Care Management Entity Pilot Site in El Paso County:

Evaluation Report 2014

Strong minds, strong futures.

COACT COLORADO

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EXECUTIVE SUMMARY

Systems of Care (SOC) are gaining research support as an effective way to meet the diverse needs of youth and their families who are facing behavioral health challenges. A SOC is a coordinated network that includes a comprehensive spectrum of behavioral health and other necessary services to meet individual and changing youth/family needs.

In 2012, The Colorado Department of Human Services (CDHS) was awarded a System of Care Implementation Grant from the U.S Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA). The Colorado Trauma Informed System of Care (TSOC) focuses on children with serious behavioral health challenges from birth through age 25 who are in, or at imminent risk of, out of home placement. Key features of Colorado's system of care framework include trauma informed individualized and culturally and linguistically relevant services and supports facilitated by an intensive care coordination and service delivery model known as high fidelity wraparound.

As part of this grant, **Colorado elected to test a model of service delivery oversight known as a care management entity (CME).** A CME is an organizational entity that serves as the "locus of accountability" for youth who are involved in multiple public systems and their families. CMEs are accountable for improving care quality, treatment outcomes, and reducing the cost of care.

El Paso was applied and was chosen as the pilot site for the CME because it had an existing Collaborative Management project, was already a community of excellence in the TSOC project, and represented nearly 20% of a FY2011-12 sample of the highest cost children in the Child Welfare system.

El Paso CME has served 25 youth, all with behavioral challenges and multi-system involvement. These youth present with complex family and social issues as well has high behavioral health needs. Six month follow-up data or discharge data was available for five to seven youth for clinical and satisfaction measures. System level outcomes such as out of home placements and cost measures were calculated for all youth.

The positive findings include a decrease in Child Welfare Core Services expenditures, a possible reduction in out of home placements, a decrease in Medicaid services (except for case management), decreases in clinical symptoms, and high levels of satisfaction with services. Overall, costs to Child Welfare and Medicaid decreased in the form of a shift to less intensive, community-based services.

Family functioning did not improve at the six month follow up indicating that six months may not be enough time to see changes and this area and thus, this should remain a focus for those youth and families still receiving services through the CME.

It is important to note that while promising, these results are preliminary and are based on few youth so must be interpreted with caution. Future evaluation of this program will include additional youth who have enrolled in the CME since the end of data collection for this analyses as well as longer term outcomes for the 19 youth still receiving services in the CME. These future analyses will be far more powerful to reveal results that, at this point, are promising.

CARE MANAGEMENT ENTITY BACKGROUND

System of Care Network

Youth who have complex behavioral health conditions are typically involved with multiple State and local service systems. The uncoordinated involvement of various public and private entities in service delivery is often associated with service gaps and overlaps and contributes to poor outcomes and unnecessarily high costs. Systems of Care (SOC) are gaining research support as an effective way to meet the diverse needs of youth and their families. A SOC is a coordinated network that includes a comprehensive spectrum of behavioral health and other necessary services to meet individual and changing youth/family needs. In 2011, Colorado received a one-year system of care expansion planning grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) to develop a blueprint for expanding the SOC approach statewide. The Colorado SOC focuses on children with serious behavioral health challenges from birth through age 25 who are in, or at imminent risk of, out of home placement. Colorado's plan centers on developing local community-based service systems supported by a state-level steering committee of the Behavioral Health Transformation Council, which was established in 2010 pursuant to Section 27-61-101, et seq., C.R.S. The Council, whose mission is to improve the behavioral health system, consists of representatives of the Governor's Office, General Assembly, Judicial Branch, state agencies that fund or provide behavioral health services, individuals who have lived experience with behavioral health challenges, family members, and service providers.

High Fidelity Wrap Around Service Delivery Model

Key features of Colorado's system of care framework include individualized and culturally and linguistically relevant services and supports facilitated by an intensive care coordination and service delivery model known as high fidelity wraparound. Colorado has been working to developing and implement trauma-informed services and family advocates to assist families whose children are experiencing difficulties. The wrap around service delivery process leverages the individual strengths and needs of each youth /family to steer youth /family identified treatment outcomes by way of a coordinated Child and Family Team (CFT) facilitated by a care coordinator, and including the youth, family, a family advocate, and other relevant professional and community stakeholders.

Care Management Entity Oversight

In 2012, The Colorado Department of Human Services (CDHS) was awarded a System of Care Implementation Grant from the U.S Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA). Colorado is one of 16 sites nationally to be awarded the grant, and will receive up to one million dollars per year, for four years, to implement the system of care approach across the state. As part of this implementation grant, **Colorado elected to test a model of service delivery oversight known as a care management entity (CME).** A CME is an organizational entity that serves as the "locus of accountabil-

ity" for youth who are involved in multiple public systems and their families. CMEs are accountable for improving care quality, treatment outcomes, and reducing the cost of care. CMEs work to blend funds, and ensure service/support integration across care systems[1].

