National COMMUNITY CARE CORPS

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Community Care Corps (C3)

Five Year Final Report

Prepared by The Altarum Institute and The Oasis Institute for the Administration of Community Living

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Introduction

The Community Care Corps program (C3) was established and funded by the Administration for Community Living (ACL) in 2019 through a cooperative agreement. C3 is a national program that awards grant funding to local organizations providing innovative volunteer-based nonmedical assistance to family and informal caregivers, older adults, and adults with disabilities. Grantee efforts have had a lasting impact on the families and individuals served, allowing them to maintain their independence and live with dignity in their homes and communities. Further, it provides volunteers with fulfillment and opportunities to explore career options.

C3 aimed to test and support local models to place volunteers in communities to support caregivers and provide nonmedical assistance to older adults and adults with disabilities so that they can maintain their independence. Volunteer assistance includes companionship, caregiver respite, and other forms of assistance. Not only does their presence support family caregivers and direct care workers, but volunteering can benefit the volunteers themselves, teaching them valuable skills and helping them pursue more formal employment in various health and human services settings. Through this program, ACL has supported innovative models in which volunteers assist family caregivers, older adults and/or adults with disabilities with nonmedical assistance in order to maintain independence; and evaluating the effectiveness of those models in different communities nationally. The Leadership Team, consisting of the Oasis Institute, Caregiver Action Network (CAN), USAging, and Altarum Institute, provided technical assistance to grantees, supported data collection efforts for the program, and evaluated the results and impacts of the program. Grant funding has been awarded to four cohorts in total since 2020. This evaluation report builds on previous reports to present a cumulative narrative on impact across all cohorts. Outcomes for survey respondents are presented to demonstrate change over time and respondents who responded to initial and follow-up surveys were matched for comparison wherever possible.

This report details grantee programs from Cohorts 1-4. Organizations in Cohort 1, 2, 3, and 4 initiated their programs in 2020, 2021, 2022, and 2023, respectively. Grantees in Cohorts 1 and 2 were funded for 12 months, while Cohort 3 grantees had the option to receive 12 or 18 months of funding, and Cohort 4 were all funded for 18 months. Grantees proposed, implemented, and maintained various programmatic models leveraging volunteers to support family caregivers. Specific services provided by grantees included:

Grantee Cohorts

Cohort 1 (2020-2021): 23 Grantees
Cohort 2 (2021-2022): 33 Grantees
Cohort 3 (2022-2024): 23 Grantees*
Cohort 4 (2023-2025): 30 Grantees

**14 grantees in Cohort 3 opted for an 18-month period of performance of 2022-2024*

- Assisting care recipients with instrumental activities of daily living, such as yard work, light housework and chores, and home maintenance and modifications.
- Offering training, peer support, and mentorship to boost family caregivers' confidence and reduce their stress.
- Providing door-through-door assistance to medical appointments, including arranging transportation.
- Ensuring the needs of care recipients and family caregivers were met through food and nutrition assistance, handling finances, and support with various assistive devices to increase independence.
- Supporting family caregivers' health through respite services.

As part of their participation in the C3 program, grantees received technical support from the C3 leadership team. Technical assistance activities supported program implementation, maintenance,

and sustainability of volunteer services. Examples include:

- Online resources, including access to helpful tools and a publicly available resource library to assist organizations to design and right-size their own volunteer nonmedical assistance programs.
- Technical assistance with crafting compelling value propositions to pursue additional funding and strategically expand partnerships.
- Opportunities for peer learning focused on common challenges C3 grantees faced, such as recruiting volunteers and sustaining funding.
- Coaching on data collection to evaluate their individual and collective impact.

The national evaluation aims to demonstrate how this program supports individuals to maintain their independence and high quality of life within the community, alleviates caregiver stress, and allows volunteers to provide meaningful support to those in their community. To capture data for the evaluation, grantees administered surveys to volunteers, caregivers, and care recipients.

