/rolling	Fostering the five protective factors for families – parental resilience, social connections, knowledge of parenting and child development, concrete support in times of need, and social-emotional competence of children. Using case management and leveraging strong relationships with families seek to increased engagement, targeted interventions, and co-creation of strategies with families to build capacity and greater resilience. Intensity correlated with family need.

*Note: Organizations listed in **bold** are the lead organization for each partnership.*

Evaluation Planning

The six-month planning grants were intended to give partnerships time to work directly with the evaluator, build and strengthen their partnerships, and hone their proposed approach prior to the start of the Implementation Phase. Detailed information about the activities and findings from the process evaluation of the Planning Phase are reflected in the ***Planning Phase Process Evaluation Report***[2].

The Planning Phase culminated in the development of final implementation plans by each partnership and the final overarching evaluation plan by the evaluator, HRiA. The overarching evaluation plan was based on the ***Overarching Logic Model***[2] that was developed in collaboration with the Committee and all four funded partnerships early in the Planning Phase and reflected the set of evaluation questions set forth by the Committee for the Implementation Phase (**Appendix A**). The overarching evaluation plan identified and defined all project activities, evaluation measures, methods of data collection, timing of data collection activities, and level of data collection (i.e., family level or partnership/systems level) for the process and outcome evaluations of the Implementation Phase. Additionally, the plan encompassed the common vision and outcomes of this funding initiative and considered the details from each partnerships' proposed implementation models. The final evaluation plan was fully documented and described in the ***Community Benefit Fund Process and*** **Outcome Evaluation Plan**[2].

[2] Deliverable/Report produced by Health Resources in Action as part of the overarching evaluation efforts, for more information reach out to: communitybenefits@cambridgema.gov or (617) 349-9164.

Family-Level Outcomes of Interest

The guiding aim of the family-level evaluation was to determine the experience and impact of program participation on families engaged by each of the four funded partnerships. From a *process perspective*, the Committee was interested in understanding who was served and what services were delivered. From an *outcome perspective*, the Committee was interested in identifying and documenting the successes and outcomes experienced by the individuals and families served by these programs. See **Appendix B** for a table detailing the key family-level process measures and outcome indicators that were operationalized for data collection during the 3-year Implementation Phase.

Family-Level Evaluation Activities and Methods

The evaluation activities conducted to identify family-level outcomes used a mixed methods approach (i.e., both qualitative and quantitative methods) to best capture and reflect the perspectives and feedback of funded partnerships, enrolled families, and Committee members over the three years of implementation. The following section details each of these evaluation methods.

Qualitative Data Collection

Interviews and Focus Groups with Partnerships

Partnerships participated in key informant interviews and/or focus groups to share their experiences at the conclusion of each implementation year. This qualitative data collection was conducted after partnerships had been informed of their successful funding extension for the following year of the Implementation Phase. Discussion guides were developed by HRiA to capture partnership perspectives on what went well during the year, what could have been improved, and any concerns heading into the next year of implementation. During discussions, partnerships provided their perceptions on a wide variety of topics including communication with the Committee and evaluator, as well as partnership communication and dynamics. They also spoke in-depth about the implementation of their program, participant recruitment and engagement, coordination of service delivery, and the impact of their implementation efforts on families enrolled to date.

Interviews and focus groups were conducted virtually by members of the HRiA evaluation project team with each of the four partnerships. Typically, the interviews were conducted with one individual from the lead nonprofit organization of each partnership, while the focus groups included representatives from all, or most, of the organizations in each partnership and included the key/front-line staff who had been working directly with enrolled families. All participants were able to provide insight into the day-to-day programming operations and speak broadly about the short and long-term impact of programming on participants.

Interviews and Focus Groups with Program Participants

The perspectives and experience of program participants were collected through focus groups or individual interviews with a subset of participants from each partnership at the end of Implementation Years 2 and 3. Interview and focus group discussion guides were developed by HRiA and reviewed by the Committee and partnerships to capture the participants' perspectives on their experience enrolling in the program, working with the program to identify their needs, and receiving services through the partnership and/or referrals to the community.

Each partnership determined which format (focus group or interview) was best suited for their program participants and a mix of the two formats were conducted in both Years 2 and 3 across the partnerships. Additionally, while all partnerships played an integral role in recruiting participants for qualitative data collection, two partnerships opted to facilitate interviews with their participants themselves in Year 2, and one partnership decided on a mix of facilitating some interviews themselves while allowing HRiA to

also facilitate some interviews in Year 3. This flexibility helped to ensure all felt comfortable participating and sharing their experiences. Overall, a total of 18 participants across the four partnerships were engaged in Year 2 (seven through two focus groups and 11 through individual interviews) and 24 participants in Year 3 (13 through two focus groups and 11 through individual interviews).

Qualitative Analysis

Notes from the interviews and focus group discussions were analyzed thematically. Frequency and intensity of discussion on a specific topic were used as key indicators of themes. Selected paraphrased quotes, with identifying information removed, are presented in the narrative of this report. To help visually distinguish between quotes from partnerships and quotes from program participants throughout this report, different font colors have been used - ***'orange'*** font indicating partnerships, and ***'green'*** font indicating program participants.

Quantitative Data Collection

Administrative Data

As illustrated in **Table 2**, the Committee funded four unique projects which approached the development and delivery of their programs to participating families independently and using different designs (e.g., cohorts, continuous enrollment, etc.). Furthermore, each partnership maintained their own approach to documenting program delivery to participating families. To ensure that some level of data pertaining to program implementation and delivery was available and reportable across partnerships, an administrative data tracking template was developed to collect a common set of indicators during the Implementation Phase. Specifically, this involved monthly or quarterly reporting of the numbers of families enrolled/engaged by the program, numbers of families having an identified top-tier need, and numbers of families receiving a referral and/or having an identified top-tier need addressed. Because program design and organizational capacity to collect/track data varied greatly, these administrative data indicators were not required to be tracked at the individual level, rather partnerships only reported their monthly and/or quarterly aggregate counts. Administrative data was updated and shared with the evaluator each quarter for review and analyses.

Organizational Capacity Survey

To assess more specific aspects of partnerships' implementation efforts, a web-based Organizational Capacity Survey was developed to capture details about program implementation and delivery by partnerships. The survey included questions regarding policies and practices, staffing capacities, referral network composition and adequacy, referral processes, utilization of case-management and warm handoffs, organizational understanding of vulnerable populations, and perceptions of successes in their work. The survey was completed annually by the 'lead' staff person of each organization within each of the partnerships. A total of 15 responses were received in each of Years 1, 2 and 3, representing each of the organizations engaged across the four partnerships.

Family Survey

A comprehensive Family Survey was initially drafted at the end of the Planning Phase, and further finalized/tailored for each partnership during Implementation Year 1. More specifically, multiple versions of the family-level survey were finalized, programmed into Qualtrics or SurveyMonkey, and operationalized to meet partnerships' unique needs, capacity to collect data, and the reality that each was proceeding towards implementation and data collection at a different pace. The survey instrument was developed to align with the overarching logic model and included self-reported outcomes related to housing stability, economic/financial stability, behavioral health needs, mental health status, self-efficacy, resilience, etc. While the COVID-19 pandemic prevented the on-time launch of family-level data

collection in Year 1, by the end of Implementation Year 2, family-level data collection had begun within all four partnerships and continued through the end of Year 3.

The Family Survey included two validated screening tools to assess mental health symptoms. First, the **Patient Health Questionnaire-2 (PHQ-2)**[3] which is a validated scale that asks about the frequency of depressed mood and little interest or pleasure in doing things over the past 2 weeks. Second, the **Generalized Anxiety Disorder-2 (GAD-2)**[4] which is a validated scale that asks about the frequency of anxiousness and worry over the past two weeks. For both tools, items are rated on a 4-point scale, ranging from 0 (not at all) to 3 (nearly every day), for a total score ranging from 0 to 6. Scores over the cut point are considered 'positive' and indicative of symptoms that rise to clinical concern. For this evaluation, a cut point of 4 was selected to ensure a higher specificity (i.e., fewer false positives).

The survey was designed to be administered to participating families at baseline (at or near the time they first engaged with the program to receive services) and at 6-month follow-up internals (i.e., 6-, 12-, and 18-months after baseline). Each partnership approached the collection of Family Survey data differently based on size of the population being served and the internal staff capacity to collect and manage longitudinal data. While cohort-models were able to collect survey data from most of their families reached, the ongoing/rolling enrollment models served far more families than they were able to feasibly collect Family Surveys from. Throughout Implementation Years 2 and 3, all complete Family Survey data were reviewed, analyzed, and summarized quarterly by the evaluator. Quarterly Family-level Data Memos were shared with the Committee and partnerships quarterly to foster collaboration, discussion, and program improvement activities.

At the end of Implementation Year 3, Family Survey data collection was concluded and final analyses for the outcome evaluation began to determine program impact among families. As shown in **Table 3**, 185 families completed the baseline Family Survey and 101 of them also completed at least one follow-up survey, ***thus the final sample size for the outcome evaluation was n=101.*** It should be noted that these sample sizes do reflect exclusions from analysis based on reported baseline monthly household incomes > 80% City Median Income[5] which was done to ensure families included in the outcome evaluation aligned with the priority population identified by the Committee. In total, 20 families were flagged and excluded from final Family Survey analyses based upon this income threshold.

Table 3. Families Included in the Outcome Evaluation Dataset, by Partnership

	Families with Baseline Data [A]		Families included in Outcome Evaluation [A, B]	
	n	%	n	%
All Partnerships	**185**	**--**	**101**	**--**
Families Moving Forward	29	16%	25	25%
Family Stability Project	30	16%	10	10%
Port Arise	29	16%	27	27%
Strengthening Families Together	97	52%	39	39%

[A] After exclusions based on baseline household income above 80% City Median Incomes

[B] Families were included if they had completed at least one follow-up survey (at 6, 12, or 18 months)

[3] Kroenke K, Spitzer RL, Williams JB. The Patient Health Questionnaire-2: validity of a two-item depression screener. Med Care. 2003 Nov;41(11):1284-92.

[4] Kroenke K, Spitzer RL, Williams JB, Monahan PO, Löwe B. Anxiety disorders in primary care: prevalence, impairment, comorbidity, and detection. Ann Intern Med. 2007; 146:317-251.

[5] https://www.cambridgema.gov/-/media/Files/CDD/Housing/incomelimits/hudincomeguidelines.pdf

For final analyses, the evaluation endpoint was based upon either the 6- or 12- month follow-up, whichever occurred later. This approach was taken to improve comparability in program exposure across cohort- and non-cohort models, and in recognition that follow-up data collection was challenging, with high variability in the actual time elapsed between surveys. **Table 4** details the median and the range of follow-up time that had elapsed between the baseline and the actual evaluation endpoint survey included in the outcome evaluation. Across all partnerships, the median time between baseline and the evaluation endpoint was roughly one year (12.7 months) and ranged from approximately 6 months to 20 months. By partnership, most had median follow-up times of at least 12 months, with respondents at Strengthening Families Together having a slightly lower median of 9 months.

Table 4. Time Between Baseline and Selected Endpoint Surveys, by Partnership

	Median Follow-up Time, in Months	Range of Follow-up Time, in Months
All Partnerships (n=101)	**12.7**	**5.2 - 20.4**
Families Moving Forward (n=25)	14.6	5.9 - 20.4
Family Stability Project (n=10)	14.4	12.3 - 19.1
Port Arise (n=27)	12.2	5.8 - 15.0
Strengthening Families Together (n=37)	9.0	5.2 - 16.0

Quantitative Analysis

Family Survey data was analyzed using paired samples t-tests for continuous variables and McNemar's tests for categorical variables to determine if there was change in outcome measures between baseline and endpoint. P-values of less than 0.05 were considered statistically significant (i.e., change not explainable by chance alone). Given the small sample size available for analyses, P-values between 0.10 and 0.05 were also flagged as 'marginally significant' in order to also highlight areas where there is promising evidence of impact, though it is not conclusive.

Evaluation Limitations

As with all evaluation efforts, there are limitations related to the methods that should be acknowledged. One challenge, common to most overarching evaluations of separate and distinct program models, is that the evaluation methods and outcome indicators common to all the programs may not reflect some of the unique program activities or capture more specific areas of program impact that occur within an individual program. While the overarching logic model and subsequent evaluation process and outcome indicators were developed and defined collaboratively with all four funded partnerships, the final evaluation may not fully represent their individual effort or impact on participants. However, because grantees were required to implement programming that supported families around the same top-tier needs (housing, economic/financial, behavioral health), there is an improved likelihood that outcomes related to these areas are well represented for each partnership in the overarching evaluation.

Another limitation is the reliance on self-reported data for outcomes collected via the Family Survey. Such data should be interpreted with some caution as respondents may over- or under-report behaviors and personal concerns based on fear, social stigma, or simply misunderstanding the question being asked. In addition, respondents may be prone to recall bias—that is, they may attempt to answer accurately but remember incorrectly. Qualitative data collection is prone to similar biases. Despite best efforts to encourage interview and focus group participants to provide candid responses to the

facilitator, there is still a possibility that they did not feel comfortable sharing all perceptions and feedback with program or HRiA staff who were conducting qualitative data collection.