Pilot Site Selection

Eight communities were chosen during the planning process to create their own local system of care plans and inform development of the state plan. Those communities, known as Communities of Excellence, are: Arapahoe, Chaffee, El Paso, Larimer, Montrose, Eagle, Weld counties, and the San Luis Valley. Children in El Paso County represented nearly 20% of a FY2011-12 sample of the highest cost children in the Child Welfare system. In addition, El Paso County had an existing Collaborative Management Project. These factors created the opportunity to conduct the initial Colorado CME pilot, known as REACH, within a community of need and within an existing and strong community collaboration and governance infrastructure. The El Paso CME is made up of and governed by 20 child and family serving entities operating in El Paso County including all major systems (Department of Human Services, Mental Health Center, 8 Public School Districts, Department of Youth Corrections, Office of Probation, Juvenile Court, and Department of Public Health, Behavioral Health Organization, Managed Service Organization), community advocacy agencies, and a total of six family and youth representatives (four of these positions are currently filled). This group works collectively to integrate and improve service delivery and outcomes for youth and families from a youth and family driven perspective and provides oversight for the CME implementation. The current document reports on the first year of CME implementation in El Paso County.

Because of the importance of evaluating and documenting the effectiveness of the CME pilot project a great deal of data was collected for all the youth enrolled. As part of the System of Care grant all communities collect the National Outcome Measures (NOMs) at baseline, six month intervals while in service, and at discharge from services. The NOMs measure demographic information, functioning, family military involvement, stability in housing, education, crime and justice status, and perception of care. The Colorado Client Assessment Record (CCAR) was completed on the same schedule as the NOMs for all System of Care communities. The CCAR measures 25 functional domains mostly related to mental health symptoms (e.g. anxiety, depression, psychosis) but also other domains such as school/work performance, criminal justice involvement, and substance use. Additionally, the CME collected information about the contacts the care coordinators had with each family, the costs of Medicaid and Child Welfare Core Services before and after enrollment in the CME, measures of natural and formal supports accessed by the families, and a strengths and risk assessment of the youth and family at baseline. Analyses of all of these measures is presented in this report in conjunction with data collected through semi-structured qualitative interviews with the care coordinators regarding the specifics of each individual case.

[1] http://www.medicaid.gov/State-Resource-Center/Events-and-Announcements/Downloads/Quality-Conference-2011/Michelle-Zabel-Care_Mgmt_Youth_Behavioral_Health_FINAL.pdf

YOUTH SERVED BY THE CARE MANAGEMENT ENTITY

A total of 25 youth were enrolled in the care management entity between October 2013 and June 2014. One of these youth never engaged in services prior to moving out of the CME catchment area and thus most analyses will be presented including 24 youth. Of these 24 youth, four families/youth did not agree to participate in the data collection portion of the project and thus the National Outcome Measures (NOMs) were not completed for these individuals. Basic demographic and some system level data was available for these individuals and will be reported throughout.

Characteristics of Youth Served

- Gender: A large majority of the youth served were male (92%) this is most likely due to the fact that in the beginning of the program many of the referrals were coming from the Probation department which, like all juvenile justice systems, has a larger proportion of boys. Referrals have also come from the County Department of Social Services but these too have been largely for males. It is possible that the referring DHS case workers have seen the success of the program with male youth and been more likely to refer similar cases to the CME.

Typical Youth Served

While there are many differences in the youth and families served by the CME, the data was used to create "a prototypical youth" to illustrate the clients served in the CME the services they received, and the outcomes they achieved. The typical CME youth is a 14 year old Hispanic male and in eighth grade. He lives in an apartment with his mother and three siblings. There is frequent fighting, though the family bond is strong. He is currently on probation for fighting. His mother has been diagnosed with clinical depression and is a past victim of domestic violence. She struggles with providing discipline and structure, contributing to a sense that he is beyond her control so Social Services has become involved and there is a pending Dependency and Neglect filed. He has a history of truancy and is failing many of his classes; he has an Individualized Education Plan. He has received mental health services in the past, with two stays in residential treatment.

- Ethnicity: 25% of the youth identified as Hispanic/Latino, as compared with 15.3% of the males in El Paso county.
- Race: 54% of the youth identified their race as being White; 72% of El Paso county males are White.
- Age Group: Half (50%) of the clients were between the ages of 13 to 15 years old, 38% were between 16 to 25 years of age and the remaining 12% are were in the younger age group of 10 to 12 years old.
- Living Arrangement: 70% of youth were living in a caregiver's home at baseline; 10% were in DYC custody, 10% were in a group home, 5% were in foster care, and 5% were in residential treatment.

Presentation at Baseline

Table 1 describes the mental health diagnoses reported at baseline. Some youth have more than one diagnoses and all diagnoses are included so the total exceeds the 24 individuals who were enrolled at baseline.

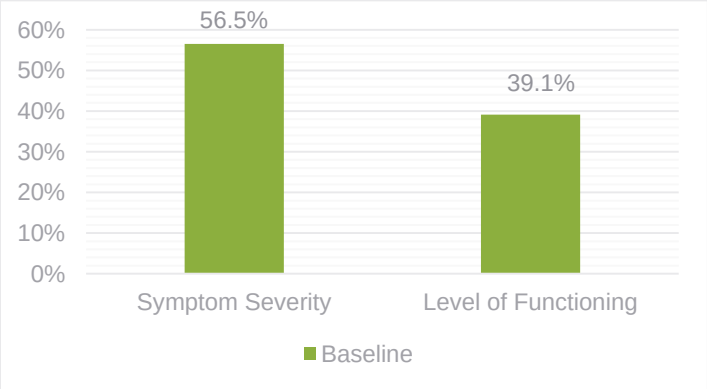
Table 1. Frequencies of Mental Health Diagnoses at Baseline

Diagnosis	ADHD	Mood	Bipolar	Post-Traumatic Stress	Reactive Attachment	Depression	Intermittent Explosive	Oppositional Defiance	Conduct	Adjustment	Social Phobia
N	6	5	5	5	4	3	1	1	1	1	1

The mean number of depression symptoms (nervous, restless, hopeless, depressed, worthless, everything is an effort) reported at baseline by the caregiver/youth was 2.27 out of a possible six. The most common symptoms endorsed were nervous and restless.