This report outlines key findings from caregiver and care recipient survey data, demonstrating how C3 has impacted several outcomes. It provides a narrative summation of the impact the program had on these two audiences. In the following sections, the report describes program impact from October 2020 through March 2025 by organizations in Cohorts 1, 2, 3, and 4. The implications of these evaluation findings demonstrate the need to grow and replicate programs that provide nonmedical volunteer assistance to older adults, people with disabilities, and family caregivers.

Data Sources and Methodology

Data collection primarily involved surveys completed by care recipients, family caregivers, and volunteers. This report will focus on impacts incurred by care recipients and caregivers. Surveys were administered by the grantees to their program participants. Throughout their grants, organizations disseminated initial and follow-up surveys to these groups, although the timing and content of the surveys varied somewhat by cohort, as described below. This report draws from surveys from the following C3 program participants:

- **Care recipients** who receive ongoing, direct volunteer assistance.
- **Caregivers** who receive ongoing, direct volunteer assistance.
- **One-time assistance recipients** who receive volunteer assistance once.
- **Volunteers** who assist caregivers and care recipients.

Altarum and Oasis provided web-based survey links and offline versions to the grantee organizations. The organizations then distributed the survey to respondents using various methods such as telephone calls, volunteer visits, and printed surveys. All the data collected offline were entered by grantees using the online surveys on a quarterly basis. Respondents completed an initial survey when they started receiving assistance or volunteering and a follow-up survey when they stopped. If their first and last time receiving assistance was not within the grant funding cycle, they completed surveys at the start and end of the funding cycle. Starting in Cohort 3, volunteers only completed a follow-up survey, and a new follow-up survey was added for care recipients who received ad hoc volunteer assistance once.

Evaluation surveys asked questions about respondents' demographic characteristics, experience providing or receiving assistance, and key outcomes. For Cohorts 1-3, outcomes for care recipients and caregivers focused on quality of life, mental and physical health, and maintaining care recipients' living situation in the community. For Cohort 4, outcomes for care recipients and caregivers focused on loneliness, social isolation, and unmet needs. Caregivers across all cohorts were also asked about their perceived levels of stress, although the measurement tool differed. One-time assistance recipients were asked about whether assistance alleviated a major concern in their

lives. Finally, volunteers in Cohorts 1-3 reported the benefits they experienced from providing assistance, whereas volunteers in Cohort 4 were asked about their motivations for volunteering. Survey questions changed somewhat across the cohorts, primarily to reduce the amount of time and effort required by respondents and grantee organizations and to shift toward standardized scales for specific outcomes.

Across all cohorts, grantees gathered responses from 6,909 care recipients (a 20% response rate), 766 of which were one-time assistance recipients (a 22% response rate); 1,993 caregivers (a 16% response rate); and 5,382 volunteers (a 33% response rate). Response rates for follow-up surveys were consistently lower than for initial surveys, and response rates varied somewhat across cohorts. Although national survey response rates vary depending on modality, the average response rate is around 33% across all modes, with online surveys having a much lower average response rate (5-15%) as compared to in-person surveys (40-50%).[1,2]

This report presents outcomes data for caregivers and care recipients from the initial and follow-up surveys to demonstrate change over time. We also matched respondents who completed both surveys and compared the individual responses. For outcomes that were measured in the initial and follow-up surveys, we hypothesized that volunteers would either help maintain or improve outcomes of care recipients and caregivers. This would be indicated by either no change or positive change in outcomes across the two surveys. This report focuses on the outcomes derived from questions asked of care recipients and caregivers across all four cohorts. While not directly tied to these outcomes, the one-time assistance and volunteer survey data supported the full evaluation of the program and provided valuable key takeaways.

Summary of Findings from Evaluation Reports

Through final evaluation activities, the following outcomes were reported across the participating groups who were surveyed.

Care Recipients

- Social isolation and loneliness both decreased slightly among care recipients as a result of this program.
- The most commonly reported unmet need was transportation.
- The majority of care recipients reported no change or improvement in their unmet need, indicating that participants maintained baseline levels across the period of performance or had their needs met during that time.
- Companionship was the most common type of volunteer assistance received.
- Care recipients tended to be older adults who lived at home.
- Care recipients were varied across sex, race, and ethnicity.