Small sample size is another important limitation which needs to be taken into consideration. While cohort-based models were able to feasibly collect data from most of their participants at each timepoint, the ongoing/rolling enrollment models were faced with more challenges collecting data from participants at each timepoint which resulted in a relatively small sample compared to their total population reached. The implications of this are two-fold. First, with generally small sample sizes across all partnerships the ability to detect statistically significant change in outcome measures was hindered, and the evaluation necessarily relied upon the aggregate sample from across all partnerships. This may obscure some of the nuances in outcomes between partnerships, but also by timepoint as participants with varying amounts of follow-up time were included. And second, for the ongoing/rolling enrollment models, the small samples size may not adequately represent their total population reached, thereby limiting the generalizability of both Family Survey and qualitative data findings for these partnerships.

Finally, these programs were launched and implemented during the COVID-19 pandemic. Changes to the program designs, timelines, and participant needs are described below, but the pandemic also spurred a change in policies that had a direct and meaningful impact on the top-tier needs addressed through the CBF. Of note, during the Implementation Phase there was a federal and state eviction moratorium giving individuals additional, temporary protection in their housing. There were also multiple federal stimulus payments and expanded unemployment benefits during 2020 and 2021 that impacted individuals' economic stability and may have had influence on measured outcomes that are separate and distinct from the work of the partnership/programming. It is not possible to tease out these impacts based on the data collected as part of this evaluation.

Family Level Evaluation Findings

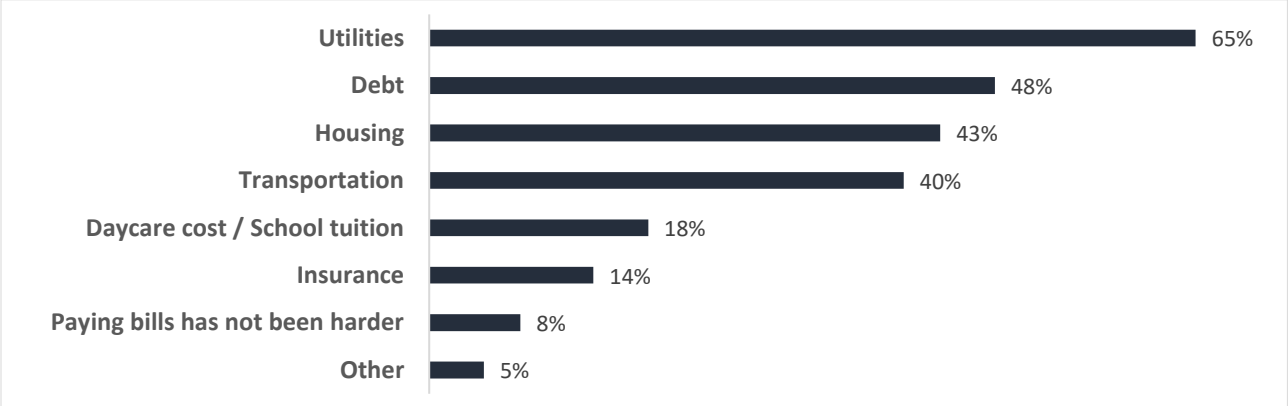
Impact of COVID-19

The timing of the COVID-19 pandemic coincided almost exactly with Implementation Year 1 and the launch of programming. The impact on city agencies, non-profit organizations, and families in Cambridge was substantial and cannot be overstated. Work in Cambridge came to an abrupt halt with the statewide closure of all non-essential businesses beginning on March 24, 2020. Though a phased re-opening began in May 2020, and continued through the Spring of 2021, the process slowed and was briefly reversed in November and December 2020. For partnerships, the closures forced them to halt much of their initial focus on planned interventions as they pivoted to focus on basic needs and emergency service provision for the families they served.

In addition to the challenges associated with meeting the increasing needs of families, the partner organizations were also internally managing the pandemic-related business closures and capacity limits/mandates which, in some cases, dramatically altered their ability to provide services to the populations in need. Importantly, implementation was delayed well into Year 1 and most in-person work had to be modified and/or shifted to accommodate virtual approaches. And while partnerships designed their programs to address the top-tier needs, once the COVID-19 pandemic started these areas of need were exacerbated and new needs emerged. The long-lasting effects of the COVID-19 pandemic have remained an overarching theme throughout implementation. Committee members interviewed in Year 1 recognized the worsening challenges for families and acknowledged that the Committee would need to adjust their expectations around implementation outcomes, as baseline indicators of need for families would likely be worse than it would have been without the pandemic.

To ensure this context was captured as part of the family-level evaluation, in Implementation Year 1, HRiA modified the Family Survey to include a set of questions related to COVID. By Fall of 2020, Several partnerships were able to begin enrolling participants in their program and these data were collected and explored via the modified baseline surveys. The findings provided insight into the early impact of the pandemic on Cambridge residents. As illustrated in **Figure 1**, at least half of respondents found it harder to pay for one or more living expenses because of the pandemic. In particular, utilities, debt payments, and housing costs. Additionally, nearly half of respondents indicated that their employment was negatively impacted– 31% had been laid off or furloughed and 17% were working fewer hours.

Figure 1. Types of expenses or bills that were harder to pay because of the COVID pandemic (n=65)



Source: Baseline Family Survey, Fall 2020-Fall 2021

Respondents also indicated whether the COVID-19 pandemic had impacted their housing stability, physical health, or mental health (**Figure 2**). More than two of five respondents reported that their

housing stability became less stable (45%), or their mental health had gotten worse (46%), while 31% reported that their physical health had gotten worse.

Figure 2. Impact of Pandemic on housing stability and health status (N=65)

Source: Baseline Family Survey, Fall 2020-Fall 2021

Throughout implementation, partnerships continued to adapt, modify, and, in some cases, delay their planned intervention activities. During qualitative conversations in Year 2, partnerships were asked to elaborate on the needs of families during the pandemic. All said that the top-tier needs generally did not change but were worsened because the needs of the community increased substantially. Partnerships also agreed that they began serving populations they would not have before the pandemic because those individuals had become less financially stable.

Program participants also reported during qualitative discussions that their needs had changed because of COVID-19. The most frequently cited needs impacted by the pandemic were related to changes in their job status and income. For example, some participants were laid off or furloughed while others experienced a decrease in their hours worked. Both scenarios led to a substantial decline in their income and had a cascading effect on their ability to afford housing and basic needs (e.g., food, utilities, etc.).

> ***"I kept my job, but the other adults in my home didn't so money had to stretch farther, longer."*** – Year 2 Program Participant
>
> ***"I still have a lot of bills to pay. Sometimes I worry about how I'll pay them. I don't work as many hours because of COVID."*** – Year 2 Program Participant

During conversations in Year 3, early pandemic-related challenges (e.g., city-wide closures and illness) were less obviously stated. Ongoing or more current challenges were associated with the long-term economic impacts of the pandemic. Specifically, participants cited inflation as a primary concern.

Program Implementation

Program Reach

By Implementation Year 2 all partnerships were enrolling and serving families in their programs and participating in evaluation activities. Partnerships continued to serve families through Year 3, and those programs with ongoing enrollment or new rounds of cohorts, continued to outreach and enroll new families. Partnerships reported varying techniques of outreach and recruitment to their programs, with some programs reaching program capacity without extensive formal outreach, while other programs utilized a more formal application processes to ensure program participants met enrollment criteria.

Partnerships began submitting Administrative Data on a quarterly basis beginning in Year 2 of implementation. As shown in **Table 5**, together the partnerships reached many families each quarter ranging from a low of 113 families in Year 2, Quarter 1 to a high of 540 families in Year 3, Quarter 3.

Between program models, the reach looks quite different from one another. The single cohort model (Families Moving Forward) continuously served their group of 25 families, while the multiple cohort model (Port Arise) added to the number of families they continuously served throughout implementation. In contrast, at the two ongoing/rolling enrollment models (Family Stability Project and Strengthening Families Together) the number of families served varied from quarter to quarter as families sought services and support as needed. It is important to note that families engaged by these two partnerships may be represented in counts across multiple or different quarters, preventing the calculation of a true total number of unique families reached over the entire Implementation Phase.

Table 5. Administrative Data - Families Reached with Services, by Partnership

	Families Moving Forward	Family Stability Project	Port Arise	Strengthening Families Together	All
	Single Cohort	Ongoing Enrollment	Multiple Cohorts	Ongoing Enrollment	
Population Reached by Qtr.	n	n	n	n	*n*
Y2 Quarter 1 (Apr - Jun 2021)	25	-	19	69	113
Y2 Quarter 2 (Jul - Sep 2021)	23	134	33	154	344
Y2 Quarter 3 (Sep - Dec 2021)	25	128	40	151	344
Y2 Quarter 4 (Jan – Mar 2022)	25	233	43	152	453
Y3 Quarter 1 (Apr - Jun 2022)	25	195	44	144	408
Y3 Quarter 2 (Jul - Sep 2022)	25	273	55	185	538
Y3 Quarter 3 (Oct - Dec 2022)	25	315	56	144	540
Y3 Quarter 4 (Jan - Mar 2023)	25	236	60	164	485

Source: Partnership Administrative Data through Y3 Q4

> ***"I said, 'I am from a low-income family,' she said, 'apply!' She asked if I had children under 18, I said yes, and she said, 'apply!' I told her, 'What did I do to deserve this [opportunity]?' She said, 'you're just a mom, you deserve it.'"*** – Year 3 Program Participant reflecting on recruitment experience

From the participant perspective, enrollees described their interactions with the partnership organizations positively and many expressed gratitude for the assistance that had been provided to them over the months and years. Across Years 2 and 3, program participants of both model-types, stated that they learned of the grant-funded programming through the organizational staff they had already been working with. Several participants in the cohort model programs stated that they learned of the program through flyers in the community (e.g., postal mail, social service offices, community boards, etc.) and community events, suggesting the importance of "on-the-ground" recruitment to reach the population of interest.

Family Needs

The process to identify participant needs varied across partnerships. Program participants from the two cohort models recalled completing a formal assessment prior to their enrollment in the program which served to identify their initial needs, assessed whether they met enrollment requirements, and gave

program staff the opportunity to discuss the expectations and commitment of program participants. For the ongoing/rolling enrollment models, there was no consistency in how participants recalled the programs identified their initial needs. And at the time of the qualitative data collection, generally at least 3-months after enrollment, not all participants reported that they currently had many needs for the program to assist with, ***"right now, I don't even really need any of these programs because I have come so far. But if you had asked me four or five years ago, I really needed all of them."***

Administrative data pertaining to the types of needs identified among the families engaged by each partnership are detailed in **Table 6**. The average quarterly percentages of participants with top-tier needs are presented along with the range in quarterly percentages across the Implementation Phase. Overall, the quarterly averages ranged from 12% to 40% for Housing needs; from 15% to 94% for economic needs; and from 11% to 47% for Behavioral Health Needs.

These data can be interpreted as an indicator of the focus of work each partnership was doing with families during any given quarter of the Implementation Phase. It is important to note that these data likely represent both the acute and chronic needs of any given family and that acute needs are very likely to fluctuate over short periods of time. The data on the range in quarterly percentages helps provide some insight into how families' needs fluctuated across the Implementation Phase.

Table 6. Administrative Data – Needs Identified among Families Reached, by Partnership

		Families Moving Forward	Family Stability Project	Port Arise	Strengthening Families Together
		%	%	%	%
Housing Needs Identified	Quarterly Average	37%	40%	32%	12%
	Range	28% to 52%	36% to 40%	20% to 50%	1% to 31%
Economic Needs Identified	Quarterly Average	94%	29%	15%	18%
	Range	80% to 100%	20% to 37%	5% to 33%	3% to 40%
Behavioral Health Needs Identified	Quarterly Average	42%	47%	11%	21%
	Range	32% to 56%	34% to 63%	2% to 20%	15% to 29%
Other Needs Identified	Quarterly Average	32%	48%	10%	73%
	Range	24% to 56%	44% to 53%	4% to 17%	29% to 91%
Public Benefit Needs Identified	Quarterly Average	5%	13%	6%	1%
	Range	0% to 12%	8% to 23%	0% to 9%	0% to 2%

Note: Quarterly percentages were based on a denominator of total families served in the given quarter
Source: Partnership Administrative Data through Y3 Q4

Service Delivery

Between Implementation Years 2 and 3, partnerships had expanded their use of case management when working with enrolled families. Based upon data from the Organizational Capacity Survey which represents the work of the approximately 15 individual organizations that make up the four partnerships, the percentage reporting that case management was being used with 'all families' increased from 33% in Year 2 to 53% in Year 3.

Program participants described a range of services that were provided by the programs across partnerships – they included needed services (e.g., childcare) and supports (e.g., food and household

necessities), connecting them to additional resources, assisting with applications for services or benefits, and coaching them on skill development (e.g., financial literacy, resume writing), as well as listening and working with them to identify and set goals.

When describing the services they accessed through program staff, participants highlighted the top-tier needs (housing, economic security, and mental/behavioral health). They also noted that the programs they worked with often provided more than just the top-tier needs. For example, many participants in one ongoing/rolling enrollment program reported a need for childcare services (e.g., day care, afterschool care, camp) and highlighted the gap filled by the program. A handful of others – across programs – mentioned the tax assistance they receive from the program staff they work with. Participants also appreciated that program staff helped them navigate conversations and situations with other organizations they worked with. For example, receiving guidance communicating with Massachusetts Department of Children and Families was the most cited by participants. Several program participants also commented that, at times, their needs extended beyond what program staff had the capacity to provide (e.g., food pantries, legal assistance, behavioral health treatment). When this happened, program staff worked to connect participants to the additional services.

