New York State
Office of
Children & Family Services

THE NEW YORK STATE CARE COORDINATION PILOT PROJECT

Process & Impact Evaluation Study Findings

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Chapter 1
Introduction

Children who are removed from their homes as a result of child abuse and neglect typically enter the foster care system with multiple health related needs. In an effort to enhance the system's capacity to readily identify and address these needs, the New York State Office of Children and Family Services (OCFS) gave funds to nine local service providers to develop and implement "Care Coordination" programs. Initiated in 2003, these programs sought to improve the health, well-being, and permanency of children living in foster care by designating a particular individual (i.e., a Care Coordinator) or set of individuals to monitor, coordinate, and facilitate all aspects of a child's health care while in foster care. Although specific models and operating procedures varied across the selected sites, each of the sponsored programs strove to promote the comprehensive identification of children's health problems, timely access to necessary programs and services, health education, and improved communication between health professionals, service providers, and families. Long-term goals included reducing time to permanency and pregnancy prevention.

To assess the impact of Care Coordination services on children's health and foster care experiences, a multi-faceted evaluation plan, incorporating both process and impact evaluation activities, was undertaken by the Bureau of Evaluation and Research (BER) and the Bureau of Services Planning within the Office Strategic Planning and Development (SPPD) within OCFS. Intended to provide a working picture of Care Coordination, the multi-site process evaluation gathered comprehensive, descriptive information on all of the Care Coordination programs sponsored by the initiative. Gathered data included the number and type of children served by Care Coordination, and the kinds of health care services both needed and received by program participants. Impact evaluation activities moved beyond implementation issues,and compared the experiences of children who participated in a Care Coordination program to the experiences of children who received traditional foster care services. Designed to complement the process study, the impact evaluation asked whether Care Coordination receipt positively impacted desired outcomes, including: initial assessment receipt, identification of health care needs, service access, communication, permanency, and pregnancy prevention.

Included in this report is an overview of the Care Coordination model and the pilot programs supported by OCFS (Chapter 2). Chapter 3 reviews the evaluation design developed by OCFS to monitor program implementation and evaluate impacts, and lists the main research questions addressed within the process and impact studies. Chapters 4 and 5 focus on the multi-site process evaluation, while Chapters 6 and 7 present the impact evaluation methods and findings. Specifically, Chapter 4 reviews the research methods employed in the process study, and provides in-depth information on data collection and sample selection procedures. Findings from the process study are presented in Chapter 5, with particular attention paid to issues of program fidelity and achievement of state program goals. Chapter 6 reviews the random assignment design used in the impact study and discusses the analytical approach applied to impact analyses. The impact of Care Coordination receipt on service delivery, need identification, communication, and permanency is presented in Chapter 7.

Chapter 8 integrates the findings from the multi-site process evaluation and single-site impact study, and offers some overall conclusions regarding the functioning and effectiveness of Care Coordination. Recommendations for future program and evaluation efforts are also presented.

Chapter 2
The New York State Care Coordination Pilot Project

Children who enter the foster care system as a result of child abuse and neglect are more likely than other children to have a wide array of health care needs and issues. According to the American Academy of Pediatrics (AAP)[1], children who enter foster care have higher rates of birth defect, developmental delay, and physical disability than children from similar socio-economic backgrounds. They are also more likely to suffer from serious emotional, mental health, and behavioral problems. Add complex, and often over-burdened, child welfare and state Medicaid systems into the mix, and effectively meeting the health care needs of children residing in foster care can become a serious challenge.

The AAP and The Child Welfare League of America (CWLA) recommend that child welfare agencies address these issues by adopting a "Care Coordination" approach to the assessment, treatment, and follow-up of children residing in foster care. Although specific program models vary, a central component of all programs adopting a Care Coordination approach to service delivery is that a single individual (i.e., Care Coordinator) or team of individuals (i.e., Care Coordination Team) be given primary responsibility for managing all aspects of a child's health related needs. For children entering or residing in foster care, tasks assigned to the Care Coordinator typically involve: information gathering, accessing and coordinating service delivery efforts, facilitating communication between treatment providers, and educating parents and foster parents about a child's needs and services. A Care Coordinator works with other members of a child's service team to arrange a comprehensive assessment of the child's needs and issues, locate appropriate service providers, and establish an integrated system of care.

Providing children with a Care Coordinator is presumed to produce both short and long-term benefits. Unlike a foster care caseworker who must address all aspects of a family's child welfare services case, a Care Coordinator's primary responsibility is to manage a child's health related needs and issues. A Care Coordinator, therefore, has more time to devote to acquiring the expertise needed to arrange and monitor access to health and health education services, presumably increasing the likelihood that a child's health-related issues will be identified and appropriately treated. Regular, repeated contact with treatment providers may also facilitate the establishment of strong working relationships between a Care Coordinator and local health care professionals, potentially facilitating a Care Coordinator's ability to access services in a timely fashion. Thus, anticipated short-term benefits of Care Coordination receipt include:

- An increased likelihood that a child will receive a full array of comprehensive health- related assessments at foster care intake;
- Better identification and documentation of health care needs;
- More timely access to health care and service providers; and
- Increased education of and communication between biological parents, foster parents, and service providers regarding a child's health needs and services.

[1] Committee on Early Childhood, Adoption, and Dependent Care (2002). Health care of young children in foster care. *Pediatrics*, 109 (3), 536-541.

In turn, these short-term benefits are believed to improve the overall health and well-being of children receiving Care Coordination services, and may in the long run promote permanency. Assuming that children who are well connected to an integrated system of care are more likely to have their health and mental health needs met, receipt of Care Coordination services may reduce demands placed on substitute caregivers, thereby reducing changes in foster care placement. Likewise, efforts to educate biological parents/caregivers about a child's health needs and involve family members in the child's health care may also help to prepare parents to safely and effectively care for their child at home, thereby reducing time in foster care. In addition, increased access to health education, reproductive services (e.g., family planning, gynecological care, etc), and mental health and/or substance abuse services may also help to reduce the likelihood that children in foster care will engage in risky behavior and become teenage parents.

The NYS Care Coordination Pilot Project

As part of its on-going efforts to increase the availability and quality of the state's children and family services programs, OCFS initially funded and oversaw the development of nine Care Coordination programs located across the state (see Table 1). Funded agencies were selected based upon two primary factors: 1) readiness, and 2) need. The diversity of program sites was also important to state developers, resulting in the selection of both up and downstate agencies and a wide range of foster care populations. Contracts began in State Fiscal Year 2002-2003 and, with one exception, have been renewed each year. Due to implementation difficulties, program operations at the Jewish Board of Children and Family Services (JBFCS) were not funded after SFY 2002-2003.

Funds for the NYS Care Coordination Pilot Project were drawn from the OCFS-administered Quality Enhancement Fund (QEF), which uses TANF dollars to support the development and evaluation of innovative child welfare services aimed at promoting a family's ability to safely care for children in their own homes and preventing teen pregnancy.

Table 1
Programs Participating in the NYS OCFS Care Coordination Pilot Project

AGENCY	ANNUAL CONTRACT AMOUNT*	REGION SERVED	LEVEL OF CARE	STAFF
Abbott House	$196,000	NYC	Foster Boarding Home Hard To Place	3 BA @ FTE 1 LPN @ FTE 1 RN @ .5 FTE
Catholic Guardian Society	$130,000	NYC	Foster Boarding Home Mother/Baby Group Home	2 MSW @ .6 FTE 1 RN @ FTE 1 RN @ .5 FTE
Children & Adolescent Treatment Services	$150,000	Erie County	Foster Boarding Home	2 BA @FTE 1 MA @ FTE 1 Support Staff @ .8FTE
Episcopal Social Services	$100,000	NYC	Foster Boarding Home	2 MPH @ FTE

AGENCY	ANNUAL CONTRACT AMOUNT*	REGION SERVED	LEVEL OF CARE	STAFF
Green Chimneys	$85,000	NYC, Lower Hudson Valley	Institution	1 BA @ FTE
House of the Good Shephard	$125,000	Oneida County and surrounding area	Therapeutic Foster Boarding Home, Institution	1 MA @FTE 1 MSW @ FTE
Jewish Board of Family and Children's Services	$155,000	NYC	Institution	-
Kinship Family and Children Services	$82,000	Southern Tier	Therapeutic Foster Boarding Home	1 RN @ FTE 1 MS @ FTE
St. Vincent's Services, Inc	$150,000	NYC	Foster Boarding Home	1 BA @FTE 1 RN @ FTE 1 Support Staff @ FTE

*With the exception of JBFCS, amounts listed reflect funding levels for the 2003-2004 appropriation year. JBFCS no longer has an active contract; amount listed reflects funding given in the 2002-2003 State Fiscal Year, the last year of that program's operation.

Program Structure

To help promote the development of programs that were responsive to local needs and issues, state developers provided technical assistance to encourage sponsored agencies to develop the service delivery model best suited to their target population, staffing resources, and existing operational structure. Thus, as depicted in Table 1, programs differed in the level of foster care served and the qualifications set for the Care Coordination staff.

Although each Care Coordination program served children placed into foster care as a result of child abuse and neglect, the level of foster care targeted by participating sites ranged from regular foster boarding homes to institutional settings. The qualifications of Care Coordinators also differed across sites. As shown in the column labeled "Staff", the qualifications set by the individual agencies for their Care Coordination staff included: Registered Nurse (RN), Licensed Practical Nurse (LPN), Bachelor of Arts (BA), Master of Arts (MA), Master of Science (MS), Master of Social Work (MSW), and Master of Public Health (MPH). The Care Coordinators at Episcopal Social Services were foreign-licensed physicians in the process of obtaining licensure in the United States.