Caregivers

- Cohort 4 caregivers either maintained or decreased stress levels at a higher rate than previous cohorts.
- The most common form of volunteer assistance received was companionship/friendly visits and training and education.
- Across all cohorts, most caregivers were female.
- Caregivers most often assisted friends and loved ones with instrumental activities of daily living (e.g., transportation and handling finances).

One-Time Assistance

[1] WorldMetrics. (2024). Average survey response rate: Benchmarks by industry, survey method & type.
[2] U.S. Bureau of Labor Statistics. (n.d.). Response rates – Current Population Survey.

- Nearly three-quarters of one-time assistance recipients said volunteer assistance significantly alleviated a major life concern.
- The most common services one-time assistance recipients received from volunteers included chaperoning or transportation assistance for medical appointments.
- The majority of one-time assistance recipients were women 65 years and older, however more than a quarter of recipients were under age 25.
- More than two-thirds of recipients were non-white, with the largest proportion being African American.

Volunteers

- In Cohort 4, the most frequently cited motivation for volunteering was associated with 'values', referring to the desire to engage in activities that focus on altruistic and humanitarian principles.
- Companionship was the most common form of assistance volunteers provided.
- Most volunteers were female and almost half were 65 and older.

Program Outcomes

The C3 program demonstrated value and positive impacts across care recipients, caregivers, and volunteers, as evidenced by the outcomes and findings from these multiple formal evaluation reports. **As noted, this evaluation report builds on previous reports to present a narrative on cumulative impact across all cohorts. For full descriptive and analytic data that highlights those specific impacts and outcomes, please refer to the Cohort 1-3 Interim Report and Cohort 4 Addendum.** This narrative outlines how the program impacted specific outcomes and performance indicators, as detailed in initial project planning efforts, including:

- Functional Status of Care Recipient
- Well-Being of Care Recipient and Caregiver: Physical Health, Mental Health, and Loneliness
- Care Recipient and Caregiver Confidence in Sustaining In-Home Care
- Caregiver Self-Efficacy
- Caregiver Stress and Burden
- Care Recipient and Caregiver Program Satisfaction
- Care Recipient Social Isolation and Social Connectedness

Functional Status of Care Recipient

Older adults and people with disabilities who received assistance from C3 volunteers were diverse and had significant care needs. Many lacked the necessary support from friends and family members to maintain independence in their home. Their responses to the initial and follow-up surveys indicated that volunteers helped them maintain or improve their stress levels, social isolation, and loneliness.

Functional status refers to an individual's actual ability to perform tasks necessary for independent living, including both basic and instrumental activities of daily living. In this evaluation, we did not directly measure the functional status of care recipients using standardized assessment tools or performance-based scales (e.g., Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs) assessed through clinician or structured self-report instruments). However, we did collect care recipient-reported data on whether they have an unmet need with specific IADLs, such as transportation, managing finances, or preparing meals. While this does not provide a direct measure of functional ability, it offers relevant insight into functional limitations from the perspective of those providing care. This perceived need for IADL support is inherently related to functional status: when care recipients require more assistance, it often reflects a decline in the care

recipient's functional capacity.[3] Therefore, these responses can serve as an indirect or proxy indicator of functional status, helping to illustrate areas where support is lacking, even if not formally quantified through clinical tools.

Care recipients across all cohorts reported on several unmet needs at baseline. The highest unmet need was regarding transportation, with 36% indicating this need was not met, followed by unmet needs for housework (33%), shopping (29%), and yard work (28%). The majority of care recipients reported no change or improvement in their unmet need at follow-up assessment, indicating that participants maintained baseline levels across the period of performance or had their needs met during that time, therefore supporting and maintaining their functional status.

