



CENTER FOR HUMAN SERVICES RESEARCH  
UNIVERSITY AT ALBANY State University of New York

*New York State Kinship Navigator System of Care Project*  
**Year 5 Midterm Update**  
**October 1, 2022 – March 31, 2023**

April 2023

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***I. Overview***

The Center for Human Services Research (CHSR) at the University at Albany serves as the evaluator for the New York State Kinship Navigator (Kinship Navigator) program of the Catholic Family Center in Rochester, New York. Kinship Navigator works to improve kinship caregiver outcomes through its information, referral, and education services. With support from the Administration for Children and Families and the New York State Office of Children and Family Services, Kinship Navigator implemented the two-year New York State Kinship Navigator System of Care Project (October 1, 2018-September 30, 2020), which was subsequently extended through five years, until September 30, 2023. To evaluate whether the project is achieving its intended goals, researchers from CHSR are collecting caregiver self-reported and agency-reported data in a quasi-experimental mixed methods study. This midterm report provides an overview of evaluation activities completed during the first six months of Year 5, and the evaluators' goals for the rest of Year 5.

***II. Background***

Kinship caregivers are grandparents, other non-parent relatives, or anyone with a positive relationship to the family who care for a child in the absence of a biological parent. Many kinship caregivers are older adults who experience high levels of stress, have limited incomes, and lack emotional support and recognition. Because the majority of these caregivers (95% in New York State) provide oversight outside the formal foster care system, kinship caregivers do not receive the benefits and services received by foster caregivers.

The project employs two separate interventions to serve kinship caregivers:

1. The County Based Kinship (CBK) intervention carried out by local service agencies that provides in-person, or more recently due to COVID-19 pandemic restrictions, by-phone case management and peer-to-peer support groups; and
2. The Virtual Case Management (VCM) intervention carried out by New York State Kinship Navigator that provides virtual case management services by email, phone or video call. The remote nature of this intervention was unique at its conception due to being implemented 12 months prior to the first New York State COVID-19 pandemic restrictions requiring the movement of many case management services from in-person to virtual provision.

Kinship caregivers in the CBK intervention are divided between self-selected comparison and target groups, while the caregivers in the VCM intervention are assigned to the comparison or

target group based on the county in which they live. Each comparison group receives “services as usual.” CBK comparison group caregivers receive case management without participation in a peer support group. VCM comparison group caregivers receive virtual information, referral, and education services without sustained follow-up by a case manager.

The target groups receive the following interventions and are surveyed via phone interview at the noted intervals:

1. CBK kinship caregivers receive case management in-person (or now by phone due to the pandemic), participate in peer support meetings in-person (or now by phone or video call due to the pandemic), and are surveyed at baseline, six, and 12 months post enrollment.
2. VCM kinship caregivers receive intensive and sustained case management; and are surveyed at baseline, three, and six months post enrollment.

The VCM component of this project was originally implemented across New York State in 15 counties (seven target counties: Albany, Onondaga, Rensselaer, Saratoga, Schenectady, Warren and Washington; and eight comparison counties: Chemung, Delaware, Genesee, Greene, Niagara, Ontario, St. Lawrence and Steuben). Project funding changes at the start of Year 3 meant that caregivers in Albany, Greene, Onondaga, and Schenectady Counties began being served by local agencies rather than VCM. Five additional VCM target counties came on board in Year 3: Fulton, Otsego, Montgomery, Orange, and Sullivan. Lewis was added in late Year 4.

The CBK component of this project was originally implemented across New York State at six agencies in seven counties: Berkshire Farm (Erie County); Cornell Cooperative Extension (Dutchess County); Family Enrichment Network (Broome and Tioga Counties); Liberty Resources (Oswego County); The Family Center (Kings and Queens Counties); and The Jewish Board (Kings County). During Year 1, participants from The Jewish Board were subsumed by The Family Center. Project funding changes at the start of Year 3 eliminated Berkshire Farm from the project and limited The Family Center to only Queens County.

### ***III. Year 4 Data Collection as of March 31, 2023***

#### ***a. VCM Specific Evaluation Summary***

As of March 31, 2023, 375 potential participants have been approached to participate and 187 (50%) provided informed consent and completed a baseline phone interview with VCM staff. Group assignment is determined by county of residence (see description of evaluation above). Of the 187 participants who provided informed consent, 128 (68%) reside in the target counties, while 59 (32%) reside in the comparison counties. Participants are contacted by CHSR three months after their initial baseline interview to do their first follow up interview. To date, 84 participants have completed this three-month follow up phone interview (53 from the target group and 39 from the comparison group). Participants are contacted again by CHSR six months after their initial baseline interview to do their final interview. To date, 93 participants have completed this 6-month follow up phone interview (63 from the target group and 30 from the comparison group). Data collection is still ongoing.