Responsibilities of Care Coordination Staff

Despite these differences in program structure, the day-to-day functions of the Care Coordinator were expected to be highly similar across pilot sites. In all of the programs, Care Coordination staff were expected to work with the caseworker assigned to the child's family by the local social service agency, and to assume primary responsibility for managing all aspects of the child's health care. Activities deemed to fall under the general purview of Care Coordinator staff included:

- Collecting information on a child/family's health history from primary caregivers;
- Establishing and maintaining a comprehensive and up-to-date medical file;
- Obtaining written consent from biological parents for routine medical treatment as well as specialty care;
- Scheduling and overseeing the completion of medical, dental, developmental, mental health, and substance abuse assessments at foster care intake and obtaining any necessary and appropriate follow-up evaluations;
- Establishing service relationships and coordinating and monitoring on-going therapeutic services;
- Communicating the results of initial assessments and on-going health care treatment with the child's primary care provider, case manager, and other relevant service professionals;
- Educating the child, biological parents/caregivers, and foster family about a child's health needs and issues;
- Coordinating treatment planning meetings with child, parents/caregivers, family members, and all potential service providers;
- Facilitating the development and incorporation of health-related goals in the child's treatment plan;
- Arranging for and/or providing age appropriate pregnancy prevention educational classes;
- Compiling health, mental health, developmental, and substance abuse information for use by agency personnel in routine court hearings;
- Communicating with schools regarding the health and developmental needs of children; and
- Establishing a medical home for children preparing to exit foster care.

Summary

The NYS OCFS currently funds and oversees eight Care Coordination programs aimed at improving the health, well-being and permanency of children in residing in foster care. Each program adheres to a general mode of Care Coordination in which a single individual or team of individuals assumes primary responsibility for managing all aspects of a child's health care while in foster care. Key Care Coordinator activities include: collecting and updating health information, accessing and coordinating health services, health education, and facilitating communication between families and health care professionals.

Chapter 3
Evaluation Design

To document the process, outcomes, and impacts associated with the receipt of Care Coordination, OCFS devised and implemented a multi-faceted evaluation plan. Included in the evaluation design were two primary elements: 1) a multi-site process study, and 2) a random assignment impact study. The following chapter summarizes the research design utilized in each component and lists the specific research questions addressed by the selected design.

A. The Multi-Site Process Evaluation

By monitoring program performance in key areas over time, process studies provide insight into program functioning and can be used to assess the extent to which program activities and outcomes are consistent with stated program goals. A process evaluation considers whether the program being evaluated was implemented as intended. Are program participants drawn from the targeted population? Are program services and activities consistent with the program model? Process evaluations can also be used to monitor program progress and likely effectiveness. Are programs achieving desired levels of service provision? How many program participants achieve intended program goals?

To answer these questions, a multi-site process evaluation was initiated alongside program implementation efforts. Designed to gather comprehensive, descriptive information on each of the Care Coordination programs sponsored by the pilot project, the study collected information on both program fidelity (participant characteristics, Care Coordination activities) and intended outcomes (initial assessments, health care services). Specific questions addressed by the process study included:

Participant Characteristics

- What were the characteristics of Care Coordination participants?
- What were the health care needs of Care Coordination participants? Are the children who receive Care Coordination services well matched to the intervention chosen?

Care Coordination Activities

- What types of services do Care Coordinators provide? Are these services consistent with Care Coordination model?
- What types of changes were made to participating agencies' service delivery systems following the development and implementation of Care Coordination?

Initial Assessments

- What percentage of Care Coordination recipients received initial assessments?
- What percentage of Care Coordination recipients received initial assessments within state recommended time frames?
- Did the provision of initial assessment services improve over time?

Health Care Services

- How successful were Care Coordinators in linking program participants to needed health care services?
- What percentage of Care Coordination recipients received pregnancy prevention education?
- What percentage of Care Coordination recipients received other health education services?

B. Impact Evaluation

While process studies are useful for monitoring program implementation and progress toward stated goals, impact studies provide insight into whether program involvement benefits participants. Random assignment designs are generally considered to be the "gold standard" of scientific research. In the classic random assignment study design, study participants are drawn from the pool of eligible program participants and randomly placed into either a "treatment" or "control" group. Individuals assigned to the treatment group receive a program or service not offered to members of the control group, and the functioning of both groups is then compared over time. Because the decision to place a given individual into either the treatment or control group is randomly decided, the two groups should be initially equivalent at study intake. The formation of initially equivalent groups is important, in that it allows the researcher to make causal statements about the effects of the selected treatment on targeted participants. If individuals in both groups are similar on key areas at study intake, any differences that emerge between the treatment and control group over time can be attributed to the treatment received.

A two-site random assignment experimental design, like the one described above, was therefore developed to examine the impact of Care Coordination receipt on children's health and foster care experiences. Areas targeted for examination centered around key program goals, including: initial assessment receipt, the identification of health care needs, access to health care programs and services, communication, and use of foster care services. The specific questions asked within each of these areas are listed below.

Initial Assessments

- Are children who receive Care Coordination services at intake into foster care more likely than other children entering foster care to receive state-recommended initial assessments?
- Are children who receive Care Coordination services at intake into foster care more likely than other children to have their initial assessments completed within recommended time frames?
- Is the wait-period between placement and initial assessment shorter for children who receive Care Coordination services than those not receiving Care Coordination?

Identification of Health Care Needs

- Are children who receive Care Coordination services more likely than those not receiving Care Coordination to be identified as having a health-related need?
- Do children who receive Care Coordination services have a greater number of health problems detected than those not receiving Care Coordination?

Health Care Services

- Are children who receive Care Coordination services more likely than other children residing in foster care to gain access to health care services?
- Do children who receive Care Coordination services receive more preventative care than other children residing in foster care?
- Are children who receive Care Coordination services more likely than other children residing in foster care to gain access to age-appropriate pregnancy prevention services? To other forms of health education?

Communication

- Does receipt of Care Coordination services increase the number of health-related communications that take place between the foster care agency and parents/caregivers? And foster parents? And service providers?

Permanency

- Do children who receive Care Coordination services experience fewer foster care moves than children who receive traditional foster care services?
- Do children who receive Care Coordination services spend less time in foster care than those not receiving Care Coordination?
- Are children who receive Care Coordination services more likely than children without services to exit foster care within the 18-months following study intake? Are children receiving Care Coordination services more likely than others to leave foster care for home? Adoption?

C. Chapter Summary

To examine the implementation and effectiveness of the NYS Care Coordination Pilot Project, a comprehensive evaluation plan, incorporating both process and impact evaluation activities, was developed. Process evaluation activities were implemented at each of the sponsored Care Coordination program sites, and were intended to provide a comprehensive picture of how Care Coordination was implemented and functioning Statewide. Impact evaluation activities were limited to two of the nine original Care Coordination sites, and were designed to address issues pertaining to program effectiveness.

Chapter 4
Process Study: Methodology

Process evaluation activities were implemented alongside program development efforts at each of the nine sponsored Care Coordination sites. Information on how data was collected across programs and the criteria used to identify process study participants are presented below.

A. Data Collection Procedures

All agencies participating in the NYS Care Coordination Pilot Project were required to maintain a services-related database. Databases contained information on each child who participated in the host agency's Care Coordination program and were designed to track both health care needs and service delivery efforts throughout a child's receipt of Care Coordination. Information on physical, dental, and mental health needs and services was gathered, along with information on developmental, educational, and substance abuse-related issues. The types of activities carried out by Care Coordination staff on behalf of the targeted child was also documented by having staff complete a checklist of service activities done for each child each week.

To improve the quality and accuracy of the process evaluation databases, agencies were trained on how to use the database system and given a codebook that defined the types of activities subsumed under each of the general database categories. Ongoing training and monitoring procedures were also implemented. Agencies submitted a copy of their program database to OCFS each month, and BER staff reviewed the submissions for missing and/or inconsistent data entries. Agencies were then provided with a written report summarizing potential data errors and asked to check the accuracy of their entries prior to their next submission.

Information on program activities and service models was also gathered from agencies' progress reports and routine site visits made by OCFS staff. Recognizing that program implementation was likely to influence agency activities and culture in ways not readily captured by the evaluation database, OCFS staff asked each Care Coordination program to provide written descriptions of the changes made to their service delivery model following program implementation. Routine site visits and conversations with Care Coordination staff, were also useful tools for documenting system-based changes.

B. Sample Selection

Information for the process evaluation was gathered over a three-year period, beginning in February 2003, when Children and Adolescent Treatment Services (CATS) in Erie County enrolled its first program participant, and ending approximately three years later in March 2006. A total of 1,113 children received Care Coordination services during this time period (see Table 2).

As indicated in Table 2, start dates and enrollment procedures varied across sites. While the Kinship Family and Youth Services program was able to provide Care Coordination services to all children residing in its therapeutic foster boarding home program, limited resources necessitated that other sites enroll a sub-sample of their targeted foster care population. As a result, participant selection at most sites was need-based, with program staff choosing to enroll

those children deemed most likely to benefit from Care Coordination services. At Abbott House and CATS, the two programs selected for the impact evaluation, random assignment procedures were initially used to place eligible children into either a control group or a Care Coordination treatment group. However, once the desired sample size for each site was obtained, agency staff adopted the need-based criteria used in other sites and selected the children who would receive Care Coordination services.

Table 2
Care Coordination Participation by Agency: February 2003- March 2006

AGENCY	DATE OF 1ST INTAKE	PARTICIPANT SELECTION CRITERIA	TOTAL # CHILDREN SERVED	# PARTICIPANTS IN CC FOR 45 DAYS OR MORE	% FINAL PROCESS STUDY SAMPLE
Abbott House	March 24, 2003	Random Assignment, Need	155	135	15%
Catholic Guardian Society	April 1, 2003	Need	131	123	14%
Children & Adolescent Treatment Services	February 10, 2003	Random Assignment, Need	262	200	23%
Episcopal Social Services	July 1, 2003	Need	49	48	5%
Green Chimneys	April 5, 2004	Need	41	40	5%
House of the Good Shepard	May 1, 2003	Need	151	143	16%
Jewish Board of Family & Children's Services	August 22, 2003	Need	116	N/A	0%
Kinship Family and Children Services	March 24, 2003	All	108	99	11%
St. Vincent's Services, Inc	July 1, 2003	Need	100	94	11%
Total	N/A	N/A	1113	882	100%

Once enrolled, children remained in Care Coordination until they no longer met the programs' eligibility requirements. Children were discharged from Care Coordination when they left the foster care program targeted by the sponsored agency for any reason (e.g., returned home, transferred to a different level of foster care, adopted, etc) or when they exceeded the age limit placed on program services by the TANF funds used to support program development efforts. As

shown in Table 2, approximately 79%, or 882 children, had received a minimum of 45 days of Care Coordination by the end of the process study period.

