ConnectFamilias

Social Network Analysis Partnership Evaluation Report 2010

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Executive Summary

This report includes the results of an evaluation study conducted during 2009-2010 for the ConnectFamilias (CF) partnership. The study included interviews with 40 individuals, randomly sampled from among participants in Care Coordination and Leadership activities of CF. The interviews were conducted in-person by evaluation team members on March 23-25, 2010 in the Little Havana neighborhood of Miami-Dade, FL.

The study was designed to determine the extent and value of services and supports available to participants after six months of involvement with CF. This approach was based on the concept of "social support", which can be defined as supportive social relationships that increase a person's ability to cope with challenging situations (Walker & Sage, 2006). Increasing the quantity and quality of social support is a major goal of the service coordination and wraparound process that is facilitated by CF, and therefore an important aspect to consider in evaluating partnership effectiveness. The study addresses the following evaluation research questions:

- What role does CF play in connecting participants to what they need?
- What are the characteristics of social networks of participants in Care Coordination and Leadership development?
- Are there any differences in social networks based on demographic characteristics, such as length of time in the program or length of time in the U.S.?

Each evaluation research question is intended to lead to information about outcomes for families as articulated in the CF theory of change. Desired outcomes include providing coordinated services, facilitating development of formal and informal supports and strong networks, and families demonstrating effective management of their environment. These outcomes were identified in a series of discussions and interviews with stakeholders of CF in 2008. The theory of change that was agreed upon was grounded in the mission of CF, which is to establish an efficient, consistent, and holistic network of coordinated services that increases the safety and well-being of children and families living in Little Havana. Key components of the partnership strategy include governance, service provision, and community engagement strategies that are strength-based, culturally and linguistically competent, and data driven. It is expected that these strategies will result in increased social support and positive changes in attitudes and behaviors in the service system, participating families, and the community as a whole.

The idea of studying social networks emerged from focus groups conducted with stakeholders in 2009. Focus groups indicated that CF was promoting family and community safety through increasing connections to services in the Little Havana community. According to respondents, this was being accomplished through the care coordination (including activities such as outreach to families, referrals, wraparound services) and community engagement activities (including capacity building and leadership development). Focus group discussions also indicated that as a result of participation in CF, policy and practice changes were occurring among partners and safety awareness was increasing among residents. ConnectFamilias was consistently described as a facilitator of effective connections between services and community residents, among residents, and among providers. ConnectFamilias was also described as a "true partnership" that has successfully engaged stakeholders in service provision, leadership development, and community involvement.

Method

Because of the central role of connections between people and resources seen in both the CF theory of change and the focus group discussions, it was recommended that the partnership carry out a social network analysis of participants during 2009-2010. Social network analysis is a systematic method to collect information from participants about their connections to specific people or resources. Using the data collected, maps were created to illustrate various connections within a given population or community. Individual-level network maps were created to illustrate

the network of connections for each participant, and an overall map illustrates connections across participants and supports. The social network analysis for CF was developed to show connections between the identified needs of participants and people or agencies that are meeting their needs. The study was primarily descriptive and exploratory, as it was conducted at a single point in time, and there was no comparison group.

A computerized random sample of 60 potential participants was generated from a list of 194 families who had participated in CF's Care Coordination and/or Leadership development activities during the past year. Forty-five family members agreed to participate, and a total of 40 social network interviews were completed. In-person interviews were conducted by four trained data collectors over the course of three days on-site at the CF office in Little Havana, Miami. Data from paper interview forms were coded using a pre-determined list of codes (See Appendix A) based on the categories of services tracked by CF and entered into an online database. Responses were coded by two evaluation team members with input or clarification from consultants and CF staff/ Governance Board members when needed.

Results

Most respondents were female (87.5%) and had lived in the U.S. for more than five years (70%). More than half (60%) of respondents were involved in Care Coordination. Seventy percent of respondents had been involved in CF more than six months, and 7.5% had been involved less than three months.

Interview respondents listed basic needs (e.g., clothing, food, shelter, financial assistance, etc.), employment, and childcare as primary needs they had experienced within the past six months. Secondary needs included healthcare (e.g., chronic illness, insurance, emergency/urgent care, etc.), mental health (e.g., domestic violence, counseling, therapy, etc.), and immigration. Needs mentioned varied slightly by type of involvement in CF; for example, those involved in Care Coordination named basic needs most often as their primary need while Leadership participants named it more often as a secondary need.

Analysis of individual level social networks revealed higher levels of connections than those anticipated in the theory of change. Individual networks had a mean of 9.9 connections, with an average of 5.2 different types of assistance received from an average of 7.9 unique individual assistance providers/helpers. Recipients of Care Coordination program assistance tended to have more connections than Leadership participants.

Participants were referred to assistance providers/helpers most often by Natural Helpers/ Community Health Workers (NH/CHW), Care Coordinators, family members, self-referrals, and La Alianza members. Referrals made by NH/CHWs and Care Coordinators were primarily for basic needs, immigration, employment, social support, and youth issues. Referrals made by family members and self-referrals were primarily for basic needs and childcare.

Social network maps developed for average participants in Care Coordination and Leadership programs illustrated differences in the number and type of connections; for example, NH/CHWs were associated with a greater number of assistance types for Care Coordination participants compared to Leadership participants. The network map of an average Care Coordination participant showed a greater number of connections to a variety of assistance types compared to Leadership participants. There was a visible, but not statistically significant increase in connections based on length of time in the program for both Leadership and Care Coordination participants (lack of statistical significance may be due to limited sample size). However, examination of participants' networks indicated a change in quality and type of network connections over time.

Assistance providers/helpers included 187 individuals. The number of assistance providers/ helpers named by each participant ranged from 3 to 23. For the purposes of this study, an assistance provider (also referred to as "helper" throughout) includes any individual that renders support or

aid to a CF participant in need. Assistance providers may be affiliated with formal social service agencies, community organizations (including local businesses), or they may be individuals who provide support on an informal basis (i.e., a friend, neighbor, or community leader.) The helpers identified through this study were affiliated with a total of 37 organizations, including CF, partner agencies, and other organizations in the community, as well as unaffiliated community members (such as business owners and neighbors), family members, and friends. On average, assistance providers had helped 2.1 individual participants. Those that were most active were affiliated with CF NH/CHWs (36), Abriendo Puertas (12), Acción Community Service Center (9), Big Brothers Big Sisters of Greater Miami (9), and Other CF staff (9). Informal supports and/or assistances were mentioned by 34 participants.

Organizations were mentioned an average of 4.6 times by participants. The organizations that were mentioned most often included CF and partner agencies. The top *areas of primary need* as reported by respondents were basic, employment, mental health, and childcare. Connections to services was the most common type assistance provided. However, the top area of direct service *received* as reported by respondents included basic, social support, and childcare. In some cases one primary need was cited while several needs were met, suggesting that primary needs were often tied to multiple needs within participating families.

Conclusion

Social network analysis results provide evidence that CF is meeting the desired outcomes of providing three or more coordinated services, increasing network connections, and helping Little Havana residents to manage their own environment. There is evidence that CF is connecting and supporting Little Havana residents in meeting their most important needs as well as a variety of related needs and that service recipients recognize CF as a lead assistance provider. Participants are also receiving a substantial amount of assistance through self-referrals and family/community referrals. The number and type of connections appear to differ for service recipients depending on whether they participate in Care Coordination or Leadership activities.

ConnectFamilias staff and funded partners are providing assistance through the Service Provider Network as anticipated. Funded agencies are among the most frequently cited organizations providing assistance. In addition, Care Coordinators, NH/CHWs, and partner organization staff are the most frequently cited helpers, often in carrying out a connecting role. The services provided by or through connections made by these helpers were given ratings at least as high, if not higher than other sources of assistance and referrals.

Overall, evaluation results indicate that the CF partnership is accomplishing the important goal of connecting families to needed services and supports. In addition, self-referrals and family and community member referrals are providing important informal links to resources that help to meet the multiple needs of respondents. Future studies of change in individual networks over time could provide important information about growth in these informal supports, as well as the strength of overall networks. Periodic examination of referral sources that include categories of self-referrals and family or community member referrals could also provide important information about participants' ability to manage their own environment.

ConnectFamilias

Social Network Analysis

In 2009-2010, the partnership evaluation of ConnectFamilias (CF) focused on the informal and formal connections of Little Havana residents that were developing through the work of the partnership. This study was based on the concept of "social support", or supportive social relationships that increase families' ability to cope with challenging situations (Walker & Sage, 2006). Increasing the quantity and quality of social support is a major goal of the care coordination process that is facilitated by CF and therefore an appropriate target for evaluation of the partnership. Social support is understood to occur in various forms, including emotional, informational, and instrumental (e.g., money, goods, and services) (Walker & Sage, 2006). Sources of social support have been classified as informal (e.g., relationships with friends and family) and formal (e.g., professional) or mixtures of formal and informal (often through involvement in community-based or peer-run organizations). A social network analysis method (Durland & Fredericks, 2006) can document the types of support provided to families, as well as the pattern and level of support. For the CF evaluation, social network analysis was chosen to assess the types of connections families have made, the role of CF in making these connections, and how well families' needs are being met (from the perspective of family members). The 2010 evaluation was designed to answer the following evaluation research questions:

- What role does CF play in connecting participants to what they need?
- What are the characteristics of social networks of participants in Care Coordination and Leadership development?
- Are there any differences in social networks based on demographic characteristics, such as length of time in the program or length of time in the U.S.?

The evaluation is guided by a theory of change, or vision for change, developed by the partnership in 2008 (Chen, 2005; Hernandez & Hodges, 2003). The CF theory of change includes the following key concepts: care coordination, which connects families to services; development of strong networks that include both formal and informal supports; and improvement of the effectiveness of residents in managing the safety of their environment.

The evaluation questions were developed after examining themes from focus group discussions conducted with a variety of CF stakeholders in 2009. Focus group participants indicated that CF was a facilitator of connections between services and residents, between residents, and between providers. This connecting role was associated most closely with Natural Helpers/Community Health Workers (NH/CHWs) who were considered to be the key to developing relationships of trust among various stakeholders and the community.

Because of the central role that relationships of formal and informal support appeared to play in the implementation and impact of CF, it was decided that the partnership evaluation include a social network analysis during 2009-2010. Social network analysis was considered to be an ideal method because it provides a systematic process for collecting relationship information that can be used to show both how relationships are structured and the value of those relationships (Durland & Fredericks, 2006). The method also provides a way to create visual maps to illustrate an individual participant's network of connections as well as maps showing the overall connections across participants and their sources of support (Scott, 2000).

ConnectFamilias Theory of Change

The CF partnership evaluation employs a collaborative approach that works closely with partnership members in identifying research questions, designing and carrying out data collection methods, and interpreting results. This process is guided by a theory of change, or set of ideas about what kind of change is desired that is based on stakeholder beliefs about what is needed and what strategies will meet those needs (Hernandez & Hodges, 2003).

The CF theory of change was developed by stakeholders in 2008, through a series of discussions and interviews conducted by the evaluation team from the University of South Florida. The theory of change that was agreed upon was developed into a diagram with three main components showing the community context and who the partnership aims to serve, how the partnership work, and what outcomes are expected to result from that work (See Figure 1). It is grounded in the mission of CF, which is to establish an efficient, consistent, and holistic network of coordinated services that increases the well-being of children and families in Little Havana. The goals included in the theory of change are to improve social networks, address safety issues, connect families to needed services and informal supports, and develop leadership capacity among community members. Guiding principles include a strength-based approach, a child and family-centered focus, cultural and linguistic competence, community leadership, and data-driven implementation of best practices. ConnectFamilias seeks to accomplish these goals through partnership with residents and service providers in a Governance Board, a community residence council (La Alianza Hispana de la Pequeña Habana), a Service Provider Network (SPN), and care coordination teams that include NH/CHWs and Care Coordinators.

ConnectFamilias stakeholders believe that change will be facilitated through the implementation of a common practice model that includes shared decision-making and planning, promotion of strengths in families, expansion of networks at all levels, facilitation of both policy and practice change, and promotion of family safety awareness. It is believed that integration of the common practice model across domains of service provision, community engagement, and partnership development will result in outcomes such as improved service coordination, more positive perceptions of safety, and improved parental management of their environment.

During the second year of full implementation in 2009, it became important to determine whether the CF partnership was making progress toward the desired outcomes that were articulated in the theory of change. The partnership had evolved from a grassroots planning effort that worked on creating buy-in among stakeholders during 2007-2008, to a formalized service coordination structure with funded staff and partner agencies in 2009. The development of informal and formal connections between families and services/supports was chosen as the focus of outcome evaluation due to the central role played by service coordination and relationship-building within the CF theory of change.

The next sections detail the method and results of the social network analysis used by the evaluation, application of results to the theory of change, and conclusions.