One person, when describing the process to get connected to additional services said of the staff they work with, ***"[Staff person] is really on top of her game in communicating with me. I really appreciate everything she does, and I like that she's straight up with me when a resource may not be the best fit and to keep trying other places. Whenever I email her, she responds right away."***

In some instances, the process of engaging families was broad and non-specific, allowing participants to decide for themselves whether they were ready to be connected to services. Participants described instances where program staff sent newsletters and emails to alert them about a new program or service available in the community. For more discrete needs, the process was like the one used to understand participants' initial needs – detailed and intentional. In several cases, participants and staff reviewed resources together to decide what the best course of action was. For example, one participant recalled an instance where they needed help editing their resume ahead of applying to new jobs. After explaining this to the staff person they worked with, the participant noted that the staff person connected the participant to the necessary resources and made sure that no part of the job transition process was ***"uncomfortable."*** In a similar story, another participant recalled a ***"pretty quick"*** process of being referred to the Cambridge Employment Program to connect with a career counselor.

> ***"It's been extremely helpful to feel like I have someone in my corner. It's made a difference for me having someone dependable and available to me when I need it. It takes the pressure off me to solve everything by myself all the time."*** – Year 3 Program Participant

Administrative data also captured the numbers of families whose needs were addressed by the partnership during a given quarter, either internally between the partnering organizations or externally via a referral to other organizations. **Table 7** summarizes these data and provides the average quarterly percentages of participants that had top-tier needs addressed along with the range in quarterly percentages across the Implementation Phase. Overall, the quarterly averages ranged from 5% to 28% for housing needs; from 8% to 19% for economic needs; and from 3% to 21% for behavioral health.

Similar to the needs identification data shown above, these data can be interpreted as an indicator of the focus of work each partnership was doing with families during any given quarter of the

Implementation Phase. However, successfully addressing a given family's needs takes time and meeting an identified need in one quarter likely reflects the programmatic efforts of several prior quarters. These data provide some insight into how the ability to meet a families' needs fluctuated across the Implementation Phase.

Table 7. Administrative Data – Needs Ever Addressed among all Families Served, by Partnership

		Families Moving Forward	Family Stability Project	Port Arise	Strengthening Families Together
		%	%	%	%
Housing Needs Addressed	Quarterly Average	18%	9%	28%	5%
	Range	0% to 28%	8% to 12%	5% to 50%	0% to 25%
Economic Needs Addressed	Quarterly Average	19%	8%	15%	15%
	Range	8% to 32%	1% to 16%	2% to 22%	0% to 44%
Behavioral Health Needs Addressed	Quarterly Average	10%	3%	4%	21%
	Range	4% to 16%	2% to 5%	0% to 11%	13% to 35%
Other Needs Addressed	Quarterly Average	7%	27%	12%	68%
	Range	4% to 12%	15% to 33%	0% to 25%	47% to 91%
Public Benefits Addressed	Quarterly Average	4%	12%	4%	1%
	Range	0% to 8%	4% to 23%	0% to 16%	0% to 4%

Note: Quarterly percentages were based on a denominator of total families served in the given quarter; the needs addressed designation is based on the number of families reported by partnership as either having 'need being addressed by partnership' or 'needs being addressed outside of partnership', or who were categorized as successfully having a specific identified need being met
Source: Partnership Administrative Data through Y3 Q4

Relationship Building

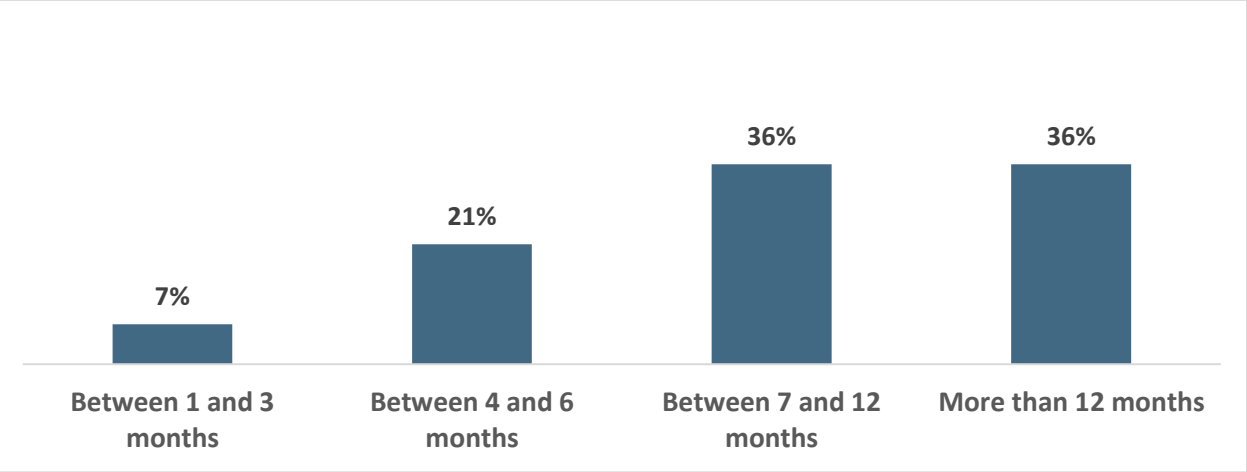
> ***"I have some fear and put up a wall…a few people stuck with me through all of it and it makes me feel good."*** – Year 2 Program Participant

In qualitative discussions, all partnerships emphasized that building deeper and trusting relationships with participants was necessary before they were able to truly engage families and gain a fuller understanding of their needs. And that such relationship building takes continued dedication and effort of program staff over time in order to establish those trust and communication pathways. As some partnership participants stated, ***"some were not very open to us. They were not sharing all their needs at the beginning."*** and ***"Six months in and we are just learning what the real needs [of a participant] are."*** Program participants also communicated the importance of building relationships with program staff before they were able to feel comfortable discussing their needs and situation.

Organizational Capacity Survey data illustrate the depth of this effort. By Year 3, case managers were working with families for extensive periods of time. As illustrated in **Figure 3**, across the organizations reporting, more than two thirds were actively working with families for at least 7 months. When

examined by partnership, this length of engagement was true for at least two of the reporting organizations within each partnership, including both cohort- and ongoing/rolling enrollment models.

Figure 3. Average Length of Time Case Managers were Actively Working with Families in Year 3 (n=14)



Data source: Organizational Capacity Survey Y3, based on a total of 14 organization-level responses

Across discussions in Years 2 and 3, program participants from all partnerships noted that program staff and the strength of the relationships they built with them were key drivers of the successes they achieved. In emphasizing the value of trust and relationships, one participant explained that the staff person they work with is the first person ***"outside of my circle"*** with whom they shared their challenges and added that ***"she helps me a lot. She makes me laugh. We spent two hours talking about my dreams and what I want."*** And one participant who has since been off boarded from programming said, ***"I stay involved even though my child is no longer in the program because I know that [program staff] will always help me. During my toughest time when living in a shelter with my child, they took us in, in a way that I will never forget."***

Participants echoed sentiments heard from partnerships regarding the importance of building deep and trusting relationships before they are comfortable sharing the information about the true needs of their family. Year 3 discussion participants were especially vocal about this. Several pointed out that while they were now comfortable sharing their needs and challenges with program staff, at the start they found it difficult to be completely honest about their needs. For these individuals, the level of depth of the questions felt intrusive and for one person, the combination of the detailed questions with the lack of racial/ethnic concordance was a substantial barrier at first. As this person said, ***"it was hard to be completely honest with someone who didn't look like me. I see this White lady asking me all these questions. I was reserved. I wasn't completely honest about my needs. If I share too much, am I going to put my family in danger?"*** While this person said they eventually "warmed up" to program staff, it was a challenge at first.

> ***"It's a lot of personal questions. You're very vulnerable and you need assistance but you're not sure how open you can be. You gradually open up to the person supporting you. Only then do you realize the program is benefiting you throughout the process."*** – Year 3 Program Participant

Priority Population and Demographic Characteristics

The overall aim of the CBF initiative was to benefit families with children that are low-income or in poverty, particularly those headed by a single woman. Demographic data were collected via the baseline Family Survey and as noted in the methods section, were only available for a subset of families reached across partnerships. Therefore, the demographic information reported in this section is limited to those with survey data and may not accurately reflect the total population reached. However, the data do provide insight into the degree to which intended beneficiaries of the initiative were successfully reached and provides context for the interpretation of evaluation findings. To ensure interpretation could be as accurate as possible, demographic characteristics described in this section are presented for all families with baseline data (n=185) as well as just those families included in the outcome evaluation (n=101). ***Note that the subsequent sections of this report which focus on change between baseline and endpoint, are necessarily based only on the 101 families with follow-up data***.

Partnerships appeared to have reached the priority populations well based on the Family Survey data. As detailed in **Table 8**, there was a median of 1 adult and 2 children in each household and 70% of respondents were unmarried, separated, or divorced. A slightly larger percentage in the outcome evaluation were unmarried, separated, or divorced (76%). By partnership, this percentage was slightly lower for Strengthening Families Together (62%) and higher for Family Stability Project (100%).

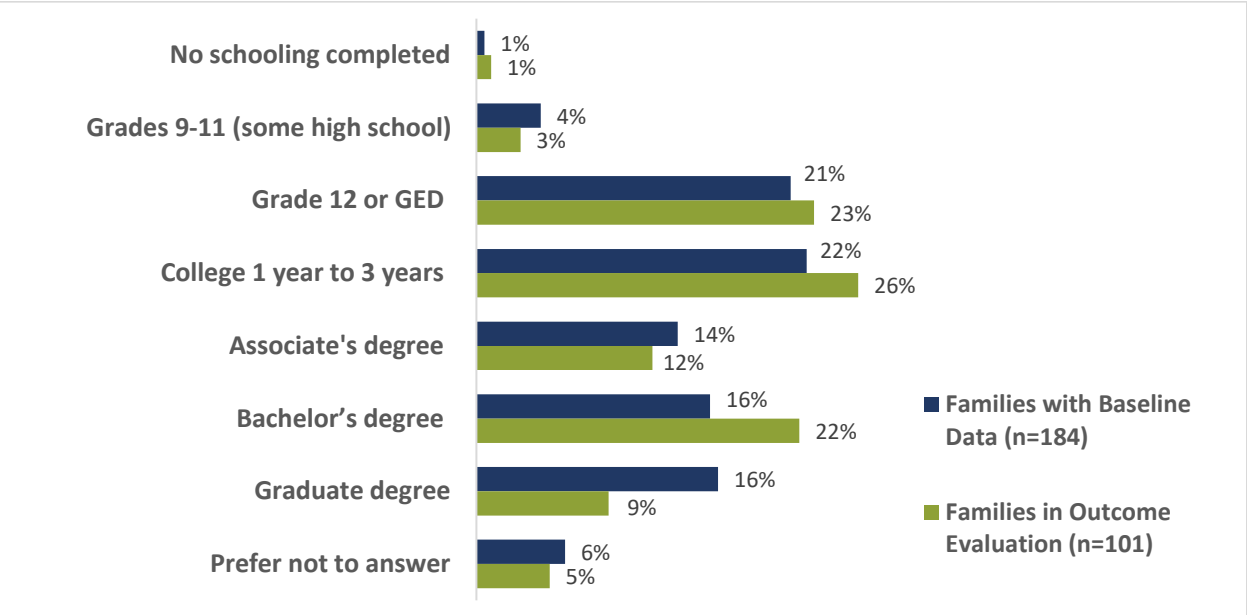
Table 8. Household Composition and Relationship Status of Family Survey Respondents

	Families with Baseline Data (n=185)	Families included in Outcome Evaluation[1] (n=101)
	Baseline	Baseline
Household Composition		
Number of families with data	179	99
Median number (range) of adults in HH	1 (1, 5)	1 (1, 5)
Median number (range) of children in HH	2 (0, 6)	2 (0, 6)
Relationship Status		
Number of families with data	180	98
Percent that are unmarried, separated, or divorced	70%	76%

[1] *Families were included if they had completed at least one follow-up survey (at 6, 12, or 18 months)*

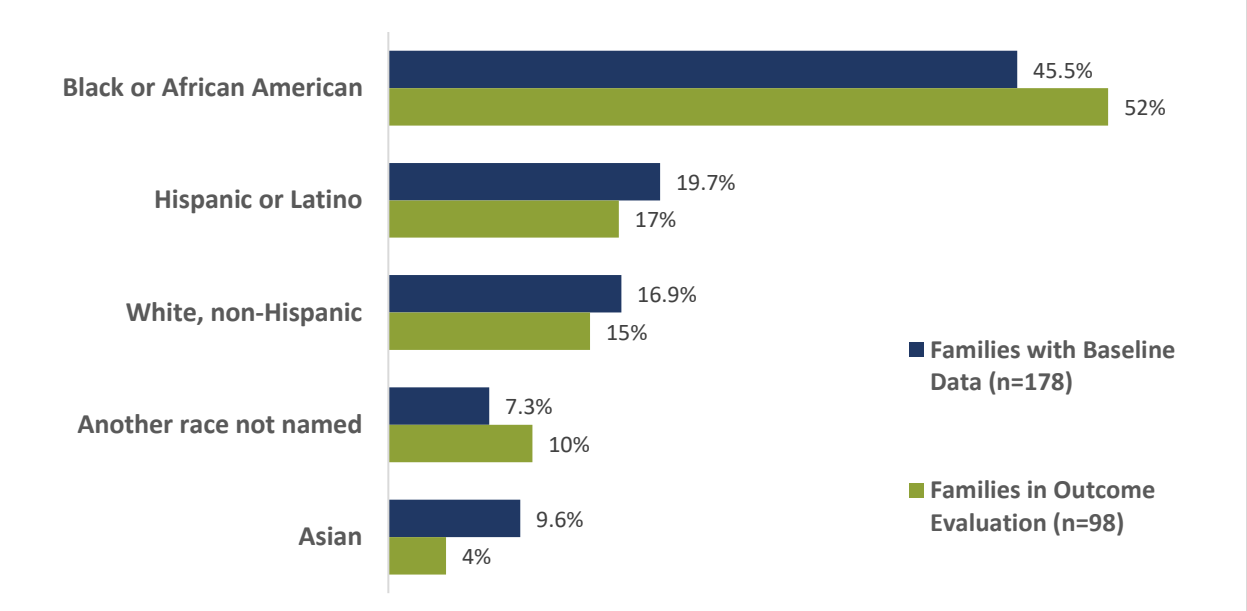
Among those reporting their educational attainment (**Figure 4**), nearly all respondents possessed at least some high school education and over half had completed at least some college or beyond. When looking specifically at families included in the outcome evaluation – 21% had completed high school, 22% had completed some college, 30% had either an associate or bachelor's degree, and 9% had a graduate degree. While most respondents were not currently enrolled in school, one in four (25%) did report that they were currently enrolled in school. The percentage reporting having a graduate degree was highest for Strengthening Families Together (21%) compared to the other three partnerships (all <5% each).

