



Quality improvement learning collaborative to examine foster care guidelines☆



Sandra Jee^{a,b,*}, Moira Szilagyi^{a,b,c}, Jan Schriefer^b, Anne-Marie Conn^b, Julia Weld^{b,d}, Philip V. Scribano^e, Linda Sagor^{f,g}, Heather Forkey^{f,g}, Janet Arnold-Clark^h, Adrienne Carmackⁱ, Chris Chytraus^j, LaRene Adams^j, David Harmon^k, Kelly Hodges^l, Mike Scahill^l, Tom Tonniges^m, Deb Shropshireⁿ, Stephen Meister^o

^a Starlight Pediatrics, Monroe County Health Department, United States

^b General Pediatrics, University of Rochester Medical Center, Rochester, New York, United States

^c Dept. of Pediatrics, UCLA, United States

^d University of Albany Medical Center, United States

^e SafePlace Center for Child Protection and Health, Children's Hospital of Philadelphia, United States

^f General Pediatrics, University of Massachusetts Memorial Health Care, United States

^g FaCES, University of Massachusetts Memorial Health Care, United States

^h LAC + USC Community-based Assessment and Treatment Center, United States

ⁱ The Key Clinic, Penobscot Pediatrics, Bangor, Maine, United States

^j Fostering Healthy Children, Utah, United States

^k STAR Health-Texas Medicaid for Children in Foster Care, United States

^l Child Protection Center, Medical College of Wisconsin, United States

^m Boys Town Pediatrics, Boys Town Institute for Child, Health Improvement, Omaha, NE, United States

ⁿ Oklahoma University Medical Center, United States

^o Family Health Division, Maine Center for Disease Control, Edmund N. Ervin Pediatric Center, MaineGeneral Medical Center, Maine, United States

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ABSTRACT

Learning collaboratives (LC) are an important method of implementing quality improvement by serving as laboratories to translate research into practice and sharing knowledge. We created a Foster Care Learning Collaborative (FCLC) of 11 foster care health sites to share best practices on providing health services for children in foster care. Using a collaborative approach involving monthly conference calls, we invited each health site to present specific health care delivery issues for the purpose of developing collaborative quality improvement projects regarding the delivery of healthcare to children placed into foster care. For health sites providing primary care (n = 8 of 11 sites), we examined adherence to two American Academy of Pediatrics (AAP) guidelines for children entering foster care: a) the initial health screen, and b) the comprehensive medical evaluations. At least four distinct types of health care models that provide either direct primary care or administrative oversight for children in foster care were identified: 1) medical home sites (n = 3); 2) foster care evaluation/intake sites (n = 2); 3) specialized primary care sites (n = 1); and, 4) state administrative programs (n = 2). Data from the six direct primary care sites (n = 586 children) and two state administrative models (n = 3855 children) was collected. The time-frame for the initial health screen was adjusted to 7 days after entry and adherence (31%) was comparable among primary care sites. Adherence to AAP guidelines regarding completion of a comprehensive medical evaluation within 30 days of intake varied among medical homes (30%–86%), intake models (23%–33%), specialized primary care site (43%), and state models (43%–73%). No site was fully compliant with the AAP guideline for universal comprehensive medical evaluation within 30 days, and there is variation within and among care models. A foster care learning collaborative identified significant variability in adherence to a commonly accepted guideline for timely access to healthcare for children placed into foster care. The LC c model offers the opportunity to evaluate best practices, identify barriers to care, and provide objective feedback for improvement.

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* Corresponding author at: University of Rochester Medical Center Dept. of Pediatrics, box 777 601 Elmwood Avenue Rochester, NY 14642, United States.

1. Introduction

Multi-site learning collaboratives (LC) can assess and address quality of care by engaging a community of experts around a common goal to improve standards of care (Hayes, Batalden, & Gldmann, 2014). The LC model, which utilizes Plan-Do-Study-Act (PDSA) cycles for quality improvement and measurement, has been gaining traction and has been implemented across many different service delivery systems (Devers, Foster, & Brach, 2013; Harvey et al, 2015; Lannon & Peterson, 2013; Lanter et al., 2015; Lau, 2015; Mold et al., 2014; Nadeem, Olin, Hill, Hoagwood, & Horwitz, 2013). LC methodology is used in quality improvement projects to evaluate outcome measures and to refine practice guidelines, and has highlighted the importance of active, inspirational team leadership and management (Versteeg, Laurant, Franx, Jacobs, & Wensing, 2012). Effective practice strategies can then be shared with relevant users and policy makers, and efficiently disseminated across systems. This type of practical quality improvement work is vital, for children in foster care, a population with special health care needs who have inconsistent access to health care. This high risk population could benefit from improved adherence with well-established health guidelines developed through expert consensus (Jee, Conn, et al., 2010a; Jee, Szilagyi, Blatt, et al., 2010c; Mekonnen, Noonan, & Rubin, 2009).