ConnectFamilias Partnership Context

The initial stage of development of the CF partnership has been described by stakeholders as implementing a planning approach in which "no promises were made"; rather, stakeholders were asked to be involved in developing the goals and building the organization from the ground up. Involvement in developing the partnership has led to the type of "change in business as usual" described by Williams, Torres, and Margolin (2003) in their primer on collaboration. Organizations that build successful partnerships are described as achieving high levels of trust, gaining substantial time commitment from partners, and reducing the need to protect organizational turf (Williams, Torres, & Margolin, 2003). As reported in CF focus groups, trust and commitment have been facilitated by joint participation of community residents and providers in developing the

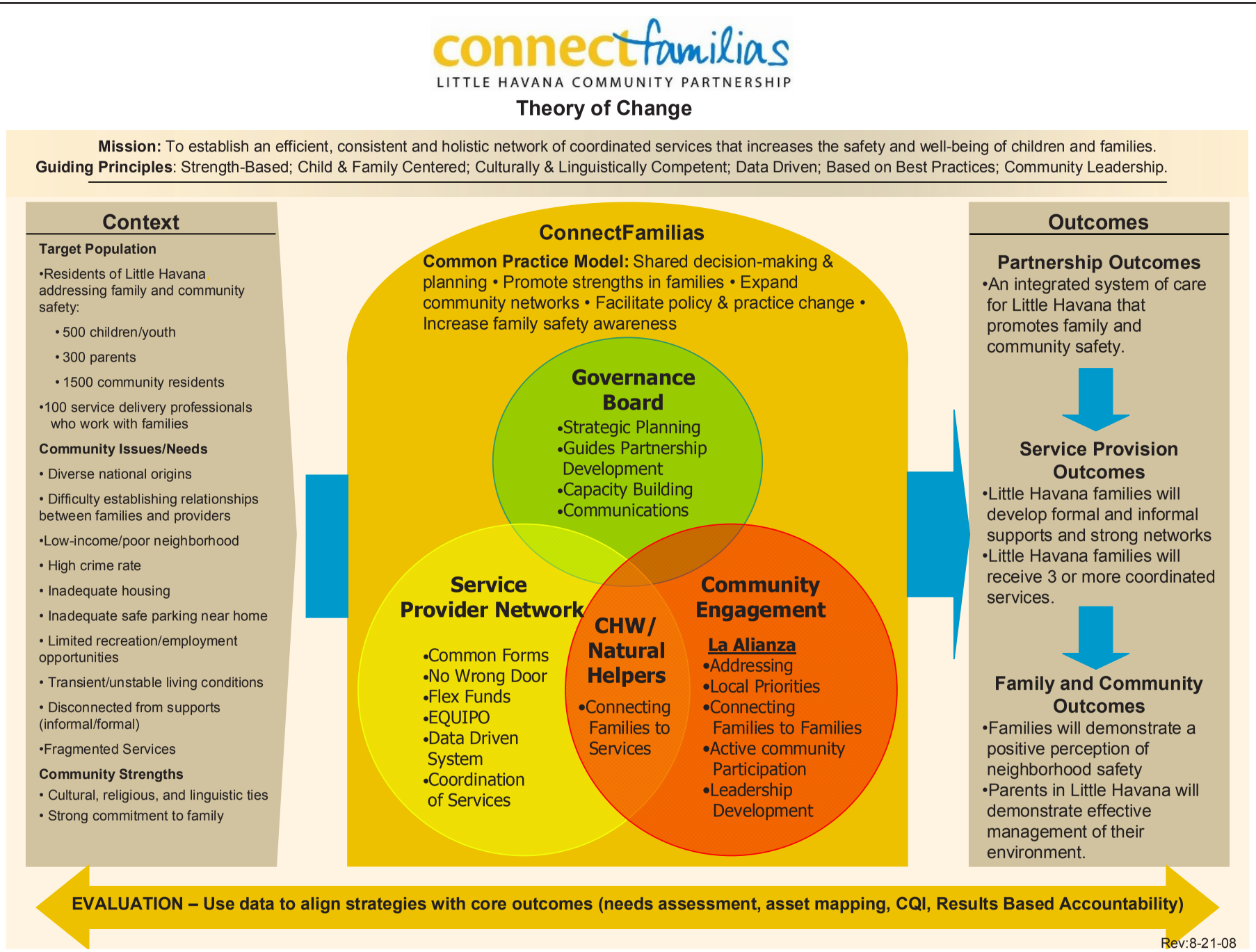

Figure 1. **ConnectFamilias' Theory of Change Logic Model.**

organization, as well as the integration of community residents into service provision teams in the role of NH/CHW. These NH/CHWs are able to maintain connections with the community while also building effective relationships with provider agencies and staff. The partnership building process has provided important learning opportunities for stakeholders and resulted in a new way of thinking about family, safety, community, and service coordination. The CF partnership is also credited with improving relationships between providers and the community, improving the ability of residents to identify and address issues, and improving the ability of agencies to use money efficiently in helping families. As indicated in the literature and evaluation findings, a key contributor to the trust and commitment that are considered to be essential to collaboration is building relationships and linkages between people and resources.

Community Context

The community context has provided both supports and challenges for the work of CF, which impacts the way in which the partnership carries out its mission of coordinating services and increasing safety awareness within the community. Context issues that emerged from focus groups discussions included important strengths present within the community, such as a willingness to take risks, a sense of community similar to an extended family, a desire to work together to improve community safety, and especially, having a goal of providing a better life for their children. Challenges were also mentioned, such as lack of trust, fear of legal consequences for undocumented immigrants, and isolation due to language and cultural barriers as well as separation from their families and home countries. Historically there has also been underemployment, limited police protection, and limited support for cleaning up the community from business owners and local government.

Supports and challenges for the partnership point to the complexity of the issues in the community, limited availability of resources, and the need for strategies to improve access to services. As discussed in focus groups, CF's care coordination process has resulted in connections to services and supports through the work of NH/CHWs and Care Coordinators; however, needs continue to outpace the help that can be provided, especially for undocumented families and families with serious and multifaceted issues. Within the partnership there have also been challenges related to the time it takes to build relationships among NH/CHWs and Care Coordinators, developing a common database system, and developing agency understanding about family and community perspectives. In spite of these challenges, focus group discussions mentioned many benefits to participation in the CF partnership at personal, professional, and community-wide levels.

Key Structures and Processes

Key structures within CF include a core group that carries out management and administrative tasks, technical support, and coordination for the partnership; a network of funded agencies with designated staff to provide partnership services (Service Provider Network); a group of outreach and community support workers (Care Coordination Teams); and an organized and active group of community residents. The management, support, and coordination aspects are shared between staff, an Administrative Services Organization (ASO)[1], and Governance Board members. Administrative tasks such as care coordinator training, database development, coordination of referrals, and communication across agencies are overseen by the Governance Board and carried out by staff and the ASO. Communication is a key to the partnership process and tends to be open and two-way among CF's various stakeholder groups and is guided by values of being strength-based, building capacity, and sharing decision-making.

[1]The Administrative Services Organization (ASO) is responsible for maintaining the administrative and fiscal integrity of ConnectFamilias and ensures contract compliance. The ASO also oversees financial controls, payment of contracts, and program operation.

Key processes within CF include community engagement, leadership development, and coordination of service access and delivery. Community engagement is accomplished by members of the resident group, La Alianza Hispana de la Pequeña Habana (La Alianza), and NH/CHWs. Activities include providing information and advice about safety to residents, assisting with navigating service systems, empowering families, and motivating residents to get out of their homes and get involved in activities in the community. Natural Helpers/Community Health Workers are considered to be a "bridge" between families and providers; they also facilitate access to services and engage families in active community participation. La Alianza has been credited with reducing a feeling of isolation, fear, and helplessness of residents and providing members with valuable information about how to function in a different culture, where to go for services, and opportunities for social interaction in a safe and comfortable environment.

Training and leadership development occurs through La Alianza, which helps to prepare residents to participate in civic engagement activities that are of benefit to the entire Little Havana neighborhood. Leadership training provides information and skill building in accessing resources and reaching out to neighbors while leadership development focuses on skills and values that enhance abilities to lead groups and serve as role models. Committees established by Alianza members provide opportunities to carry out community building activities such as coordinating community events, developing sports and recreational opportunities for children and youth, cleaning up the community, and educating Little Havana residents about safety, health and overall well-being. The trainings and committee work provide opportunities to gain knowledge and credentials that can increase skills and therefore future employability of residents.

The service provider network (SNP) carries out coordination of services among agencies and programs that have agreed to work with families referred by CF. Providers that are funded by CF appoint or hire a Care Coordinator whose function is to initiate and respond to referrals and facilitate the connection between referred families and services, in teamwork with NH/CHWs. Funded providers also keep records and enter data into a shared electronic database.

Coordination of services is carried out by teams of Care Coordinators and NH/CHWs who identify needs and coordinate referrals so that families receive "wraparound" care (child and family-focused care that addresses needs across all life domains). Teams are currently made up of two agencies, two NH/CHWs, and a Care Coordinator. The Care Coordinator does not necessarily work for an agency that is providing services for a family but rather acts as a connector to needed services. NH/CHWs are members of the community that are trained to work with families in a personalized manner, to provide informal support and linkages to formal services, and to increase the comfort of families as they participate in services. An important aspect of linking families to services is considered to be the process of empowerment that occurs, as families gain skills and confidence to overcome barriers and learn to obtain resources to meet family needs.

The common practice model is based on an emerging understanding within the partnership that CF is a "convener" rather than a provider of services. This model requires promotion and support among partner agencies, which are facilitated by the Governance Board and ASO. Care coordination that is based on a wraparound philosophy depends upon having smaller case loads than those typically carried by partner agencies. This is because care coordination requires flexible scheduling of appointments, greater amounts of time spent with each family, and ongoing attention to families through connection to a NH/CHW. This model of care coordination can be time consuming, challenging, and in many cases requires new skills and mind-sets because of the emphasis on making sure the referral is acted upon and followed through in a timely manner. The level of intensity in working with families using this model requires agency support, which is promoted through the partnership's values and principles related to shared decision-making and policy and practice change. Implementation of the model at partner agencies is also supported by funding, training, and technical assistance provided by CF.

Expected Outcomes

The theory of change points to important outcomes that are expected from CF activities. These include providing three or more coordinated services for families in Care Coordination, building formal and informal supports and strong networks among families in Little Havana, and building family capacity to effectively manage their environment.

Focus groups with CF stakeholders provided some evidence that desired outcomes were being reached through improved relationships and increased access to services and supports. Stakeholders indicated that CF was having multiple levels of impact in Little Havana, including at the personal, family, community, agency, and partnership level. Examples of impacts included:

- Reported changes in individual behaviors supporting safety and improved perception of safety in the community.
- Improved family functioning, empowerment, connection to resources, and engagement in services.
- Community member buy-in and participation in activities, increased knowledge and confidence in seeking resources, increased desire to help others, and motivation to work together to produce positive changes in the community.
- Improved relationships between agencies and the community, policy changes to support care coordination, and increased understanding of the ability and desire of residents to improve the community.
- Recognition and credibility of the partnership in the community, and perceptions of being helpful, caring, and effective in meeting real needs.
- Expectations that youth would become engaged in community advocacy in the near future.

Enhancing the formal services and informal supports utilized by families in maintaining safety and well-being of children is the ultimate goal of the partnership. Therefore, examining the characteristics of social networks of families who are receiving services can be useful in informing the partnership about the level at which they are producing desired outcomes.

Method

This social network study was primarily descriptive and exploratory, as it was conducted at a single point in time, and there was no comparison group. A research plan was developed by the evaluation team in collaboration with CF Governing Board representatives and two consultants who are experts in social network analysis. One consultant has conducted numerous social network analysis studies as part of evaluations of community-based projects. She assisted with the evaluation design, instrument development, data collection, and interpretation of data. The second consultant provided expertise in instrument development, data coding, data analysis, and visualization. The consultants worked with the evaluators and Governance Board representatives to ensure that the evaluation would answer key questions about partnership functioning using social network methodology.

Instrument Development

An interview protocol was developed to guide the questions asked of participants and record the data directly on paper, to be transferred later to a web based format linked to an electronic database. Initial instrument items were developed by evaluators based on discussions with the Governance Board. Each question was linked to an outcome listed in the theory of change or data from the focus groups conducted in 2008-09. It was decided to focus on both needs experienced by participants and the people/agencies who met those needs in order to best explain participants' networks. Responses were to be elicited in face-to-face interviews with each participant. Data

collected during interviews would be used to create individual network maps for each participant showing the number and types of needs and the level of need met by each assistance provider in their network. Choices for the level of need met included 1- A small amount of assistance, 2- Some assistance, 3- Moderate amount of assistance, 4- A lot of assistance, and 5- Met all my needs completely.

The instrument that was developed included demographic items designed to collect information on gender, preferred language, and length of time in the U.S. to help provide context for interpretation of the social networks. Instructions were also provided for data collectors that explained the goal for each question (i.e., what kind of information was being elicited) and ways to focus the responses. Lists of CF staff, agencies, and resources were included with the instrument to guide data collectors in identifying the type of need and type of connection. The instrument was developed in English and Spanish simultaneously in order to ensure that meanings and intentions were considered in both languages. The Spanish instrument was piloted with two Spanish-speaking family members who were demographically similar to the target survey participants and were receiving similar services. Following completion of the pilot surveys, revisions were made to better focus the discussion so that desired information would be collected. The instrument was discussed by the full evaluation team before the final version was created.