Figure 4. Educational Attainment of Family Survey Respondents



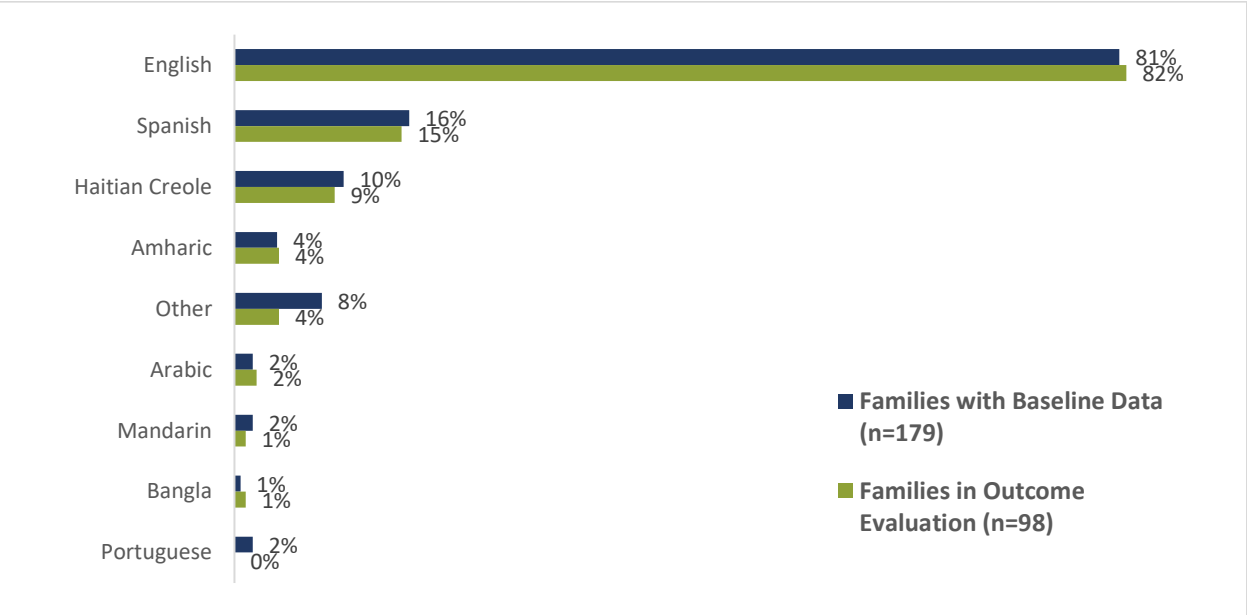
When asked to identify their race and ethnicity (**Figure 5**), about half of respondents identified as Black or African American. Looking specifically at families included in the outcome evaluation, 52% identified as Black or African American, 17% as Hispanic or Latino, 10% as another race not named, and 4% identified as Asian. Additionally, 15% identified as white. This latter percentage was slightly higher for Strengthening Families Together (24%) compared to the other three partnerships (all <16% each).

Figure 5. Race and Ethnicity of Family Survey Respondents



Most respondents indicated English was a primary language (**Figure 6**). Looking specifically at those in the outcome evaluation, 82% reported speaking English, 15% reported speaking Spanish, and a wide range of other languages were also reported, including Haitian Creole (9%), Amharic (4%), Arabic (2%), Mandarin (1%), and Bangla (1%). The percentage reporting speaking Spanish at home was slightly higher for Families Moving Forward (30%) and Family Stability Project (22%) compared to the other two partnerships (both <10%).

Figure 6. Languages Spoken at Home of Family Survey Respondents



Taken together, the demographic data suggest that partnerships successfully reached a very diverse population of Cambridge residents with their programming that did include the priority populations the CBF initiative had intended to reach. The following sections of the report detail the various impacts and outcomes observed among the 101 participating families that were included in the outcome evaluation.

Housing Stability

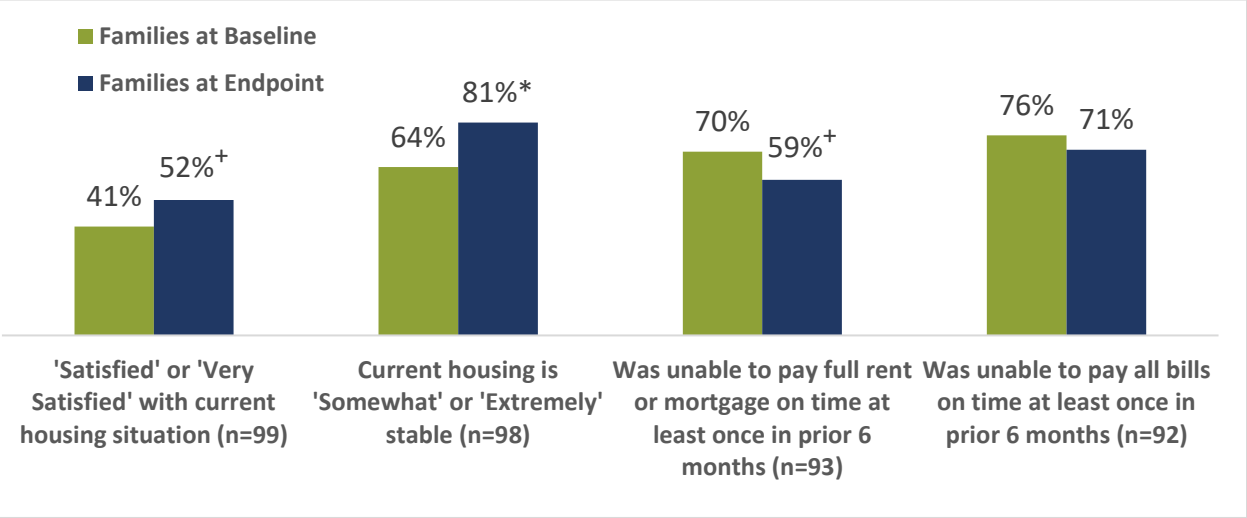
In qualitative discussions, program participants expressed mixed opinions regarding their overall satisfaction with their current housing situation. Some participants experienced substantial improvements in their housing while others did not. For example, one person noted that their life has ***"completely changed"*** for the better thanks to program staff sorting out their housing challenges, while another noted that while they have housing, their concerns about safety in the building continue to trigger their post-traumatic stress disorder leading to substantial and ongoing dissatisfaction with their housing situation.

Many participants described barriers related to Section 8 housing vouchers. These participants highlighted many challenges with communicating with landlords about their housing comfort and safety concerns. Several participants highlighted the power dynamic that exists between themselves and their landlords/building managers. This dynamic, they noted, can make it difficult for them to confidently advocate for themselves. Program participants named program staff as well as Cambridge Housing Authority as helpful resources in housing advocacy. Specifically, participants were grateful for the staff who help them navigate the ***"headache"*** of housing issues because as one participant perceived, ***"they don't treat you well when you have section 8."***

Based on Family Survey data, a similar percentage of respondents reported living in rented house, condo, or apartment at both baseline (80%) and endpoint (81%). Furthermore, about 85% of these renters were living in affordable or subsidized rental housing at each timepoint. Only a few families reported living in very unstable situations (i.e., staying with friends or family, staying in a shelter, etc.) at either baseline (7%) or endpoint (4%). However, there was evidence that the stability of said housing was improving over follow-up.

As illustrated in **Figure 7**, the percentage who reported their housing to be 'somewhat' or 'extremely stable' increased significantly from 64% at baseline to 81% at endpoint ($p<0.05$). Additionally, there was a marginally significant increase in the percentage that reported they were 'satisfied' or 'very satisfied' with their housing situation (41% at baseline and 52% at endpoint; $p<0.10$) and a marginally significant decrease in the percentage that reported they were unable to pay their full rent or mortgage in the prior 6 months (70% at baseline and 59% at endpoint; $p<0.10$). These overall findings were reflective of results by partnership, particularly Family Stability Project, Families Moving Forward, and Port Arise, though significance was attenuated due to smaller sample size.

Figure 7. Indicators of Housing Instability, by Timepoint



*Change between baseline and endpoint is statistically significant: *P<0.05, **P<0.01, ***P<0.001*
Change between baseline and endpoint is marginally statistically significant: $^{+}$P<0.10

Among the other indicators of housing stability included in the Family Survey, the percentage reporting that they had been homeless in the prior 6 months declined from 13% of families at baseline to 6% at endpoint, however this difference was not statistically significant. And a similar percentage of families reported receiving a notice to quit (i.e., initial step of eviction) at each timepoint (8% at both baseline and endpoint). Sample size was too small to support analyses of these indicators by partnership.

Economic Stability

Qualitatively, program participants found the economic/financial support to be helpful and in some cases, life changing. Participants expressed a great deal of appreciation for the staff they work with saying their time in the program has been ***"a great experience"*** and one person put it simply by saying, ***"if I didn't have them, I would not be able to live in Cambridge."***

During their time in their respective programs, participants said that they were able to access several economic-focused services including, Cambridge Employment Program (CEP), an adult employment program offered by the City of Cambridge Office of Workforce Development, SNAP (after staff help with completing the paperwork), and various financial literacy workshops. These resources, participants said, had both concrete and socio-emotional impacts. For example, the CEP assisted participants in areas such as resume and cover letter development and refinement, while the financial literacy workshops helped participants in areas such as developing a budget, saving money, and building/repairing credit. From a more socio-emotional perspective, participants repeatedly noted that the experiences overall helped to build up their confidence and expand their understanding of how they can achieve their financial goals.

Other program participants mentioned the importance of being able to access food-related services in recent months/years due to the impact of inflation on already rising food costs. Program participants with access to food pantries and grocery store gift cards repeatedly highlighted these as positive and substantial benefits as they worked to manage their economic security. For many, this not only provided needed food and other household supplies, but it freed up their limited resources to cover other household expenses.

> ***"If you hadn't had the funds or resources for it [food and household items], I don't know what I would have done."*** – Year 2 Program Participant

Participants of some program models received monetary stipends as part of their participation, and they indicated that these funds had improved their economic situation and quality of life simply because the funds improved their ability to afford basic necessities such as housing, food, and medications. A few participants also commented that the funds allowed them to afford some of the aspects of life that, while non-essential, allow them and their families to have nice experiences. These participants noted that while they still prioritize the physiological needs of their families, the additional funds have helped them to enjoy life more rather than constantly feeling like they are just making ends meet.

> ***"The benefit has been not just for me but for my kids too. With the stipend, I was able to pay for Taekwondo for my son. I've been able to get some wants in life, not just working to pay my bills."*** – Year 3 Program Participant

While participants frequently commented that their economic stability had improved in some ways, they were clear that the assistance they received had not resolved all their economic concerns. This was especially clear during conversation with participants in Year 3. For example, one participant commented that while they received assistance through social security, SNAP, and part-time employment, they still perceived themselves to be in an unstable financial position.

Specifically, this individual was worried about losing their job and/or having their hours reduced and noted that either situation would force them into a financial ***"hole"*** from which they would ***"never dig out."*** Additionally, multiple participants in Year 3 said that the recent inflation had ***"definitely"*** made it hard to afford basic necessities such as food and utilities. Regarding the impact of inflation, one participant stated ***"Now, I buy worse things than better things. At the grocery store, I'm not getting the small, healthy pound of beef; I'm buying the bigger, less healthy one. Which pack is the cheapest?"*** These findings suggest how precarious stability can be for families in Cambridge, particularly given the broader context of the larger economy.