For the purposes of further clinical analyses, the Colorado Client Assessment Record (CCAR) was used. The CCAR is an assessment completed by providers to rate the current functioning on 25 domains of every individual receiving public mental health services. It is conducted at admission, at six month follow-ups, and at discharge and each domain is rated on a 1-9 point scale. A score of 9 indicates the greatest severity, and a score that is greater than or equal to 5 indicates symptoms of clinical concern. We focus on a limited set of domains related to our specific outcomes of interest, reporting the percent who exhibit clinically elevated scores (5 or greater). Two domains reflect the overall mental health of individuals; Overall Symptom Severity (the severity of mental health symptoms) and Overall Level of Functioning (Extent to which a person is able to carry out activities of daily living, despite the presence of mental health symptoms). There were 23 CCARs completed at baseline the percent of youth with scores that are considered clinically elevated are presented in Figure 1.

Figure 1. Percent of Youth with Clinically Elevated Overall Domain Symptom Scores at Baseline



Risk Factors

The screening process for entry into the CME includes identification of presenting concerns (ADD/ADHD, Sex Offender, Developmental Disability/Autism, Drug/Alcohol abuse, Fire-setter, History of Sexual Misconduct, High Risk, History of Psychiatric Hospitalization, Major Affective Illness, Sex Trafficking Victim, Physical Disability, Previous Physical Abuse, Psychosis, Runaway, School/Community Concerns, Severe Aggression, Sex Offender Register, Sex Abuse Victim, Suicidal, Teen parent, Victim Notification, Other) for the youth, as well as Adverse Childhood Experiences (ACE) indicators (Physical Abuse Exposure, Emotional Abuse, Sexual Abuse, Substance Abuser in Home, Incarcerated Household Member, Mental Illness in Family, Mother Treated Violently, Single/No Parent in Home, Emotional Neglect, Physical Neglect, Other).

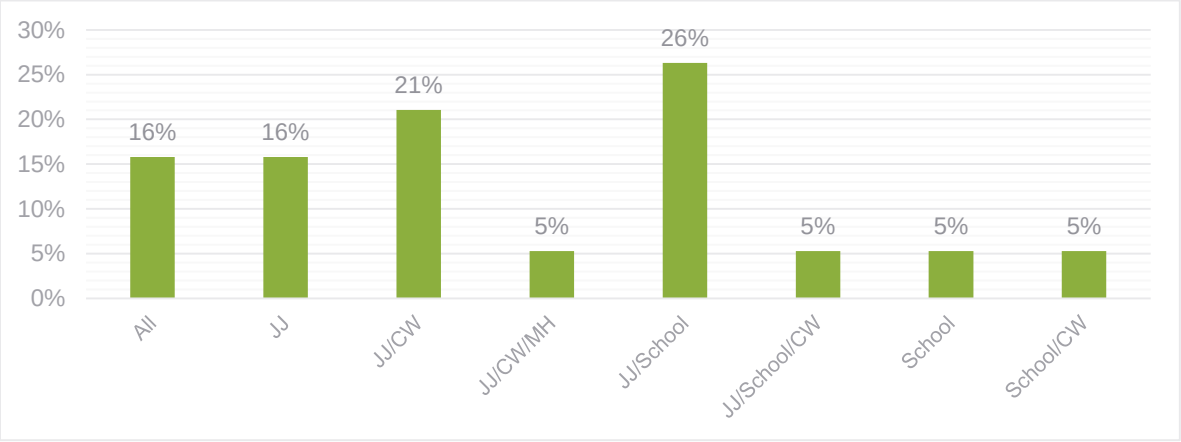
The mean number of Presenting Concerns identified on the CME screening at Baseline is 4.25 out of 22. Three-quarters are identified as High Risk, while 80% have School/Community concerns. Almost half of youth have ADD/ADHD and/or Severe Aggression. The mean number of Adverse Childhood Experiences indicators endorsed was 3.21 out of 11. ACE indicators are stressful and traumatic experiences that can affect development of youth. The same screening process specific to the CME identified 70% of youth living in single parent homes; half of youth have family members with mental illness and half are in families where the mother has experienced violence. Alcohol and/or drugs are present in slightly less than half the homes.

In addition to the previously mentioned risk factors, the CCAR includes a measure of family functioning. The family domain is defined as the extent to which issues within the individual's identified family and family relationships are problematic. At baseline, 48% of youth had clinically elevated scores on this domain.

System Involvement at Baseline

At each meeting of the CME Individualized Service and Support Team (ISST) system involvement is documented. The initial ISST for the 19 youth, with completed ISST forms, show all youth with at least one other system issue; 17 of 19 had Juvenile Justice Involvement. Fifteen of the 19 were involved in more than one system. Figure 2 shows the detail.

Figure 2. Percent of Youth by System Involvement



**CW = Child Welfare; JJ=Juvenile Justice; MH=Mental Health System*

At baseline, 20 of the 24 enrolled youth had some type of court involvement. Additionally, many (10) families had Dependency and Neglect cases open with the Department of Social Services. Court involvement is summarized below:

Table 2. Court Involvement at Baseline

Court Involvement	Probation	Truancy	DYC Commitment	Diversion
N	**16**	**2**	**1**	**1**

School Performance at Baseline

At screening almost 80% of youth had identified School/Community concerns. Fifty-eight percent were receiving school-based social, emotional or behavioral services. Thirty-five percent of youth had one or more unexcused absences from school at baseline.

