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Pediatric Return Appointment Adherence for Child Welfare-Involved Children in Los Angeles California

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Abstract

Objectives—This study of primarily Latino caregivers and Latino child welfare-involved children had the following aims: (1) explore the return appointment adherence patterns at a pediatric medical clinic; and (2) determine the relationship of adherence to return appointments and caregiver, child, and clinic variables.

Methods—The sample consisted of caregivers of child welfare-involved children who were asked to make a pediatric outpatient clinic return appointment ($N = 87$). Predictors included caregiver demographics, child medical diagnoses and age, and clinic/convenience factors including distance from the clinic to caregiver's home, days until the return appointment, reminder telephone call, Latino provider, and additional specialty appointment. Predictors were examined using χ^2 and t tests of significance.

Results—Thirty-nine percent of all caregivers were nonadherent in returning for pediatric appointments. When return appointments were scheduled longer after the initial appointment, caregivers were less likely to bring children back for medical care.

Conclusions—The 39% missed return appointment rate in this study is higher than other similar pediatric populations. Better coordination between pediatricians and caregivers in partnership with child welfare case workers is needed to ensure consistent follow-up regarding health problems, especially when appointments are not scheduled soon after the initial appointment.

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Keywords

Return appointment adherence; Latino caregivers; Child welfare; Foster care

Introduction

In 2012, child welfare agencies in the United States received an estimated 3.4 million referrals, which included 6.3 million children (1). A higher proportion of children investigated by child welfare workers have special health care needs than the national population (2), and these children are considered one of the most medically vulnerable populations in the United States. Specifically, children removed from their home and placed in foster care have more health problems than a similar Medicaid-eligible population (3) and a higher prevalence of chronic health conditions than national estimates (4). Most children served by child welfare remain in their homes (5), and young children in child welfare who remain at home have a similar prevalence of health problems as children placed in foster care. (6). Foster children receive fewer outpatient services than their Medicaid-eligible peers, and as foster children age and experience more placements, their reliance on emergency room visits increases (7). Thus, improving follow-up for health problems in primary care pediatrics may lead to better health outcomes and less use of acute health services. This study examined factors associated with primary care return appointment adherence for child-welfare involved children.

Often the lack of health insurance is identified as the causative factor limiting health care access and use. Most children in the child welfare system have stable health insurance coverage, primarily Medicaid, state-provided health insurance (8). Even with health insurance, pediatric health care utilization for children in foster care remains insufficient to meet their needs (9). Some of these children receive limited preventive care, such as well-child visits and dental care, and even initial physical assessments are inconsistent (10, 11). Recommendations to improve health care services have been directed toward children in foster care, although children who remain in their homes likely also need better services to ensure early identification of unmet and preexisting health conditions, treat acute health problems, and manage chronic conditions (6, 12). The American Academy of Pediatrics (AAP) and the Child Welfare League of America has issued recommendations for children in foster care regarding rigorous and periodic physical and mental health assessment, development of an individualized health care plan, more frequent health maintenance visits and follow-up, and systematic health record keeping (9, 13).

Within vulnerable populations, diverse factors can negatively impact pediatric appointment adherence. For example, caregiver characteristics ranging from parenting style (14) to driving a car (15) predict pediatric appointment-keeping. In addition, features of the clinic setting, such as shorter waiting times or more clinician continuity, are associated with improved appointment-keeping (16). Specifically for Latino families, the ability for the pediatric provider to speak Spanish as well as understand the culture of the Latino family affects health care utilization and adherence (17). Additionally, when caregivers have many pediatric appointments, there is sometimes appointment fatigue and they are less likely to

attend the appointments (18). For children involved in the child welfare system, caregivers are understood to be the gatekeepers of accessing and utilizing pediatric primary care for children under their care (19). Therefore, examining individual caregiver *and* environmental factors in terms of the caregivers' central role in pediatric adherence may be a useful way to understanding what puts child welfare-involved children at risk for missing appointments.