The questionnaire was used as a guide for developing a web-based database to be used for data entry and coding. The database included both write-in and drop-down selection boxes. A drop-down box was created to identify the top five "Types of Needs" named by respondents based on pre-determined coded categories such as Basic Needs, Health, and Mental Health. Write-in boxes were used to fill in the names of people who had provided assistance and drop-down lists provided names to choose from among CF staff. A drop-down box was also created to identify "Affiliation" from among a list of partner agencies to help in identifying organizations that had provided assistance. Another drop-down box included choices for the type of "Relationship to Respondent", which could be classified as Formal or Informal as well as Family, Community, or Child-related, among others. Drop down boxes also provided choices for the "Type of Assistance Provided", the "Level of Support" (i.e., 1 through 5), and the "Referral Source".

Sampling

The evaluation team discussed possibilities for sampling for the social network analysis early in the planning process. Possible participants included NH/CHWs, Care Coordinators, managers, and families involved in services and training. It was decided to focus on families who had received Care Coordination services and/or had been involved in Leadership training in the past year in order to best link the findings to the desired outcomes. It was thought that it would be important to examine characteristics of social networks for these two groups of participants since they were involved directly in the implementation of two key strategies (i.e., Community Engagement/ Leadership and the common practice model Care Coordination/Service Provider Network). They also could provide first-hand information about whether the partnership was moving in the direction of the desired outcomes for Little Havana residents.

A list of ID numbers for the 207 families who had participated in Care Coordination and/ or Leadership development activities during the past year was extracted from the CF common database and provided to the evaluators. Of the original 207 families, 127 were involved in Care Coordination, 96 were involved in Leadership, and 13 were involved in both Care Coordination and Leadership. The list was then subjected to a computerized random selection process to choose 60 potential participants with the goal of having 40 participants complete the interviews. The selected list of 60 ID numbers was sent to the recruitment team.

Recruitment

Recruitment was carried out by NH/CHWs who were familiar with and trusted by the families. These procedures have worked very well in the past, resulting in high levels of participation and willingness to answer questions completely. Natural Helpers/Community Health Workers completed IRB training online and participated in an orientation provided by the evaluators via long distance telephone conferencing in combination with Skype technology. During the orientation, evaluators provided background information for the study, explained the study goals and procedures, and reviewed an invitation script that was developed for them in Spanish. The informed consent procedure was also reviewed and sample forms were provided to aid in explaining the study to potential participants. The scheduling of interviews was also discussed, and a formatted sign-up sheet was provided that included contact information and preferred time for the interview, which was to be gathered directly from families who agreed to participate. Recruitment occurred over the following two weeks, resulting in 45 families being scheduled for participation during the three days of data collection.

Data Collection

In-person interviews were conducted by four trained data collectors over the course of three days on-site at the CF office in Little Havana, Miami. Forty out of 45 scheduled interviews were completed, each lasting about 45 minutes. Most interviews were conducted at the CF offices; a few were held in the homes of participants due to health, childcare, or transportation complications. Interviews conducted at the CF office took place in four separate rooms, making it possible to conduct up to four interviews at a time.

Interviewers explained informed consent process and obtained signed consent prior to beginning the interview. During the interview, responses were recorded on paper response forms, which included fill in boxes to enter social network information as well as space for writing notes to describe the context and needs of respondents. Interviews were conducted in English or Spanish based on the preferences of the respondents. A CF staff member was available at all times to greet family members as they arrived for interviews, answer questions, make phone calls to no-shows, re-schedule as needed, and distribute compensation to participants who completed interviews.

Data Analysis and Interpretation

Data were coded using a pre-determined list of codes based on the categories of services tracked by the CF database (See Appendix A). For responses that were unclear or provided insufficient information to code using the established coding scheme, clarification was sought from CF staff without giving the name or identifying information of the respondent. Two evaluation team members coded interviews and entered data into the electronic database. Coding was compared between the two coders to ensure consistency in data entry and differences in interpretation were resolved through discussions that referred back to the goals of the analysis. Once all data were entered into the electronic database, two Excel files were created for the demographic data and network data. The Excel files were checked for completeness, consistency, and mistakes in coding and corrections were made in the electronic database as needed.

Data were analyzed using SPSS software version 18 to determine the most important needs, demographics of respondents, types of assistance provided, relationships of helpers to the respondent, and referral sources. Comparisons were calculated to indicate the level of assistance provided by each type of relationship with the respondent. Relationships were categorized and analyzed by frequencies for each type of assistance provided. Excel tables were also created to compare needs met, relationship to the respondent, affiliated organizations and source of referral. Ratings of the level of need met by each type of assistance were compared for each category (person, relationship to respondent, and organization).

Social network data were analyzed separately and will be described in more detail later in this report. The social network analysis used UCINET 6 (Borgatti, Everett, & Freeman, 2010), as well as other statistical and support packages to develop social network maps and generate results related to the characteristics of connections within CF. Findings are presented in terms of the overall types of questions they can address about the Little Havana community network.

Results

Descriptive Statistics

Of the 40 families that completed the social network analysis interview, a majority (87.5%) completed the interview in Spanish. Most respondents were female (87.5%) and had lived in the U.S. for more than five years (70%). Over half (60%) of the respondents were involved in Care Coordination; 10% were involved in both Care Coordination and Leadership activities. Seventy percent of respondents had been involved in CF for more than six months; only 7.5% had been involved less than three months. Table 1 shows the number of respondents, gender, years lived in the U.S., and months involved in CF for the respondents in the two program types (Care Coordination and Leadership).

Table 1
Demographics of Respondents

Program	Number of Respondents	Gender		Years in the U.S.			Months involved in CF		
		Male	Female	1-5	5-10	10 +	1-3	3-6	6+
Care Coordination	24	2	22	9	6	9	2	5	17
Leadership	16	3	13	3	2	11	1	4	11
Total	40	5	35	12	8	20	3	9	28

During interviews, respondents were asked to list in order of importance the needs they had experienced within the past six months. Basic needs (e.g. clothing, food, shelter, financial assistance, etc.), employment, and health (e.g. medical) were listed most frequently as a primary need by both care coordination and leadership recipients. Mental health (e.g. domestic violence, counseling, therapy, etc.) and school were listed most often as secondary needs by respondents overall. Other needs mentioned less frequently were childcare, immigration, and safety.

Table 2
Primary and Secondary Needs Cited by Respondents

	Care Coordination		Leadership	
	Primary	Secondary	Primary	Secondary
Adult Education	0	0	2	2
Basic	10	0	10	5
Childcare	3	1	6	2
Child Development	1	0	4	0
Connections	0	0	3	5
Custody	0	0	1	1
Employment	2	3	9	1
Health	2	0	9	5
Immigration	1	1	6	1
Leadership	0	1	0	2
Legal	1	1	4	0
Mental Health	3	3	3	3
Parenting Support	0	1	0	0
Safety	0	2	1	3
School	0	3	2	3
Social Support	1	0	1	3
Substance Abuse	0	0	1	0
Transportation	0	0	2	0
Youth	0	0	2	4

Reported primary needs appeared to be slightly different for those involved in Care Coordination compared to those involved in Leadership activities. For example, those involved in Care Coordination named basic needs most often as their primary need while Leadership participants named employment, mental health, and school more often as their primary needs (See Figure 2).

Reported secondary needs were more similar for participants involved in Care Coordination and in Leadership activities. Those involved in Care Coordination named basic needs, employment, and health most often as their secondary need while Leadership participants named basic needs, connections, and health more often as their secondary needs (See Figure 3).

Assistance Provided to Respondents

Respondents identified a total of 399 connections with individuals who had provided assistance in meeting their needs within the past six months. The most frequently cited assistance providers were CF affiliated, including the NH/CHWs, La Alianza leaders, and Care Coordinators. CF partner agencies that provide care coordination were included as CF affiliated assistance providers for the purposes of analysis. The next most frequently cited assistance providers were informal supports such as family, friends, and community members, followed by formal providers who provide services through the CF Service Provider Network (see Table 3) (see Appendix A for coding categories of assistance provided to respondents).