#### *b. CBK Specific Evaluation Summary*

As of March 31, 2023, 353 participants have enrolled and provided informed consent. Of these participants, 109 (31%) were assigned to the target group, and 244 (69%) were assigned to the comparison group. Initial group assignment was based on the participant's interest in attending a peer-led support group. If the participant expressed interest in attending support groups, they were assigned to the target group; if the participant was not interested in attending support groups, they were assigned to the comparison group. During Year 4 a more precise method of assignment was implemented; ahead of the first follow-up survey, all recorded support group attendances were calculated. If two or more attendances were recorded, the participant was assigned to the target group. If one or less attendances were recorded, the participant was assigned to the comparison group.

Regardless of group assignment, all participants are contacted by CHSR within two months of their intake date to conduct a baseline phone interview. To date, 252 participants have completed a baseline interview (70 from the target group and 182 from the comparison group). Participants are contacted again by CHSR at six months and also one year after their baseline interview date to do follow up interviews. To date, 154 participants have completed their six-month follow up (61 from the target group and 93 from the comparison group). One hundred and nine participants have completed a 12-month interview (53 from the target group and 56 from the comparison group). Data collection is still ongoing.

#### ***IV. Year 5 Activities to Date***

To date in Year 5 CHSR has finalized the following activities:

1. *CHSR Final Report Year 4 with Data Analysis*—CHSR submitted report on November 15, 2022;
2. Brief Year 4 report for federal submission was submitted March 1, 2023;
3. The *CHSR Final Report Year 4 with Data Analysis* was heavily revised and resubmitted to OCFS March 22, 2023;
4. Enrollment of new clients in both VCM and CBK were stopped in early 2023; and
5. Discussions were held with OCFS and KN regarding possible ways to use remaining funds for 2023 and Year 6 funding.

#### ***V. Year 5 Future Activities***

Year 5 activities:

1. Finish the *Outcome Evaluation Report: New York State Kinship Navigator System of Care Project* data collection, associated data management, and analyses;

2. Create a report of appropriate format and with required analyses for submission to the Title IV-E Clearinghouse; and
3. Possible additional activities to make use of remaining Year 5 funding, pending further discussion with OCFS and KN.

## **Appendix**

### **Title IV-E Prevention Services Clearinghouse**

#### **Chapter 5: Evidence Review**

**March 31, 2020**

The following is an overview of the outcome evaluation of the New York State Kinship Navigator System of Care Project currently being conducted by the Center for Human Services Research (CHSR) at the University of Albany and its alignment with the Prevention Services Clearinghouse design and execution standards (see Wilson et al., 2019).

#### **5.1 Prevention Services Clearinghouse Ratings are Applied to Contrasts**

The CHSR final evaluation report will include results of two separate studies: County Based Kinship (CBK) and Virtual Case Management (VCM). Each study has its own, non-overlapping sample with one intervention group and one comparison group. Each study will have results for multiple outcomes, or contrasts. The design and execution ratings from multiple contrasts will be used by the Prevention Services Clearinghouse to determine the program or service rating.

#### **5.2 Design and Execution Rating Categories**

Each program under review receives a design and execution rating for each contrast. Ratings can be high, moderate, or low. However, because the CBK and VCM studies have a quasi-experimental design with no random assignment to the intervention and comparison groups, the highest rating they can receive is moderate. Only randomized studies can receive high ratings. To receive a moderate rating, the contrast must meet baseline equivalence standards, statistical model standards, all measurement standards, all design confound standards, and missing data standards (described below).

#### **5.3 Method of Assignment**

All contrasts in the CBK and VCM studies do not use random assignment. Reviewers will follow the steps for quasi-experimental designs (QEDs).

#### **5.4 Integrity of Random Assignment**

n/a – for RCTs only.

#### **5.5 Additional Standards for Cluster Randomized Studies**

n/a – for RCTs only.