The CCAR domain of Role Performance reflects the extent to which a person adequately performs his/her occupational role; for school-aged youth the score reflects school performance. At baseline, 65.2% displayed elevated scores indicating frequent disruption in role performance.

IT IS QUITE CLEAR THAT YOUTH ENROLLED IN THE CME HAVE COMPLEX NEEDS AND DEEP SYSTEM INVOLVEMENT. CARE COORDINATORS REPORT THAT THE MAJORITY OF REFERRALS ARE COMING FROM PROBATION OFFICERS AND DHS CASE MANAGERS WHO FEEL LIKE HIGH FIDELITY WRAP COULD ASSIST CLIENTS WHERE OTHER APPROACHES HAVE NOT.

SERVICES RECEIVED IN THE CARE MANAGEMENT ENTITY

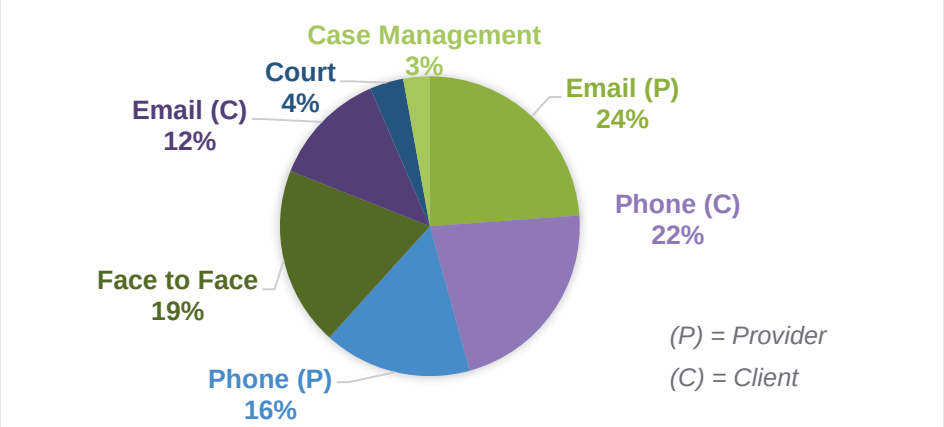
As of September 1, 2014, 19 youth were still enrolled in the CME. Mean length of time in services for all youth is 5.54 months, with a range of 2.0 to 11.2 months. Length of time in services for those who have been discharged (n=6) is 3.7 months. The shorter length of stay for those that were discharged is primarily due to the fact that these families and youth never engaged with the WRAP team. The Care Coordinators, however, made every effort to connect with the families than thus left the cases open for several months prior to closing the case.

Typical Services Received

Prior to entering the CME, the typical youth was receiving school-based services, and juvenile justice from separate providers. Upon entry into the CME the care coordinator worked with agency representatives for a coordinated Plan of Care and an Individualized Service and Support Team. The Care Coordinator worked to establish contact and maintain involvement with all relevant services and supports through phone calls, e-mail and text. Through WRAP the youth and his family built on existing family strengths and supports. Since the family didn't own a car, flex funds were used to purchase bus passes. With the initiation of SOC services, the overall need for formal services and high cost residential services significantly decreased

The average number of contacts with the Care Coordinator is 62.0 for all youth; the minimum number of contacts was 22 and maximum is 147. Percent of types of contacts are displayed below. Case Management was used for activities such as paperwork, data entry, or processing a referral.

Figure 3. The Percent of total Contacts with SOC Care Coordinator by Type



Flex Funds Usage

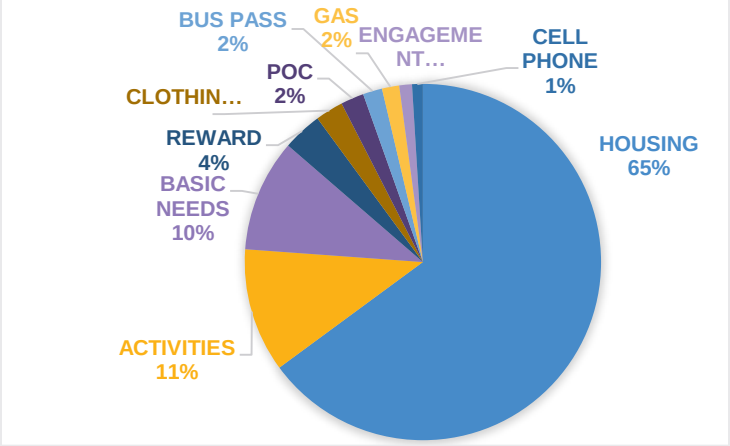
Twenty youth received some amount of flex funding. The mean amount of flex funds per child was $541 with a standard deviation of $638; this indicates a wide range of dollars spent per person. Eighty-five percent of funds were for daily needs including housing, transportation, and clothing.

MICHAEL'S STORY OF FAMILY VOICE

Michael has struggled with mental health and behavioral issues since childhood. Recently, these behaviors escalated to the point of stealing and bringing a gun to school. There were multiple systems involved in Michael's case prior to enrollment in the CME. At the time the family became involved in the WRAP process, decisions had been made that they didn't feel represented their values or desires. The WRAP team listened closely to the family and family and helped them communicate their perspective in a non-combative positive way.

Michael is now back at home with increased formal and informal supports. Many of the systems that Michael was previously involved with have closed their cases and Michael is back in school full-time.