As it is recommended that agencies complete initial assessments within the first 45 days of placement into foster care, a decision was made to limit process study participation to only those children who met this 45-day milestone. Children served by the JBFCS were also excluded. As noted in Chapter 2, the Care Coordination program at JBFCS was not funded beyond year one due to implementation difficulties. Database information on the children served by JBFCS during this period was sparse, and therefore not useable. Thus, as shown Table 2, process study analyses were limited to a sub-sample of 882 children who received a minimum of 45 days of Care Coordination services between February 2003 and March 2006.

Chapter 5
Process Study: Findings

As noted in Chapter 2, sponsored sites were given considerable flexibility when designing and implementing their Care Coordination programs. To help state developers monitor local implementation efforts and assess issues related to program fidelity and performance, a multi-site process evaluation was undertaken. The key areas examined in the process study and the findings associated with each are discussed below.

A. Program Participants

1. *What were the characteristics of Care Coordination participants?*

As indicated in Table 3, the final process study sample was composed of a diverse group of children who received foster care services. A little over half (52%) of the children served by Care Coordination programs during the study period were male. Most were minorities, with African-Americans making up 48% and Hispanics 16% of the process study sample. Sample children also tended to be of preschool age or older—81% were three or older at time of entry into Care Coordination. The majority (79%) of the children served resided in a foster boarding home-- either regular (51%), kinship (12%), or therapeutic (16%)-- when assigned to Care Coordination.

Sample children also differed in admission status and length of program stay. Slightly more than half (52%) of the children served by Care Coordination were "Under Care" children, meaning that they had been in out-of-home care for 46 days or more when they began receiving Care Coordination services. The remaining children were "New Admissions" to both foster care and Care Coordination services. For these children, enrollment in Care Coordination occurred within 45 days of their placement into foster care.

Once enrolled in Care Coordination services, the majority of sample children remained in the program for an extended period of time. Approximately two-thirds of sample children received over six months of Care Coordination services during the study period selected.

Table 3
Participant Characteristics: Process Study Sample

Characteristic	Percent (Sample Size =882)
Sex	
Male	52%
Female	48%
Race/Ethnicity	
White, Non-Hispanic	30%
Black, Non-Hispanic	48%
Hispanic	16%
Other	6%

Age at Entry into Care Coordination	
0-2 years	19%
3-9 years	29%
10^{+} years	52%
Placement Level At Entry into Care Coordination	
Approved Relative Home	12%
Foster Boarding Home	51%
Therapeutic Foster Boarding Home	16%
Group Home	9%
Institutional Placement	12%
Admission Status at Entry into Care Coordination	
Under Care	52%
New Admission	48%
Length of Stay in Care Coordination Program	
Less than 6 months	31%
6 to 12 Months	21%
12 to 18 Months	18%
18 Months or longer	30%

2. *What were the health care needs of Care Coordination participants? Are the children who receive Care Coordination services well matched to the intervention chosen?*

A key issue to be addressed in any process evaluation is the extent to which the individuals enrolled in the program match the characteristics of the population the program was intended to serve. A central premise behind the provision of Care Coordination services is that permanency-related efforts are often complicated and/or impeded by the myriad of health-related problems and issues faced by children who reside in foster care. Care Coordinators are therefore necessary to help manage and address these needs.

To examine whether the children served by the NYS Care Coordination Pilot Project had multiple health needs, information on the number and type of health care problems faced by each Care Coordination participant was extracted from agency databases. As depicted in Table 4, 95% of the children served by Care Coordination programs had a at least one health-related problem, and over three-quarters (77%) experienced difficulties in multiple health-related domains. Medical problems were most common, with 80% of sample participants experiencing physical problems such as allergies (19%), asthma (17%), visual impairments (20%), ear/nose/throat issues (16%), and dermatological problems (21%). Similarly, mental health problems were noted in 70% of participants. Commonly applied diagnoses included: attention deficient/hyperactivity disorder (21%), depression (9%), post-traumatic-stress-disorder (9%), and oppositional defiant disorder (10%). Developmental and/or education-related concerns rounded out the top three issue areas, and were raised for 48% of sample children. Commonly cited developmental/educational concerns included: speech/language problems (16%), learning disabilities (6%) and fine and/or gross motor delays (6%).

In addition, just under a third of all children receiving Care Coordination services (31%) were identified as having dental problems or issues. Tooth decay was the most common dental ailment (20%), followed by orthodontic needs (5%) and abscess/infection (3%).

Substance abuse problems were recognized least often, with only 8% of Care Coordination participants identified as abusing alcohol, tobacco, or other drugs. This percentage was slightly higher (14%) when only children over the age of 10 were considered.

Table 4
Health-related Problems Among Children Receiving Care Coordination Services

Health Problems	
Experienced at least one…	
Medical Problem	80%
Dental Problem	31%
Mental Health Problem	70%
Developmental/Educational Problem	48%
Substance Abuse Problem	8%
Health Problem of Any Type	95%
Number of Health Domains Affected	
0	5%
1	17%
2	32%
3	29%
4	15%
5	2%
Total	100%

B. Care Coordination Activities

One of the most important tasks of any process evaluation is to monitor program fidelity. Although program developers generally have a specific set of program activities in mind when developing new services, actual program services often differ from the envisioned model. Real world constraints such as limited resources, inadequate training, and high staff turn-over can all interfere with program implementation efforts, shifting program services and activities away from intended models of functioning. It is therefore important to monitor key program activities and services, in order to determine whether the program being evaluated represents a legitimate test of the service model developed.

As noted in Chapter 2, certain activities are central to the Care Coordination model. While programs may differ in staffing and structure, all Care Coordinators are expected to engage in activities aimed at improving the documentation, access, communication, educational, and advocacy practices that surround a child's health care experiences. The extent to which the Care Coordinators at each of the sponsored sites met these expectations was monitored by having each Care Coordinator complete a weekly activity checklist for each child on his/her caseload.

1. *What types of services do Care Coordinators provide? Are these services consistent with Care Coordination model?*

Consistent with stated service goals, activity records indicate that the vast majority of Care Coordination recipients received services within each of the service areas emphasized in the Care Coordination model (see Table 5).

In the majority of their New Admission cases, Care Coordinators reported engaging in activities intended to improve institutional records and understanding of children's health-related needs. These activities included documenting the child's health history (90%) by obtaining release of information consents from parents/caregivers, gathering information on the child's health history from caregivers and previous treatment providers, and obtaining immunization records. Care Coordinators also frequently assumed responsibility for creating and/or updating a child's health record (87%). In 86% of New Admission cases, Care Coordinators also arranged for the child's initial assessments, identified a medical home for the child, and/or linked the child to health education services. Under Care children received services aimed at documenting health history (73%), updating medical files (71%), and arranging health assessments (66%) less often than children newly admitted into foster care. These discrepancies are likely the result of the difference in the timing of their foster care entry. By definition the Under Care children included in the study sample had been in foster care for at least 46 days at Care Coordination intake, thus many of these initial activities might have been completed by the time these children entered Care Coordination.

Table 5
Responsibilities and Activities Carried Out By Care Coordinators

Care Coordinator Activity	% Children Receiving Service		
	New Admission	Under Care	Total
Documentation of Health History	90%	73%	81%
Establish/Maintenance of Medical File	87%	71%	78%
Arrange Assessments/Health Education Services	86%	66%	75%
Access and Coordination of Health Care Services	94%	87%	90%
Development/Monitoring of Treatment Goals and Plans	89%	86%	87%
Information Gathering and Sharing	97%	91%	93%
Family/Child Education and Advocacy	91%	87%	88%

Activities pertaining to the coordination of on-going health care services, treatment planning, and education/advocacy occurred in the vast majority of both New Admission and Under Care cases. Care Coordinators monitored children's use of preventative and other needed health care services in 90% of all cases, and worked with service providers to develop and evaluate treatment plan goals for 87% of the children served. Information sharing activities occurred in 93% of all cases and included discussing health care needs and findings with biological families/caregivers, foster parents, and/or other health care providers. Finally, in 88% of cases, Care Coordinators reported educating children, parents/caregivers and foster parents about a child's health-related issues and/or acting as an advocate for the child's needs, rights and preferences.

2. *What types of changes were made to participating agencies' service delivery systems following the development and implementation of Care Coordination?*

In addition to influencing the types of services provided to individual participants, implementation of the new Care Coordination function resulted in a variety of systems-based changes within each participating agency designed to support the early detection and treatment of children's health care needs.

According to program progress reports, many agencies enhanced their intake and assessment process to better comply with expectations set by the pilot program. For example, CATS initiated a new process for obtaining early mental health evaluations and began 30-day re-checks to provide another opportunity to identify unmet needs. House of the Good Shepherd also focused on developmental assessments and worked to develop mechanisms for gaining a richer and more comprehensive understanding of the individual child and family dynamics and needs. They created a strengths-based approach that considers "What happened to this child?" rather than "What's wrong with this child?" The Care Coordinator at St. Vincent's began scheduling "dental dates" to get recalcitrant adolescents to participate in their dental appointments.

The receipt of Care Coordination funds also prompted agencies to carefully scrutinize and modify their existing delivery model for health services. Following the development of its Care Coordination program, Green Chimneys began a capital improvement project to expand and modernize its health center facility. When completed, the facility will support a greatly enhanced staff, provide dedicated space for crisis management, and improve the agency's ability to contain illness outbreaks on campus. Similarly, ongoing communication problems with treatment providers and non-compliance with appointments, despite enormous efforts by the Care Coordinators, prompted Abbott House to establish an on-site medical clinic in January 2006. According to agency staff, this change has resulted in remarkable improvement in foster parents' compliance with medical appointments and has given staff immediate access to documentation of the children's physical health status.

Care Coordinators have engaged the provider network at several agencies, resulting in improved communication with health and mental health providers, developmental and special education services, pediatric sub-specialties, and a formalized agreement with a local Planned Parenthood. One administrator noted the Care Coordinator's "unparalleled success in opening the lines of communication between the agency and our outside contractor for substance abuse and children

of abusers services". Three agencies developed new forms for better documentation. This includes a comprehensive, portable Child Health Profile, used at CATS.