We explored whether characteristics of caregivers, the child, and the clinic environment were associated with adherence to return appointments. We hypothesized that caregivers who had less education, spoke only Spanish, lived farther from the clinic, and who did not have another caregiver in the home would be associated with higher nonadherence (20–22). We also hypothesized that when a child had more health problems, the child was younger, the family received a telephone call reminder about the appointment, and the return appointment was scheduled closer in time to their initial appointment there would be greater adherence (23, 24). We expected that adherence would be higher in foster families because case management services provided by the child welfare system are more rigorous than those provided to birth parents (25). Also for this primarily Latino population of caregivers, we expected that having a Latino pediatric provider request the return appointment would increase adherence (17). This study of primarily Latino caregivers and Latino child welfare-involved children had the following aims: (1) explore the return appointment adherence patterns at a pediatric medical clinic; and (2) determine the relationship of adherence to return appointments and caregiver, child, and clinic variables.

Methods

Setting and Sample

The setting for data collection was the Community-Based Assessment and Treatment Center (CATC), a pediatric clinic linked to the Los Angeles County Department of Children and Family Services (DCFS) that provides initial assessments and primary health care to children involved in the child welfare system. CATC provides care regardless of health insurance status. The majority of clients served at CATC and their caregivers are Latino or belong to other ethnic minority groups. The University of Southern California Institutional Review Board, DCFS, and the County Juvenile Court granted approval for this research.

Procedures

Between May 2012 and January 2013, three pediatricians and two nurse practitioners, all bilingual, working at CATC invited caregivers of children who were scheduled for follow-up appointments to participate in the study. Return appointments were scheduled for children who required follow-up for a medical problem identified on the initial examination or when the caregiver requested that the child's primary health care continue at CATC. Children were scheduled for routine health maintenance exams as recommended by the AAP foster care policy, which includes a recommendation that all children in foster care over age 2 have a health maintenance visit every six months. Children received a sooner follow-up appointment if indicated by the medical needs of the child. Most follow-up appointments for medical problems were scheduled every 3–4 months. All children served at CATC receive services from DCFS and either are in foster care or remain at home with

DCFS oversight. Thus the caregivers who came to the clinic were either foster caregivers or birth parents. Caregivers could only participate in the study once, and if they had more than one child with a follow-up appointment, the pediatric health providers randomly chose one of the children as the target child for the study. Pediatric providers obtained informed consent from caregivers who agreed to participate and administered self-report questionnaires. More than 80% of potential caregivers consented participated in this study. Of the 92 caregivers who consented, 87 reported that the target child was living with them at the time of the scheduled follow-up appointment and thus constituted the final study population. DCFS confirmed that the child's foster placement had changed for the five caregivers who reported that the child was no longer living with them.

Caregivers were asked to schedule their return appointment at CATC prior to leaving the clinic and were provided with a written confirmation of the date and time of their return appointment. When time permitted, staff members at CATC called caregivers before return appointments to remind them to attend.

Measures

Information regarding child's age, type of maltreatment, number and type of medical diagnoses, referrals for specialty appointments, the ethnicity of the provider, and whether reminder phone calls were made was collected from CATC's computerized medical records. When caregivers consented to participate in the study, they reported their level of education, language, age, address, marital status, ethnicity, relation to the child, and child's ethnicity. The caregiver's address was used to determine the distance from their home to the clinic using Google Maps. A missed appointment was defined as any appointment a child did not attend while living with the same caregiver who attended the initial appointment, a cancelled appointment that was not rescheduled and attended, or an appointment that was not scheduled by the caregiver when the pediatric provider requested a return appointment for the child.

Analysis

Caregiver and child demographics were described. Hypothesized predictors of return appointment adherence and nonadherence were examined using χ^2 and *t* tests of significance, depending on whether variables were categorical or continuous. Additionally, we examined some within group samples (e.g. unrelated foster caregivers versus relative foster caregivers, children with no medical diagnoses versus children with a medical diagnosis) for differences in adherence rates. We also examined the subsamples of monolingual Spanish-speaking caregivers' and Latino caregivers' adherence rate for the predictor, Latino provider.

Results

The caregivers who participated in this study were 44.43 years old on average (*SD* = 10.78), and the children in their care had a mean age of 3.44 years old (*SD* = 4.12). Almost 20% of the children were considered healthy and did not have a medical diagnosis, although 44% had multiple diagnoses. The most frequent type of maltreatment and the most prevalent

medical problem were both related to parental drug use and prenatal drug exposure. The majority of return appointments were scheduled in the fourth month after the first appointment. Further descriptive data for both caregivers and children are presented in Table 1.

