Breaking Down Silos: Decreasing Child Maltreatment Fatalities by Improving Collaboration between Medical Professionals and Child Protective Services

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Acknowledgements

- Casey Family Programs – Senior Policy Fellow Program
- My CAC Colleagues
- The CAC research team
- Allegheny County Child Protective Services
- The Child Health Evaluation and Coordination Service (CHECS) nurses

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Objectives

By the end of this talk, you should be able to

(1) Report how common child maltreatment-related fatalities are in the United States

(2) Describe how lack of communication between Child Protective Services (CPS) and medical professionals can contribute to morbidity and mortality from child maltreatment

(3) Learn about several new approaches which enhance communication and collaboration between CPS and medical professionals

Child Maltreatment

- Encompasses
  - Physical abuse
  - Sexual abuse/exploitation
  - Medical child abuse
  - Emotional abuse Human Trafficking
  - Neglect – multiple types (e.g., Supervisional, Medical, Physical, Educational)

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The Reality of Child Maltreatment

Each year in the US

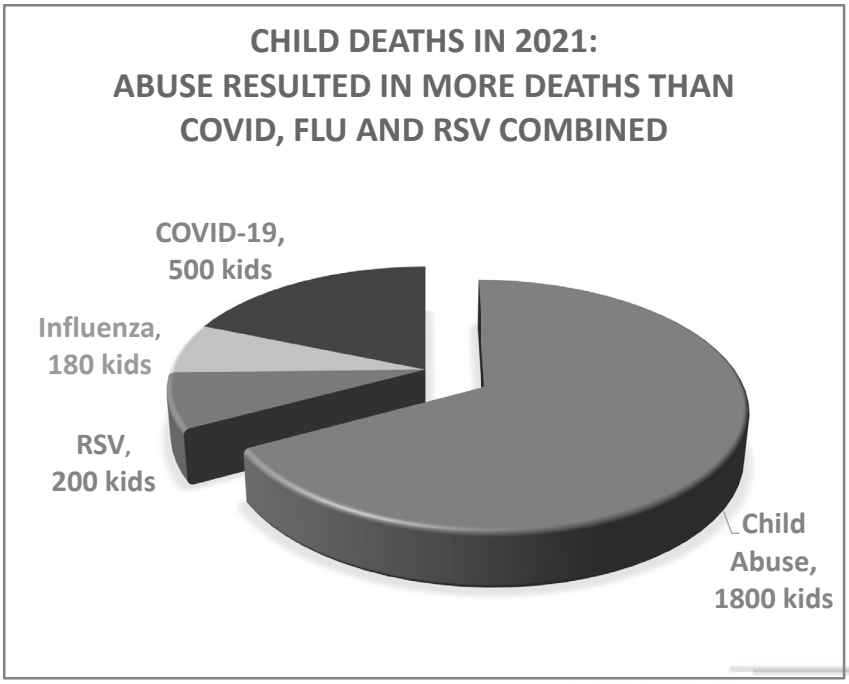
~ 4 million referrals made to CPS

~ 700,000 children maltreated

Mortality has increased > 10% over the past 5 years

Most deaths occur in children < 3 years old

50% of deaths are in infants < 12 months old



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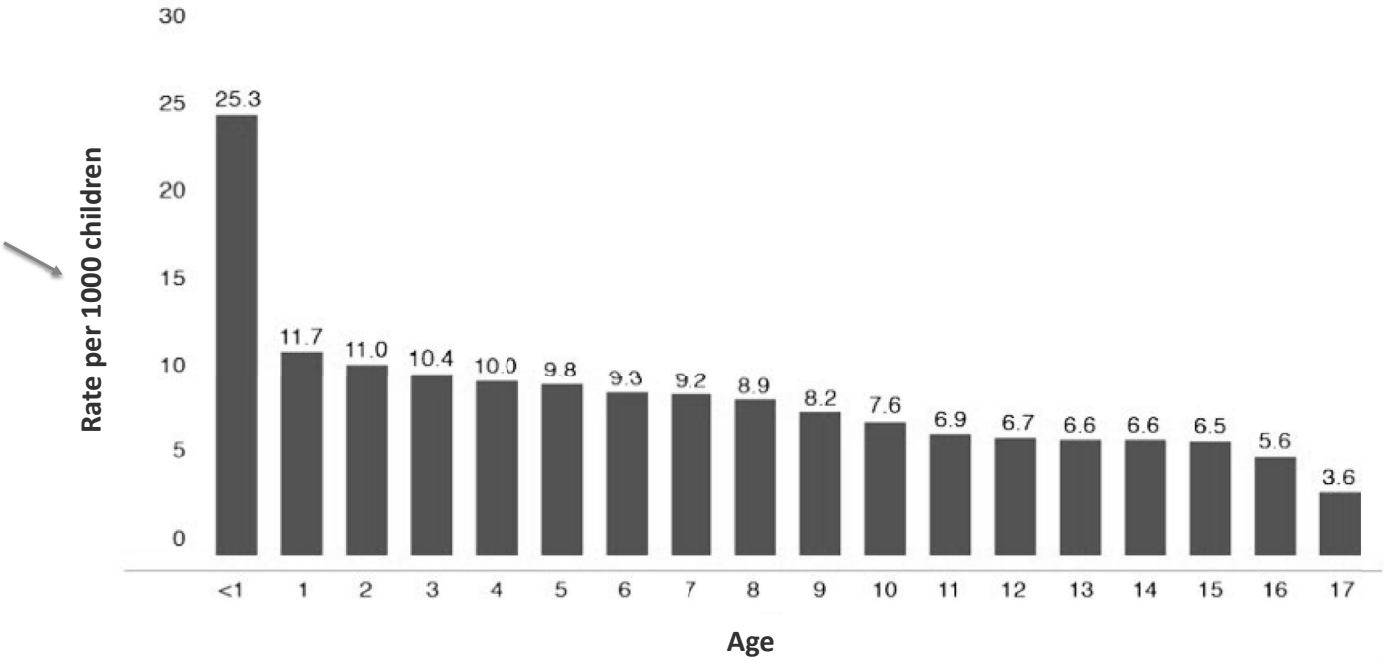
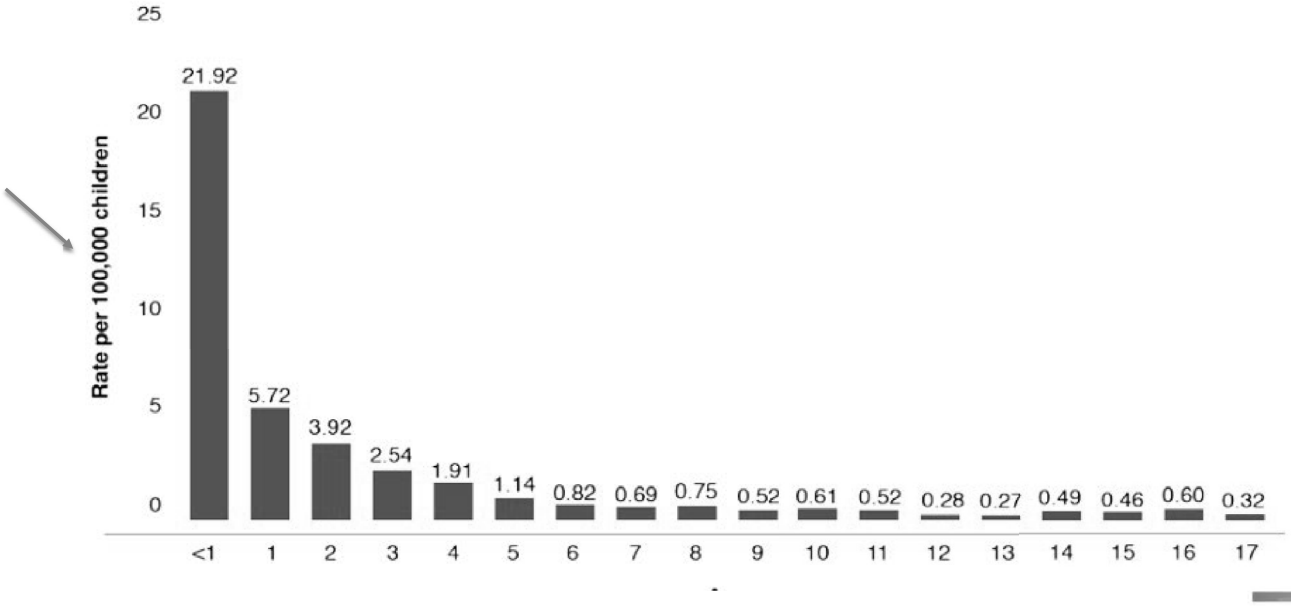
Child Maltreatment Victims by age



Child Maltreatment FATALITIES by Age



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The Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF)

- Established by the Protect Our Kids Act of 2012
  - broad, bipartisan support in the House
  - passed the Senate unanimously
  - signed by Obama on January 14, 2013