### **5.6 Attrition Standards**

n/a – for RCTs only. If needed, CHSR would be able to analyze attrition rates based on the number of participants who completed a baseline survey compared to the number of participants who completed a follow up survey, or the number of consent forms received compared to the number of participants who completed baseline and/or follow up. CHSR could break this down by intervention and comparison group (i.e. differential sample attrition).

### **5.7 Baseline Equivalence Standards**

CHSR has not yet completed data collection and analysis, but CHSR will be able to conduct a baseline equivalence assessment using direct pre-tests on most of the outcome variables (the preferred method described in the Handbook). For any outcome measure where a direct pre-test is not possible, baseline equivalence will be determined using available race/ethnicity and socio-economic status (SES) data. For SES data there is a choice of household income, education level, and employment status for both CBK and VCM. In addition, race/ethnicity and SES characteristics between intervention and comparison groups will be examined regardless of whether or not a direct pre-test is available to determine if there are any large imbalances (i.e. if baseline effect size  $>.25$ ).

Baseline effect sizes less than .05 are considered equivalent, and the contrast can receive a moderate rating. Baseline effect sizes between .05 and .25 are in the adjustment range, and the contrast can only receive a moderate rating if the baseline variables are controlled in the impact analysis. If statistical controls are not used, the contrast receives a low rating.

Baseline effect sizes greater than .25 are not considered equivalent.

### **5.8 Acceptable Methods for Controlling for Pre-tests**

Based on the baseline effect sizes, appropriate statistical adjustments/controls will be applied according to the Handbook guidelines. Acceptable methods include: regression models with the baseline variables as covariates, gain score models where the dependent variable in the regression is a difference score equal to the outcome minus the pre-test, repeated measures analysis of variance models, difference-in-difference models, and models with fixed effects for individuals.

## **5.9 Other Design and Execution Requirements**

### *5.9.1 Statistical Model Standards*

There are three standards described in the Handbook:

1. The standard addressing unequal allocation to intervention and comparison conditions within randomization blocks does not apply to these QED studies.
2. Impact models cannot include endogenous measures as covariates. An endogenous covariate is one that is measured or obtained after baseline and that could have been influenced by the intervention. Data analysis has not been completed yet, but it can be assumed that no endogenous measures will be used as covariates.
3. Data cannot be highly skewed or have obvious collinearities that make estimates of program impacts suspect or uninterpretable. This point is currently difficult to address without having analyzed the data. Upon completion of data collection, CHSR will check the data for skewness and collinearity. CHSR will confirm data meets these standards, or document specifics if it does not.

### *5.9.2 Measurement Standards*

*Face Validity.* To satisfy the criterion for face validity, there must be a sufficient description of the outcome measures for the reviewer to determine that the measure is clearly defined, has a direct interpretation, and measures the construct it was designed to measure.

Outcome measures for CBK:

1. Family Needs Scale (FNS, Dunst, Cooper, Weeldreyer, Snyder, & Chase, 1988). 41 item self-report instrument developed to measure a range of needs identified by caregivers including: primary needs/resources, education and leisure, employment and finances, transportation, future planning for the child, budgeting, social support and friendship. See Lee et al. (2016) for discussion of validity and reliability of the FNS for the kinship population.
2. Parenting Stress Index 4-Short Form (PSI-4-SF, Abidin, 2012). 36 item self-report instrument used to identify parents experiencing high stress due to their parenting roles. Divided into 3 domains: Parental Distress, Parent-Child Dysfunctional Interaction, and Difficult Child, which combine to form a Total Stress scale. Appropriate for parents of children who are birth through age 12. Empirical validity has been established in studies that focused on parenting of Head Start children, medication adherence, and cognitive development of infants.



3. SAMHSA NOMs Functioning Scale. Seven item parent-report questionnaire about the child's overall health, how well they are able to deal with everyday life, interpersonal relationships, and overall satisfaction with family life.
4. Columbia Impairment Scale Parent Report (CIS, Bird et al., 1993, 1996). 13 item parent-report questionnaire that assesses general impairment in various functional domains including: interpersonal relations (family members and peers), academic or occupational functioning, and involvement in general interests and activities, as reported by the caregiver, for youths age nine through 17. It provides a unidimensional measure of functional impairment. Several validation studies have been conducted; this instrument is widely used and accepted.
5. Pediatric Symptoms Checklist Parent Report (P-PSC-17, Gardner et al., 1999). 17 item parent-report questionnaire designed to identify children with difficulties in psychosocial functioning and includes 3 subscales that screen for distinct domains of psychosocial problems: internalizing, externalizing, and attention. Several validation studies have been conducted; this instrument is widely used and accepted.