Finally, the emphasis placed on family engagement by OCFS and the pilot project has prompted agencies to develop specific strategies for working with biological parents. Kinship Family and Youth Services now formally tracks the attendance of biological parents at children's appointments. The Care Coordinator at Episcopal Social Services assists biological and foster families in working together to make choices and informed decisions about the child's care. Green Chimneys developed a parents group that evaluates and advises the agency and provides peer support. At Abbott House, on site clinic appointments are scheduled to occur during agency-supervised visits to help encourage parents to become involved in their child's health care. At Catholic Guardian Society's mother/child group homes, the Care Coordinator offers both formal and informal workshops to teen parents to help them develop good parenting skills.

C. Initial Assessments

OCFS recommends that all children who receive foster care services also receive a series of initial assessments within the first 30 to 45 days of their entry into foster care. The assessments cover five general areas (physical, dental, mental health, developmental, and substance abuse) and are intended to serve as indicators of a child's current functioning and potential health-related needs. Depending upon the child's age at placement into care, up to five initial assessments are recommended (see Table 6).

Table 6
State Recommended Initial Assessments

Initial Assessment	Guidelines
Physical	Mandated for all children within 30 days of placement
Developmental	Mandated for all children, 45 day time frame recommended
Dental	Mandated for children 3 years and older within 30 days
Mental Health	Mandated for children 3 years and older, 30-day time frame recommended
Substance Abuse	Recommended for children 10 years and older within a 45-day time frame

A central goal of the Care Coordination Pilot Project is to maximize the number of children receiving initial assessments within the state recommended timeframes. To examine programs' progress toward achieving this goal, the percentage of age-eligible children receiving each assessment was documented.

1. *What percentage of Care Coordination participants received initial assessments?*

As depicted in Table 7, children who received Care Coordination services at intake into foster care had a high rate of initial assessment completion. Medical assessments occurred most often,

with 94% of New Admissions receiving a physical and 86% receiving a routine dental examination. Developmental, mental health, and substance abuse assessments were also completed for at least 80% of all age-eligible New Admission children.

Table 7
Initial Assessment Completion Rates for Age Eligible, New Admission Children

Initial Assessment	# of Age Eligible Children	% Complete
Physical	424	93%
Developmental	424	81%
Dental	305	86%
Mental Health	305	84%
Substance Abuse	167	81%

Unlike New Admission children for whom the Care Coordination intake and initial assessment period overlap, children in the Under Care group should have received their initial assessments prior to Care Coordination intake. However, as illustrated in Table 8, 14% to 25% of children who had been in foster care for at least 46 days before entering Care Coordination had an initial assessment completed after Care Coordination intake. While it is possible that some of these assessments were scheduled prior to the child's admission to Care Coordination, program practices suggest that Care Coordinators were instrumental in getting these assessments completed. If a child had not received all of the assessments for which he/she was age-eligible at foster care intake, his/her Care Coordinator was expected to obtain the missing assessment upon the child's entry into Care Coordination. Thus, in addition to promoting high rates of initial assessment receipt among New Admissions to foster care, Care Coordination may also help to address gaps in service delivery for children already in care.

Table 8
Under Care Children Receiving Initial Assessments Post-Care Coordination Intake

Initial Assessment	# Age Eligible Children	% Completed Post-Care Coordination Intake
Physical	458	14%
Developmental	458	20%
Dental	405	25%
Mental Health	405	17%
Substance Abuse	289	24%

2. *What percentage of Care Coordination recipients received initial assessments within state recommended time frames?*

In addition to maximizing the number of children who receive recommended assessments, state sponsors also hoped to increase the number of children receiving these assessments in a timely manner. To examine this question, the percentage of children receiving an initial assessment within the number of days recommended by the state (see Table 6) was calculated for two distinct groups of Care Coordination participants: a) New Admissions and b) Under Care

children served by the sponsored agency within the first 45 days of their entry into foster care. Under Care children served by other agencies at intake into foster care were excluded. Comparing the timeliness of initial assessment receipt across the two groups should provide insight into the potential impact of Care Coordination services on initial assessment receipt. Both groups of children were served by the same agency at intake into foster care, with one key difference. Children in the New Admissions group entered both Care Coordination and the agency's foster care program at the same time. Conversely, the sub-sample of Under Care children selected entered the sponsored agency's foster care program within the first 45 days of their placement into care, but before Care Coordination services were available. Thus, the Under Care group selected serves as a sort of historical comparison group, allowing us to compare the agency's ability to obtain timely initial assessments for new entrants into foster care before and after the implementation of their Care Coordination program.

As shown in Table 9, for each of the five assessment areas the percentage of New Admission children receiving their initial assessment within state recommended timeframes was significantly higher than the percentage of Under Care children assessed on time. While 79% of New Admissions had a physical assessment completed on time, only 54% of Under Care children had a physical within 30 days of placement. The percentage of New Admissions with timely dental exams (36%) was double that of the Under Cares (18%); and differences of nearly 30% were found between New Admission and Under Cares in the timely completion of both developmental (66% vs. 37%) and substance abuse (68% vs. 42%) assessments. Mental health assessments showed the smallest gain, with 46% of New Admission and 36% of Under Cares receiving an assessment within 30 days.

Thus, while 100% completion and timeliness rates for all initial assessments would obviously be ideal, findings indicate that Care Coordination receipt positively impacted the number of children receiving initial assessments on time.

Table 9
Percentage of Children With Initial Assessments Done "On Time"

Initial Assessment	% Completed Assessments Done "On Time"	
	New Admission	**Under Care**
Physical***	**79%**	**54%**
Developmental***	**66%**	**37%**
Dental***	**36%**	**18%**
Mental Health**	**46%**	**36%**
Substance Abuse***	**68%**	**42%**

**Group difference significant at the $p < .01$ level.
*** Group difference significant at the $p < .001$ level.

3. *Has the provision of initial assessment services improved over time?*

Finally, operating under the assumption that it takes time to develop and fully implement effective service delivery strategies, we compared rates of initial assessment receipt and timeliness over the life span of the programs studied. As noted earlier, process data were

collected for a period of three years, allowing us to divide our New Admission children into two categories: those who entered Care Coordination services within the first year of their program's implementation, and those who entered Care Coordination after the program had passed its one year anniversary. As shown in Table 10, significantly more physical, dental, and substance abuse assessments were completed on time in Years 2-3 than in Year 1. The percentage of developmental assessments completed on time was also higher; however, this increase only approached statistically significance. This pattern of results suggests that, with the exception of mental health, Care Coordination teams have improved their ability to link children to necessary assessment providers.

Table 10
Percentage of Initial Assessments Done "On Time" by Care Coordination Year

Initial Assessment	% Completed Assessments Done "On Time"	
	Year 1	**Years 2-3**
Physical[+]	**74%**	**82%**
Developmental	62%	69%
Dental[*]	**28%**	**41%**
Mental Health	48%	45%
Substance Abuse[+]	**60%**	**74%**

[+]Group difference significant at the $p < .10$ level.
*Group difference significant at the $p < .05$ level.

D. Receipt of Health Care Services

Increasing access to needed health care, health education, and pregnancy prevention services are also stated goals of Care Coordination. We therefore examined children's need for and receipt of health-related services in seven key areas: medical, dental, mental health, developmental/ educational, substance abuse, general health education, and pregnancy prevention. To provide an overall picture of the types of services accessed by children receiving Care Coordination we calculated the percentage of children who received at least one needed service within each general service category during their stay in the Care Coordination program. We also considered the extent to which levels of service receipt were consistent with identified service needs. If a member of the Care Coordination team attempted to access a specific kind of service for a given child, but the child never received the sought after service within the study timeframe, the child was classified as having an "unmet" service need.

1. *How successful were Care Coordinators in linking program participants to needed health care services?*

As illustrated in Table 11, Care Coordinators were generally successful in linking program children to needed health care services. The majority of children who needed preventive medical care received services, with 94% of those in need receiving well childcare and 86% receiving routine dental services. Approximately 60% of those who did not receive well childcare were waiting for an appointment or on a provider wait-list; an additional 14% were listed as refusing services. Reasons given for not receiving routine dental care were similar, with 77% of those without routine dental services waiting for an appointment or on a provider wait-list and 31%

refusing services. Percentages exceed 100% as some children waited for and then refused dental services, or initially refused services and were then placed on a wait-list by their Care Coordinator.

Table 11
Percentage of Children with Met and Unmet Health Services Needs

Service Area	**% Total Sample Needing Service**	**Children with Identified Needs**	
		% Need Met	**% Need Unmet**
Medical			
Well Child Care	72%	94%	6%
Primary Care	47%	97%	3%
Specialist Care	40%	91%	9%
Dental			
Routine Preventive	65%	86%	14%
Acute	21%	82%	18%
Mental Health			
Medication Management	37%	93%	7%
Individual Therapy	60%	90%	10%
Group Therapy	16%	93%	7%
Family Therapy	23%	93%	7%
Developmental/Education			
Early Intervention (includes only children 3 or younger at intake)	31%	91%	9%
Therapeutic Pre-School (includes only children 5 or younger at intake)	14%	88%	12%
Rehabilitative Services (e.g., speech, physical or occupational therapy)	19%	86%	14%
Substance Abuse			
Therapy (individual, group, or family)	7%	83%	17%

Access rates for non-preventive care were slightly lower, particularly when specialist care was needed. Approximately 9% of children referred to a medical specialist did not receive specialist care during the study period. Likewise, nearly a fifth of children (18%) with acute dental needs never received non-preventive dental treatment. Again, wait periods for service intake (61%) and refusal (26%) were common reasons for the failure to receive acute dental services.

In the mental health arena, slightly more than half of the study sample (60%) was referred for individual therapy, and the majority of those referred received therapeutic services (90%). Reasons for not receiving recommended individual therapy included: awaiting intake/on a provider wait-list (57%), refusal (37%), and lack of an available and appropriate service provider (9%). Although the overall need for family and group therapy was considerably lower (23% and 16% respectively), access to these services was also high. Over 90% of those needing family and/or group therapy received services.

