A PILOT RCT OF A COLLABORATIVE CARE PRACTICE BETWEEN CHILD WELFARE AND CHILD HEALTH CARE

Mary Kathryn Curcio (Kristine Campbell, MD MSc)
Department of Pediatrics

Child Protective Services (CPS) comes to the aid of many families and youth throughout the state of Utah. Families that have referrals to CPS for suspected child maltreatment of their infant are often posed with social determinants that could have long-term negative health consequences for that child. CPS is a great resource to help address some of those determinants, however, there are many ways in which their involvement could be improved. This study focused on creating a communication and support system between families and infants involved in an open case with CPS, child welfare caseworkers (CWC), and primary care providers (PCP) as one way to improve the health outcomes of these infants. This work was supported by the Utah Division of Child and Family Services and the University of Utah Department of Political Science. This research was funded by the Interdisciplinary Research Leaders program, a national leadership program supported by the Robert Wood Johnson Foundation.

It is important to include PCPs in this chain of communication because they are often unaware of the involvement of CPS with their infant patients. This makes it difficult to completely understand their overall health as it can be greatly impacted by home life. It was hypothesized that this collaborative care practice would improve parental perceptions of infant health, child health care, and the child welfare mediations. Since this is a fairly novel study, the objectives included the feasibility of testing the collaborative care model on qualifying cases and
estimating the effects of the practice on infant-related quality of life (HR-QOL), CPS involvement, and PCP quality. The measures of this study were feasibility of collaborative care assessed with child welfare data for all eligible subjects, the number of CWC trained in collaborative care, and the percentage of cases where collaborative care was introduced, accepted, and completed. The effects of collaborative care evaluated with longitudinal surveys of consenting parents of eligible subjects (baseline to six months), infant HR-QOL, Parents’ Perception of Primary Care (3PC), and parents’ Perception of Child Welfare.

The pilot was a randomized control trial in seven counties in Salt Lake and western regions of Utah’s Division of Child and Family Services spanning from October 2017 to December 2019 and centered on infants aged less than twelve months at referral. All CWCs in these areas were trained in the care process model and then randomized 2:1 in collaborative to standard practices implementation after training. Qualifying families would give their informed consent to participate in the research and the independent variable would be whether the caseworker used the model.

The collaborative care practice model can be separated into four steps: an engagement by caseworkers with parents on issues of infant health and health care, a formal request from caseworkers for parental consent to contact an infant’s primary care provider, consented telephone outreach to an infant’s primary care provider early in CPS casework to discuss infant health and social risks, and consented written follow up at CPS case closure to provide outcome information to the primary care provider. All participating families were interviewed at case opening and six months later, after their case had closed, to mark any changes in parent or guardian perceived infant health and wellbeing. They were also questioned about their perceived primary care provider quality of care and overall benefit of DCFS involvement.
Analyzation of the preliminary data showed many important findings. At the baseline interview, 46% of interviewees under the collaborative practice and 75% of those under the standard practice agreed with the statement “Overall, my family benefitted from DCFS involvement.” Children in the standard practice portion of the study had a lower HR-QOL which can allow for more opportunity of improvement over their course with CPS. Conversely, early surveys showed that children in the collaborative practice portion of the study had a reduction in social and emotional HR-QOL at the six-month interview. Parent perceptions of PCP at six months under the standard practice was 97/100 and under the collaborative practice was 96/100. Parent reports showed recall of discussions of health and health care are not associated with collaborative care and outreach to PCPs is rare. Lastly, of the 142 caseworkers that were trained and randomized, only 54% had eligible cases to participate in the study.

While the data did not show major differences in perceived health and quality of care between families who received the practice and those who did not, this does not mean collaborative care implementation is unsuccessful. Our findings show that it is unknown how to properly implement these practices. Cross-sector collaboration is not an intuitive task as there are very different languages and procedures between the child health care and child welfare organizations. New relationships are required to build a more cohesive, cooperative community. Proper implementation of these practices is also difficult as Child Welfare Caseworkers are generally underfunded and given a very heavy caseload. The study needs to learn how to properly implement these practices while working more with the challenges presented and ultimately apply the collaborative practice to a larger scale. Ultimately, there is hope that through this research, the relationship between child welfare caseworkers and child health care communities can be strengthened to provide the best possible support for families and well-being for infants involved with Child Protective Services.