Based upon Family Survey data, no significant change was observed in monthly household (HH) income over follow-up (**Table 9**). The median monthly HH income was $2,220 at each timepoint. When explored by partnership, median monthly incomes were lowest for Port Arise ($1,200, n=23) and highest for Strengthening Families Together ($3,100, n=34), however no significant change was observed for any individual partnership.

Table 9. Monthly Household (HH) Income of Family Survey Respondents, by Timepoint

	Families at Baseline	Families at Endpoint	P-Value
Count of Families with data	85	85	
Median Monthly HH Income	$2,523	$3,340	n.s.
Mean Monthly HH Income	$2,200	$2,200	
Range Monthly HH Income	$0, $9,000	$0, $52,500	

n.s. indicates results were not statistically significant over time

Similarly, no significant change in employment status was observed between timepoints, either in overall analyses (**Table 10**) or by individual partnership. However, employment status did differ slightly by partnership at baseline suggesting some differences in the populations prioritized for enrollment. Among families enrolled with Families Moving Forward and Port Arise, about half were employed at baseline (48% and 42%, respectively), while among families enrolled with Family Stability Project and Strengthening Families Together, the majority were employed at baseline (80% and 82%, respectively).

Table 10. Employment Status of Family Survey Respondents, by Timepoint

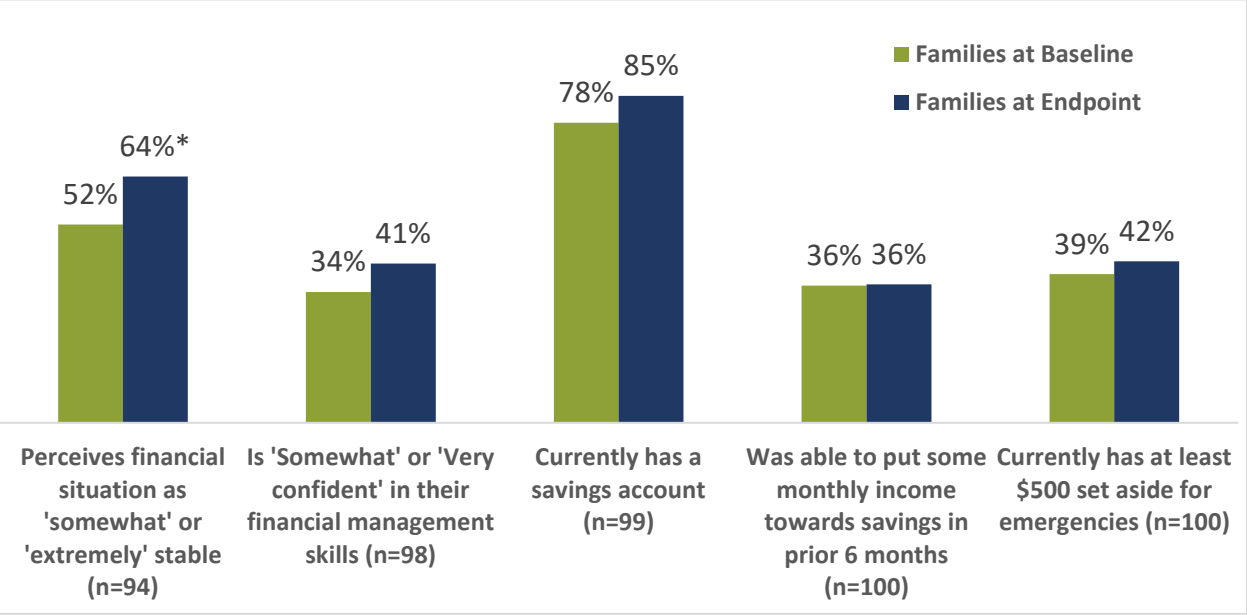
	Families at Baseline		Families at Endpoint		P-Value
Count of Families with data	71		71		
	n	%	n	%	
Employed for wages	50	70%	48	68%	n.s.
Unemployed	10	14%	12	17%	n.s.
Self-employed	1	1%	5	7%	--
Homemaker	5	7%	1	1%	
Student	3	4%	4	6%	--
Retired	0	0%	1	1%	--
Unable to work	1	1%	1	1%	--
Other	2	3%	0	0%	--
Not Applicable	1	1%	1	1%	--

n.s. indicates results were not statistically significant over time; -- indicates sample size was too small to support significance testing

Despite no observable change in income and/or employment status between baseline and endpoint, some improvement was observed in respondents' perception of their financial situation which echoes the qualitative findings described above. Specifically, the percentage who reported their financial situation to be 'somewhat' or 'extremely stable' increased significantly from 52% at baseline to 64% at endpoint ($p<0.05$) (**Figure 8**). This finding was reflective of results stratified by partnership, particularly Family Stability Project, Families Moving Forward, and Port Arise.

The other indicators did not improve significantly over follow-up, though they all were trending in a positive direction. However, when stratified by partnership one finding did reach marginal significance -- for Port Arise the percentage of respondents that reported they were 'somewhat' or 'very confident' in their financial management skills increased from 53% at baseline to 76% at endpoint ($p<0.10$).

Figure 8. Indicators of Financial Instability, by Timepoint



*Change between baseline and endpoint is statistically significant: *P<0.05, **P<0.01, ***P<0.001*
Change between baseline and endpoint is marginally statistically significant: ⁺P<0.10

Behavioral Health

> ***"Just knowing there is someone there to talk to about anything I need is good…even just for a conversation, feeling less alone, not feeling like things are 'over my head.'"*** – Year 2 Program Participant

Among the participants who felt comfortable sharing their experiences addressing the mental and behavioral health needs of themselves and their families, several services were highlighted. For example, some participants and/or their children were receiving therapy through a social worker or medical provider. Many others received some form of coaching and/or informal encouragement that, while it may not be classified as formal therapy, still had a substantial impact on participants' perceptions of the emotional well-being of themselves and their children. This type of support was most frequently cited by participants and program staff alike. Through the numerous qualitative conversations with both groups over the years of implementation, it became clear that coaching and encouragement were a crucial part of relationship and trust building for families.

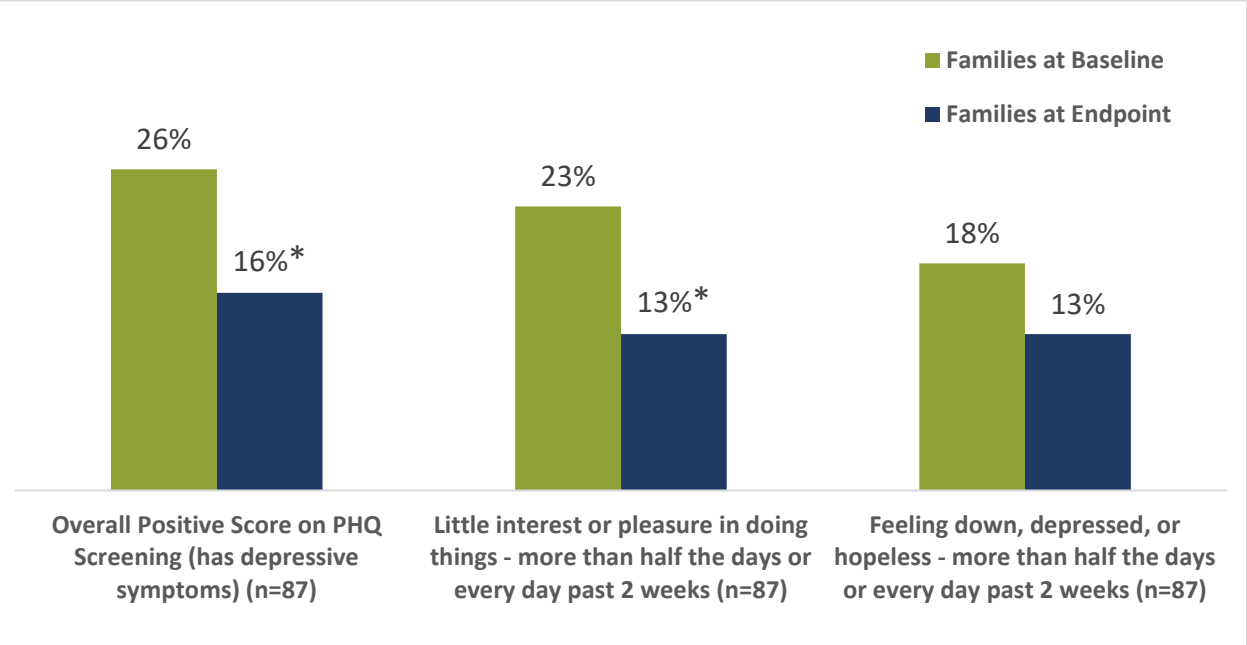
Beyond these less formal therapeutic interactions, program participants in one partnership also had the opportunity to work with a social worker and expand their parenting skills and techniques. One parent described that by gaining tools around parenting, they were better able to manage the behavioral

> ***"This [program] changed my life entirely. I lost hope and I was even thinking of relocating to restart again. I was depressed. When I got into the program, they made me believe that there is still hope. Since I've joined the program things have been working."*** – Year 3 Program Participant

health needs of their children, saying the advice had changed the way they communicate and respond to their children.

More directly related to the mental health symptoms experienced by participants, the Family Survey included a set of screening questions for symptoms of depression and anxiety experienced in the prior 2 weeks. Results of the *Patient Health Questionnaire (PHQ-2)* screening, which identifies clinically relevant symptoms of depression, are shown in **Figure 9.** The percentage of respondents that screened positive for depression symptoms (defined by an overall score over 4, on an 8-point scale) decreased significantly from 26% at baseline to 16% at endpoint. In exploration of the two individual questions that comprise the PHQ-2, the percentage reporting that they had experienced little interest or pleasure doing things either 'more than half the days' or 'every day' decreased significantly (23% to 13%; p<0.05). However, the percentage reporting feeling down, depressed, or hopeless 'more than half the days' or 'every day' in the prior 2 weeks did not change significantly, though the trend was positive.

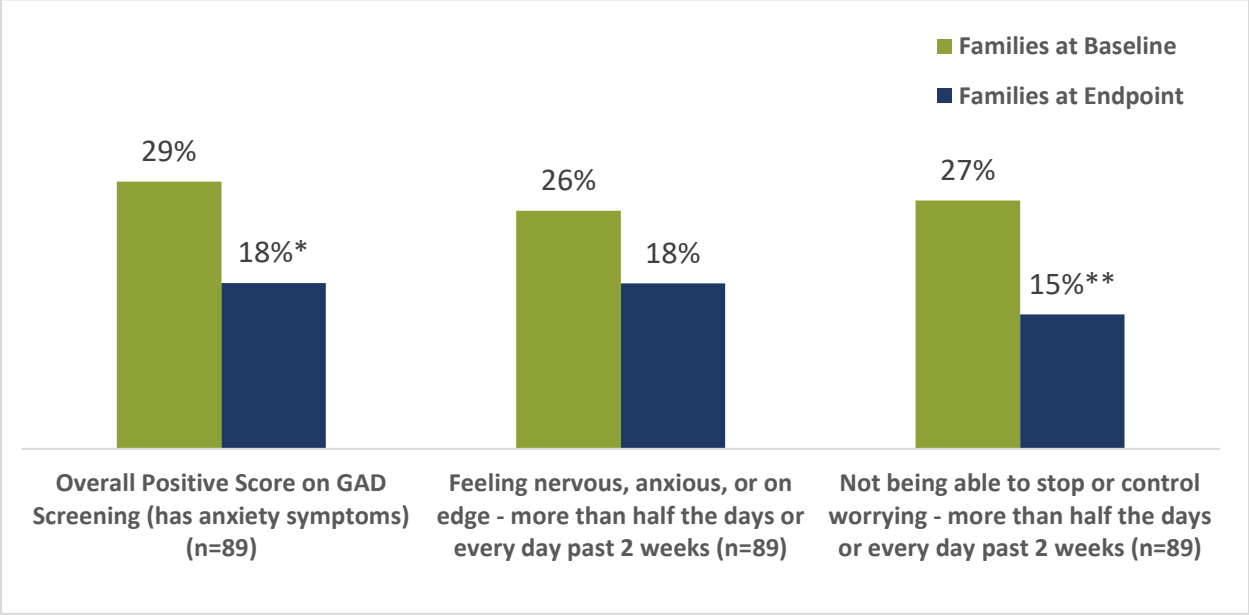
Figure 9. Depression Screening and Symptoms among Family Survey Respondents, by Timepoint



*Change between baseline and endpoint is statistically significant: *P<0.05, **P<0.01, ***P<0.001*
Change between baseline and endpoint is marginally statistically significant: $^{+}$P<0.10
Note: Patient Health Questionnaire-2 (PHQ-2) is a validated scale that asks about the frequency of depressive symptoms over the previous 2 weeks. A positive score is indicative of symptoms that rise to clinical concern.

Results of the *Generalized Anxiety Disorder-2 (GAD-2)* screening, which identifies clinically relevant symptoms of depression experienced in the prior 2 weeks are shown in **Figure 10.** The percentage of respondents that screened positive for anxiety symptoms (defined by an overall score over 4, on an 8-point scale) declined significantly from 29% at baseline to 18% at endpoint (p<0.05). When each of the two individual questions that comprise the GAD-2 were examined, the percentage reporting not being able to stop or control worrying 'more than half the days' or 'every day' decreased significantly from 27% at baseline to 15% at endpoint (p<0.001). However, the percentage reporting feeling nervous, anxious, or on edge 'more than half the days' or 'every day' trended in the positive direction but did not reach the level of statistical significance.