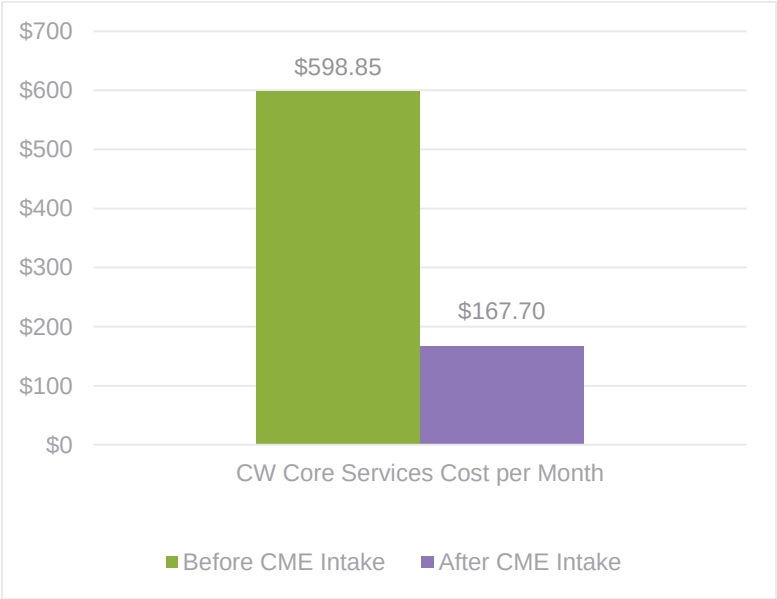
Figure 4. Total Amount of Flex Funds by Category



Child Welfare Core Services Before Intake and During the CME

Eight youth were recipients of Child Welfare (CW) Core Services. Core Services consist of Family Therapy, Life Skills, Day Treatment, Mental Health and Substance Abuse Services, Sexual Abuse Treatment, Aftercare, and County designed services. Total cost of CW Core Services in the time prior was $31,507; total cost during enrollment was $9,853. The following chart presents mean Core Services cost per month prior to intake into the CME and during the CME.

Figure 5. Child Welfare Cost Per Month: Before and After CME Intake



The number of out of home placements (DYC and CW) decreased from 29 to 13 from the time prior to CME intake to after. These include multiple placements for some youth, and no placements for the majority of youth. It must be noted that these numbers represent different time frames; the time up to the CME included years, while time after enrollment into the CME was on average about 6 months. A more relevant comparison is number of days in residential placement in the six month before enrollment and six months post enrollment in CME. For the 11 youth who had a residential placement, the numbers of days in the six months before and six months after CME intake are nearly identical at an average of 96.9 and 97.4 days respectively. It is important to note that seven youth were in placement at the time of their referral to the CME, therefore, there was no way the CME could have prevented their placement. However, the WRAP team became actively involved in planning for a transition back to the community. Comparing the days in the six months before intake into the CME to days after, shows 5 youth with a decrease in days, 3 with essentially the same, and 3 with increased days.

Medicaid Units of Service Before Intake and During the CME

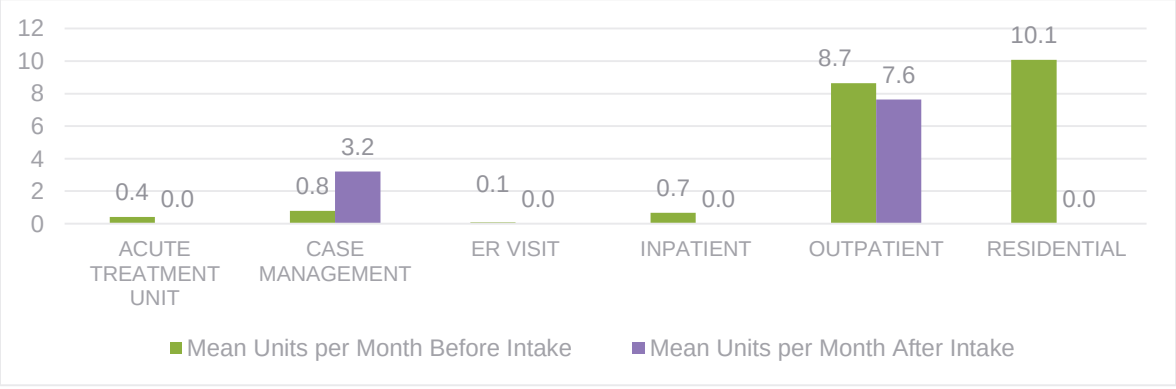
The mean number of overall Medicaid units per client, determined from paid claims records, decreased after CME implementation. Only Case Management showed an increase; all other modalities decreased. This increase is desirable and expected given the WRAP model's focus on an integrated case plan.

ISAAC'S STORY OF RESIDENTIAL TREATMENT

Isaac had been in and out of residential treatment for several years before enrolling in the CME. Each time insurance benefits expired he returned to his adoptive parents' home with little or no transition planning. Since the WRAP became involved in Isaac's case, the family has a comprehensive plan to get Isaac the services he needs while in residential placement and during transition home. The transition plan includes positive home visits and all family members agreeing to a timeline for a successful return home.

Isaac's Care Coordinator reported that this approach has allayed the families' fears that Isaac would return to the home before he was ready; due solely to matters of funding. They are now able to work on issues that help them welcome Isaac home.