Thirty-nine percent of children did not return for their follow-up appointment, and there was no statistically significant difference in adherence patterns between foster caregivers and birth parents (Table 2). In the foster care group, there was no difference in adherence patterns between kinship ($n = 33, 42.9\%$) and unrelated foster caregivers ($n = 44, 57.1\%$; $\chi^2[1,74] = .26, p = .61$). Of the hypothesized predictors of nonadherence, only one was statistically significant. When return appointments were scheduled later after the initial appointment, caregivers were less likely to bring children back for medical care ($t[83] = 2.65, p = .01$). For example, when appointments were scheduled within 2 months after the initial appointment, 86% of caregivers returned. When appointments were scheduled 5 months or more after the initial appointment, only 45% of caregivers returned. Very few caregivers received appointment reminders via telephone ($n = 12, 13.8\%$). Receiving a reminder phone call before the scheduled appointment did not affect return rates ($\chi^2[1,87] = .04, p = .84$).

Discussion

This study found that the nonadherence rate for return appointments was slightly higher for children in the child welfare system than in studies with other pediatric populations, in which nonadherence rates ranged from 21% to 35% (18, 23, 26, 27). The 39% missed appointment rate in this study is disturbing since case management services are provided by child welfare to caregivers to ensure that children have the best possible health care (25). This study did not identify many characteristics that significantly predicted nonadherence, aside from the length of time before a follow-up appointment was to occur.

It could be that from the caregivers' perspective, the difference in length of time between the original appointment and the follow-up could be viewed as a proxy for the significance or perceived importance of the follow-up. The number of medical diagnoses, which could also be viewed as a proxy for the medical need for a return appointment, was not related to adherence. A longer time between the first appointment and the return appointment could have made it more likely for caregivers to forget about their appointment. Although receiving an appointment reminder was not related to adherence in this study, this could have been due to the fact that few of the caregivers in this study received a telephone appointment reminder.

Child welfare case managers and pediatric providers need to reinforce that medical follow-up appointments are important, even when they are not scheduled close to the initial appointment. Engagement of caregivers by the child welfare system improves adherence to required mental health services, thus engagement by caseworkers with caregivers regarding their child's health care problems and needs could also be helpful in improving the adherence to needed pediatric health services (28, 29).

Most of the caregivers in this study were foster caregivers. Many foster caregivers have stressful lives with many responsibilities (30), and family stress is related to non-adherence to pediatric appointments in other pediatric populations (31). The convenience factor studied, distance from clinic to home, was not significantly associated with adherence, but it should be noted that the caregivers traveled great distances to reach the clinic (on average, 11 miles). Los Angeles is a very large metropolitan city where geographical access to health care may depend on the caregivers' ability to have use of a car or proximity of a bus stop. Although Los Angeles has a small subway system, CATC is not near any of the subway stops. It could be that some caregivers had to balance the convenience of having a closer health clinic with the quality of health care provided by pediatric physicians and nurse practitioners who already know their children.

Limitations

The study population was primarily Latino and urban, so these findings cannot necessarily be generalized to other populations. The low representation of birth parents in our sample limited our ability to test for differences in adherence rates between children placed in foster care and children who remained at home. The reasons for child welfare involvement in the medical record were noted by DCFS when participating children were referred to CATC and may not represent all types of maltreatment they experienced. Information about the extent of involvement of child welfare caseworkers was not available. It is not known whether caregivers who did not bring their children back for their return appointment went to another pediatric clinic. The medical record did not distinguish whether the return appointment was for follow-up on a medical problem or for a routine appointment.

Conclusion

This was the first study we know of to examine caregiver, child, and clinic/convenience characteristics associated with pediatric return appointment adherence for children in the child welfare system. The findings from this study illustrate the need for better coordination between pediatricians and caregivers in partnership with child welfare case workers to ensure consistent follow-up for health problems, especially when appointments are not scheduled soon after the initial appointment. Although identification of the type of health problems identified for children in this study was not a research aim, we found that almost 35% of the children in the study were exposed to drugs in utero, making their need for consistent pediatric health care even more urgent. Child welfare case workers need to make sure that the new caregivers of foster children who change placements, which occurred for five children who entered the study, are aware of and attend scheduled pediatric health appointments.