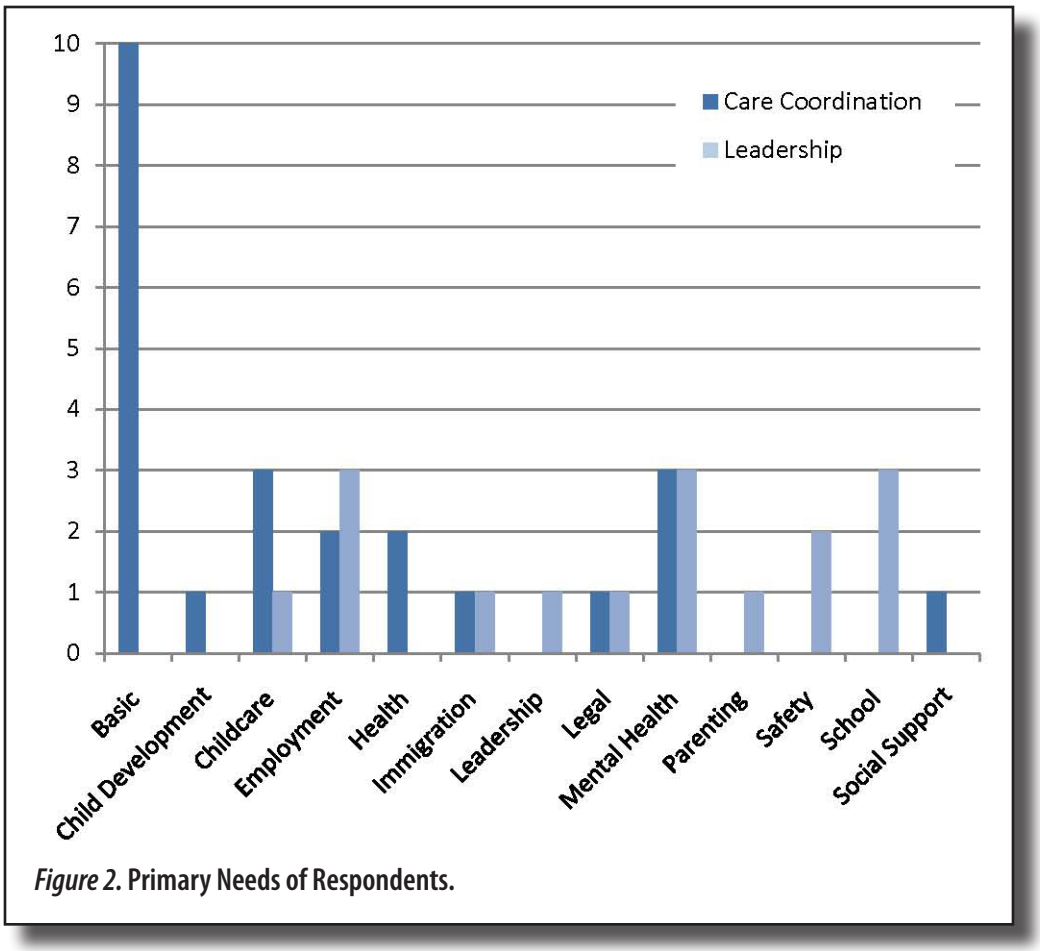

Figure 2. **Primary Needs of Respondents.**

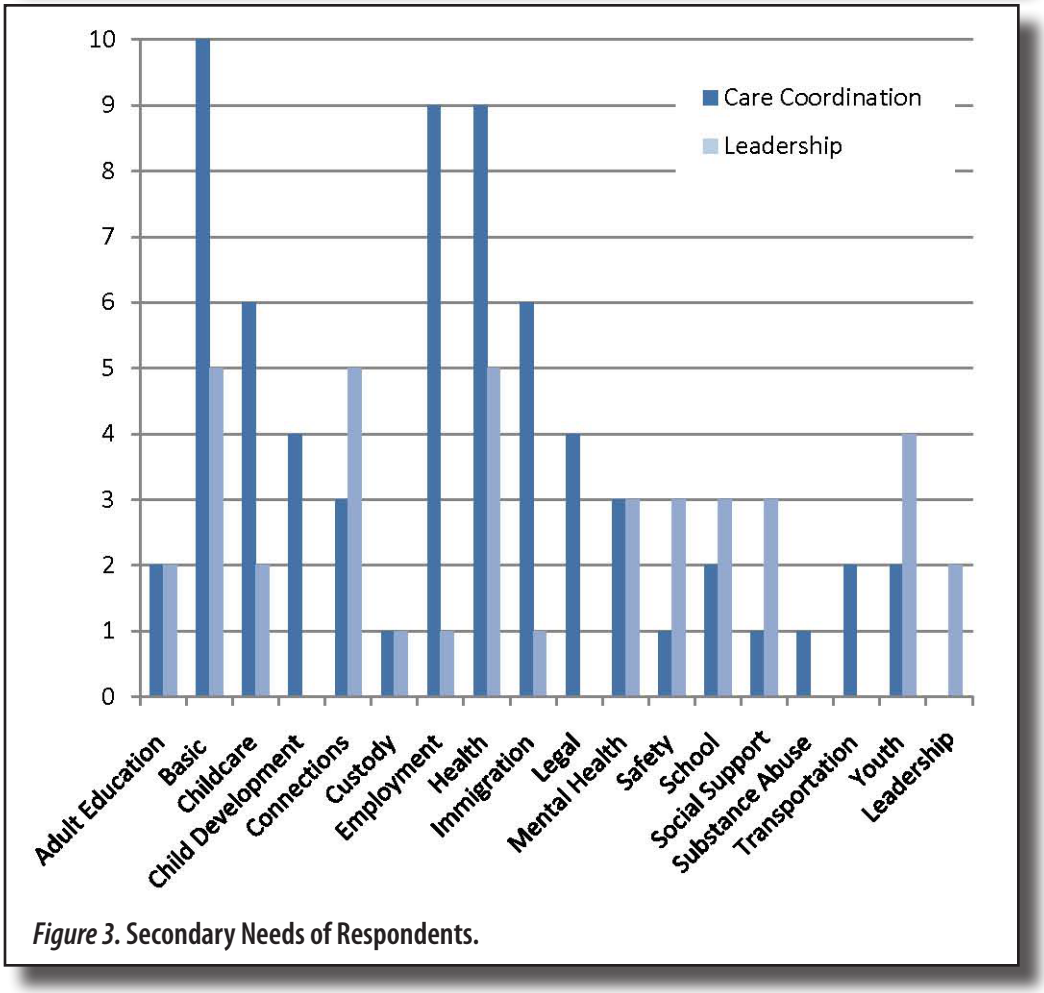

Figure 3. **Secondary Needs of Respondents.**

Table 3

Connections: Relationships, Affiliations, and Assistance Provided

Assistance Provider	Total Times Cited	Affiliation
CF Affiliated	190	Acción Community Service Center
		Adult Mankind Organization
		Amigos for Kids
		Big Brothers Big Sisters
		Community Coalition
		ConnectFamilias
		Family Counseling Services
		La Alianza Meeting
		Natural Helpers
Formal Providers	75	Abriendo Puertas
		American Fraternity
		CASA
		Child Development
		Clínica Peñalver
		CVAC
		Dade County Legal Aid Society
		Dept Children & Families
		FIAC
		Human Services Coalition
		Jackson Memorial Hospital
		Legal Services
		Lighthouse for the Blind
		Lincoln Marti
		Miami Behavioral Health Ctr.
		Miami Dade Community College
		Miami-Dade County Public Schools
		Police Department
		Respect for Life
		Sagrada Familia
		Sherriff's Office
		Switchboard of Miami
Informal Supports (Friend/Family/Community)	134	No Affiliation Listed
		Other/Not Indicated

ConnectFamilias' NH/CHWs and Care Coordinators were most often listed as meeting a need by "connecting" families to services or other people and providing social or emotional support. Qualitative analysis of interviews indicated that NH/CHWs and other CF personnel also played an important role in providing information about workshops and events as well as information about parenting and safety through informal conversations and advice/counsel. Other organizations provided formal services such as counseling and assistance in meeting basic needs, and were named as locations for meetings, and as hosts or sponsors for community events and youth activities. Interview responses also indicated that friends and family members provided financial and other basic help, served as sources of emotional support and advice, helped make connections, and filled in when childcare or transportation was needed. Community organizations and lay residents (i.e., neighbors, daycare providers, rental agents, etc.) assisted with connections, especially for employment, childcare and recreation, and helped meet basic needs such as rent and electricity. La Alianza members contributed to building social capital by providing opportunities for community connections, recreation, connections to services, and information about safety.

Social network interviews also provided information related to expected outcomes in the CF theory of change, including whether participants were receiving three or more coordinated services, increasing networks connections, and increasing their ability to manage their own environment. Interview data indicated that respondents had been connected to at least three services while involved with CF. As shown in Table 4, the minimum number of services cited was 3 for both Care Coordination and Leadership respondents while the maximum number of services cited for both Care Coordination and Leadership respondents was 23.

Table 4
Number of Services Cited by Each Type of Respondent

Respondent	Mean	Minimum	Maximum
Care Coordination	11.1	4	23
Leadership	8.4	3	23
All	9.9	3	23

To provide insight into how well services were coordinated, respondents were asked about who referred them to the people and agencies that them provided assistance. The top sources of referrals were NH/CHWs, Care Coordinators, family members, self-referrals, and La Alianza members (See Table 5). Referrals made by NH/CHWs and Care Coordinators were primarily for connections to services, basic needs, immigration, employment, social support, and youth issues. These categories matched several of the primary and secondary needs named by respondents (See Table 2). Other primary needs, such as mental health and health services, were accessed through referrals to formal service providers made primarily by NH/CHWs or other professionals (in particular those related to the legal and child welfare system). Referrals made by family members and self-referrals were primarily for basic needs and childcare, which were also primary and secondary needs named by respondents.

In addition to identifying the sources of referrals, respondents were asked to quantify the amount of help received in relation to their need by using a five point scale in which 1- A small amount of assistance, 2- Some assistance, 3- Moderate amount of assistance, 4- A lot of assistance, and 5- Met all my needs completely. Two of the highest mean ratings for needs met (Table 5) were related to self-referrals (4.3) and referrals made by family members (4.2). These referrals were made primarily to community and family members who helped to meet basic needs, provide social support, or provide childcare. Natural Helpers/Community Health Workers (3.9), Care Coordinators (3.8), and other professionals (4.2), as well as La Alianza members (3.7) were also frequently cited as referral sources and were associated with high ratings for needs met.

Table 5
Ratings of Overall Assistance Received

Referral	Mean
Self-Referred	4.3
Family Members	4.2
Other Professionals	4.2
Natural Helpers	3.9
Care Coordinators	3.8
La Alianza Members	3.7

Although it may not be possible for this study to show a clear connection between the work of CF and the growth of strong networks over time due to the single point in time collection of data, information from the social network analysis does provide useful information about the network characteristics of respondents. These characteristics are described in the next section, with additional detail on statistical calculations provided in Appendix B.

Social Network of Respondents

The CF network consists of service recipients, assistance providers ("helpers"), and connections among them through which various needs have been met. Recipients can receive one or more types of assistance, from one or more providers, which can be matched against self-stated areas of primary need. Assistance providers/helpers included individuals affiliated with a community organization or business, a social service agency, as well as individuals with no formal organizational affiliation. Further, multiple assistance providers/helpers may be affiliated with one organization. Those with no formal organizational affiliation were most often sources of informal support (e.g., friend, neighbor, local leader naturally recognized in the community). Assistance providers/helpers can also provide assistance to one or more recipients. In fact, providers can provide more than one type of assistance to a single recipient, resulting in multiple connections between individual recipients and individual assistance providers/helpers. Thus, the network has a "many to many" set of relationships with connections defined by assistance provided from providers/helpers to recipients (Figure 4).

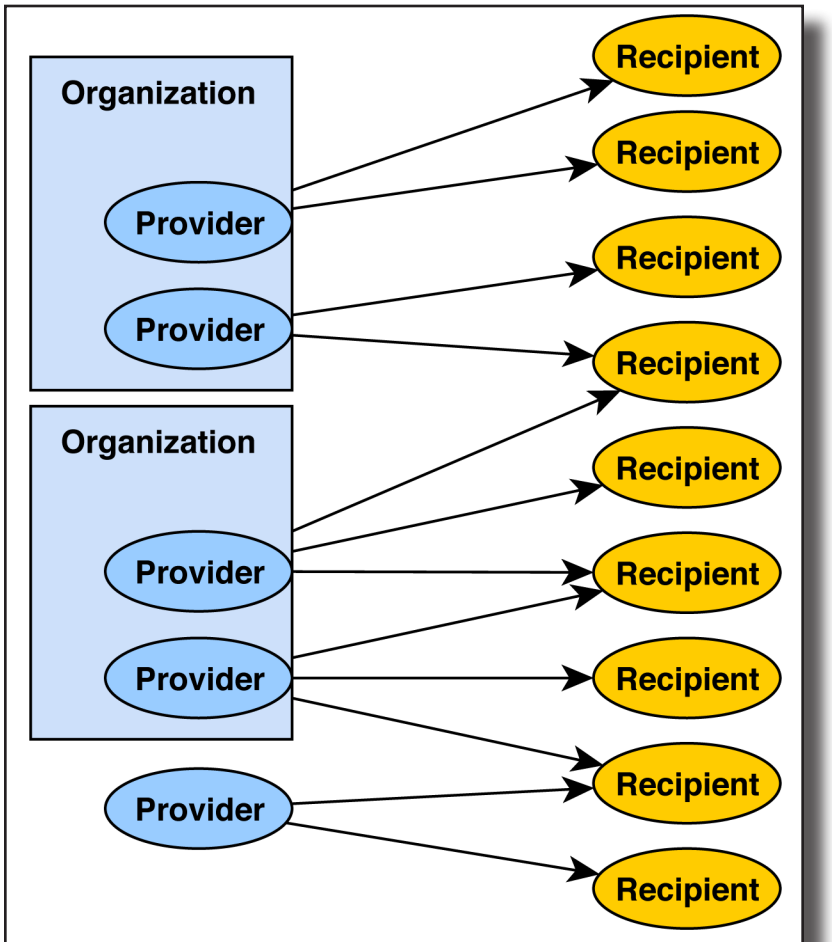

Figure 4. **Connections from individual providers to individual recipients.**

Social network analysis is often performed by looking at the relationships between individuals; however, it is also frequently performed at more abstract levels. One example would be to look at connections between groups of recipients and/or providers/helpers. In the case of the CF community network, looking at connections between groups makes more sense analytically because we have information only from a sample of recipients in the network and not the entire network population. Having nearly complete network connection information is required for many types of social network measurements. Figure 5 shows how an "organizationally grouped" version of Figure 4. Individual recipients can be grouped in terms of the types of assistance they needed most (primary need) since there are far fewer types of need than there are individual recipients.

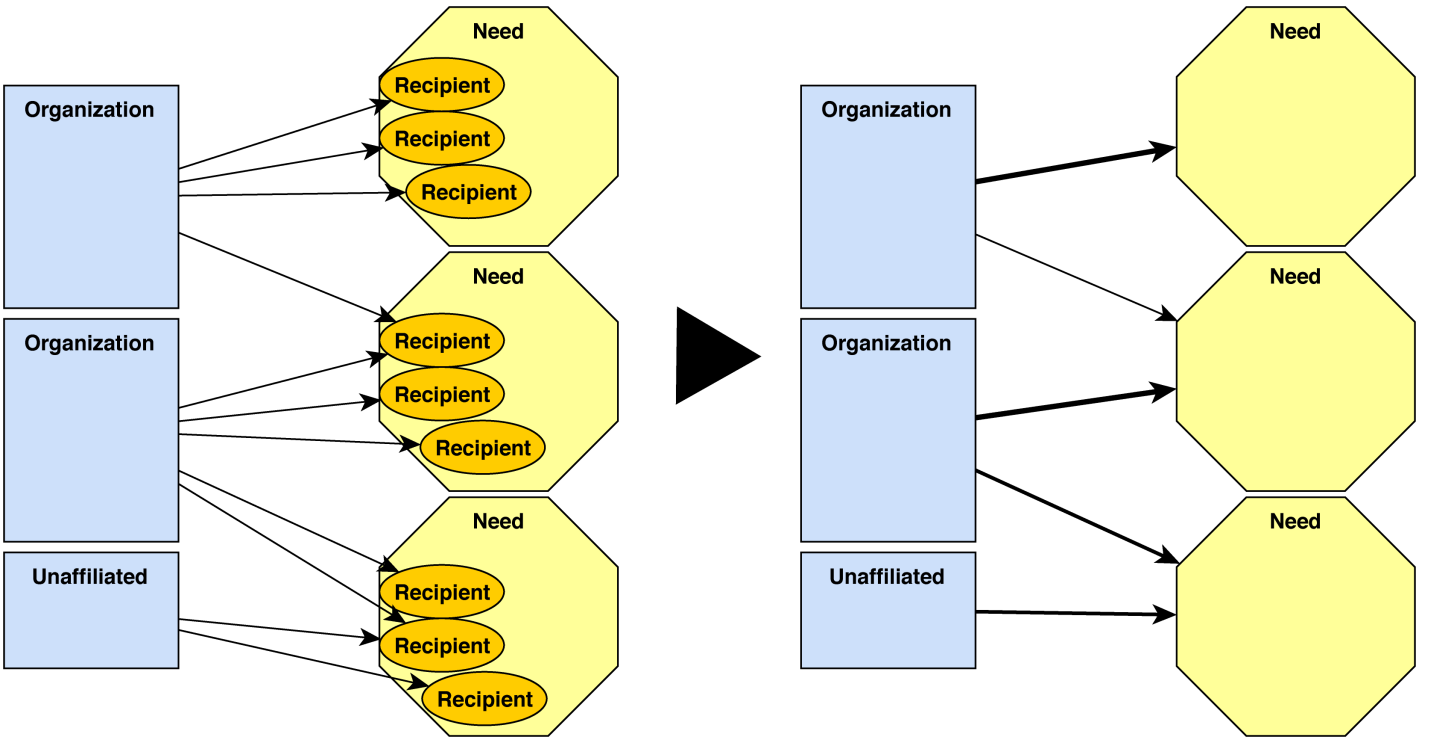

***Figure 5*. Connections to recipients grouped by type of need.**

In the following sections, results are provided from social network analyses conducted at several different levels, including connections for individual recipients, connections from individual providers/helpers, connections from organizations, and connections to recipients grouped by type of need served.