Compared to other monitored health areas, need for developmental/educational services was relatively modest. Early Intervention services were identified as a need most often, with Care Coordinators seeking to access such services for approximately 31% of those 3 years old or younger at program intake. Other types of intervention programs and services (e.g., therapeutic preschool, speech therapy, etc) were sought for less than a fifth of Care Coordination participants. Gaining access to these types of services, however, was sometimes problematic. Nearly 12% of those identified as needing therapeutic preschool services did not attend a program and 9% of children needing Early Intervention services were not served during the study period. Likewise, about 14% of children referred for rehabilitative services (e.g., speech, physical therapy, occupational therapy) did not receive the services sought. Reasons for not receiving rehabilitative services included: awaiting intake/on a provider wait-list (56%), refusal (13%), and lack of an available and appropriate service provider (22%).

Identified need for substance abuse services was extremely low. Care Coordinators sought therapeutic substance abuse services for 7% of the sample population, and were successful in getting 83% of children to attend appointments with a treatment provider.

2. *What percentage of Care Coordination recipients received pregnancy prevention education?*

As noted in Chapter 2, TANF dollars were used to fund Care Coordination programs. Programs were therefore expected to target pregnancy prevention, as the reduction of teen pregnancy is a primary goal of the TANF program. Table 12 lists the percentage of Care Coordination participants who received pregnancy prevention services during the process study period. Overall, services were sought for 42% of the process sample, with 36% of the entire sample receiving services on at least one occasion. Rates of service receipt were higher for those children most at risk for sexual activity. Slightly less than half (46%) of 10 to 14 year olds received pregnancy prevention education, as well as 56% of those 15 years and older.

Table 12
Receipt of Pregnancy Prevention Education by Age of Care Coordination Participant

Age Group	Pregnancy Prevention Education	
	% Received Service	% Unmet Service Need
0-2 years	24%	1%
3-4 years	16%	1%
5 to 9 years	21%	3%
10 to 14 years	46%	13%
15 years and older	56%	6%
Total	36%	6%

3. *What percentage of Care Coordination recipients received other health education services?*

Contrary to expectations, linking children to health education services did not appear to be a major focus of Care Coordination programs. Rates of participation in health education services ranged from 6% to 29%, with HIV education services received most often and substance abuse education least often (see Table 13).

Table 13
Receipt of Health Education Services

Health Education	Percent Received Service
HIV Education	29%
Substance Abuse	6%
Physical Health /Wellness	17%

In addition, several programs offered educational programs aimed at enhancing children's nutrition, fitness, and socialization skills (data not shown).

E. Chapter Summary

Since the program's inception in the spring of 2003, over a thousand children placed in foster care have received Care Coordination services from one of nine Care Coordination programs. Programs continue to operate in eight sites across the State and appear to be functioning in a manner consistent with the goals and expectations of program developers. Agency records indicate that Care Coordinators engage in a wide range of activities intended to facilitate children's health care experiences and promote permanency. Care Coordinators document children's health history and current health needs, facilitate the acquisition of initial assessments, link children to treatment providers, and monitor ongoing services. They also work with other service providers to develop and implement health-related treatment plans and goals, and act as advocates for children's needs.

The types of services provided by the Care Coordination teams also appear to be well matched to the needs and issues of the foster care population being served. All children placed in foster care must receive preventive medical and dental care, and initial assessments are mandated and/or recommended for all new admissions. In addition, program records indicate that over three-quarters of the children who receive Care Coordination services have multiple health-related needs in two or more health domains. The high level of need observed in this population suggests that the children enrolled in Care Coordination programs are likely to benefit from services aimed at monitoring and managing their health care needs.

Moreover, examination of children's service utilization patterns suggests that receipt of Care Coordination services may improve an agency's ability to identify and treat children's health care needs. Having Care Coordination services in place at the time of entry into foster care is associated with higher rates of initial assessment completion and timeliness. Data tracking children's access to needed health care services also indicate that Care Coordinators generally succeed in linking program children to health care services.

Chapter 6
Impact Study: Methodology

To document the impacts of Care Coordination, random assignment designs were initiated alongside program implementation efforts at two Care Coordination sites: Abbott House, a voluntary agency providing foster care services to families living in the Hudson Valley/NYC area, and CATS, a voluntary agency working with children in foster care in Erie County. Problems with the randomization process led to the CATS program being dropped from the study design in early 2004, leaving the Abbott House Foster Boarding Home Care Coordination Program in Bronx, New York as the sole impact evaluation site. The following chapter describes the research methods used in the Abbott House impact study. The sample selected and the analytical approach applied to subsequent data analyses are also discussed.

A. Random Assignment Procedures

Beginning in March 2003, Abbott House staff were asked to randomly assign families from their targeted foster care caseload to either receive or not receive Care Coordination services. In order to be eligible for study participation, families had to have less than five children under the age of 18 years old in foster care. Once assigned, children were to remain in either the Care Coordination or Control group for the duration of their stay in the foster boarding home program, or until they were no longer eligible to receive Care Coordination services based on age-related funding eligibility requirements. Children who left and later reentered the foster boarding home program retained their original random assignment status. Children previously assigned to Care Coordination were placed back into Care Coordination at reentry, and children in the Control group remained ineligible for Care Coordination services.

Study enrollment took place between March 2003 and July 2004, when the desired sample size of 160 participants was obtained.

B. Data Collection

To assess the impact of Care Coordination on initial assessment receipt, documented health care needs, service provision, and communications, the medical and foster care case files of all study participants were independently read and coded by two members of the OCFS research team. Files were coded for a period of 18 months following the child's assignment into either the Care Coordination or Control group. When a child exited the foster boarding home program prior to his/her 18-month anniversary, coding on all constructs was stopped on the day of discharge from the foster boarding home program. Children on trial discharge, absent without leave, or hospitalized for more than 30 days during the study window were considered to have been discharged from the foster boarding home program and coding was stopped at the first day of program absence. Differences between readers were resolved through group discussion and review of available records.

Information on permanency outcomes, including changes of placement, length of time in care, discharge date, and reason for discharge were extracted from OCFS-maintained administrative databases that track children's foster care entries, movements, and exits from all levels of foster

care. Data was collected for the full 18-month period, regardless of whether the child exited the foster boarding home program prior to the end of his/her follow-up window.

C. Sample

As indicated in Table 14, not all of the children randomly assigned were included in the final impact study sample. Initial case file reads indicated that two children assigned to the Control group had unknowingly received services from the Care Coordination team. These children were therefore dropped from all aspects of impact study. In addition, the case files for five children assigned to the Care Coordination group, and one Control group child could not be located. These children were therefore dropped from the case file review component of the impact study, and are not included in the analyses examining differences in children's initial assessments, health care needs, service use, or communications. Information was, however, available within the OCFS-administrative databases. These children are therefore included in the analyses examining foster care use and other permanency-related outcomes.

Table 14
Impact Study Sample

Sample Group	Sample Size		
	Care Coordination	Control	Total
Randomly Assigned	**83**	**81**	**164**
Removed due to contamination	*0*	*2*	*2*
Permanency Outcomes Sample	**83**	**79**	**162**
Removed due to missing agency records	*5*	*1*	*6*
Case File Review Sample	**78**	**78**	**156**

Given these unanticipated losses to the original random assignment sample, a series of analyses comparing children included in the final Care Coordination and Control groups were completed. The purpose of these analyses was to determine whether random assignment procedures had, in fact, been successful in creating two groups of children who were highly similar to each other at study intake.

Despite sample attrition, random assignment procedures produced treatment and control groups that were highly similar in their demographic composition and case characteristics (see Table 15). Both groups were composed of slightly more females than males. A sizable proportion of each study group was Hispanic (39% Care Coordination, 48% Controls). In addition, both groups were predominately composed of younger children, with approximately three quarters of the participants in each group under the age of 10.

Groups were also similar on indicators of case history and service receipt. About half of the children in each study group were involved in child welfare cases that had been open for less than one year at study intake. Time spent at Abbott House was also comparable across groups. At study assignment, approximately half of the children placed in each group were characterized as "New Admissions"- meaning that they had been in out-of-home care for 45 days or less at study intake. The remaining children were "Under Cares". For these children, enrollment in either the Care Coordination or Control group occurred more than 45 days after placement into

foster care. Moreover, although children may have received either preventive or foster care services from Abbott House prior to their study enrollment, case records indicate that 63% of the Care Coordination and 68% of the Control group had been receiving services from Abbott House for less than six months when assigned to participate in the randomized study. The lack of significant differences between the groups on these variables is noteworthy, as it suggests that prior opportunity to identify health care needs and establish service delivery networks was comparable across the two groups.

Table 15
Demographic and Case Characteristics of Sample Children

Characteristic	Study Group		Total (n=162)
	Care Coordination (n=83)	Control (n=79)	
Sex			
Male	42%	46%	44%
Age at Study Intake			
0 to 2 years	38%	30%	35%
3 to 9 years	37%	49%	43%
10+ years	24%	20%	22%
Ethnicity			
Hispanic	39%	48%	43%
Placement Type at Study Entry			
Approved Relative	**54%**$^{+}$	**41%**$^{+}$	47%
Foster Boarding Home	46%$^{+}$	59%$^{+}$	53%
Admission Status			
New Admission	54%	57%	56%
Under Care	46%	43%	44%
Time Between Case Initiation and Study Entry			
0 to 6 months	39%	42%	40%
6 months to 1 year	16%	17%	16%
1 to 2 years	15%	14%	14%
2 or more years	31%	28%	30%
Time Between Agency Intake and Study Entry			
0 to 6 months	63%	68%	65%
6 months to 1 year	23%	13%	18%
1 to 2 years	13%	20%	17%
2 or more years	1%	0%	1%

$^{+}$Difference between groups approached statistical significance, $p < .10$.

Only one difference between the Care Coordination and Control groups approached statistical significance. The percentage of children living in approved relative, rather than non-kinship foster boarding homes at intake, was slightly higher among the Care Coordination group than the Control group. However, this difference no longer approached significance when only children eligible for the case file reviews were examined, making it unlikely that initial placement type would influence the needs and services related analyses.