Most importantly, this study identified a serious health care delivery issue for children in child welfare: 39% of caregivers did not bring their child back for a return pediatric appointment. Almost all the child, caregiver and clinic factors studied (except time between the first and second appointment) were not related to adherence to return appointments. There could have been other clinic processes, e.g. how appointments were made, timing of appointments, and wait times at the clinic, that were more important for predicting adherence for this population of caregivers, who may already be stressed by child care

responsibilities. The problem of scheduling medical appointments optimally for the patient has received national attention, and may also be of importance to child welfare caregivers. (32) Further research on how child welfare caregivers view the pediatric health care they receive and whether they value these services could lead to a better understanding on how to improve health services for this vulnerable population of children. Also research on the efficacy of appointment reminders is necessary for children in child welfare as it has improved appointment adherence in other populations. (33) It would be important to include return appointments that were a longer time after the initial appointment in research on return appointment reminders because in this study these appointments were the most likely ones to be missed.

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Table 1Descriptive Information for Sample ($N = 87$)

	<i>N</i>	%
Child information		
Male	56	64.4
Race and ethnicity		
White	8	9.2
Latino	66	75.9
Black	8	9.2
Other or multiracial	5	5.7
Medical diagnoses		
Drug exposure in utero	30	34.5
Respiratory	14	16.1
Dermatological	13	14.9
Developmental	13	14.9
Head and neck	9	10.3
Behavioral	8	9.2
Ophthalmology	7	8.0
Failure to thrive	6	6.9
Gastrointestinal	6	6.9
Obesity	6	6.9
Urological or gynecological	4	4.6
Orthopedic	3	3.4
Infectious disease	3	3.4
Neurological	1	1.1
Hematological	1	1.1
Reason for child welfare involvement		
Drug exposure	38	43.7
Neglect	28	32.2
Emotional abuse	20	23.0
Physical abuse	13	14.9
Caregiver absence or incapacity	8	9.2
Sexual abuse	3	3.4
Caregiver information		
Male	15	17.2
Race and ethnicity		
White	7	8.0
Latino	66	75.9
Black	7	8.0
Other or multiracial	5	5.7
Time between initial and follow-up appointment		
First month	4	4.6

	<i>N</i>	%
Second month	10	11.5
Third month	15	17.2
Fourth month	30	34.5
Fifth month or later	26	29.9
Never Scheduled	2	2.3

Note. Caregiver ethnicity was missing for two participants. Eighteen children did not have a medical diagnosis. Eighteen children had more than one reason for child welfare involvement listed in their medical record.

Table 2

Differences between Adherent and Nonadherent Participants

	Missing	Overall (N = 87)		Adherent (n = 53)		Nonadherent (n = 34)		p
		n	%	n	%	n	%	
Caregiver factors								
Monolingual Spanish	0	41	47.1	24	58.5	17	41.5	.67
Relation to child	0							.45
Birth parent		10	11.5	5	50.0	5	50.0	
Foster caregiver		77	88.5	48	62.3	29	37.7	
Education level	9							.31
< High School diploma		21	24.1	11	52.4	10	47.6	
High School diploma		57	65.5	37	64.9	20	35.1	
No. of caregivers	6							.12
One caregiver		37	42.5	19	51.4	18	48.6	
Two caregivers		44	50.6	30	68.2	14	31.8	
Clinic factors								
Specialty Referral	0	7	8.1	5	71.4	2	28.6	.55
Latino Provider ^a								
For Latino caregivers	0	40	46.0	21	52.5	19	47.5	.14
For Spanish-speaking caregivers	0	25	28.7	13	52	12	48	.28
Received reminder call	0	12	13.8	7	58.3	5	41.7	.96
		M	SD	M	SD	M	SD	
Miles from clinic	0	11.13	7.81	11.37	6.93	10.77	9.13	.73
Days until return appointment*	2	104.39	52.64	93.04	50.34	123.16	51.72	.01
Child factors								
Age, months	0	41.28	49.46	34.00	41.00	52.62	59.24	.09
No. of diagnoses	0	1.45	1.11	1.45	1.17	1.44	1.02	.96

There was no significant difference in adherence between healthy children (no diagnoses) and those with one or more diagnoses ($\chi^2[1.87] = .00, p = .99$).^a 54.0% of first appointments were conducted by Latino providers.

$50' > d'$
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