Service Recipient Responses

Only a sample of individuals in the entire network was surveyed, so structural network metrics (observations about network components or the network as a whole) are not applicable for this project at the individual level. However, we can make some descriptive observations about survey respondents (recipients of assistance) who represent the average.

Forty participants provided survey responses. On average, these individuals reported 9.9 connections in their personal networks. These 9.9 connections consisted of an average 5.2 different types of assistance (standard deviation ±2.3), received from an average 7.9 unique individual assistance providers/helpers (Table 6).

Table 6
Unique Service Recipients (Network Contacts), All Responses

	Mean	Standard Deviation	Minimum	Maximum
Connections Listed (out-degree)	9.9	5.5	3	23
Types of Assistance Received	5.2	2.3	2	10
Unique Assistance Providers (unique service recipients)	7.9	3.9	3	20

Note. The out-degree of a node is defined as the number of arcs originating from that node, or the number of connections emanating from one identified service recipient.

For purposes of analysis, recipients were categorized in two groups: participants in the CF Care Coordination program, who receive multiple services and are involved in wraparound with a team of Care Coordinators and NH/CHWs, and participants in the CF Leadership program, who receive leadership training and are involved in community engagement activities. We briefly examine how the average participant in each program differs. Care Coordination network characteristics are shown in Table 7.

Table 7
Unique Service Recipients in Care Coordination Program Only

	Mean	Standard Deviation	Minimum	Maximum
Connections Listed (out-degree)	11.1	5.9	4	23
Unique Assistance Providers (unique service recipients)	8.2	4.4	4	20

Note. The out-degree of a node is defined as the number of arcs originating from that node, or the number of connections emanating from one identified service recipient.

A comparison of Tables 6 and 7 shows that recipients of Care Coordination assistance tend to have more contacts than survey respondents overall, both in terms of number of connections to unique assistance providers/helpers (8.2 compared to 7.8 actual people who provide assistance) and also the number of connections (links through which assistance was provided), 11.1 connections compared to 9.9.

The social network map that follows (Figure 6) represents the network of an average participant in the Care Coordination program. The square shapes represent organizations and arrows represent the flow of assistance (labeled by type of assistance provided). Each arrow denotes a single network connection. The centermost node (#2322) represents the service recipient; the surrounding boxes represent assistance providers reported in their network. The organizational affiliation of each assistance provider is indicated by linked (round) nodes. Note that provider #10170 was not indicated as affiliated with any formal organization, which means he or she was a family member, neighbor, or other source of informal support. Natural Helpers/Community Health Workers were associated with one organization only (#10156, CF), which had the largest number and variety of connections to the assistance recipient. They also had connections to several other organizations that provided one or two specific types of service assistance.

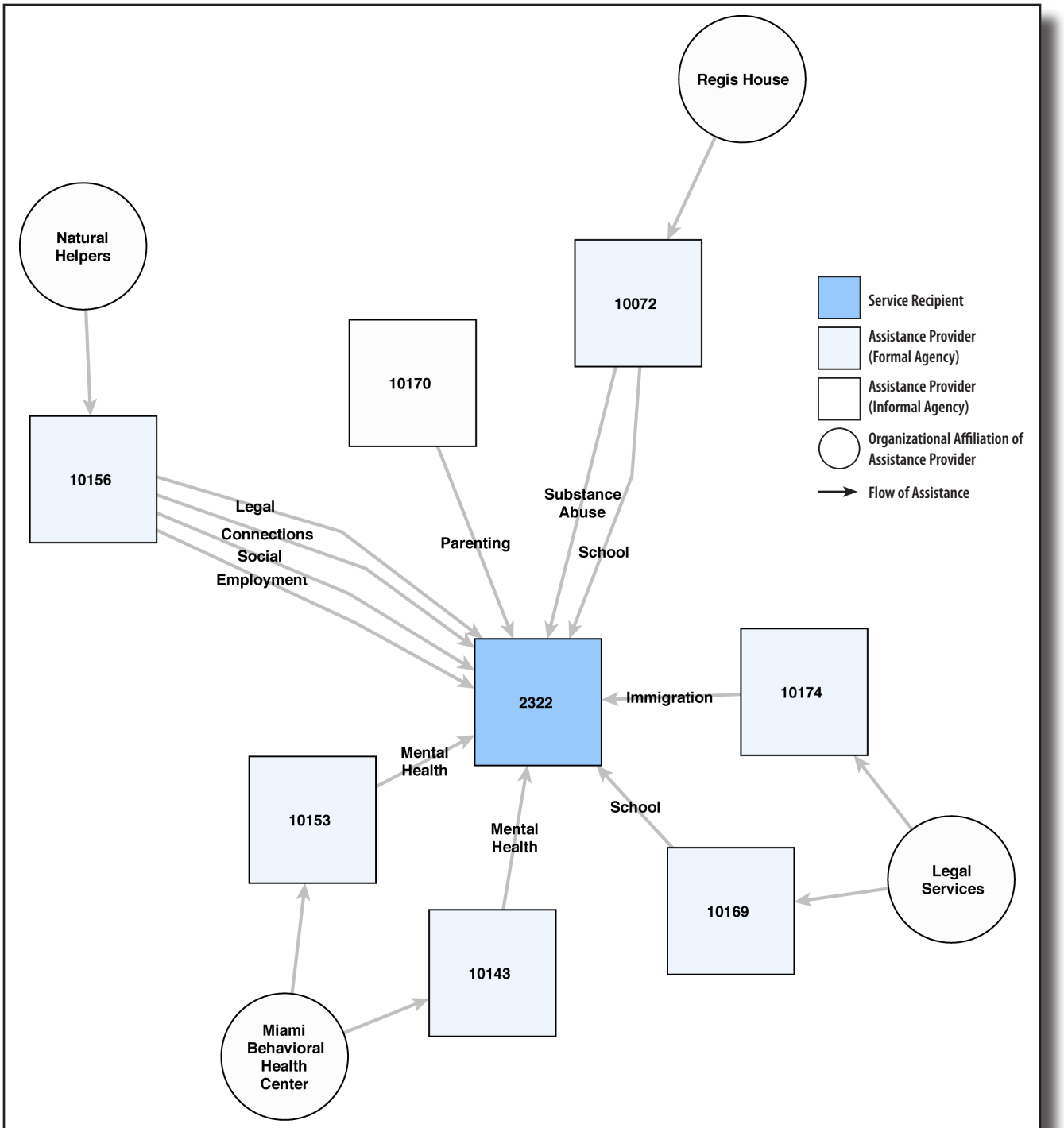

Figure 6. **Network of a sample participant in the care coordination program.**

Participants in the Leadership program (Table 8) tended to have fewer contacts than the average survey respondent overall. This difference can be seen both in number of connections to unique assistance providers/helpers (7.4 actual people who provide assistance) and the number of connections, or links through which assistance was provided (8.4).

Table 8
Unique Service Recipients in Leadership Program Only

	Mean	Standard Deviation	Minimum	Maximum
Connections Listed (out-degree)	8.4	4.5	3	23
Unique Assistance Providers (unique service recipients)	7.4	3.4	3	16

Note. The out-degree of a node is defined as the number of arcs originating from that node, or the number of connections emanating from one identified service recipient.

Figure 7 represents the social network map of an average participant in the Leadership program. The centermost node (#1194) is the service recipient; the surrounding boxes are assistance providers/helpers reported in their network (not organizations, as was shown in the Care Coordination map - Figure 6, page 23). The organizational affiliation of each provider/helper is indicated by linked (round) nodes. The types of assistance provided are indicated by the link labels. Notice that NH/CHWs and other CF staff are associated with several different assistance providers/helpers in this diagram and only a few types of assistance are named (social support and leadership development). This map does not show the level of connections and coordination of services that is evident in the map of the identified Care Coordination participant (Figure 6). This finding, however, is not altogether unexpected given that many of the individuals participating in the CF Leadership program are considered to be "graduated from" care coordination and therefore, may require less assistance from multiple agencies and organizations. By contrast, families receiving services through the Care Coordination program often have multiple needs requiring assistance from numerous service providers.

The next individual-level social network map (Figure 8) represents a Leadership participant who has received a significant amount of training. The individual's network is more complex than the previous examples, with more connections, more unique contacts (providers), and more types of assistance channels in the network. It is expected that for a leader with significant additional training and leadership skills, it may be easier to form new connections within the community as they engage in active community participation and in turn, provide support or assistance to families in need.

One of the questions posed in this study was related to the impact of each recipient's length of residence in the U.S. on the size of his or her support network. A simple crosstabs analysis shows that there is no consistent correlation with length of residence in the U.S. and individuals' number of network connections (relative to the Little Havana community network; individuals may have social support connections outside of the community) (See Table 9).

Table 9
Network Contacts of Unique Service Recipients by Time in the United States

Years in United States	Mean	Standard Deviation
1-5	7.8	3.7
5-10	8.7	4.4
10+	7.7	4.1

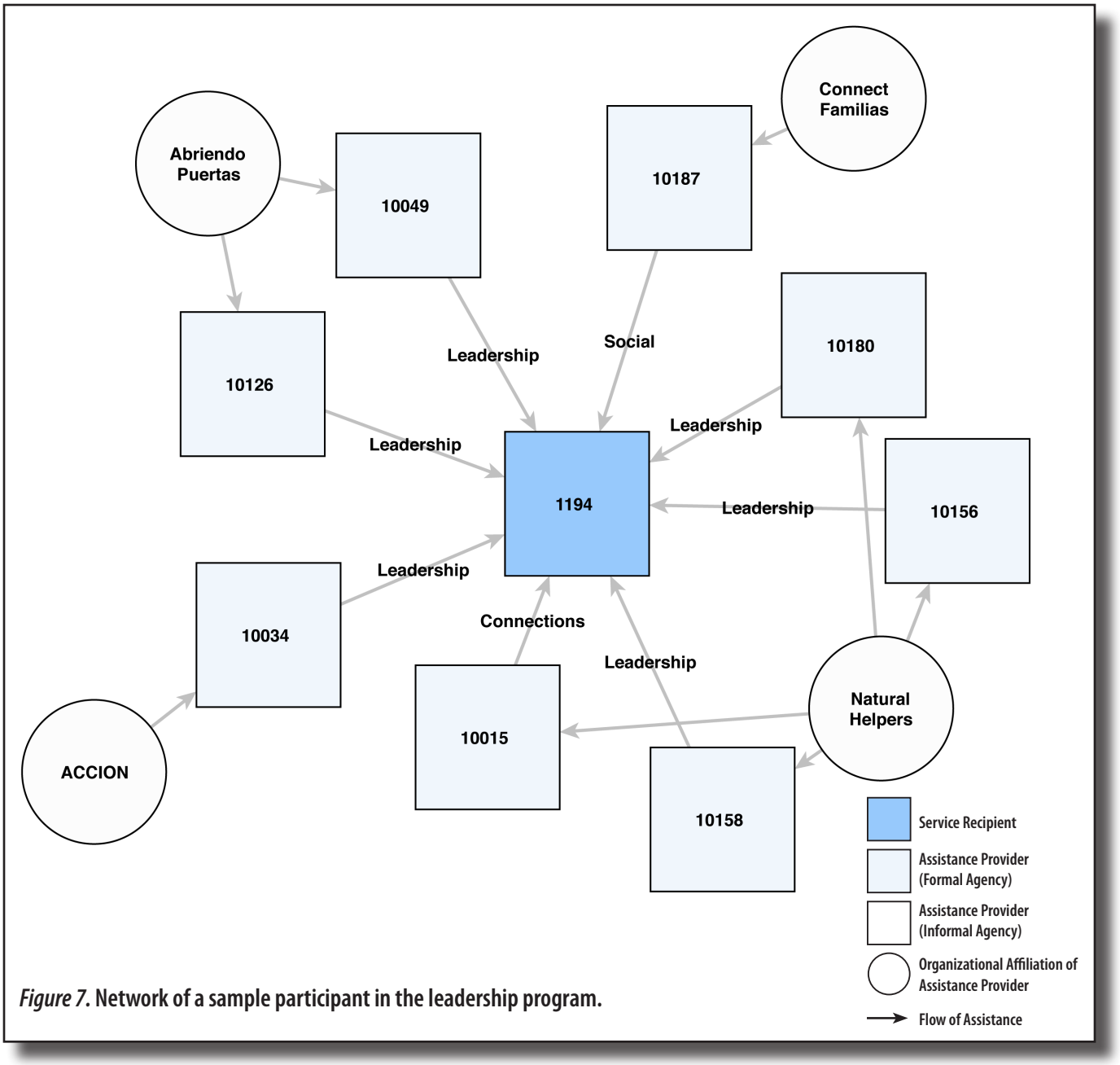

Figure 7. **Network of a sample participant in the leadership program.**

A similar research question dealt with the correlation between an individual recipient's ability to form assistance connections and the length of time they have been participating in the CF program. The assumption is that the longer a recipient is engaged with CF, the larger their network of support will become. The following two tables imply that there is indeed a limited correlation between time in the CF program and network growth.