Outcome measures for VCM:

1. Family Needs Scale. (see above)
2. CHSR-Developed Child Permanency Questions. Caregiver-report items related to the permanency and stability of the child's living situation and custody arrangements.
3. CHSR-Developed Referral to Services Questions. Caregiver-report items related to the types of assistance and referrals they have received. This outcome domain will also reference KN administrative records of referrals made.
4. CHSR-Developed Satisfaction with Programs and Services Questions. Caregiver-report items related to their satisfaction with the services they have received and their interactions with KN staff.

*Reliability*. Reliability standards apply to all outcome measures and any measure that is used to assess baseline equivalence. To satisfy the reliability standards, the outcome measure must be a measure which is assumed to be reliable (e.g. administrative records obtained from social service agencies, demographic characteristics) or must meet one or more of the following standards for reliability:

- Internal consistency (such as Cronbach's alpha) of 0.50 or higher.
- Test-retest reliability of 0.40 or higher.
- Inter-rater reliability (percentage agreement, correlation, or kappa) of 0.50 or

higher

When required, reliability statistics are preferred on the sample of participants in the study under review, but statistics are permitted from test manuals or studies of the psychometric properties of the measures. CHSR has not yet analyzed data and, as such, does not yet know the reliability statistics on the sample of participants in the study. This can be reported once analysis is complete. A quick literature review of all validated scales listed above confirmed that the internal consistency reliability coefficients (Cronbach's alpha) are all higher than .50. Reliability coefficients from previous studies are not available for the NOMs Functioning Scale or the CHSR-developed questions.

*Consistency of Measurement Between Intervention and Comparison Groups.* Measures were constructed the same way for both intervention and comparison groups. The data collectors and data collection modes for data collection do not differ between intervention and comparison groups. There is one CHSR employee conducting CBK interviews at baseline, six months past baseline, and one year past baseline for all participants regardless of group assignment. For VCM, KN staff conduct the baseline interview for all participants and one CHSR employee conducts the three-month and six-month follow-up interviews for all participants regardless of group assignment. The time between baseline and follow ups did not systematically differ between intervention and comparison groups.

### **5.9.3 Design Confound Standards**

In quasi-experimental designs, confounds are often a potential issue due to lack of random assignment. The CBK study does have a *substantially different characteristics confound* as described on page 36 of the Handbook due to the assignment of groups being based on *refusal of offer of treatment*. CBK participants are assigned to the intervention group if they wanted to, and did, participate in peer support groups, and were assigned to the comparison group if they did not want to participate in, or never attended, the support groups.

Because this evidence standard cannot be met, any contrast CHSR submits for the CBK study will receive a low rating. If this were the only substantially different characteristics confound of this study, it might be worth it to adjust the approach to group assignment. However, there are several other confounds that cannot be adjusted for (e.g., COVID disruption in services which subsequently led to a switch to virtual peer support groups in Year Two; uneven intervention and comparison groups; one program providing case management via phone instead of in-person like all other programs; and one original program stopped providing services at the end of year one, causing participants to be shifted to a different

program). CHSR will carefully document each confound, but will likely receive low ratings based on this standard.

For the VCM study, this above is not a concern due to participants being placed into groups based on county of residence, with specific counties designated as intervention or control.

#### **5.9.4 Missing Data Standards**

Once data has been fully collected and analyzed, CHSR will follow missing data standard guidelines in the Handbook, with the assumption of using the complete case analysis method described on pg. 38 (i.e., exclude observations with missing data from the analysis).

#### **5.10 Procedures for Recording, Correcting, and Summarizing Impact Estimates**

This section summarizes what the Clearinghouse does when they calculate effect sizes (i.e., use Hedges' *g*) and explains that they may send queries to study authors for additional data so they can calculate standard error and statistical significance themselves.

#### **Reference Cited**

- Lee, E., Choi, M. J., and Clarkson-Henderix, M. (2016). Examining needs of informal kinship families: Validating the family needs scale. *Children and Youth Services Review, 62(C), 437-471*.
- Wilson, S. J., Price, C. S., Kerns, S. E. U., Dastrup, S. D., & Brown, S. R. (2019). Title IV-E Prevention Services Clearinghouse Handbook of Standards and Procedures, version 1.0, OPRE Report #2019-56, Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.