Figure 6. Mean Number of Medicaid Services per Client: Before and After CME Intake



OUTCOMES

Outcomes were measured at six months for a few youth. The generalizability of the findings in this section are limited by the small number of youth for whom data was available at the time of this report. Results are reported in the following areas; perception of care, functioning, clinical symptoms, school performance, alcohol and drug use, social connectedness, and family functioning.

Typical Outcomes Achieved

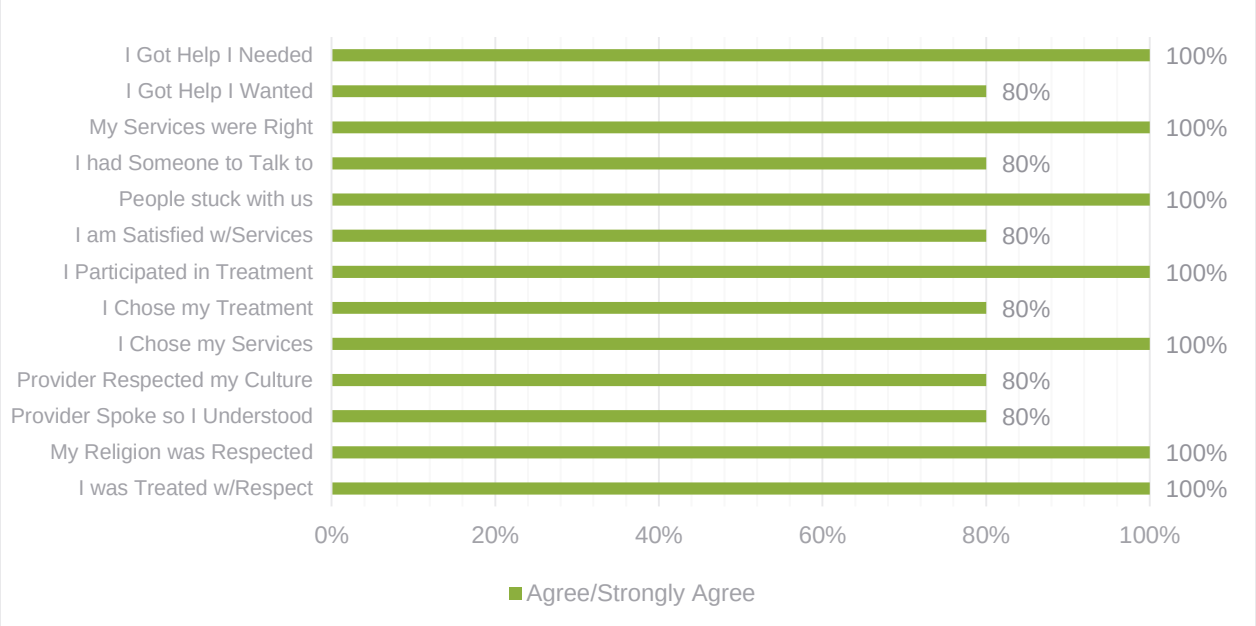
The typical youth and his family are working on communication and resolving conflicts. He is meeting all his terms of probation and hasn't had any new offenses. His school attendance has improved, with only one unexcused absence. His mental health is better, with less time spent anxious and nervous. He hasn't had any residential services since enrollment in the CME. He is fighting less with his siblings and mother

Perception of Care

Two measures assess the youth and caregivers' experience of care. The Perception of Care survey is administered at 6 months, and subsequent six month intervals and discharge.

Youth indicated 80-100% agreement with satisfaction items at 6 months. This suggests that youth are pleased with the services they are receiving.

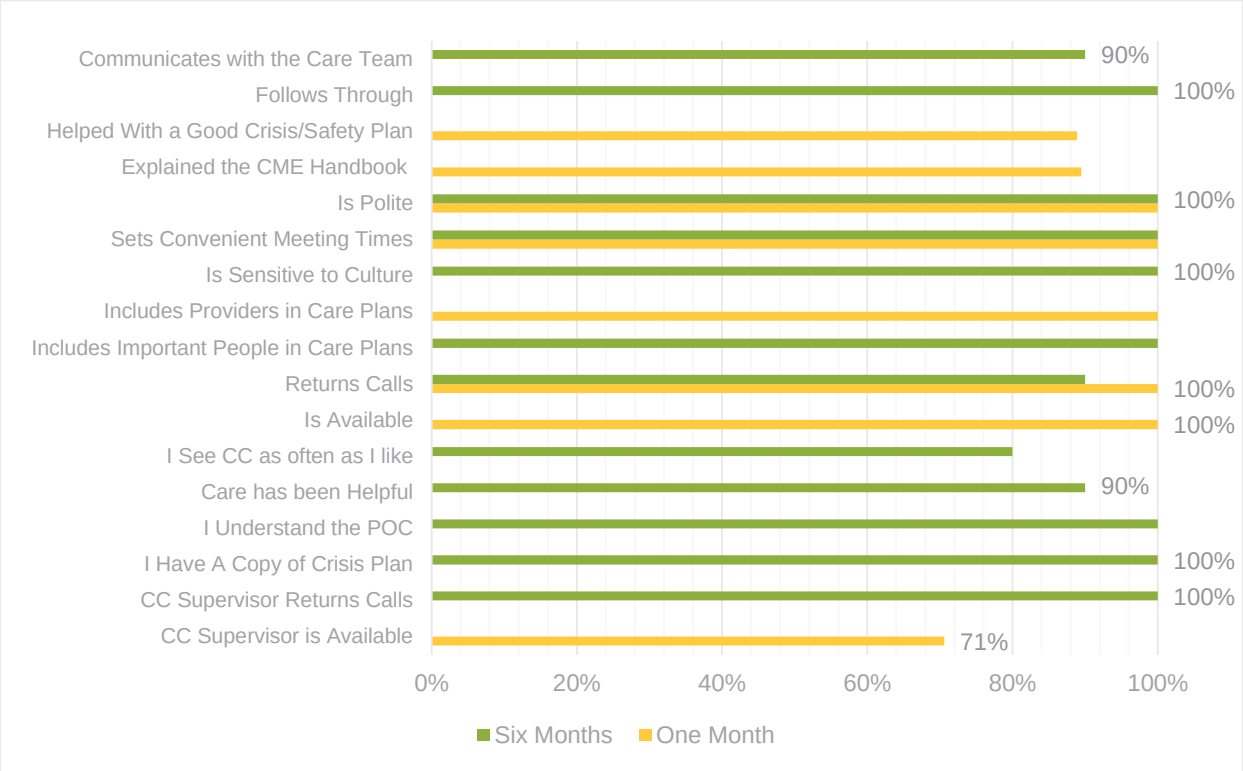
Figure 7. Percent of Youth Agreement with Positive Measures of Satisfaction at Six Months