Well-Being of Care Recipient and Caregiver: Physical Health, Mental Health, Stress, and Loneliness

Although a single measure of well-being was not used in this evaluation, several key indicators that collectively reflect overall well-being were assessed. These included measures of physical health, mental health, perceived stress, and feelings of loneliness. Each of these domains captures a distinct but interrelated aspect of an individual's overall state of well-being. For the purposes of this evaluation, we define well-being as a multidimensional construct comprised of these components, recognizing that together they offer a comprehensive view of participants' health, functioning, and emotional state. This approach allows us to examine well-being holistically, even in the absence of a single summary measure. It should be noted that global quality of life, global physical health, disability, depression, and anxiety were only assessed in Cohorts 1-3. With the population these programs served, maintaining physical health, mental health and level of loneliness is important for maintaining independence and the ability to remain in the community. As such, no change in these metrics were viewed as positive outcomes of the program across all cohorts. All cohorts included assessments of loneliness and stress, although types of measurement differed.

Care Recipient Physical Health

Care recipients in Cohorts 1-3 were surveyed about their physical health on a four-point scale from "poor" to "excellent." In Cohort 1-3 combined, the proportion of those who reported good or excellent physical health was 41% in the initial survey and 39% in the follow-up survey. Most care recipients (87%) reported improvement or no change in their physical health, and 14% of care recipients who responded to both surveys indicated their physical health improved. Physical health was not assessed in Cohort 4.

Care Recipient Mental Health

In Cohorts 1-3, the proportion of care recipients who reported good or excellent global mental health was 64% in the initial survey and 66% in the follow-up survey. In all three cohorts, most care recipients (85%) reported improvement or no change in their mental health. Delving further into mental health issues, care recipients were asked about the frequency in the past month that they felt worried (a symptom of anxiety) and downhearted or blue (a symptom of depression). For both questions, four response options ranged from "never" to "all of the time." In Cohorts 1-3 combined, the proportion who felt worried most or all the time declined by 4 percentage points, from 24% in the initial survey to 20% in the follow-up survey for all cohorts. Similarly, the proportion of care recipients who felt downhearted or blue most or all the time fell from 20% in the initial survey to 18% in the follow-up. Most care recipients (88%) reported a decrease or no change in their frequency of feeling worried, and the same exact percentage reported a decrease or no change in their frequency of feeling downhearted or blue. As noted, neither mental health, anxiety, nor depression were assessed

[3] Jutkowitz E, Gozalo P, Trivedi A, Mitchell L, Gaugler JE. The Effect of Physical and Cognitive Impairments on Caregiving. Med Care. 2020 Jul;58(7):601-609. doi: 10.1097/MLR.0000000000001323. PMID: 32287048; PMCID: PMC7289673.

in Cohort 4.

Care Recipient Loneliness

In Cohorts 1-3, loneliness was assessed via a single-item assessment (*during the past month, how often have you felt lonely?*). Responses were on a 4-point Likert scale ranging 'Never' to "All of the Time". The companionship volunteers provided appears to have reduced the frequency that care recipients felt lonely most or all of the time, from 23% in the initial survey to 19% in the follow-up. Additionally, across Cohorts 1-3, 15% of care recipients who responded to both surveys reported feeling lonely less frequently over time, however, as with other outcomes, most care recipients (87%) reported a decrease or no change in how frequently they felt lonely.

In Cohort 4, care recipients were asked about their social connections, loneliness, and relationships with friends and relatives. Care recipients completed the UCLA 3-item loneliness scale which assesses lack of companionship, feeling left out, and feeling isolated on a 3-point scale ranging from hardly ever to often. At baseline, 31% of respondents had scores indicating loneliness, and at follow-up 28% met this threshold representing a 3-percentage point decline in loneliness. Care recipients additionally completed questions about social isolation from the six-item Lubben Social Network Scale which asks about the number and frequency of social contacts with friends and family members and the perceived social support received from these sources. At baseline, 56% of respondents met the threshold to be considered socially isolated, whereas 54% met this threshold at follow-up representing a slight decline overall.

Caregiver Physical Health

In Cohorts 1-3, caregivers were also surveyed about their physical health on a four-point scale from "poor" to "excellent the percentage of caregivers with good or excellent physical health was similar across cohorts and in the initial and follow-up surveys. Overall, around three-quarters of caregivers reported good or excellent physical health in both the initial survey (73%) and the follow-up survey (74%). Most caregivers who responded to both surveys reported either improvement or no change in their physical health (87%). Physical health was not assessed in Cohort 4.