Figure 10. Anxiety Screenings and Symptoms among Family Survey Respondents, by Timepoint



*Change between baseline and endpoint is statistically significant: *P<0.05, **P<0.01, ***P<0.001*
Change between baseline and endpoint is marginally statistically significant: ⁺P<0.10
Note: Generalized Anxiety Disorder-2 (GAD-2) is a validated scale that asks about the frequency of symptoms of anxiety over the past two weeks. A positive score is indicative of symptoms that rise to the level of clinical concern.

Services and Support in Cambridge

While the indicators described above suggest successful program implementation and impact, the extent of engagement of families and service delivery to participants by the partnerships was limited by the organizational capacity and availability of resources in the greater Cambridge community. All partnerships shared that there were many more families and individuals in need of their services than they had the capacity to serve during the Implementation Phase. For many, this meant that families were put on a waitlist or turned away. One partnership also raised the idea that this sets up further inequities in the community as the available services are not available to all who need them.

Program participants echoed these challenges in their previous experiences seeking help for housing or mental health concerns. Participants identified some barriers to accessing services that related to challenges with application systems, ***"you don't know where to apply, what to do, what you need."*** But participants from several partnerships noted the assistance from these funded programs helped them to navigate these systems and complete the necessary forms. Despite that assistance, participants still struggled to gain access to services external to the partnerships, noting ***"there aren't many [housing] resources out there,"*** and that waitlists for mental health services can be extensive.

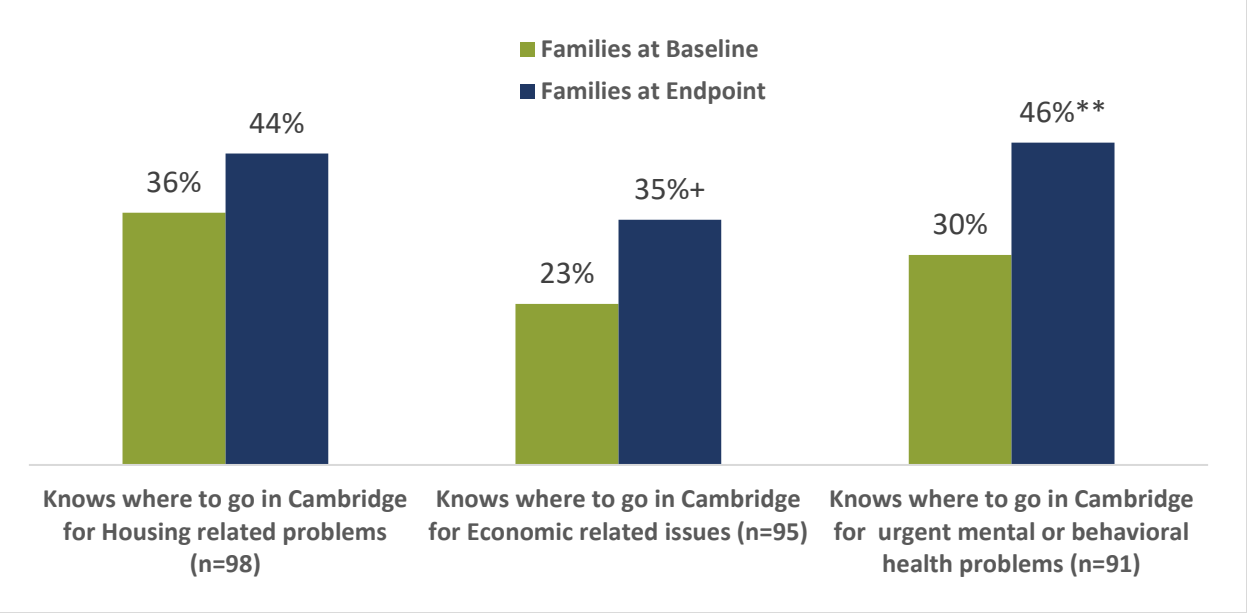
Program participants emphasized the importance of improving the accessibility to the resources and elimination of barriers as these exacerbate the sense of vulnerability and urgency that people often have when seeking services. For example, a handful of participants described themselves as being in a state of crisis when they were connected to services (i.e., experiencing domestic violence or housing eviction, etc.). While these participants were able to be connected to services quickly, they acknowledged that it was not always the case based on prior experiences in Cambridge. Importantly, most participants did not report experiencing any challenges in accessing services during program implementation. Of the handful who did, their challenges were representative of the larger economic and/or service delivery system, such as long waiting lists for affordable housing, long wait times to see

mental/behavioral health providers, frequent changes in providers, and inflation.

For a small proportion of program participants, there appeared to be a lack of awareness of the breadth of resources available to them within a partnership, either directly or by referral, even after having engaged with the organization as a program participant for many months. Some of these participants shared that they only expressed a need for or discussed services they thought the partnership offered and then sought out other organizations in the community to meet those other areas of need. For example, one program participant recalled accessing financial resources outside of their partnership (which could have connected them through the partnership) because ***"that is the place in the community that I knew had [the resources to help]."*** While they were able to locate services, this was a missed opportunity for a warm handoff by the partnership they currently worked with.

The Family Survey included a range of questions designed to understand whether respondents' knowledge and ability to find services related to their top-tier needs changed through their program participation. At endpoint, a significantly larger percentage of families reported that they knew where to go in Cambridge for urgent mental or behavioral health problems (30% at baseline to 46% at endpoint, p<0.01) (**Figure 11**). And a marginally larger percentage knew where to go in Cambridge for economic-related issues (23% at baseline to 35% at endpoint, p<0.10). No significant change was observed in knowledge of where to go for housing-related problems, though the trend was in the positive direction. Findings were consistent by partnership, but significance was attenuated due to smaller sample size.

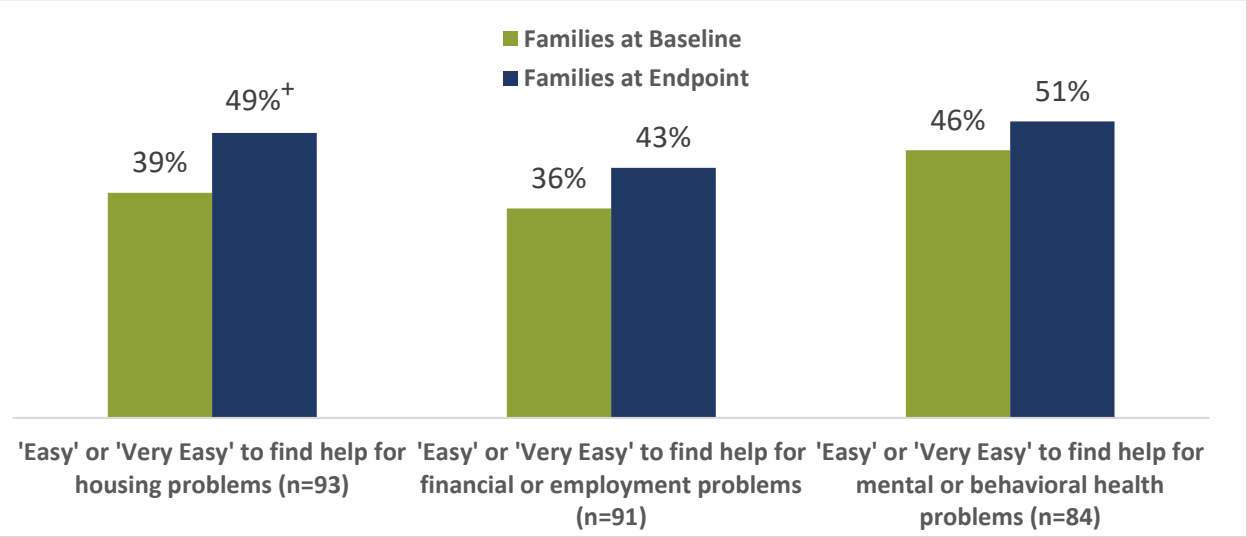
Figure 11. Knowledge of Where to go for Help in Cambridge for Top-tier Needs among Family Survey Respondents, by Timepoint



*Change between baseline and endpoint is statistically significant: *P<0.05, **P<0.01, ***P<0.001*
Change between baseline and endpoint is marginally statistically significant: ⁺P<0.10

Improved knowledge of where to go for support around the top-tier needs did not necessarily translate into how easy or hard the process of finding help was perceived to be. As illustrated in **Figure 12**, while trends were in the positive directions in each case, the percentage of families reporting that it was 'easy' or 'very easy' to find help only increased marginally for housing-related problems (39% at baseline to 49% at endpoint, p<0.10). However, in stratified analyses by partnerships, this percentage did increase significantly among families at Port Arise (from 20% to 44%; p<0.05).

Figure 12. Perceived Ease of Finding help in Cambridge for Top-tier Needs among Family Survey Respondents, by Timepoint



*Change between baseline and endpoint is statistically significant: *P<0.05, **P<0.01, ***P<0.001*
Change between baseline and endpoint is marginally statistically significant: +P<0.10

Program Satisfaction

A key aspect of each of the funded partnership models was a focus on better understanding the complex and interrelated needs of the families served. Additionally, each partnership sought to work directly with families using comprehensive case management that leveraged the current strengths and assets of the family, including them in problem-solving and/or goal setting.

Many participants described the program staff as being advocates on their behalf. This ranged from having program staff accompany them to appointments, to being present and vocal in meetings with agencies, and for some empowering them with the skills and confidence to advocate on their own behalf. As one program participant stated, ***"It helps to have someone be your voice that they actually listen to."*** Participants consistently commended the staff they worked with and expressed gratitude for the support they received. Staff were described as patient, understanding, and **"good helpers"** who pushed participants to stay engaged and continue their commitment to improving their lives.

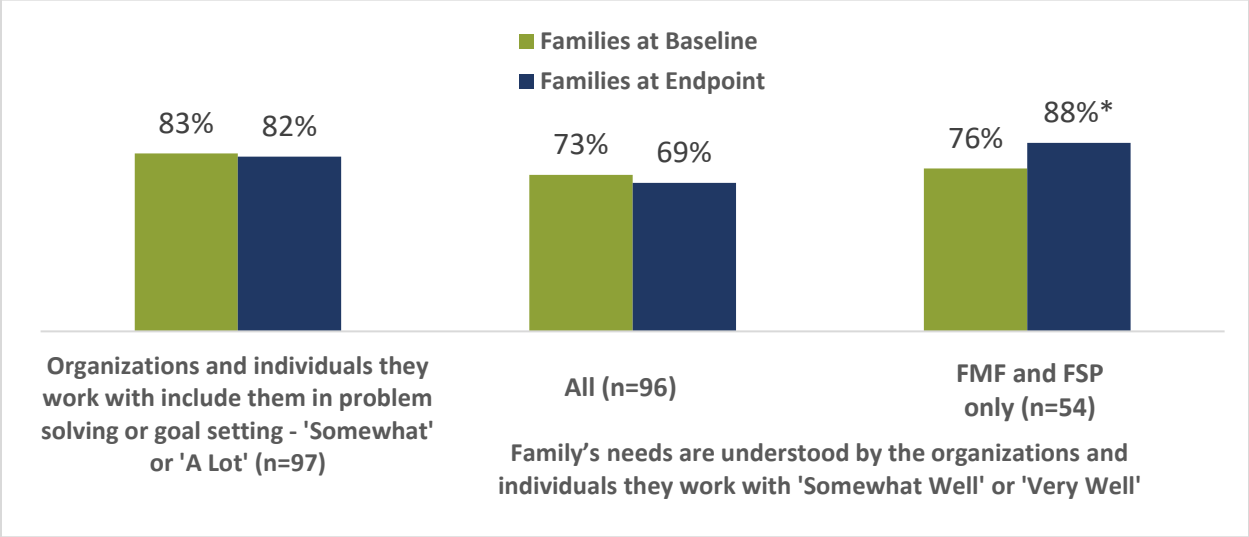
Several participants also commented that just as they had learned of the partner organizations through friends and family members, they now recommend the organization(s) they worked with to others in their community. Participants remarked that the positive impacts they and their children have experienced has been a primary facilitator in speaking about the program to others. As one person said, they encouraged folks in their network to **"just try it"** because **"you cannot lose."** A few participants also shared stories of helping their friends get connected to one of the programs for services.

In describing their positive experiences with the program, one participant commented that they would continue program engagement even if the stipend stopped because ***"I like the community aspect of it. I am meeting people in my own community. I've been here since 2018 and I am getting to know people more. The staff are right across the street. You can go in for office hours, you can call, you can text."***

Data from the Family Survey did not show any significant change in how families perceived the organizations they were working with, likely because regard for them was already high from the beginning. As illustrated in **Figure 13**, most (approximately 82%) indicated the organizations they worked with included them in problem solving or goal setting 'A lot' at both baseline and endpoint.

Additionally, a large percentage of families (approximately 70%) felt the organizations understood their needs either 'somewhat well' or 'very well' at both baseline and endpoint. However, as is further shown in the figure, a significant improvement in this latter indicator was observed among respondents specifically at Families Moving Forward and Family Stability Project (76% at baseline to 88% at endpoint; p<0.05) which contrasted with the lack of change observed in the overall sample.