D. Analytical Approach

Despite the apparent similarities between the Care Coordination and Control group, steps were taken to statistically control for key variables likely to influence the outcomes of interest in each of the analyses presented in Chapter 7. First, since all of the data used in the services-related outcome analyses were derived from the case records maintained by Abbott House's foster boarding home staff, the length of time each child spent in the Abbott House foster boarding home program was taken into consideration in each of the analyses presented. Staff had more opportunity to assess and serve children who remained in the foster boarding home program longer. Thus, by entering the length of each child's foster boarding home stay into our equations, we were able to isolate the effects of Care Coordination receipt from those of service opportunity.

In addition, in all of the analyses examining initial assessments, need identification, service receipt, and communication the child's age at study intake was also entered as a control. Again, the likelihood that a child will be diagnosed with a particular health problem (e.g., mental illness) or require a particular health care service (e.g., well childcare), is apt to vary with child age. Young children are less likely to be diagnosed with conduct disorder, and older children require fewer well childcare visits than infants. Thus, by accounting for child age at study intake, we were able to obtain a clearer picture of the impact of Care Coordination participation on our service-related constructs.

The child's status as either a "New Admission" or "Under Care" was also taken into account in all analyses utilizing the entire case file sample. By definition, New Admission children have only been served by the foster boarding program for 45 days or less at study intake, thus, for these children the opportunity for agency workers to develop strong service networks prior to study enrollment was limited. It therefore seemed reasonable to anticipate that differences in service receipt might exist between New Admission and Under Care children, regardless of their study status (i.e., Care Coordination or Control). These potential differences were accounted for by including admission status as a control.

Finally, given that many factors are likely to influence how and when a child enters and exits care, steps were also taken to statistically account for factors, other than Care Coordination receipt, that might influence children's foster care experiences. Specifically, the child's age at study intake, and the length of time elapsed between case initiation and study intake, were entered as control variables in each of the analyses examining permanency-related outcomes.

Chapter 7
Impact Study: Findings

Designed to complement the multi-site process evaluation study, impact evaluation activities considered the extent to which Care Coordination receipt benefited children residing in foster care. While process study analyses monitored the level of program performance over time, impact evaluation activities compared the experiences of children receiving Care Coordination to the experiences of children receiving traditional foster care services.

A. Initial Assessments

1. *Are children who receive Care Coordination services at intake into foster care more likely than other children entering foster care to receive state-recommended initial assessments?*

As noted in Chapter 2, a primary goal of Care Coordination is to facilitate the timely receipt of state recommended initial assessments. To examine whether receipt of Care Coordination services increased the number of children receiving these assessments upon entry into foster care, the percentage of age-eligible children receiving each assessment was compared across the Care Coordination and Control groups. Analyses were limited to those children who entered foster care within 45 days of study enrollment (i.e., the "New Admissions"). This was done to allow for a fairer test of the impact of Care Coordination Services on initial assessment receipt. New Admissions in the Care Coordination group received Care Coordination services during the period in which initial assessments are recommended (i.e., within the first 45 days of entry into foster care). For the "Under Care" children in the Care Coordination sample, this window of opportunity had, by definition, already passed. The Abbott House Care Coordination team therefore had the most opportunity to influence initial assessment receipt in the New Admission group.

In order to be included in a given comparison, children also had to be considered "age-eligible" for that particular assessment. All children, regardless of age at placement, require an initial physical and developmental assessment. Only children three years or older at the time of foster care placement require dental and mental health assessments; thus, only children over the age of three at foster care intake were included in the dental/mental health analyses. Analyses for initial substance abuse assessments were not conducted due to small sample size. Only 13 New Admission children were over the age of 10, the minimum recommended age for conducting an initial substance abuse assessment.

As indicated in Table 16, Care Coordination had a significant, positive impact on the receipt of both initial physical and dental assessments. The percentage of New Admission children receiving an initial physical assessment was 95% in the Care Coordination group, compared to 82% of the Control group. Similarly, 76% of the children in Care Coordination who were over the age of three received an initial dental assessment, while 50% of Control group children received this service.

Table 16
Initial Assessment Completion Rates for New Admissions by Study Group

Type of Initial Assessment	# Age Eligible Children	% Completed
Physical*		
Care Coordination Group	42	**95%**
Control group	45	**82%**
Developmental		
Care Coordination Group	42	73%
Control group	45	82%
Dental+		
Care Coordination Group	21	**76%**
Control group	28	**50%**
Mental Health		
Care Coordination Group	21	76%
Control group	28	89%

+Group difference significant at the $p < .10$ level.
*Group difference significant at the $p < .05$ level.

Contrary to expectations, no differences in completion rates were found for the initial developmental and mental health assessments. Examination of Abbott House's daily operations suggests that this lack of anticipated findings may stem, at least in part, from current foster boarding home practices. The Abbott House foster boarding home program has a clinical psychologist on staff who is responsible for assessing the mental health, developmental status, and substance abuse related needs of most New Admissions, regardless of their Care Coordination status. Given this universal practice, the Care Coordination team may not have had much of an opportunity to influence assessment receipt within these areas. Conversely, most physical and dental assessments are completed by community-based professionals and are therefore not supported by existing agency infrastructures. Having a Care Coordinator to facilitate the scheduling and completion of these assessments appears to be beneficial.

2. Are children who receive Care Coordination services at intake into foster care more likely than other children to have their initial assessments completed within recommended time frames?

Included in the OCFS guidelines for initial assessments are recommended time frames for completion. Prior analyses addressed whether receiving Care Coordination services altered the likelihood of *getting* an initial assessment. The primary purpose of the present analysis was to determine whether receiving Care Coordination increased the likelihood that those who received an initial assessment got that assessment in a *timely fashion*. Only children who received the initial assessment of interest were included in the analysis. If an assessment was completed within the recommended time frame listed in Table 17, the assessment was considered to be "on time."

As shown in Table 17, no significant differences in timeliness were found. Over half of New Admission children who received an initial physical or developmental assessment got that

assessment within the timeframes put forth by OCFS. Mental health assessments were completed on time for approximately 40% of both groups while dental assessments were completed on time for less than a third of all study participants. According to the Care Coordinators, the number of dental providers accepting Medicaid clients is limited in most areas, making the timely obtainment of dental assessments difficult.

Table 17
Timeliness of Initial Assessment Received by New Admissions by Study Group

Type of Initial Assessment	# Assessments Completed	% Completed "On Time"
Physical (30 days)		
Care Coordination Group	40	58%
Control group	37	67%
Developmental (45 days)		
Care Coordination Group	31	62%
Control group	36	71%
Dental (30 days)		
Care Coordination Group	16	31%
Control group	14	7%
Mental Health (30 days)		
Care Coordination Group	16	44%
Control group	25	40%

3. Is the wait-period between placement and initial assessment shorter for children who receive Care Coordination services than those who do not receive Care Coordination services?

Our findings regarding compliance with recommended time frames for initial assessment completion revealed that many New Admission children receive their initial assessments outside of state recommended time periods. Therefore, the primary purpose of this analysis was to determine whether receipt of Care Coordination services *decreased the overall wait period* between foster care placement and initial assessment for treatment group children. Many factors may interfere with the receipt of initial assessments within prescribed timeframes. For example, anecdotal evidence suggests that initial assessment timeliness can be difficult to achieve when provider availability is limited. If limited provider availability means that many foster care children have to wait to get access to a provider, does receiving Care Coordination services help to reduce this wait?

Receipt of Care Coordination services had a significant, positive impact on the wait period for initial dental assessments. New Admission youth who received Care Coordination services waited an average of 62 days before receiving their initial dental assessment, compared to the 170 days waited by Control group children. Thus, Care Coordinators were able to shorten the wait period for dental assessments by almost 3.5 months.
Wait periods for physical, developmental, and mental health assessments were not effected by Care Coordination services.

Table 18
#Days between Placement and Initial Assessment by Study Group

Type of Initial Assessment	# Assessments Completed	Average # Days till Completion
Physical (30 days)		
Care Coordination Group	40	39
Control group	37	36
Developmental (45 days)		
Care Coordination Group	31	63
Control group	36	49
Dental (30 days) *		
Care Coordination Group	16	**62**
Control group	14	**170**
Mental Health (30 days)		
Care Coordination Group	16	60
Control group	25	46

*Group difference significant at the $\underline{p} < .05$ level.

Summary

Receipt of care coordination services positively affected the receipt of initial physical and dental assessments, increasing the number of children receiving both assessments and decreasing the length of time needed to access dental providers. The program did not appear to influence developmental or mental health assessments, a finding likely to reflect Abbott House's intake policies that call for almost all newly admitted children, regardless of their Care Coordination status, to be assessed by the in-house psychologist.

B. Identification of Health Needs

1. Do children who receive Care Coordination services have more health care needs identified than controls?

A primary goal of Care Coordination services is to increase the likelihood that children's health care needs will be recognized and addressed by service professionals. To examine the impact of Care Coordination services on need identification, we compared Care Coordination and Control group children on six general categories of health-related need: medical, developmental, dental, mental health, educational, and substance abuse. Both New Admission and Under Care children were included in the analyses, and admission type was added to our standard set of control variables (i.e., age at study intake, length of program stay).

Our first set of indicators compared children on the presence and/or absence of at least one, professionally documented problem or issue within each of the six health categories listed. Issues cited in the Uniform Case Record (UCR) or noted solely by the caseworker without accompanying professional documentation, were not included in our count of professionally identified need.

As shown in Table 19, receipt of Care Coordination services increased the likelihood that a child would have at least one medical or educational problem identified by a qualified professional. Children in the Care Coordination group were also more likely than Control group children to have official documentation indicating a positive toxicology screen at birth. Given that random assignment procedures were used, the general level of health care need should have been equivalent across groups at study intake. Thus, the differences observed in the number of problems recorded within the study period are likely the result of increased access to screening/health care services and/or improved documentation practices in the Care Coordination group.