Tables 10 and 11 show the results of a nonparametric ANOVA statistical test, answering the question of how many average unique network contacts (assistance provider connections) each recipient has, contrasted by length of time they have been in the program. There is a visible, but not statistically significant increase at each level, at least in part due to limited sample size. Similar results were found when comparing just the Leadership Program participants and the Care Coordination participants. (See Appendix B for additional detail on statistical calculations).

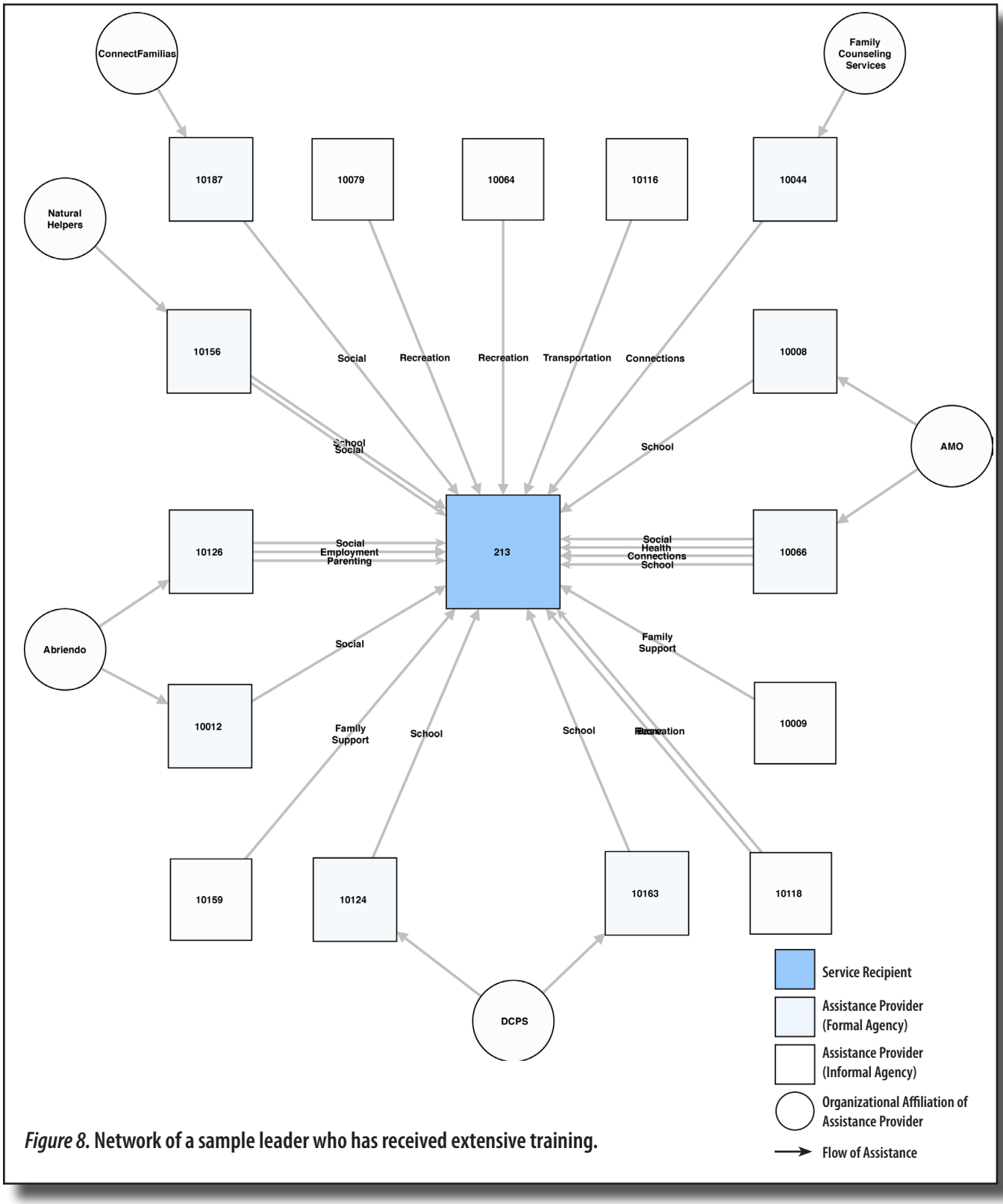

Figure 8. **Network of a sample leader who has received extensive training.**

Table 10
All Network Contacts of Unique Service Recipients by Time in CF

Months in CF	Mean	Standard Deviation	Minimum	Maximum
1-3	5.0	1.4	4	6
3-6	7.0	2.2	4	10
6+	8.4	4.5	3	20

Similar results were found when the same test was run to examine only those contacts not affiliated with CF or their cadre of NH/CHWs (Table 11). While the networks are demonstrably smaller, they again demonstrate visible, but not statistically significant growth correlated with time in the program.

Table 11
Non-Program Network Contacts of Unique Service Recipients by Time in CF

Months in CF	Mean	Standard Deviation	Minimum	Maximum
1-3	3.0	0.0	3	3
3-6	4.9	2.1	2	8
6+	6.4	3.7	1	16

Responses about the Individual Assistance Providers/Helpers

Survey respondents identified 187 individuals as assistance providers/helpers. On average, each helper (Table 12) had connections to 2.1 individual assistance recipients (network connections). Those connections comprised 1.6 different types of assistance. Assistance types were not tallied as individual "instances of help"; rather, they refer to the type of service or help that was provided by the assistance provider/helper during the past six months, which will be referred to as "assistance encounter". For instance, an individual may have been identified as having provided basic needs assistance. During the past six months, the helper may have provided up to four types of assistance – e.g., identified needs, referrals to services, assisted in filling out forms, and follow-up help – during multiple instances of help.

Table 12
Frequency of Assistance and Connections

Months in CF	Mean	Standard Deviation	Minimum	Maximum
Types of Assistance Provided	1.6	1.4	1	9
Number of Connections Listed (in-degree)	2.1	2.9	1	21

Note. In-degree connections refer to the number of times an individual was named as an assistance provider by a survey respondent.

The following table (Table 13) lists the individuals who provided the most assistance through the network. This merely shows which organizations had the most active/most connected assistance providers (helpers) in the network. ConnectFamilias staff (including NH/CHWs) and CF provider partners were most often cited by survey respondents as individual assistance providers. Codes are used to identify individual assistance providers to protect private identities.

Table 13
Most Active/Most Connected Assistance Provider and their Organization

Assistance Provider ID	Citations	Organization
10158	21	Natural Helper-CF
10156	17	Natural Helper- CF
10015	15	Natural Helper- CF
10141	13	Natural Helper- CF
10187	12	Natural Helper- CF
10037	12	Natural Helper- CF
10180	12	CF – Other Staff
10161	9	Regis House
10066	8	Adult Mankind (AMO)
10094	8	Big Brother Big Sisters
10044	8	Family Counseling Services

Responses about the Overall Network

Survey respondents reported a total of 399 connections with 187 individual assistance providers/helpers in the Little Havana assistance network. As stated previously, the 40 respondents who participated in these interviews were only a sample of the overall Little Havana service recipient population. While their individual networks may be representative of others in the entire universe of CF cases, it is not possible to reconstruct the complete CF network from just a sample of cases. As described in the section "Social Network of Respondents" it is most useful to analyze the overall Little Havana community network in terms of groups of providers with connections to recipients grouped by type of assistance received. This allows us to generate a useful picture of the Little Havana community assistance network based upon community social needs and the organizations that fulfill those needs (essentially, a "2-mode" network). Network-wide comparison metrics like density or even centralization are probably not useful in this context; however, we can produce a useful network visualization that gives a quick "snapshot" of how social assistance flows through the Little Havana network. In this social network map (Figure 9) the square shapes represent organizations or groups of assistance providers, the octagon shapes represent groups of individuals who needed certain types of assistance, and arrows represent the flow of assistance. The size and shading of the squares representing assistance providers may differ based on their centrality to the Community Network. The darker and larger squares are most central to the network. As can be seen CF, and especially their cadre of NH/CHWs, are central to the diagram, with direct or indirect connections to other major assistance providers and organizations, especially those that are funded by the partnership. ConnectFamilias is shown separately to indicate the activities of CF staff other than NH/CHWs.

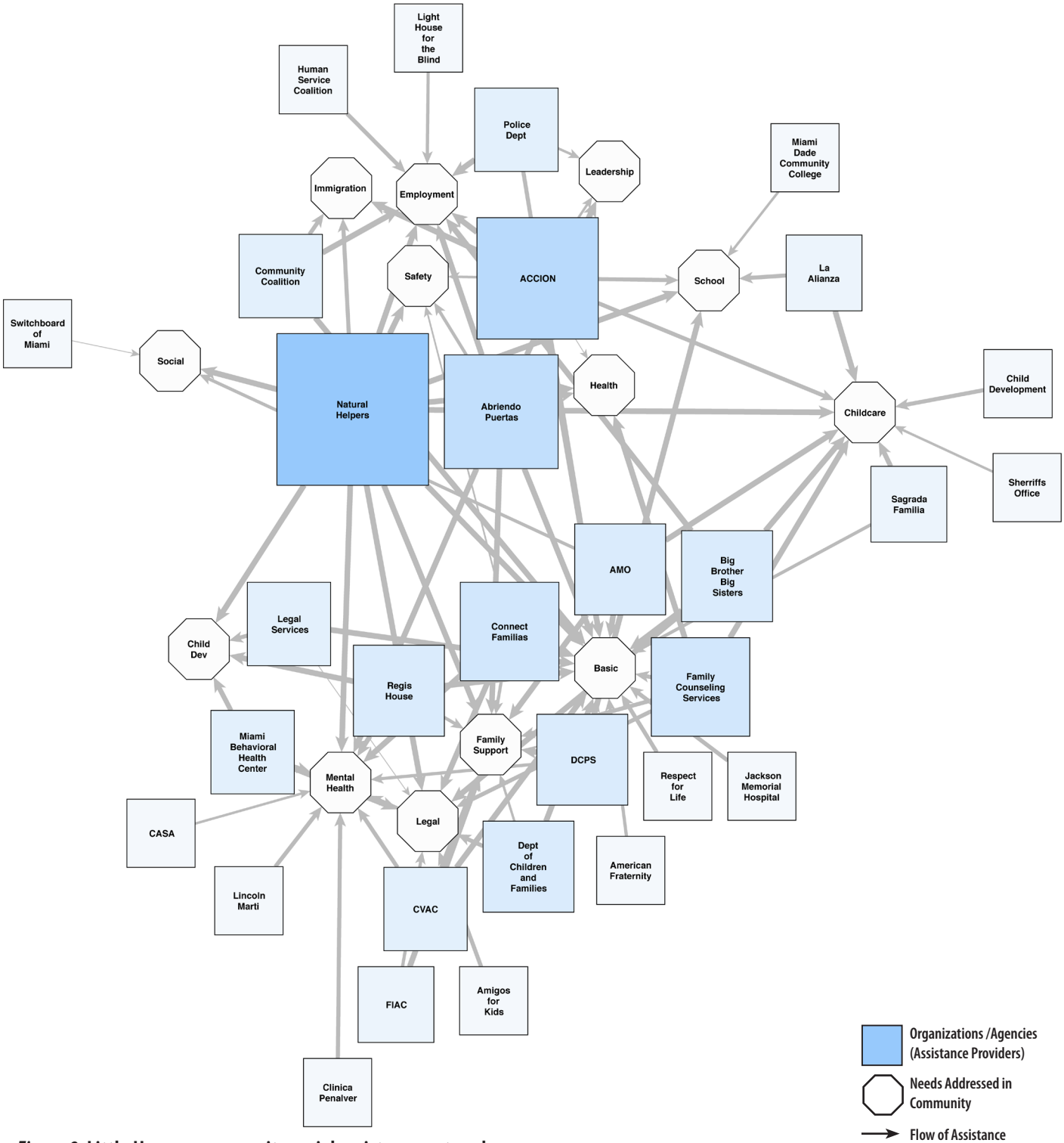

Figure 9. **Little Havana community social assistance network.**

Responses about the Assistance Provider Organizations

Network responses were aggregated to examine organizations that were cited by service recipients – specifically, the organizations that all cited assistance providers/helpers were affiliated with. In general, we find that each organization had an average number of 4.6; this means that each organization was likely to be cited by roughly five survey participants, or normalized to 11.6% of survey participants. Overall, the number of citations ranged from 1 to 36 citations. The

organizations that were cited most by recipients are listed in Table 14 (for any type of assistance provided).