Caregiver Mental Health

In Cohorts 1-3, the proportion of caregivers who reported good or excellent mental health was larger in the follow-up survey (79%) than the initial survey (74%). While these rates were similar to the rates of those who reported worse mental health, most caregivers across all cohorts (85%) and each individual cohort reported either improvement or no change in their mental health. Mental Health was not assessed in Cohort 4.

Caregiver Loneliness

Regarding caregiver loneliness, 10% of caregivers in Cohorts 1-3 in the follow-up survey reported feeling lonely most or all of the time, a decrease from 14% in the baseline survey. Of respondents who completed both the initial and follow-up surveys, 16% of caregivers reported a decrease in loneliness. The share who felt lonely less frequently was higher in Cohort 2 (20%) and Cohort 1 (13%) than in Cohort 3 (7%). Overall, most caregivers (87%) reported a decrease or no change in how often they felt lonely. Caregiver loneliness was not assessed in Cohort 4.

Care Recipient Confidence in Sustaining In-Home Care

One of the primary goals of C3 is to ensure older adults and people with disability can maintain their ability to live safely in the community. For Cohorts 1-3, both Care Recipients and Caregivers were asked about perceived difficulty in maintaining their current living situation (care recipient) or the living situation of the person they provide care for (caregiver). Responses were on a 4-point Likert scale that ranged from "not at all difficult" to "extremely difficult". This was not assessed in Cohort 4.

From the initial to the follow-up survey, the percentage of care recipients who reported that

maintaining their current living situation was difficult or extremely difficult rose from 18% to 23%, The increase in difficulty may reflect worsening disability and rising assistance needs among care recipients over time—unrelated to the services they received from volunteers.

After matching care recipients who responded to both surveys, one in five care recipients (20%) indicated that their difficulty maintaining their current living situation decreased with some variation across cohorts. Over a third (36%) of care recipients in Cohort 3 reported decreased difficulty maintaining their current living situation, followed by 22% in Cohort 1 and 16% in Cohort 2. In all three cohorts, the share of care recipients who reported decreased difficulty was larger than that share whose difficulty increased, and most respondents (84%) had either decreased difficulty or no change in difficulty.

Additionally, most care recipients (82%) reported volunteer assistance helped them maintain their current living situation and this percentage was consistently high across cohorts. These data indicate that volunteer assistance likely helped care recipients avoid experiencing greater difficulty with maintaining their current living situation and, in some cases, may have made staying at home easier.

Caregiver Confidence in Sustaining In-Home Care

Like care recipients, caregivers were asked how difficult it was to maintain the current living situation of their friend or relative, with four response options that ranged from "not at all difficult" to "extremely difficult." Fewer than 1 in 5 caregivers (18%) found it difficult or extremely difficult to maintain their friend or loved one's current living situation. While there was little change in difficulty levels over time for each group of caregivers, fewer caregivers in Cohorts 1 and 2 reported difficulty or extreme difficulty compared to those in Cohort 3.

Caregiver Self-Efficacy

For Cohorts 1-3, while we did not directly assess caregiver self-efficacy using a standardized measure, we did ask how often caregivers felt capable in their ability to provide care. Responses were on a 4-point Likert scale ranging from "*never*" to "*all of the time*". This perception of capability is closely related to the concept of self-efficacy, as it reflects a caregiver's confidence in managing care responsibilities and navigating challenges. Across cohorts 1-3, 20% of caregivers reported that they felt capable to provide care "most of the time", with the vast majority of caregivers (66%) indicating that they felt capable "some of the time". These proportions did not change from baseline assessment to follow-up and speak to the need to support and enhance caregivers' skillsets, available resources, and perceptions of capability. Neither confidence in sustaining in-home care nor self-efficacy were evaluated in Cohort 4.

Ability for Care Recipient to Live independently

While we did not directly measure the care recipient's ability to live independently, this outcome is closely related to both the care recipients' and caregivers' reported confidence in sustaining in-home care, which reflects their perceived capacity to maintain and support ongoing independence, respectively.