Table 19
Percentage of Children With At Least One Health Issue By Health-Related Category

Problem Area	**Percent**	
	Care Coordination (n=78)	**Control (n=78)**
Medical*	**88%**	**72%**
Dental	21%	13%
Mental Health	42%	33%
Developmental	47%	42%
Educational*	**21%**	**6%**
Substance Abuse*	22%	5%
Born with Positive Toxicology*	**17%**	**4%**
Substance Use Problem	5%	1%

*Group difference significant at the $p < .05$ level.

2. Do children who receive Care Coordination services have a greater number of health care problems detected than controls?

Our second set of indicators compared children on the total number of health-related issues identified. Analyses were limited to those children who had at least one problem or issue professionally documented within a given area and were conducted for only five of the six previously examined categories. (Substance abuse issues were dropped as an area of interest, as only five children were identified as having substance use problem other than positive toxicology at birth). This was done to allow for a cleaner test of the differences between groups on *the level* of documented need. While our first set of analyses asked whether *the number of children* identified as having health issues varied across groups, the primary purpose of this set of analyses was to determine whether *the number of problems* per child differed across study groups.

Table 20
Average # of Problems Identified by Health Professionals by Study Group

Problem Area	**# Children with Problems**	**Average # of Problems**
Medical*		
Care Coordination Group	69	**3.17**
Control group	56	**2.29**

Dental		
Care Coordination Group	16	1.13
Control group	10	1.10
Mental Health*		
Care Coordination Group	33	**3.55**
Control group	26	**2.11**
Developmental*		
Care Coordination Group	37	**2.60**
Control group	33	**1.93**
Education		
Care Coordination Group	16	1.19
Control group	5	1.00

*Group difference significant at the $\underline{p} < .05$ level.

Once again, significant differences in favor of the Care Coordination group were found (see Table 20). Among those with documented needs, children who received Care Coordination services had more medical, mental health, and developmental issues noted in their case files than children in the Control group. No differences in the total number of educational issues documented was found, even though Care Coordination children were more likely than Control group children to have educational issues recognized as a problem area.

Summary

Taken together, these findings suggest that receipt of Care Coordination services improved both need recognition and the comprehensive detection of children's health problems. Children in the Care Coordination group were more likely than Controls to be recognized as having a medical problem, and on average, had one more medical problem detected, than Control group children. Similarly, although the number of children with mental health and developmental issues did not vary across groups, children in the Care Coordination group had a greater number of problems detected within each of these categories.

C. Service Receipt

1. Do children who receive Care Coordination services have greater access to health care services than other children residing in foster care?

To determine whether Care Coordination services had a positive impact on children's receipt of health related services, three sets of analyses were conducted. First, the percentage of Care Coordination children receiving a particular category of health services was compared to the percentage of Control group children receiving the same service. If the child's case file contained official documentation indicating that the child had attended at least one appointment with a given type of provider during the 18-month study window (or during their stay at the foster boarding home program, whichever ended first), s/he was classified as having received that particular service. For medical and dental visits, official documentation was defined as a copy of the treating doctor's office note. For mental health, developmental, educational, and substance abuse services, official documentation also included progress notes from treating professionals, copies of the child's Early Intervention treatment plan, Individualized Education Plan (IEP), etc.

As illustrated in Table 21, receipt of Care Coordination services increased access to multiple types of health care services. Ninety-two percent of Care Coordination children received at least one well childcare service during the study period, compared to 78% of children in the Control group. Likewise, the receipt of routine dental care was considerably higher in the Care Coordination group. In the year and a half covered by the impact study, 68% of Care Coordination children had at least one routine dental check-up compared to 37% of the Control group.

Access to non-preventative care was also improved by the receipt of Care Coordination services. The percentage of Care Coordination children receiving non-well childcare care from their primary care physician and/or specialist care was approximately twice as high as that found in the Control group (27% vs. 14% for primary care; 20% vs. 9% for specialist care). Contrary to expectations, Care Coordination children were also more likely than controls to have received some form of emergency medical care (i.e., Emergency Room visits, or unplanned hospitalizations). However, this apparent increase in emergency room usage may simply be a result of better documentation practices in the Care Coordination group. While emergency services were noted in the case notes of Control group children, service receipt was not coded unless professional documentation was available. Care Coordinators made a concerted effort to track down paper records of medical visits, including emergency care. Regular caseworkers may not have exerted the same effort, limiting the number of emergency services documented by professional sources.

Table 21
Percentage of Children Receiving Medical and Dental Services During Study Period

Service Type	Percent Receiving Service	
	Care Coordination (n=78)	**Control (n=78)**
Medical Care		
Well Child Care*	**92%**	**78%**
Primary Care+	**27%**	**14%**
Specialist Care+	**20%**	**9%**
Emergency Care+	**19%**	**9%**
Planned Hospitalization	1%	1%
Medical Testing	10%	10%
Other Medical Services	3%	3%
Dental Care		
Routine Dental*	**68%**	**37%**
Acute Dental	10%	8%
Orthodontic Care	0%	1%

+Group difference significant at the $p < .10$ level.
*Group difference significant at the $p < .05$ level.

For children over the age of three at study intake, receipt of Care Coordination Services also improved access to mental health services (see Table 22). Care Coordination children were more

likely than Control group children to receive both individual (52% vs. 28%) and family (17% vs. 6%) therapeutic services.

Table 22
Percentage of Children 3 and Older Receiving Mental Health Services During Study Period

Service Type	Percent Receiving Service	
	Care Coordination (n=46)	**Control (n=54)**
Mental Health Services		
Medication Management	13%	6%
Individual Therapy*	**52%**	**28%**
Group Therapy	15%	11%
Family Therapy*	**17%**	**6%**
Emergency Hospitalization	4%	3%

**Group difference significant at the $p < .05$ level.

Benefits of Care Coordination were also observed in services areas intended to meet children's developmental and educational needs (Table 23). Approximately a third of Care Coordination children under the age of three at study intake received Early Intervention services, compared to only 4% of Control group children in the same range. Similarly, 30% of Care Coordination children over the age of three had case files that included Individual Education Plans compared to 9% of Controls. Therapeutic services were also received more often, with 8% of the Care Coordination sample and 0% of the Control group files containing documentation of physical therapy receipt.

Table 23
Percentage of Children Developmental/Educational Services During Study Period

Service Type	Percent Receiving Service	
	Care Coordination (n=78)	**Control (n=78)**
Developmental Services		
Physical Therapy*	**8%**	**0%**
Speech Therapy	12%	12%
Occupational Therapy	6%	3%
Early Intervention* (includes only children 3 or younger at intake)	**31%**	**4%**
Therapeutic Pre-School (includes only children 5 or younger at intake)	13%	12%
Educational Services		
Evaluation/Assessment	10%	10%
IEP Services* (includes only children three and older)	**30%**	**9%**

*Group difference significant at the $p < .05$ level.

Finally, substance abuse services were accessed by less than 1% of both the Care Coordination and Control group, and no group differences were noted (not shown).

2. Do children who receive Care Coordination services receive more preventative care than other children residing in foster care?

Our first set of service-related analyses addressed whether receiving Care Coordination services altered the likelihood of a child gaining access to well childcare or routine dental care service. The primary purpose of the present analysis was to determine whether receiving Care Coordination increased the frequency of service receipt. Optimum health care practices call for children to receive on-going preventative medical and dental care. Thus, to determine whether Care Coordination services had a positive impact on children's receipt of regular preventative health care, the total number of well childcare and routine dental care appointments was compared across the Care Coordination and Control groups. Only children who had received at least one well child/routine dental appointment were included, to allow for a cleaner test of the impact of Care Coordination on the frequency of health care receipt.

As anticipated, children in the Care Coordination group received more well childcare visits on average than did children in the Control group. The difference between groups, however, was modest with Care Coordination children receiving approximately half a visit more of well childcare than Control group youth. No difference in the amount of routine dental care was noted (see Table 24).

Table 24
Average Number of Well Child Care Visits by Study Group

Type of Preventative Care	# Children Receiving Service	Average # of Visits
Well Child Care^{+}		
Care Coordination	72	**2.6**
Control	61	**2.2**
Routine Dental Care		
Care Coordination	53	1.6
Control	29	1.3

*Group difference significant at the $p < .05$ level.

3. Do children who receive Care Coordination services have greater access to pregnancy prevention and other health education services than other children residing in foster care?

Pregnancy prevention education and rates of other educational service receipt were compared across groups. Children were classified as having received pregnancy prevention/STD, HIV, or Substance Abuse education if they attended at least one of the foster boarding home program's group education classes, or received topic-specific individual instruction from a health care provider on at least one occasion. Completion of the HIV Risk Assessment instrument was also coded as HIV education.

As shown in Table 25, the percentage of children over the age of 10 receiving pregnancy prevention services was higher in the Care Coordination than Control group (63% vs. 38%). This difference was not statistically significant, however, most likely due to the small number of children included in the comparison. The sample size for this comparison was only 35 children. The overall percentage of children receiving pregnancy prevention related services also appears in Table 26.

Table 25
Pregnancy Prevention Education Receipt by Study Group

Pregnancy/STD Prevention	Percent Receiving Service	
	Care Coordination	Control
Children 10 and older	63%	38%
All Ages	15%	9%

Significant differences did emerge, however, in the area of HIV education (see Table 26). No differences in substance abuse education were found.

Table 26
Health Education Services Receipt by Study Group

Educational Service	Percent Receiving Service	
	Care Coordination (n=78)	Control (n=78)
HIV Education*	**97%**	**82%**
Substance Abuse Education	3%	1%

*Group difference significant at the $p < .05$ level.

Summary

In sum, receipt of Care Coordination services appears to increase the likelihood that children residing in foster care receive needed health care services. Children in the Care Coordination group were more likely than Controls to gain access to a wide range of medical services, as well as routine dental care, and early intervention services. They also attended significantly more well childcare appointments than children who did not receive Care Coordination services. It is important to note, however, that our measures of service access and attendance are dependent upon the presence of physical documentation of service receipt within the child's case file. It is therefore possible that children in the Care Coordination group simply had better documentation of their health care services rather than improved access to service providers. The Abbott House Care Coordination Team invests considerable resources into obtaining copies of service providers' records and maintaining a child's health care record, facilitating the identification of service access, attendance and unmet needs in this group.