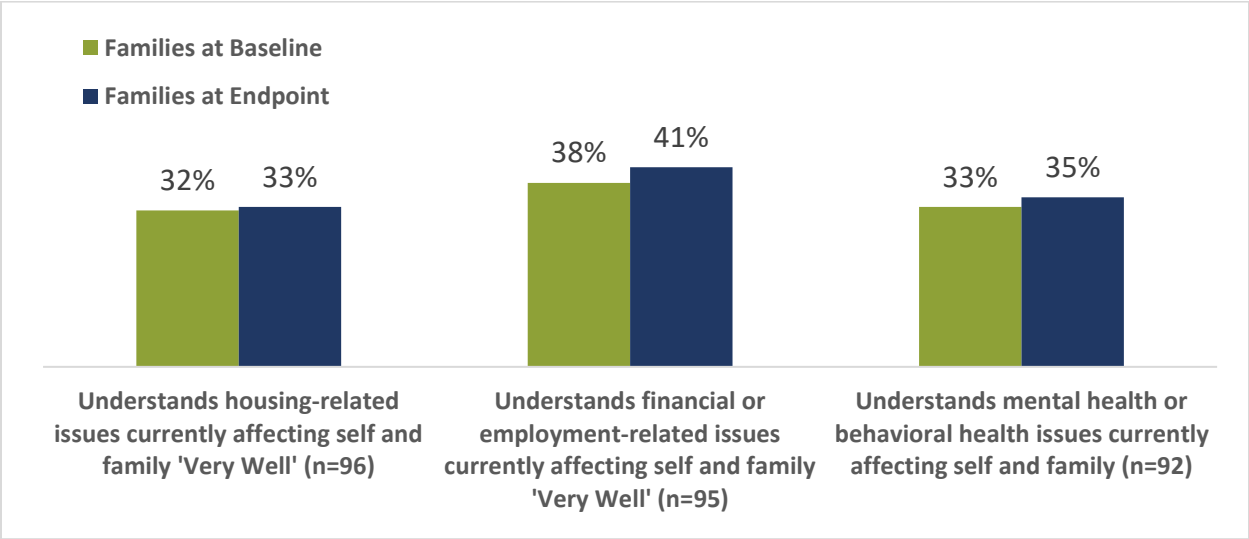
Figure 13. Perceptions of Service Organizations among Family Survey Respondents, by Timepoint



*Change between baseline and endpoint is statistically significant: *P<0.05, **P<0.01, ***P<0.001*
Change between baseline and endpoint is marginally statistically significant: $^{+}$P<0.10

Interestingly, families understanding of their own specific issues related to the top-tier needs remained unchanged and relatively low from baseline to endpoint (**Figure 14**). Regardless of whether related to housing, employment/finances, or behavioral/mental health, roughly only about one third of respondents reported their own understanding as 'very well' at either timepoint. It is possible that the complexity of needs and the length of time required to meet them prevented respondents from rating their understanding as higher. No differences were observed by partnership in stratified analyses.

Figure 14. Perception of Understanding Own Top-tier Needs among Family Survey Respondents, by Timepoint



*Change between baseline and endpoint is statistically significant: *P<0.05, **P<0.01, ***P<0.001*

Overall Wellbeing and Resiliency

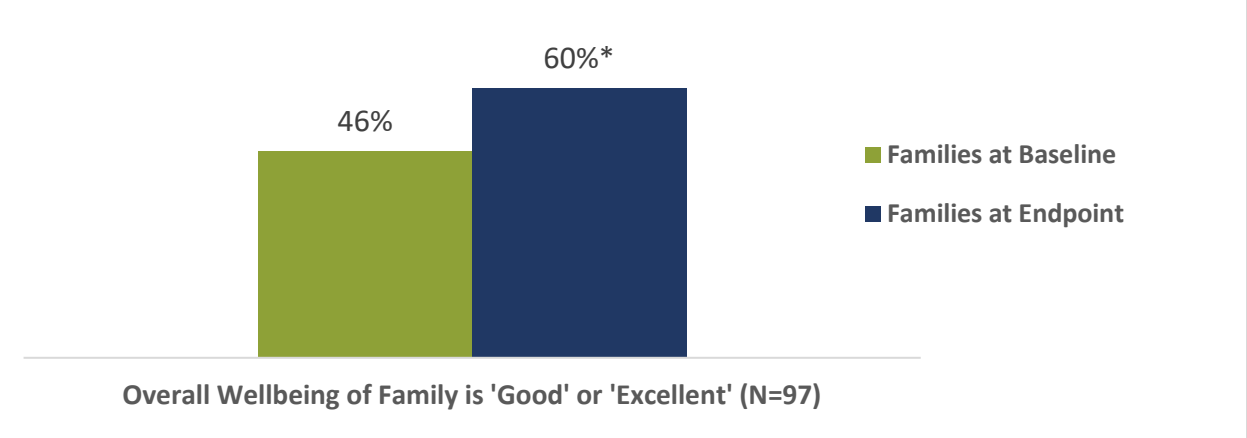
The underlying theory of the CBF initiative, and each of the models developed and implemented by funded partnerships, emphasized the interconnectedness of the top-tier needs and the idea that by addressing each of the needs more comprehensively and in collaboration between organizations, families would be better supported and experience greater wellbeing and resilience in the future.

When thinking about the overall well-being of themselves and their family members, participants generally described their well-being as having improved since they started receiving services through their respective programs. Importantly, program participants did not perceive a distinction between their overall well-being and their other needs. Rather, in describing their improved well-being, they naturally segued into conversations around the top-tier needs and other services they and their loved ones could access. For program participants who perceived themselves to be more stable than when they first began programming, they remarked on a greater level of comfort in reaching out to program staff or other resources if they need assistance. Ultimately, regardless of the type of services accessed, program participants conveyed a sense of self-confidence in their ability to participate in daily activities and access services in the future.

> ***"[The program] is good support for me – everyone is different – it helps them in different ways. They helped me to set goals, to realize there is someone to help you if you feel frustrated and if they can't help you, they will help find someone that can."*** – Year 2 Program Participant

Among Family Survey respondents, there was a significant increase in the percentage who reported the overall wellbeing of their family as either 'good' or 'excellent', from 46% at baseline to 60% at endpoint ($p<0.05$) (**Figure 15**). Stratified analyses suggested that this improvement in wellbeing was particularly strong among respondents at Port Arise, who began with a notably low level of 'good' or 'excellent' wellbeing at baseline (28% at baseline to 60% at endpoint; $p<0.01$).

Figure 15. Perception of Overall Family Wellbeing among Family Survey Respondents, by Timepoint



*Change between baseline and endpoint is statistically significant: *P<0.05, **P<0.01, ***P<0.001*
Change between baseline and endpoint is marginally statistically significant: ⁺P<0.10

Program staff described many instances of increased resiliency among program participants; however, they also discussed the struggles program participants faced in getting to a more stable footing. Some partnerships commented that the changes they and their staff have witnessed in participants have been

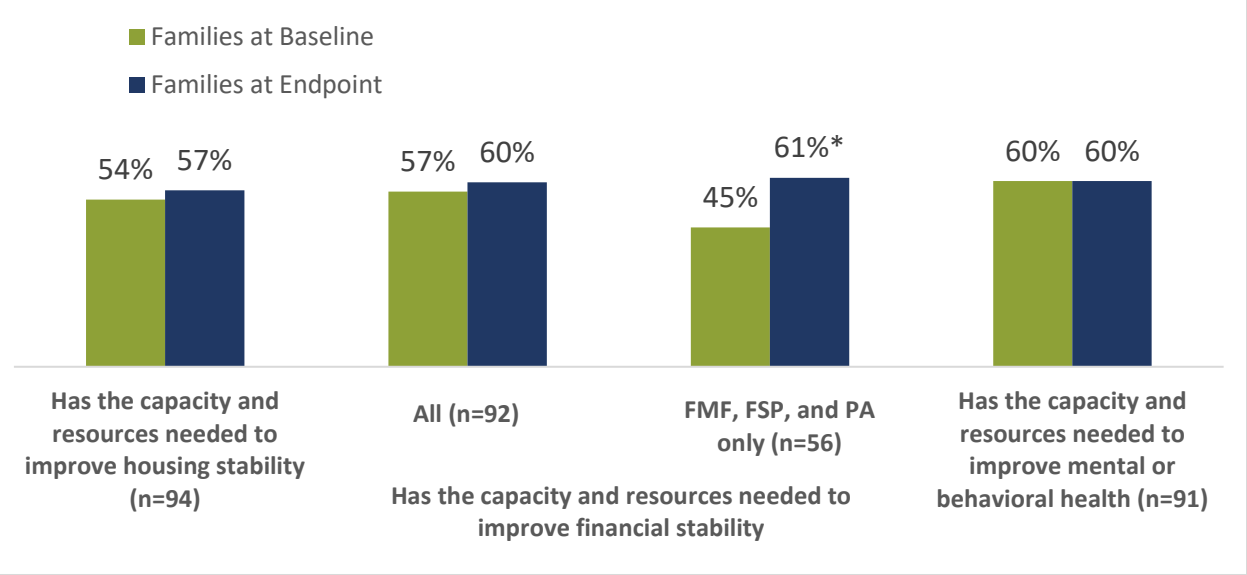
less tangible improvements to their quality of life, such as increased happiness, engagement, hope, sense of self, and confidence in making changes to their lives. These outcomes, while not as easy to define and measure, are important improvements nonetheless and do align with the measured improvements in mental health symptoms described above.

Participants shared many instances which demonstrate how services had impacted their wellbeing and quality. For example, several mentioned the importance of accessing free/reduced-cost childcare as the cost of this essential service continues to increase. In addition to the improved financial stability such a service provides to families, these participants also commented on the increased emotional well-being they experienced knowing that their children were enrolled in a program with staff they trusted, rather than being home alone.

> ***"Knowing my kid was somewhere safe was reassuring and helped ease my anxiety. Having him there was way less stressful and I could actually focus on my job more."*** – Year 2 Program Participant

To understand the impact of program participation on a family's capacity to improve their top-tier needs and begin to understand progress towards improved long-term resiliency, the Family Survey asked whether respondents felt they had the capacity and resources they needed in order to improve their housing stability, financial stability, or mental or behavioral health. As illustrated in **Figure 16**, the percentage reporting that they had the capacity and resources they needed was relatively similar across the top-tier needs and did not change between baseline and endpoint in analyses of all partnerships (approximately 55%- 60% in each case). However, in stratified analyses capacity and resources to improve financial stability trended in the negative direction among respondents at Strengthening Families (75% at baseline to 58% at endpoint; $p<0.05$). And when analysis was confined to respondents at the other three partnerships, a significant improvement in this indicator was observed (45% at baseline to 61% at endpoint; $p<0.05$).

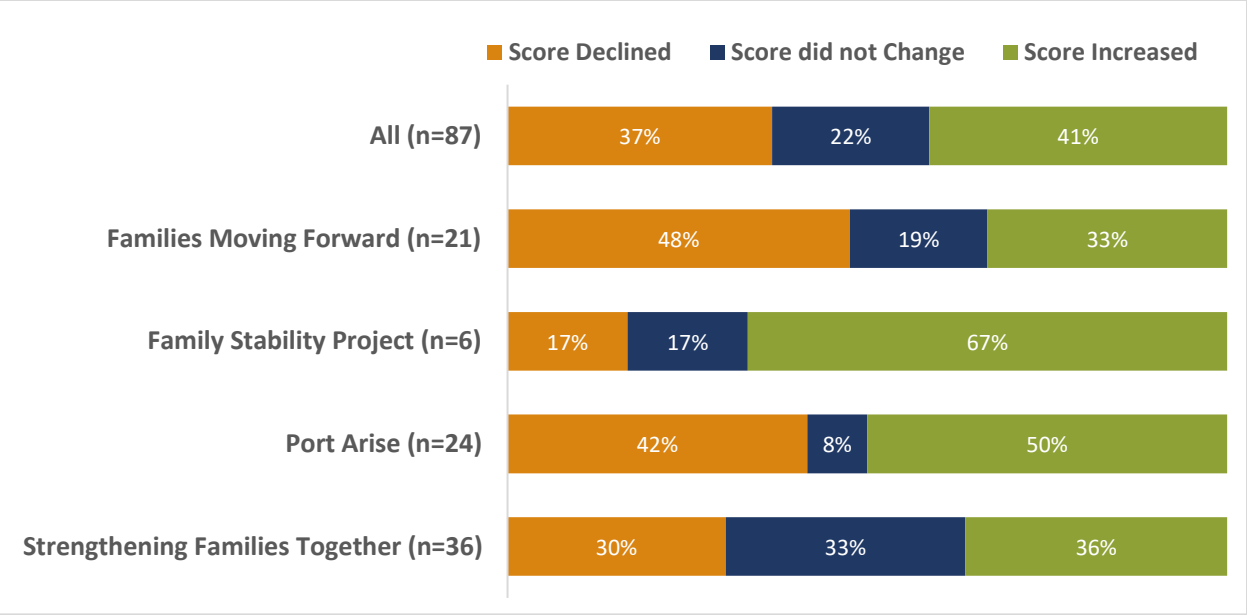
Figure 16. Perception of Family Capacity and Resources around Top-tier Needs among Family Survey Respondents, by Timepoint



*Change between baseline and endpoint is statistically significant: *P<0.05, **P<0.01, ***P<0.001*

The construct of resiliency was also assessed in the Family Survey through the inclusion of the *New General Self-Efficacy Scale* which assesses how much an individual perceives they are able achieve goals and overcome challenges. Overall, efficacy scores did not change significantly between baseline and endpoint (32.0 and 32.2 points, respectively and based on a scale of 8 to 40 points). Categorically, over one third of all respondents (41%) did have an increase in their self-efficacy score, however a nearly equal percentage (37%) had a decrease in their score (**Figure 17**). While findings varied, this pattern was generally present across partnerships. It is not possible to explain why more consistent improvement in scores were not observed, but there is anecdotal evidence to suggest that at baseline, respondents may not have been able to accurately reflect upon their own self-efficacy and it took time working with the partnerships and case managers to better understand their own room for growth. A phenomenon often framed as 'you don't know what you don't know, until you know.'