Table 14
Frequency of Providers Being Cited

Organization	Respondents
CF - Natural Helpers	36
No Affiliation Listed (family/community)	34
Abriendo Puertas	12
Acción Community Service Center	9
CF - Other Staff	9
Big Brothers Big Sisters	9

Note. SD=6.57. Range 1 to 36 citations.

Based on citations, we can also characterize each organization by the types of services they were recognized as providing, as shown in Table 15. The types of assistance listed are based on how respondents described the assistance they received from providers/helpers who were affiliated with each organization.

Responses about the Types Of Assistance Provided

We can also examine the primary needs listed by survey respondents, as compared to the actual types of assistance that they claimed to have received through the network. First, we examine the primary needs cited by each survey respondent as shown in Figure 10. In this case, "primary need" refers to the need *cited as most important during the six month period preceding the survey*. The need most often identified by recipients in this regard was basic needs, which includes requests for food, clothing, shelter/housing, financial assistance, public benefits, furniture, and hygiene items. (See Appendix A for a list of codes used to identify needs.)

Figure 11 shows the types of assistance or services received, as identified by survey recipients themselves. Because respondents were ultimately given the opportunity to identify multiple needs (although they were asked to identify which one was the most important), a one-to-one relationship between primary need identified and reported assistance received should not be expected. However, Figures 10 and 11 can be generally compared to identify how service recipient needs were generally served through the ConnectFamilias network. As expected, most service recipients reported receiving connections to services (most often through care coordination teams and especially NH/CHWs) and this category was most often identified as a type of assistance received. These connections to services are often the first step in helping service recipients meet their identified needs. After connections to services, the category "basic needs" was most often cited as the type of assistance received by survey respondents. This is consistent with its rate of citation as a primary need. As Figure 11 indicates, the type and number of services/assistance received by service recipients was more diverse and numerous than the needs that service recipients identified suggesting that families often had multiple needs, including those they identified themselves (as an initial request) and those identified by care coordination teams working with them.

Table 15
Types of Assistance Provided by Organization

Assistance Provider	Affiliation	Types of Assistance Reported by Respondents
CF Affiliated	Acción Community Service Center	Basic, social support, connections, employment
	Adult Mankind (AMO)	School, basic, employment, childcare, connections, social support
	Amigos for Kids	Basic, connections, social support, employment
	Big Brothers Big Sisters	Youth, connections, basic, social support, employment
	Community Coalition	Immigration, connections, basic, social support, employment
	ConnectFamilias	Connections, social support, basic, safety
	Family Counseling Services	Connections, mental health, connections, basic, social support, employment
	La Alianza Meeting	Social support, recreation, connections, safety
	Natural Helpers	Connections, social support, basic, safety
Formal Providers	Abriendo Puertas	Connections, social support basic, employment
	American Fraternity	Immigration
	CASA	Immigration
	Child Development	Child development
	Clínica Peñalver	Health
	CVAC	Connections, mental health, legal
	DCPS	School, connections
	Dept Children & Families	Basic, custody, legal
	FIAC	Immigration, legal
	Human Service Coalition	Social support
	Jackson Memorial Hospital	Health
	Legal Aid	Legal, immigration, school
	Legal Services	Legal
	Lighthouse for the Blind	Safety
	Lincoln Marti	Childcare, child development, social support
	Miami Behavioral Health Ctr.	Mental health
	Miami Dade Community College	Adult education
	Police Department	Safety
	Respect for Life	Basic, child development
	Sagrada Familia	Childcare
	Sherriff's Office	Safety
	Switchboard of Miami	Connections
Informal Supports (Friend/Family/ Community)	No Affiliation Listed	Basic, childcare, social support, transportation, connections, basic, employment, recreation
	Other/Not Indicated	

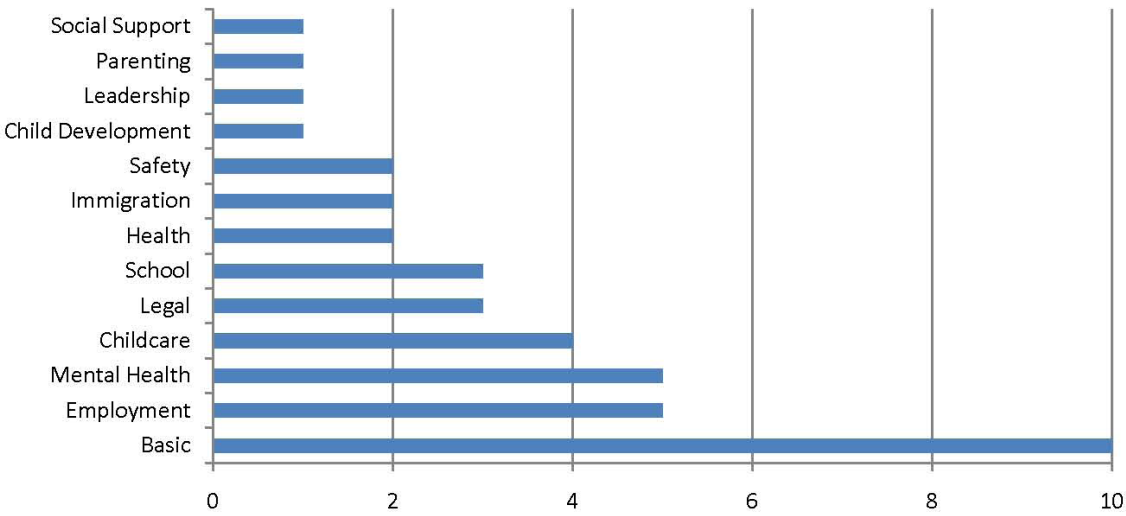

Figure 10. **Primary needs requested by interview respondents (n=40).**

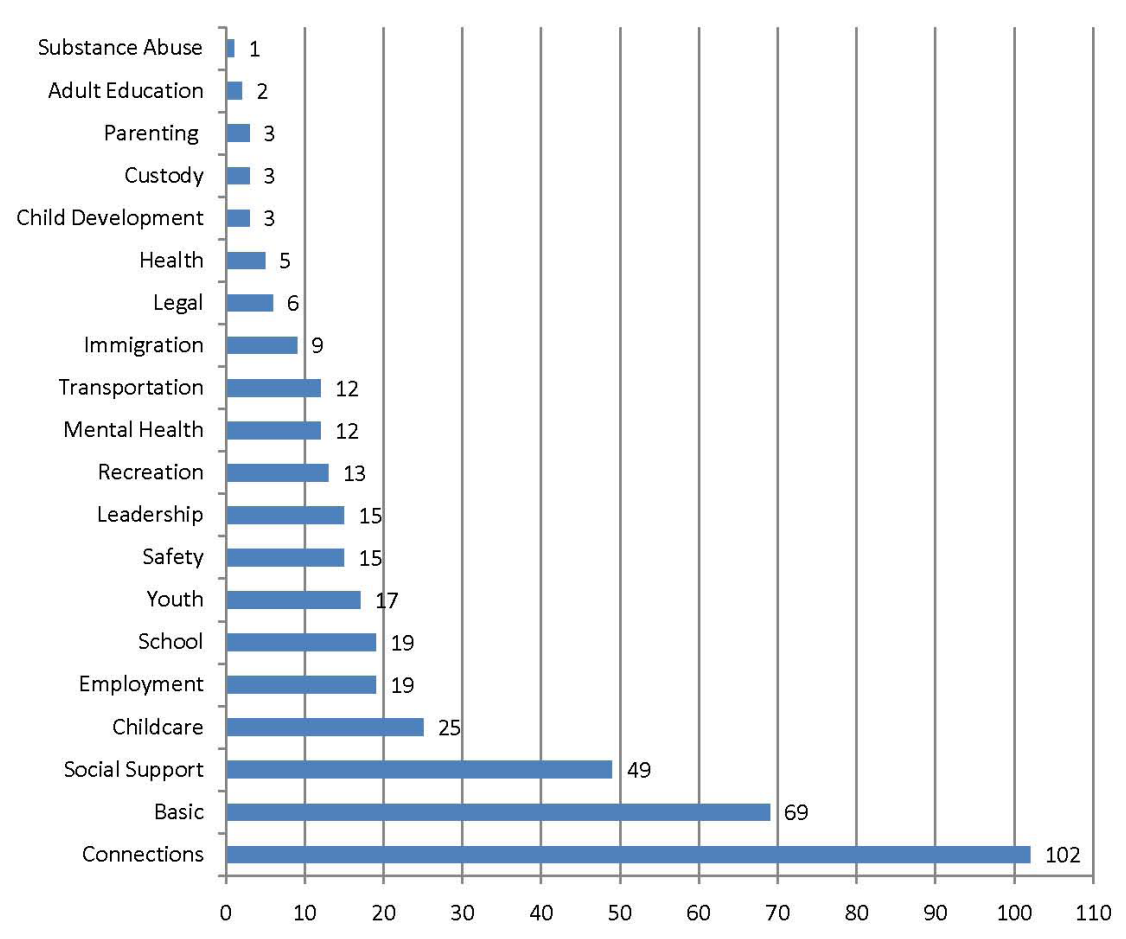

Figure 11. **Assistance or services received as self-identified by survey recipients (n=399).**

Conclusion

Social network analysis results provide evidence that CF is meeting the expected outcomes of providing three or more coordinated services, increasing networks connections, and increasing ability of Little Havana residents to manage their own environment *through the building of social networks that meet their ongoing support and assistance needs.* Interview data indicated that respondents had been connected to at least three and up to 23 services/supports while involved in CF. There is also evidence that CF is connecting and supporting Little Havana residents to meet their most important needs. In terms of the primary needs expressed by respondents, CF is assisting families in meeting these needs through direct services provided to families as well as connections to other services. For example, frequently cited types of assistance to meet basic, employment, and childcare needs match primary needs named by participants.

Based on the sources of referrals for the primary needs, it also appears that CF is successfully coordinating services so that families are connected to services they are not accessing through their own or family members' referrals. Self-referrals and family referrals were most frequently related to meeting needs for childcare and basic needs. These needs were also met through connections made by NH/CHWs and Care Coordinators, along with other primary needs such as health, employment, and legal issues.

ConnectFamilias staff and funded partners also appear to be providing assistance through the Service Provider Network as set out in the CF theory of change. Funded agencies are among the most frequently cited organizations with which assistance providers/helpers were affiliated. In addition, Care Coordinators, NH/CHWs, and partner organization staff are the most frequently cited providers of assistance, often in carrying out a "connecting" role. The services provided by or through connections made by these helpers were given ratings at least as high, if not higher than other sources of assistance and referrals.

The results do not show a clear correlation between the length of time involved in CF and the development of a greater number of connections, as stated in the theory of change. The lack of support for this hypothesis may be due to the small sample size, and especially the small number of respondents who were new to CF. Moreover, service recipients in care coordination may initially exhibit multiple needs requiring numerous connections to formal service providers providing various types of assistance. As the needs are met, the number of network connections may decrease for a period of time because service recipients may be better able to address needs on their own or with the help of informal supports (family/friends/community residents) as opposed to relying on services received through social service agencies. Overall, the analysis does indicate that networks change in complexity and type over time. As the third individual network map indicates, it may be that longer involvement in leadership training and community engagement activities may eventually lead to increased numbers of diverse connections. Examination of individual participant networks over time may provide additional information to show growth in size and/or strength of networks.

Overall, social network analysis results indicate that the CF partnership is accomplishing the important goal of connecting families to needed services and supports. It also indicates that partnership organizations and staff are active in providing families with assistance that meets the needs they consider to be primary, as well as other needs that arise during the helping process. Partnership members are also connecting to each other through referrals and connections to services. In addition, self-referrals and family and community member referrals are providing important informal links to resources that help to meet the multiple needs of respondents. Future studies of change in individual networks over time could provide additional information about growth in these informal supports, as well as changes in the strength of overall networks. Periodic examination of referral sources that include categories of self-referrals and family or community member referrals could also provide important information about participants' ability to manage their own environment.