Through a locally administered Family Satisfaction survey, caregivers report positive experiences with the CME and the Care Coordinators (CC) in particular. Note that only a few questions were asked at both time points

providing limited opportunity to see changes on measures of satisfaction at this point. The following figure depicts the percent of caregivers who agreed, or strongly agreed with positive statements about the CME Care Coordinators, their supervisors, and their overall experience with care coordination and the Plan of Care.

Figure 8. Family Satisfaction with Care Coordinator and Care Coordination Process

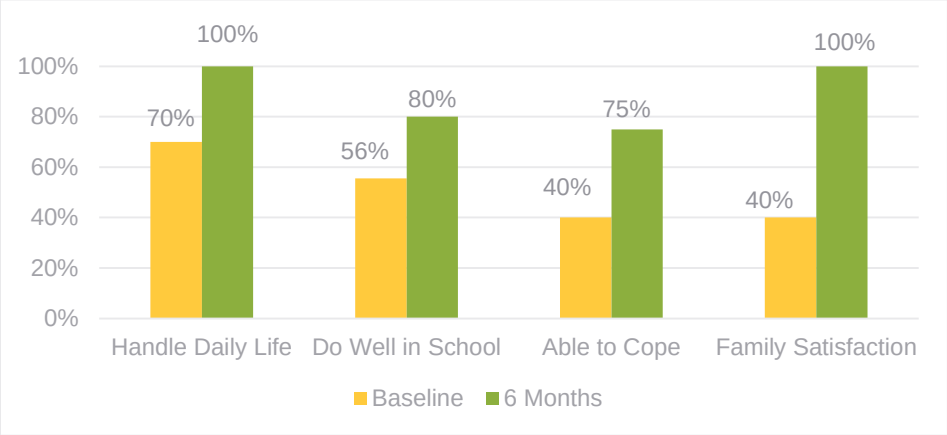


A variety of outcome measures are collected to track change in clinical symptoms and daily functioning. The following figures and graphs represent outcome measures at baseline (just prior to CME intake), and six months after CME intake, or at discharge.

Functioning

The following figure represents the percent of respondent who endorsed agreeing, or strongly agreeing to statements about how well the CME youth were doing across a variety of domains. Domains included; Handling Daily Life, Doing Well in School, Ability to Cope, and Satisfaction with Family. All measures improved from baseline, with 5 youth or families providing at least partial responses at six months.

Figure 4. Percent Endorsement of Positive Functioning: Baseline and Six-Month Measures



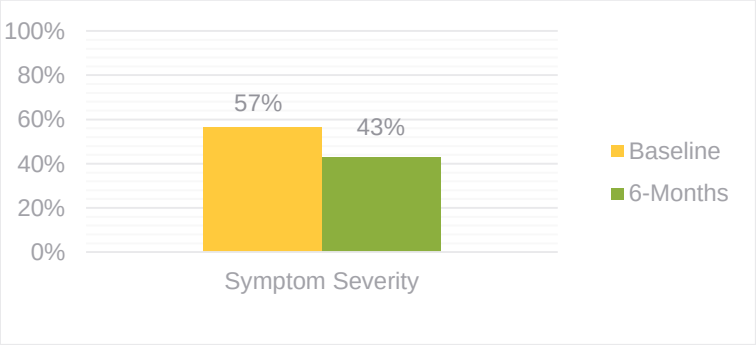
Seven CCARs were completed at follow-up. Scores in Level of Functioning improved from baseline to follow-up, decreasing from almost 40% to 29% of youth with clinically elevated scores.

Clinical Symptoms

Reported depression symptoms improved from baseline to six months, with mean number of clinical symptoms decreasing from 2.27 to 1.7 (out of 6).

Percent of youth with elevated CCAR domain score in Symptom Severity dropped by more than 10%. Figure 10 displays baseline and follow-up percent with clinically elevated scores.

Figure 5. Overall Symptom Severity: Percent of Youth with Clinically Elevated Scores at Baseline and Six-Months



Substance Use: Alcohol and Marijuana Use

Number of youth using alcohol and marijuana decreased from 14.3% and 21.4%, respectively, to 0% at six-months. It is important to note that this finding is based on youth self report for only five youth and is not consistent with reports from the Care Coordinators and thus may not be entirely representative of overall substance use.