Figure 17. Direction of Change in Self-Efficacy Score between Baseline and Endpoint, by Partnership



To explore the self-efficacy scale in more depth, responses to each of the items were also examined. As illustrated in **Figure 18**, the percentage reporting they 'Strongly Agree' with the statement trended in the positive direction for all but one item in the scale ('I believe I can success at most any endeavor to which I set my mind'). Fortunately, few respondents answered as 'Strongly Disagree' or 'Disagree' to any item (approximately 7% at baseline and 5% at endpoint) suggesting most participants fell somewhere in the middle of the scale – not too low, but not too high.

Figure 18. Self-Efficacy Scale Item Responses of 'Strongly Agree' among Family Survey Respondents, by Timepoint (n=87)

NOTE: New General Self-Efficacy Scale is an 8-item measure that assesses how much people believe they can achieve their goals, despite difficulties, using a 5-point rating scale (1= strongly disagree; 2=disagree; 3 = neither agree nor disagree; 4=agree; 5= strongly agree)
*Change between baseline and endpoint is statistically significant: *P<0.05, **P<0.01, ***P<0.001*
Change between baseline and endpoint is marginally statistically significant: ⁺P<0.10

Partnerships emphasized that most families were continuing to struggle with the top-tier needs despite some areas of success in less tangible areas, which made it extremely challenging for partnerships to effectively move families beyond survival mode. The underlying cause of these ongoing struggles generally were system limitations – either the overt lack of resources, ***"waitlists no matter where you try to connect people,"*** or the administrative rules that limit upward mobility.

One grantee discussed the impacts of the financial cliff that most program participants face when they are working to improve their job and economic situation – essentially, they must weigh any economic/financial gains with the potential loss of public benefits (e.g., affordable housing vouchers, health insurance, food stamps, childcare, etc.). This creates perverse incentives which penalizes those who seek to improve their incomes through education and employment.

> ***"I feel like we've found some band aids. A struggle to feel like we can really move the needle when the needs are so deep."*** – Year 2 Grantee Participant

Ultimately, partnerships framed the work that they did with participants as being a "safety net," providing families support and guidance to deal with the systems that exist as best as they can and to shepherd them through moments of crises and severe instability. They universally agreed that for transformational change that builds true resiliency among Cambridge families, deeper system changes – in Cambridge and beyond – are needed.

Recommendations for Cambridge based on Evaluation Findings

To better support Cambridge residents in meeting their housing, economic, and behavioral health needs, much work remains to be done. Efforts and initiatives that address the underlying challenges faced by this diverse population will be necessary. While it remains essential for direct social service organizations within Cambridge to help residents with their current unmet needs, ultimately the cycle of poverty, racism and misogyny will not change without improvement in the many systemic barriers faced by families. The following suggestions are based upon the key findings, themes, and learnings from the Family Level Evaluation of this first round of Community Benefits funding. Each represents a tangible way that the City, the Community Benefits Advisory Committee, and the many direct service organizations within Cambridge could positively impact residents' well-being and upward mobility.

Addressing Systemic Barriers: The greatest impact will require multifaceted approaches that help to address system-level issues. This could occur at varying levels of effort such as through the advocacy of service providers or by the investment in programs at a municipal level.

- *System-Level Advocacy*: Through building local advocacy efforts and seeking avenues of influence at various levels of government, system level barriers may begin to be addressed more effectively. This includes engaging with state and federal policymakers to promote policies that remove barriers and disincentives to upward mobility. Active participation in policy discussions and advocating for equitable changes can contribute to broader reforms that uplift the lives of Cambridge residents.
- *Program Investment:* Funders, municipalities, and other organizations with resources available for community investment should seek to allocate funding to initiatives that target the systemic barriers faced by residents and invest in programs that aim to dismantle the systemic structures perpetuating these problems. Through these investments a significant impact on the well-being of its residents could be made.

Housing Policy: Addressing the scarcity of affordable housing options in Cambridge will require a coordinated effort. This might include the convening of stakeholders (including residents, community organizations, and housing experts) to collectively develop innovative strategies for expanding affordable housing in the city. Through dialogue and collaboration, solutions could be generated that challenge the status quo and lead to lasting change in housing policy.

Community Engagement and Learning: Listening and learning directly from families in need is necessary to support families effectively. Without such insight, it is not possible to fully understand or improve upon the many challenges and barriers faced by families in Cambridge. By maintaining an open channel of communication and learning from families, those seeking to better support families can refine their strategies and ensure any initiatives align with the actual needs of the community.

Family-Centered Case Management: Supporting families effectively requires dedicated time and effort. Approaches which utilize a case manager model, which has proven to be effective in building strong relationships between providers, staff, and families, should be prioritized. Often resource and capacity barriers hinder organizations from delivering personalized and comprehensive services to all families in need, thus consistent advocacy and active promotion family-center approaches may be needed to secure sufficient resources.

Holistic Approach to Well-Being: Continuing to recognize the interconnected nature of families' needs is essential. Efforts to improve the stability of Cambridge families should adopt a more holistic approach that acknowledges the intricate relationships between different aspects of well-being. By facilitating or providing support that addresses not only the immediate needs (e.g., family-centered case management) but also the underlying causes (e.g., systems-level advocacy), families can be empowered to thrive in the long term.

Strengthening Inter-Organizational Connections: Initiatives that actively facilitate connections and networks between organizations are more likely to be successful in their support families. Such

collaboration enhances referral processes and allows for the leveraging of the trust established by one organization to benefit another. Programs and initiatives that foster and build a collaborative environment among organizations would contribute to a service sector within Cambridge that is better able to serve families across multiple domains (e.g., holistic approach to well-being).

Suggestions from Program Participants

The following is a list of resources and support that participants said could be helpful to them or possibly other families in the future. Note, this list includes all the requests made by participants; some represent one person while others were requested by more than one person.

REVIEW CURRENT METHODS OF COMMUNICATION

- Increase transparency and communication regarding programming and events available for parents and youth in the community.
- More advertising of the financial literacy classes that exist across the partner organizations.

IMPROVE ACCESS TO AUXILIARY SERVICES

- Ensure that auxiliary services such as food pantries are available at times that are convenient to families with parents that work earlier or later than most others.

INCREASE EDUCATIONAL OPPORTUNITIES FOR ADULTS

- Develop and affiliation with a local college to create more opportunities for participants to grow their desired skills and pursue a career path.
- Aim to help participants feel more empowered to support themselves and help them *"move up"* through education connections in the long term.

INCREASED PROGRAMS WITH A YOUTH FOCUS

- More activities for youth that are structured, mentally stimulating, and STEM-related activities in addition to the sports-related activities currently available to them.

Boston/Cambridge area perceived to have an abundance of science/educational museums so *"Why not have a night when the kids can do STEM stuff?"*

INCREASE HOUSING-RELATED ADVOCACY

- More workshops to help people learn more about navigating difficult conversations and advocating for themselves and neighbors when dealing with things like discrimination and difficult landlords.

"Having [housing] support before it gets to the point of eviction."

INCREASE OPPORTUNITIES TO FOR PARTICIPANTS TO CONNECT

- Provide opportunities for individuals with similar life experiences to connect with and support one another.

"I wish there was a group for domestic violence survivors. I didn't realize there were others that went through this. I wish there was something that connected us voluntarily to support us."

Appendix A

City of Cambridge Community Benefits Advisory Committee Aims and Questions for Implementation Phase

AIM	QUESTION / OBJECTIVE
Describe the core elements of each project, who was served, and what was delivered	○ 3.1 How feasible are the plans for implementation? ○ 3.2 Which families were served? What services were delivered? ○ 3.3 What does it take for partnerships to collaborate effectively? Are partners invested and attending? Is there consensus around problem/solution? Strength of partnerships? How do partnerships change over time? ○ 3.4 What does it take to be an effective lead organization? What does leadership look like? Are some organizations more successful than others? What is required of partner organizations? What staff were used for what roles? ○ 3.5 Did projects achieve their intended outcomes? Why or why not?
Document accomplishments and outcomes of funded projects (community-level, family-level)	○ 3.6 What has changed for families and for the community? How does change compare across partnerships? How did change impact relationships between organizations? ○ 3.7 What are the strategies that work for families? What drove the outcomes for certain families? ○ 3.8 To what degree have the short-term goals been met or enhanced? ○ 3.9 To what degree have the long-term goals been met or enhanced? Did short-term goals lead to long-term changes? ○ 4.1 To what degree has the landscape or relationships among nonprofits and service providers changed? ○ 4.2 What can we learn about the interrelatedness of the Top-tier Needs and about the theory of change? ○ 4.3 Was the amount of funding sufficient to support grantees and their plans for implementation? Was the approach to funding effective? Was funding structured to maximize impact and outcomes? ○ 4.4 What are the possible challenges/barriers to success that are beyond the scope for this process?

Appendix B

Key Outcomes Operationalized for Data Collection – Family Level

OUTCOMES / OUTPUTS	INDICATORS
Families with housing vulnerabilities have enhanced connections to programs and services that provide specific support around housing.	○ More families in need of housing support are identified ○ More families with housing needs are successfully referred and connected to appropriate partners or service providers ○ Families have increased understanding of their own housing and housing- related needs ○ Families have increased knowledge of the housing services system in Cambridge
Families with economic vulnerabilities have enhanced connections to programs and services that provide specific support around finances and income.	○ More families in need of economic support are identified ○ More families with economic needs are successfully referred and connected to appropriate partners or service providers ○ More families apply for and receive the public benefits for which they are eligible (e.g., WIC, food stamps, childcare voucher, MassHealth, etc.) ○ Families have increased understanding of their own financial and employment- related needs ○ Families have increased knowledge of the programs and opportunities available to them in Cambridge (e.g., ESL trainings, access to technology, job training, higher education, work authorization, job training, etc.)
Families with behavioral health needs have enhanced connections to programs and services that provide specific supports around mental and behavioral health.	○ More families with behavioral health needs are identified ○ More families with behavioral health needs are successfully referred and connected to appropriate partners or services providers ○ Families have increased awareness and understanding of their own behavioral health needs ○ Families have increased knowledge of the behavioral health programs and services available to them in Cambridge
Families are engaged as active participants when working with partnering organizations and their own strengths are fostered in support of their top-tier needs	○ Families perceive their needs are better understood by the partnering organizations and service providers they work with ○ Families feel more engaged while working with partnering organizations and service providers ○ Families experience reduced levels of stress, anxiety, and depressive symptoms
Families with housing vulnerabilities have improved housing stability.	○ Families have a reduction in amount of rental arrears, reduced risk of eviction, and reduction in rent burden ○ Families experience less homelessness or moves for to economic reasons ○ Families' current housing better aligns with their needs and desires (e.g., safer, higher quality, more affordable, right size, or location, etc.)
Families with economic vulnerabilities have improved financial stability.	○ Families have more balanced household budgets (i.e., reduced expenses, increased income, savings, etc.) ○ Families have increased knowledge of financial management skills (e.g., debt management, budgeting, savings, credit scores, etc.) ○ Families perceive that their overall financial well-being is improved

Families with behavioral health needs have improved mental and behavioral health.	○ Families perceive that their overall behavioral health is improved ○ Families feel better supported in improving their or their child's behavioral health ○ Families experience a resolution of acute behavioral health crises ○ Families experience improved communication and family dynamics
Families develop and practice more effective coping skills in dealing with threats to their stability in top-tier needs	○ Families perceive that their overall self and family wellbeing as improved ○ Families have increased self-efficacy (e.g., increased ability to set and achieve goals, anticipate challenges, problem solve, etc.) ○ Families perceive improved communication with service providers, program staff, landlords, etc.
Housing stability is sustained over time through the integration of efforts around all top-tier needs	○ Families experience long term stability in housing
Families have the ability to withstand minor/moderate unexpected economic or financial stressors	○ Families have increased monetary savings and/or financial assets ○ Families have increased capacity to manage debt (e.g., knowledge, skills, behavior) ○ Families have established a sufficient emergency fund or financial cushion within their household budgets
Optimal behavioral health is sustained over time through the integration of efforts around all top-tier needs	○ Children of vulnerable families have improved child development
Families are resilient against threats to stability in top-tier and related needs	○ Families have increased confidence in their ability to sustain stability in top-tier and related needs ○ Families have increased capacity to navigate the larger system of services in Cambridge ○ Families experience more trusting and empowered interactions with the larger system of services in Cambridge