The American Academy of Pediatrics (AAP) published foster care health guidelines in 2005 (American Academy of Pediatrics, 2002, AAP, 2005) to address the significant unmet health needs of the ~650,000 children in foster care annually (AFCARS, 2014). Various descriptive studies using primary data collection (Chernoff, Combs-Orme, Risley-Curtiss, & Heisler, 1994; Halfon, Berkowitz, & Klee, 1992; Hochstadt, Jaudes, Zimo, & Schachter, 1987; Horwitz, Simms, & Farrington, 1994; Jee et al., 2006; Jee, Conn, et al., 2010a; Jee, Szilagyi, Ovenshire, et al., 2010b; McCann, James, Wilson, & Dunn, 1996; Schor, 1982; Simms, 1991) and secondary data analyses (Burns et al., 2004; Hurlburt et al., 2004; Jee, Antonucci, Aida, Szilagyi, & Szilagyi, 2005; Stahmer et al., 2005) have examined the prevalence of health problems for children in foster care. However, only one study, to our knowledge, has examined quality of care guidelines with respect to this vulnerable population (Jee, Szilagyi, Blatt, et al., 2010c). Empirical data supporting the AAP's foster care health guidelines, is lacking. Adherence to the guidelines should be evaluated in the context of emerging knowledge about the population's health care needs, varying practice models, and innovations, such as electronic medical records—all of which shift health care practice.

1.1. The current study

We used a LC approach to assess adherence to two clinically relevant guidelines in health models serving children in foster care. The Foster Care Learning Collaborative (FCLC), was comprised of experts in foster care health (n = 11 sites nationally) representative of several health models for providing care for children in foster care. In addition to this

core working group of foster care medical experts, we invited other foster care health sites representing diverse practice model types and geographic areas (See Table 1) to participate in a time-limited project to develop potentially better practices by conducting quality improvement projects relevant to their clinical or administrative site. Representative sites contributing data for this project (not inclusive of the larger group of foster care health professionals participating in this project) include: (1) three pediatric medical homes (health clinics providing a comprehensive evaluation and ongoing primary care for children in foster care) in Rochester, New York, Columbus, Ohio, and Los Angeles, California; (2) two intake health models (health clinics providing only a comprehensive evaluation upon admission to foster care) in Worcester, Massachusetts and Milwaukee, Wisconsin; (3) one specialized preferred provider care models (sites with expertise in foster care but not exclusively caring for children in foster care) in Bangor, Maine; and (4) two state level health administrative sites (with state-wide administrative databases for tracking children in foster care who receive primary care in a variety of settings, often with nurse practitioner outreach efforts) in Utah and Texas. Further, our FCLC included ongoing input from the American Academy of Pediatrics, and other foster care health sites in the United States.

Expert consensus was used to determine key outcome measures to assess quality of care across different health systems. We selected, as a marker of quality of care, the rate of adherence with the AAP's recommended 30-day comprehensive health visit. A thorough health evaluation a within 30 days of placement in foster care is recommended to identify and address all of a child's health needs. We describe the characteristics of participating health sites, and some clinics, reflecting the heterogeneity of health systems serving children in foster care, and report on the importance of standardizing care across systems.

Our study aims were to assess: 1) the types of health care models serving children in foster care; 2) adherence to the AAP recommendation regarding timing of the comprehensive medical examination; and, 3) current practices for foster care health sites and practice models.

2. Methodology

2.1. Data sources and description of process measures

The core working group used expert consensus to select foster care sites representing a diversity of experience, health care models and geographic locales. Our goal was to recruit an active group of 10–15 participants committed to quality improvement and willing to contribute data and expertise. Each clinical site presented information about their program and its role in the care of children in foster care during monthly conference calls, followed by discussions that often continued in subsequent emails and conference calls. The ongoing interaction enabled participants to share details about health care processes, communication, barriers to care, and solutions.

Table 1
Health care models for children in foster care.

Model type	Definition1	Examples
Medical home	Central location for children in custody to obtain medical care. Provides ongoing longitudinal primary care.	<ul style="list-style-type: none"> Starlight Pediatrics. Rochester, NY Fostering Connections. Columbus, OH VIP-CATC Foster Care Clinic, Los Angeles Boys Town Pediatrics, Omaha, NE Fostering Hope Clinic, Oklahoma University Medical Center
Evaluation/intake model	Conduct screening/and comprehensive visits following a coordinated intake process; does not provide ongoing longitudinal primary care	<ul style="list-style-type: none"> FaCES, Worcester, MA Child Protection Center, Milwaukee, WI Pediatric Rapid Evaluation Program (PREP), Maine
Preferred provider/specialized primary care	"Lead agencies" organize networks of primary and specialty physicians, with case management	<ul style="list-style-type: none"> The Key Clinic, Penobscot, ME
Nurse coordinator	Individual healthcare case management provided by public health nurses co-located at child welfare agencies	<ul style="list-style-type: none"> Fostering Healthy Children, UT
State administrated	State organized infrastructure to track and follow medical care of children in foster care	<ul style="list-style-type: none"> STAR Health, TX

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