Caregiver Stress and Burden

In Cohorts 1 through 3, caregivers completed a single global item assessing frequency of stress at baseline and follow-up (*Overall, how often do you feel stressed by providing care*). In Cohort 4, caregivers responded to the 6-item Zarit Burden Inventory (ZBI) to assess the perceived impact of caregiving on the caregiver's life. The ZBI can be scored to indicate a threshold level of stress across respondents. For comparative purposes, program analysts created a ZBI score to reflect whether the caregiver reported feeling stress at both baseline and follow-up. In Cohorts 1 through 4 combined, on

average 28% of caregivers in the initial survey said they felt stressed about caregiving sometimes, quite frequently, or nearly always, compared to 27% in the follow-up survey. This pattern was similar in Cohorts 2, 3, and 4, but Cohort 1 experienced the only increase in this rate, from 21% in the initial survey to 26% in the follow-up survey. It should be noted that the first cohort operated during the height of the COVID-19 pandemic and innovated to provide volunteer assistance safely and remotely.

Program Relevance to both Care Recipient and Caregiver

Although program relevance was not measured across cohorts, it can be argued that this construct is closely related to program satisfaction, as participants are more likely to feel satisfied when a program aligns with their needs.

Program Satisfaction

Program satisfaction was assessed through targeted questions designed to capture participants' overall perceptions of the value and impact of the support they received. Specifically, respondents were asked whether they would recommend the program to others in a similar caregiving situation, which serves as a strong indicator of overall satisfaction and perceived benefit. In addition, participants were asked whether it would be easy or difficult to replace the assistance provided by volunteers. Responses to this question offer insight into the perceived uniqueness or irreplaceability of the support received, further reflecting the program's importance in meeting caregiver needs. Together, these items provide meaningful, though indirect, measures of satisfaction with program services.

Care Recipient Program Satisfaction

In Cohorts 1-3 combined, 97% of care recipients would recommend their volunteer assistance to friends or family members and in Cohorts 1-3, 71% reported it would not be easy to replace the volunteer assistance they received. These questions were not assessed in Cohort 4.

Caregiver Program Satisfaction

As with care recipients, most caregivers reported that they would not be able to find assistance elsewhere were it not for volunteers. Over half of caregivers across all cohorts (56%) believed that replacing volunteer assistance would not be easy. These questions were not assessed in Cohort 4.

Across Cohorts 1-4, 67% of one-time assistance recipients said services alleviated a major concern in their lives.

Care Recipient Social Isolation and Social Connections

In Cohort 4 exclusively, care recipients were asked about their social connections and relationships with friends and relatives. Care recipients completed questions about social isolation from the six-item Lubben Social Network Scale which asks about the number and frequency of social contacts with friends and family members and the perceived social support received from these sources. At baseline, 56% of respondents met the threshold to be considered socially isolated, whereas 54% met this threshold at follow-up representing a slight decline overall.

Key Takeaways

Across Cohorts 1–4, the evaluation of the C3 program highlighted meaningful impacts on care recipients and caregivers, while also identifying areas for improvement in data collection and measurement. Modifications made in Cohort 4 addressed earlier limitations by aligning instruments with validated tools to enhance data quality. Although direct measures of functional status were not used, unmet needs in instrumental activities of daily living (IADLs) served as useful proxies. Notably,

care recipients and caregivers generally reported stability or improvements in physical and mental health, stress, and loneliness, although Cohort 4 lacked some of these assessments. The findings also underscored the program's role in supporting community-based living, with most care recipients indicating that volunteer assistance helped them maintain their current living situation. Companionship was the most common form of assistance volunteers provided, and nearly three-quarters of one-time assistance recipients said volunteer assistance significantly alleviated a major life concern. Additionally, the most common services one-time assistance recipients received from volunteers included chaperoning or transportation assistance for medical appointments.

Caregivers expressed moderate levels of capability in providing care, highlighting the need for further support to enhance their self-efficacy. Program satisfaction was high among both care recipients and caregivers, with most recommending the program and reporting difficulty in replacing volunteer support. While certain measures—such as caregiver burden and social isolation—were only assessed in select cohorts, the findings overall support the research hypotheses that the C3 program contributes to maintained or improved well-being, enhanced social support, and sustained independent living among participants.