ANTHONY'S STORY OF CREATIVE SOLUTIONS

Anthony was struggling with marijuana use, fighting, and had a charge for theft that all resulted in being placed on probation. He had poor attendance and grades at school. His home life was not conducive to turning things around because he had older siblings who were involved with drugs and criminal activity. Before he was involved with the CME DHS was considering some out of home placement options for Anthony.

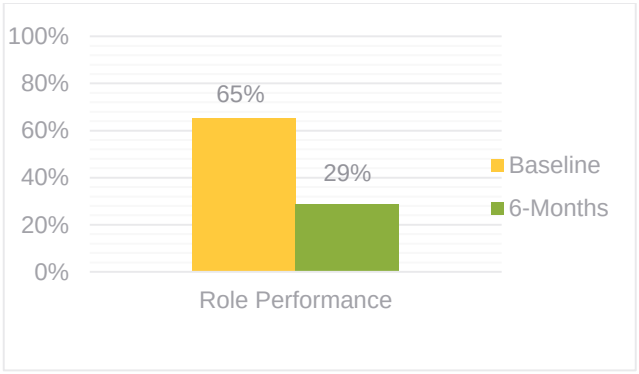
When the WRAP team became involved a family agreement was put in place to allow Anthony to live with his cousin during the school year. At her house he has space of his own to do his school work and is free from the bulling he felt from his older siblings. Jackson's attendance has improved considerably and he is currently passing all his classes. He is also seeing a MH therapist at the community mental health center and receiving substance abuse treatment.

School Performance: Unexcused Absences

School attendance improved. At baseline, 35.7% of youth had unexcused absences, dropping to 20% of youth at six-months.

CCAR ratings of Role Performance, reflecting school performance, showed improvement with a marked decrease in percent with elevated scores, displayed in Figure 12.

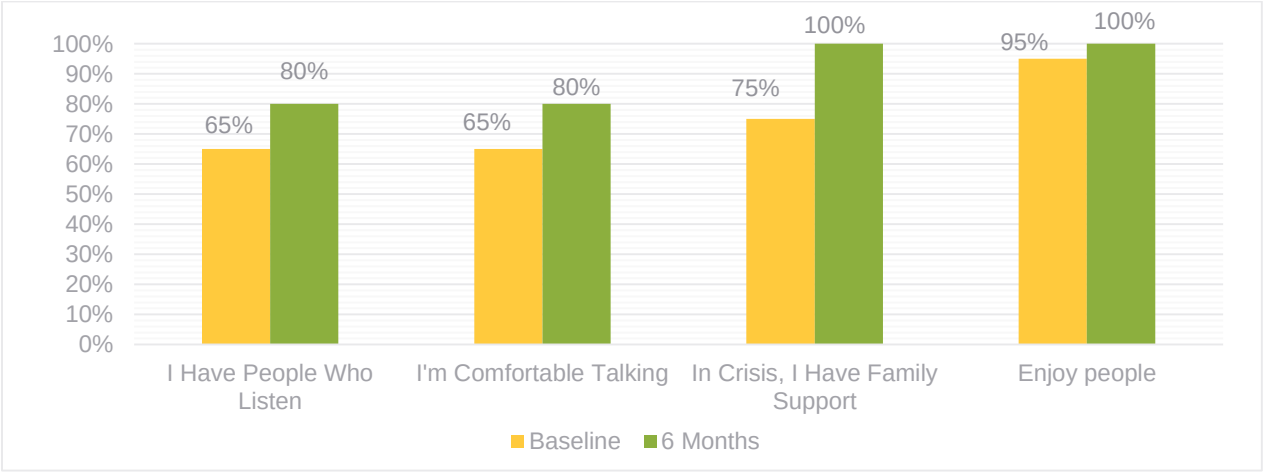
Figure 11. Role Performance: Percent of Youth with Clinically Elevated Scores at Baseline and Six-Months



Relationships/Social Connectedness

The following figure depicts the percent of youth who endorsed Agree/Strongly Agree to a variety of questions about their level of social connectedness. Youth felt more socially connected after time in the CME; endorsement of Social Connectedness items increased from baseline to six months.

Figure 12. Percent of Youth Agreement with Positive Measures of Social Connectedness



Family Functioning

The CCAR domain of Family issues did not show improvement from baseline to follow-up, increasing from 47% with elevated scores to 57%. This one non-positive finding may be indicative of family issues being directly addressed in services, with conflict being addressed rather than ignored. Additional follow-up will speak to this hypothesis.

SUMMARY

El Paso CME has served 25 youth, all with behavioral challenges and multi-system involvement. These youth present with complex family and social issues as well has high behavioral health needs. Despite the challenging nature of these cases some very promising results were revealed in both the system level and client level data. The positive findings include a decrease in Child Welfare Core Services expenditures, a possible reduction in out of home placements, a decrease in Medicaid services (except for case management), decreases in clinical symptoms, and high levels of satisfaction with services. Overall, costs to Child Welfare and Medicaid decreased in the form of a shift to less intensive, community-based services.

Family functioning did not improve at the six month follow up indicating additional work still needs to be done in this area and that this should remain a focus for those youth and families still receiving services through the CME. It is important to note that while promising, these results are preliminary and are based on few youth so must be interpreted with caution. There are still 19 youth enrolled in the CME who were included in this analyses plus additional youth who have enrolled since these data were collected. Future evaluation of this program will include these new youth and have longer term outcomes for the existing youth receiving services. These future analyses will be far more powerful to reveal results that, at this point, are promising.