D. Communication

1. Does receipt of Care Coordination services increase the number of health-related communications that take place between the foster care agency and parents? And foster parents? And service providers?

Communication is a key element of the Care Coordination approach to service delivery. To help establish an integrated and collaborative system of care, Care Coordinators are expected to act as liaisons between key parties responsible for promoting and maintaining a child's health. Communication is used to improve children and families' understanding of the child's health care needs, the importance of regular preventative care, and the purpose and benefits of potential service options. Care Coordinators also help to develop and maintain a comprehensive picture of the child's current health status and treatment plan, by facilitating communication between the various service providers that work with a child and/or family.

To determine whether children who receive Care Coordination services benefited from increased levels of communication between players, the number of health-related contacts that occurred during the study window was compared across groups. For the Care Coordination group, all health-related contacts involving the foster child, parent, foster parent, or service provider, and a member of the Care Coordination team were counted. For the Control group, the number of health-related contacts involving each of these players and the regular foster care caseworker were examined.

As expected, health-related communications occurred significantly more often in the Care Coordination, than in the Control group, for all four categories of contact (see Table 27). Differences were most pronounced when examining health-related contacts between agency workers and foster parents. On average, members of the Care Coordination team discussed health-related concerns with foster parents 8.90 times. In contrast, regular caseworker-foster parent contact occurred only 1.93 times among the Control group. Contact with service providers was the second most frequent form of health–related contact. Care Coordinators engaged service providers an average of 3.49 times, while regular caseworkers interacted with service providers on 1.29 occasions.

Table 27
Average Number of Health Related Contacts by Study Group

Health Contact with…	Average # Contacts	
	Care Coordination (n=78)	Control (n=78)
Child*	**1.17**	**.46**
Foster Parents*	**8.90**	**1.93**
Biological Parents*	**1.47**	**.35**
Service Providers*	**3.49**	**1.29**

*Group difference significant at the $p < .05$ level.

E. Permanency

In addition to improving the health and well-being of children residing in foster care, a primary goal of the OCFS Care Coordination project was to promote permanency. To determine whether receipt of Care Coordination services influenced children's foster care experiences, children were tracked for 18 months following study enrollment. Information on children's foster care moves, length of stay in care, and reason for discharge was then extracted from OCFS-maintained databases.

1. Do children who receive Care Coordination services experience fewer foster care moves than children who receive traditional foster care services?

Operating under the assumption that an integrated system of health care should improve child health and reduce behaviors likely to interfere with a foster parent's ability/willingness to provide care, it was anticipated that the receipt of Care Coordination services would promote more stable foster care placements.

To test this assumption, the percentage of children experiencing at least one intra-agency or inter-agency placement change during the full 18-month follow-up window was examined. As shown in Table 28, the experiences of both groups were highly similar, with approximately one-third of the children in each group experiencing at least one change of foster care placement during the study period.

Table 28
Foster Care Moves by Study Group

Outcome	Study Group	
	Care Coordination (n=83)	Control (n=79)
At least one change of foster care placement	33%	30%

2. Do children who receive Care Coordination services spend less time in foster care than Controls?

To examine whether Care Coordination receipt influenced foster care usage, the amount of time children spent in foster care during the 18-month study window was compared across study groups. On average, children in the Care Coordination group spent 417 days in foster care during the follow-up period. The average length of stay was slightly higher for the Control group (430 days); however, this difference was not statistically significant.

Table 29
Time Spent in Foster Care by Study Group

Outcomes	Study Group	
	Care Coordination (n=83)	Control (n=79)
# Days Spent in Foster Care	417	430

3. Are children who receive Care Coordination services more likely than Controls to have exited foster care in the 18 months following study intake? Are children receiving Care Coordination services more likely than others to leave foster care for home? Adoption?

The impact of Care Coordination receipt on children's exits from foster care was also examined. Contrary to expectations, no significant difference in the percentage of children leaving foster care during the 18-month follow-up window was found. Approximately two-fifths of the children in either group (36% Care Coordination, 38% Controls) left NYS' foster care system in the year and a half following study intake. Reasons for departure were also highly similar across groups. Most children returned to their natural parent or relative, and a small number were adopted (see Table 30).

Table 30
Foster Care Exits by Study Group

18-Month Permanency Outcomes	Study Sample	
	Care Coordination (n=83)	Control (n=79)
Exited Foster Care[1]	36%	38%
Returned to Parent	23%	30%
Released to Relative	5%	1%
Trial Discharge	5%	4%
Administrative Action	1%	1%
Adopted	2%	1%
Returned to Foster Care	4%	3%

[1]Included in the "exited" category are children officially discharged from foster care and those out on trial discharge for more than 30 days.

Summary

Contrary to expectations, receipt of Care Coordination services did not positively impact permanency indicators at 18 months post program enrollment. Children who received Care Coordination services were as likely as Control group children to experience at least one change in foster care placement. In addition, both groups exited foster care to home, trial discharge, and adoption at similar rates.

Chapter 8
Conclusions & Recommendations

Findings from the three-year process study and 18-month impact evaluation indicate that the NYS Care Coordination Pilot Project has positively impacted the health care experiences of children residing in foster care. Observed benefits extended across the health care continuum, with improvements shown in multiple areas including: assessment, diagnosis, treatment, and communication. Specific benefits included:

- *Higher rates of initial assessment completion and timeliness*. Following the establishment of their Care Coordination programs, sponsored agencies significantly increased the number of children under their care who received initial physical, dental, mental health, developmental, and substance abuse assessments within state recommended timeframes. In the impact study, receipt of Care Coordination was associated with higher completion rates for initial physical and dental assessments.

- *Better identification of health care needs.* Children enrolled in Care Coordination programs were more likely than children without Care Coordinators to have case files including documentation of physical, mental health, developmental and educational problems diagnosed and/or identified by a health care professional.

- *Improved documentation of access to health care professionals*. The percentage of children with case files including documentation of well childcare, preventative dental exams, mental health therapy, Individual Education Plans, and Early Intervention service receipt was significantly higher for children in Care Coordination programs than children in traditional foster care.

- *Increased communication with service providers and caregivers.* Care Coordination staff members had more contact with biological parents, foster parents, and service providers about a given child's health related needs and services than foster care staff working with non Care Coordination recipients.

Benefits were also visible at the institutional level. Receipt of care coordination funds provided programs with both the motivation and the opportunity to enhance their operating procedures and service delivery systems pertaining to health care issues. According to Care Coordination staff, this focus helped to shift the broader agency culture toward a more integrated, health-oriented model of service delivery. As noted in Chapter 5, having a Care Coordination program on-site has motivated agencies to: design new mechanisms for gathering and tracking health care information (e.g., the comprehensive, portable Child Health Profile used at CATS), develop assessment protocols for new admissions, enhance parent education services, establish agency-community provider partnerships, and establish and/or improve on-site health facilities. Care Coordination staff have also acted as a model for other agency staff, piloting and sharing new ways for addressing health issues.

Contrary to expectations, however, participation in a Care Coordination program did not impact children's foster care experiences. In the 18 months following program entry, children who

received Care Coordination services exited foster care at the same rate as children without such services. Likewise, the number of days spent in foster care during the 18-month period examined was comparable across the Care Coordination treatment and Control groups. Thus, while receipt of Care Coordination services improved the health care services received by children in foster care, and produced a more health focused agency climate, these service-related improvements did not increase the likelihood that a child would obtain permanency in the 18 months following program entry. Multiple factors influence permanency related decisions, including parent health, mental well-being, and substance use; thus, while improving children's health and connections to care may improve parents' ability to safely parent their child within the home, these improvements may need to be accompanied by gains in other areas outside the realm of Care Coordination for permanency to be positively affected.

A. Program Recommendations

1. Expand the availability of Care Coordination.

Given the immediate benefits associated with the establishment of a Care Coordination program, for both individual children and the health delivery systems in foster care settings, efforts to expand the availability of Care Coordination programs are recommended. Prior to the implementation of Care Coordination, children at the pilot sites received assessments and services to address health-related needs. These services were overseen by the foster parents, caseworkers, the child's primary therapist, and agency medical staff. Each of these individuals had a multitude of additional responsibilities and concerns such as caring for the child day-to-day, developing permanency plan with parents, and providing mental health therapy. In contrast, the dedicated Care Coordinators supported by this pilot project concentrated solely on the health services for a manageable number of children. This spotlight on health resulted in improvements in the provision of initial assessments and other health services, more thorough documentation, and enhanced communication. Care Coordination funds also enabled agencies to identify ways of modifying existing service structures to better serve children's and families' health related needs.

Furthermore, Bureau of Services Planning staff recommend that the following considerations be taken into account when planning future expansion efforts. First, reasonable caseloads should be established. It is recommended that health Care Coordinators manage an average of 35 children, within a range of 25 to 50. Second, qualifications of the Care Coordinators in the pilot included LPN, RN, BA, MA, MS, MSW, and MPH. Staffing decisions were influenced by the agencies' health delivery models and some agencies used a team approach. For example, an RN and an MS working together to serve 60 children. Regardless of formal education, a successful care coordinator must have a sophisticated level of knowledge and comfort with medical issues, as well as an awareness of resources. Direct access to expert medical advice and information is crucial.

2. Disseminate lessons learned.

To assist new sites in developing and implementing a Care Coordination model, a report outlining the experiences of the pilot agencies in integrating the Care Coordinator into the existing organization should be prepared and shared. Care coordinators would also benefit from

guidance regarding how to document their activities and thus track the impact of their work on behalf of the children.

3. Continued monitoring of permanency related outcomes.
Whether improvements in assessment, documentation, and communication facilitate the permanency process should be explored further. The impact study findings presented in this report found no significant differences between children who received and did not receive Care Coordination services on two key permanency indicators: number of foster care moves and time spent in foster care. It is worth noting, however, that these analyses were based on an 18-month follow-up period. Given that efforts to stabilize children's physical, dental, developmental, substance abuse, and mental health may take several months, it is possible that the true impacts of Care Coordination receipt were not readily captured within this confined time frame. It is, therefore, recommended that the impact of Care Coordination receipt on children's foster care experiences be re-examined at two and three years post-study intake.

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