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Appendix A

CODE BOOK: ConnectFamilias Social Network Analysis

INTERVIEWEE CHARACTERISTICS

Type of participant: Categories- Care Coordination, Leadership

How long has been in the U.S.: Categories- less than one year, 1-5 years, 5-10 years, more than 10 years

Length of time in program: Categories- less than one month, 1-3 months, 3-6 months, over 6 months

Gender: Categories- male, female

TYPE OF NEED

ADULT – ED (Adult Education)

- Literacy classes (Clases de alfabetización)
- GED information (Información sobre GED)
- English classes (Clases de ingles)
- Adult Education / Technical school – hairdressers, cook, etc. (Escuela técnica – peluquería, cocinero, etc.)
- College
- Citizenship classes (Clases de ciudadanía)
- Educational transcript certification (Validación estudios)

BASIC (Essential Basic Needs)

- Clothing (Ropa)
- Food (Alimentos, pavos, canastas, "food bank")
- Shelter / Housing (Refugio / Hotel)
- Utilities (Pago servicios)
- Financial Assistance / Emergency
- Public benefits (Application for Women, Infants, & Children – WIC, Food Stamps, SSI, Social Security, Disability)
- Furniture
- House payments / Purchasing a home
- Hygiene items
- Christmas presents

CH-CARE (Childcare)

- Childcare that is affordable
- Scholarships / Waivers
- Parent volunteer opportunities to cover childcare costs

CONECT (Connections and Referrals)

- Linkages to the police (Lazos con la policía)
- Information about where to get help
- Referrals to agencies to get help
- Linkages to volunteer opportunities
- Information about where/how to get involved in activities/programs

CH-DEV (Early Childhood Development)

- Developmental assessment
- Child care / Baby care
- Early Intervention
- Speech Therapy
- Physical Therapist
- Pre-natal services (Pre-natal classes, Pre-natal Services)
- Teen pregnancy (Information for teen mothers)

CUST (Parent custody related services)

- Parent advocacy
- Court mandated parents counseling or training
- Child Custody
- Child Support

EMP (Employment)

- Employment assistance (Búsqueda de empleo)
- Employment skills

HEALTH (Healthcare, Dental)

- Physicians
- Urgent care
- Emergency care
- Dentist
- Pre-natal care
- Post partum care
- Vaccinations
- HIV testing
- Family planning
- Disabilities care
- Eyeglasses
- Health insurance card / Medicaid
- Exercise
- Weight control / Diet
- Disability assistance (Help at home, etc)

IM (Immigration)

- Immigration issues
- Deportation
- Identity papers (Obtaining or validating ID papers, lost papers)

LEGAL (Legal)

- Employment paperwork
- Special needs eligibility
- Homeless issues
- Eviction advocacy
- Domestic Violence legal services
- Discrimination
- Court related services / Translation
- Transactions with lawyers

MH (Mental Health, Domestic Violence)

- Counseling / Therapy (Consejería)
- Domestic Violence (Salir de la violencia)
- Eating Disorders

PAR (Parenting Support)

- Parent Education / Skills
- Parenting groups
- Parenting Information / Advise

REC (Recreation)

- Recreation (Park programs)
- Music
- Art
- Drama
- Walking
- Dance

SA (Substance Abuse)

- Alcohol
- Tobacco
- Other drugs
- Support groups
- Detoxification ("Detox")
- Recovery
- Use and Abuse evaluation
- Parents / Siblings support group
- Substance abuse prevention program by youth (Drama presentations

SAFE (Safety)

- Relationship with police
- Care safety
- Neighborhood improvement (Lights, speed bumps, stop signs, etc.)
- Safety information (911, CV, fire safety)
- Child safety in the home
- Safety education by the police

SCH (Child's school, education)

- Advocacy for school services
- Special education
- Parent involvement in school (look for underlying need or motivation)
- Library card / membership and orientation
- After School programs
- Truancy / School attendance

- School supplies, backpacks
- Tutoring

SOC (Social Support, Emotional Support)

- Making friends in the neighborhood
- Community events involvement (look for underlying need or motivation)
- Emotional support and counsel/advice
- Caminatas (Neighborhood walks)
- Workshops
- Help with problem solving
- Adult mentoring/advice/counsel

TRANS (Transportation Assistance)

- Public transportation (tokens for busses, information about bus routes)
- Driver's license assistance for adults
- Assistance with car payments
- Providing a ride in a car, driving a child to/from school or event

YOUTH (Youth Successful Development)

- Volunteer in the community (Community hours) (e.g. for youth's school credit)
- After school activities
- Youth employment (age 14 – 16)
- Big Brother or Big Sister
- Mentoring

Note: For Leadership respondents consider the underlying need met (e.g. Connections / Information, Social Support, Safety, Recreation, Youth Development, etc.) by involvement in activities names, such as:

- Leadership training
- La Alianza committee work
- Coordinating events
- Volunteering in the community

AFFILIATION

- ACCESS Miami, City of Miami Economic Initiatives
- Acción Community Service Center
- Adult Mankind Organization/South Florida Workforce (AMO)
- All-Aboard Tutoring/Mentoring Program
- American Children's Orchestras for Peace
- American Fraternity, Inc.
- American Red Cross South Florida Region
- Amigos for Kids®
- Association of Community Organizations for Reform Now (ACORN)
- Baptist Health South Florida
- Big Brothers, Big Sisters of Greater Miami
- Borinquén Health Care Center, Inc.
- CCDH (formerly Community Committee for Developmental Handicaps)
- Camillus House
- Care Resource
- Catholic Charities of the Archdiocese of Miami
- Centro Clínico La Sagrada Familia
- Centro Mater East/Catholic Health Services
- Centro Medico Las Americas
- Citrus Health Network, Inc.
- City Year Miami
- Community Coalition, Inc.
- Cuban American National Council, Inc.
- Dade County Legal Aid Society
- Dr. Rafael Peñalver Clinic, Jackson Health System
- Early Learning Coalition Miami-Dade/ Monroe
- Elevate Miami
- Family Counseling Services of Greater Miami
- Florida Department of Children & Families
- Florida Immigrant Advocacy Center (FIAC)
- Fundación ENTRE NOSOTRAS
- Habitat for Humanity of Greater Miami
- Health Connect In the Early Years, Healthy Start Coalition of Miami-Dade
- Hearing and Speech Center of Florida (HSCF)
- Helen B. Bentley Family Health Center

- Hispanic Coalition, Inc.
- Human Services Coalition
- Iglesia Adventista Del Séptimo Día
- Iglesia Alfa & Omega
- Informed Families, the Florida Family Partnership
- Jackson Memorial Hospital
- Jefferson Reaves Sr. Health Center
- Jose Marti Riverfront Park Swimming Pool
- Legal Services of Greater Miami, Inc.
- Liga Contra El Cáncer
- Lincoln Martí Schools Miami
- Lindsey Hopkins Technical Education Center
- Mailman Center for Child Development, University of Miami
- Miami Behavioral Health Center
- Miami Job Corps Center
- Miami Lighthouse For the Blind
- Miami Rescue Mission, Inc.
- Miami-Dade County, Coordinated Victims Assistance Center (CVAC)
- Miami-Dade County, Safe Space Shelter and Outreach
- Miami-Dade County, Special Transportation Service
- Miami-Dade County Health Department, Family Planning
- Miami-Dade County Public Schools (M-DCPS)
- M-DCPS Adult Education
- M-DCPS, the English Center
- Miami-Dade College, Inter America Campus
- Miami-Dade Office of the State Attorney, Child Support Enforcement
- Miami-Dade Public Housing Agency
- Missionary Baptist Church
- National Court-Appointed Special Advocates Association (NCASAA)
- Neat Stuff, Inc.
- Nouvelle Institute
- Planned Parenthood, South Florida and the Treasure Coast
- Rainbow Child Day Care
- Regis House
- Respect Life Ministry Archdiocese of Miami
- Salvation Army Miami-Dade
- San Juan Bosco Clinic
- SHARE Florida Food Network
- Shenandoah Elementary School
- Solidaridad Sin Fronteras (SSF)
- Su Familia Helpline, National Alliance For Hispanic Health
- Switchboard of Miami, Inc.
- Trauma Resolution Center
- Unidad Hondureña
- United Way Center for Excellence in Early Education
- Vecinos en Acción
- Village South, Inc.
- World Relief
- YMCA of Greater Miami

RELATIONSHIP TO RESPONDENT

FORMAL

NH (ConnectFamilias Natural Helpers / Community Health Workers)

- Names of Natural Helpers listed

CC (ConnectFamilias Care Coordinators)

- Names of Care Coordinators listed

CF-O (Other ConnectFamilias Personnel)

- Names of other CF associated personnel listed

LEGAL (Legal Assistance, Courts, Police)

- Lawyers
- Other legal advisors/helpers
- Courts
- Police

PRO (Other Professional)

- Teachers

- Tutors
- Counselors
- Social workers
- Clinic staff

INFORMAL

NH (Natural Helpers named as a friend or neighbor)

- Names of Natural Helpers listed

CC (Care Coordinators names as a friend)

- Names of Care Coordinators listed

CF-O (Other CF Personnel named as a friend)

- Names of CF associated personnel named as a friend

LA (La Alianza Group Leaders / Members)

- Officers of La Alianza
- Committee leaders
- Child care provider at La Alianza meetings

CH-REL (Acquaintance related through child activities)

- Parents or staff at child's school, day care or after school program
- Tutor / Mentor
- Monitor or crossing guard at school (Street Patrol)
- Parent of child's friend
- PTA or other parent organization member or leader
- Play / Recreation "buddy"

COM (Community Member)

- Community Center staff or participant
- Community program leader or participant
- Health and beauty salespeople: Avon, Herbalife, etc.
- Mechanic, yard worker/gardener
- Hair dresser/barber, seamstress (costurera), shop owner/salesperson, vender

FAM (Family / Relatives)

- Family members: Hermano/a, mama, papa, abuelo/a, tíos, primo/a, esposo/a, compañero, "roommate" / compañero de cuarto, comadronas, hijos/as, consuegros, suegro/a, cuñado/a , compañero/a, vivienda

FRND (Acquaintance / Friend of Parent)

- Study companion for classes/training
- Co-worker
- Friend from the same country (paisano)

NBR (Neighbor)

- Neighbor
- Neighbor met as a CF Block Party or Caminata (neighborhood walk)

SPIR (Religious / Spiritual Leader)

- Priest, pastor, elder, deacon/deaconess, rabbi, nun, priestess, spiritual counselor, church ministry/ program director

BUS-REL (Business Relationship)

- Rental agent, property manager or administrator
- Supervisor or boss at work

TYPE OF SERVICE PROVIDED (See "Type of Need" for descriptions)

- ADULT-ED (Adult Education)
- BASIC (Essential basic needs)
- CH-CARE (Childcare)
- CONECT (Connections and Referrals)
- CH-DEV (Early Childhood Development)
- CUST (Parent Custody Related Services)
- EMP (Employment)
- HEALTH (Healthcare, Dental)
- IM (Immigration)
- LEGAL (Legal)
- MH (Mental Health, Domestic Violence)
- PAR (Parenting Support)
- REC (Recreation)
- SA (Substance Abuse)
- SAFE (Safety)
- SCH (Child's School, Education)
- SOC (Social Support, Emotional Support)
- TRANS (Transportation Assistance)
- YOUTH (Youth Development)

REFERRAL SOURCE (See "Relationship to Respondent" for descriptions)

- NH
- CC
- CF-O
- LEGAL
- PRO
- LA
- CH-REL
- SELF
- FAM
- FRND
- NBR
- COM
- SPIR
- BUS-REL

Appendix B

Details on Statistical Calculations

All Unique Providers (Network Contacts), By Time in ConnectFamilias Program (ANOVA)

Kruskal-Wallis Test (Nonparametric ANOVA)

The P value is 0.3915, considered not significant.
Variation among column medians is not significantly greater than expected by chance.

The P value is approximate (from chi-square distribution) because at least one column has two or more identical values.

Calculation detail

Group	Number of Points	Sum of Ranks	Mean of Ranks
1 to 3 months	2	20.000	10.000
3 to 6 months	10	198.50	19.850
6+ months	28	601.50	21.482

Kruskal-Wallis Statistic KW = 1.876 (corrected for ties)

Post tests were not calculated because the P value was greater than 0.05.

Summary of Data

Group	Number of Points	Median	Minimum	Maximum
1 to 3 months	2	5.000	4.000	6.000
3 to 6 months	10	7.500	4.000	10.000
6+ months	28	7.000	3.000	20.000

Appendix B

Details on Statistical Calculations (continued)

NON-PROGRAM Unique Proviers (Network Contacts), By Time in ConnectFamilias Program (ANOVA)

Kruskal-Wallis Test (Nonparametric ANOVA)

The P value is 0.2109, considered not significant.
Variation among column medians is not significantly greater than expected by chance.

The P value is approximate (from chi-square distribution) because at least one column has two or more identical values.

Calculation detail

Group	Number of Points	Sum of Ranks	Mean of Ranks
1 to 3 months	2	17.000	8.500
3 to 6 months	10	182.00	18.200
6+ months	28	621.00	22.179

Kruskal-Wallis Statistic KW = 3.113 (corrected for ties)

Post tests were not calculated because the P value was greater than 0.05.

Summary of Data

Group	Number of Points	Median	Minimum	Maximum
1 to 3 months	2	3.000	3.000	3.000
3 to 6 months	10	5.500	2.000	8.000
6+ months	28	5.500	1.000	16.000

connectfamilias
LITTLE HAVANA COMMUNITY PARTNERSHIP

The Annie E. Casey Foundation

The Children's Trust
Because All Children Are Our Children

The Children's Trust is a dedicated source of funding created by voter referendum in 2002 to improve the lives of children and families in Miami-Dade County by making strategic investments in their future – because all children are our children.

DADE COMMUNITY FOUNDATION

Department of Child & Family Studies
Louis de la Parte Florida Mental Health Institute

USF
UNIVERSITY OF SOUTH FLORIDA
COLLEGE OF BEHAVIORAL & COMMUNITY SCIENCES

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