- Mission was to develop a national strategy and recommendations for reducing fatalities across the country resulting from child maltreatment

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The Faces of Child Maltreatment

Miami Herald – Innocents Lost – March 16, 2014
477 children known to Florida CPS who subsequently died

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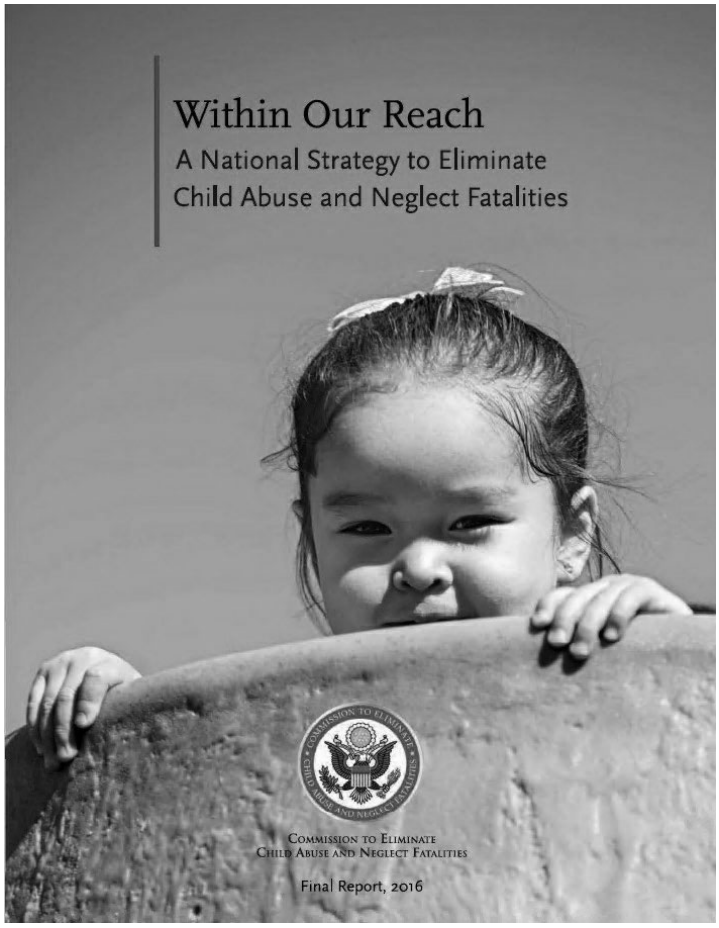
Commentary: We all share blame in kids' death – Fred Grimm

This was a mass killing. A massacre of babies.

They were beaten, burned, choked, drowned, smothered, tortured, shot, hurled against bedroom walls. They were starved to death….Each individual killing could be blamed on the cruel or negligent or raging act of a particular parent or a parent's lover. But in the aggregate, 477 child deaths over the last five years implicate other culprits.

You and I, in our detached indifference, became accomplices in this carnage, along with the government agency we've so half-heartedly tasked with protecting Florida's…kids

CECANF issued its final report to the President and Congress on March 18, 2016



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Of the 5 Significant Findings, 2 Involved Health Care

- Involvement of health care and public health agencies and professionals is vital to safety for children. Well-coordinated interagency efforts are essential

- The importance of child protection workers' access to real-time information about families cannot be overestimated

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Child Maltreatment Fatalities

- ~50% of children who die from maltreatment - neglect or abuse – were known to CPS prior to the death
  - Some had been referred multiple times

- Almost all *should* have been known

- We can have an impact when the missed opportunities to protect children involve medical professionals

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What are the potential missed opportunities to identify an at-risk child?

- Suspicion for maltreatment not IDENTIFIED by the medical provider
    - Fact that weight has dropped from 50% to <1% is not recognized when a 9-month-old comes in for wheezing
    - Provider doesn't realize the bruise on a 2-month-old should prompt a child abuse evaluation
- Potential for physical abuse or neglect not properly EVALUATED by the medical provider
    - No skeletal survey done in a 6-month-old with a fracture - Leads to inability to accurately assess the likelihood of abuse
- Suspicion of abuse not REPORTED by mandated reporter

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If the concern is reported, why might be we not be able to protect children after the first referral?

- Suspicion of abuse REPORTED, BUT the concern is not handed off in a way which allows CPS to make an accurate assessment
- Error in DECISION-MAKING by CPS leads to child not being safe
- Error in DECISION-MAKING by the judicial system leads to child not being safe
- A combination of one of the more of the above AND the reality that we are unable to accurately predict how people - particularly adults - will behave

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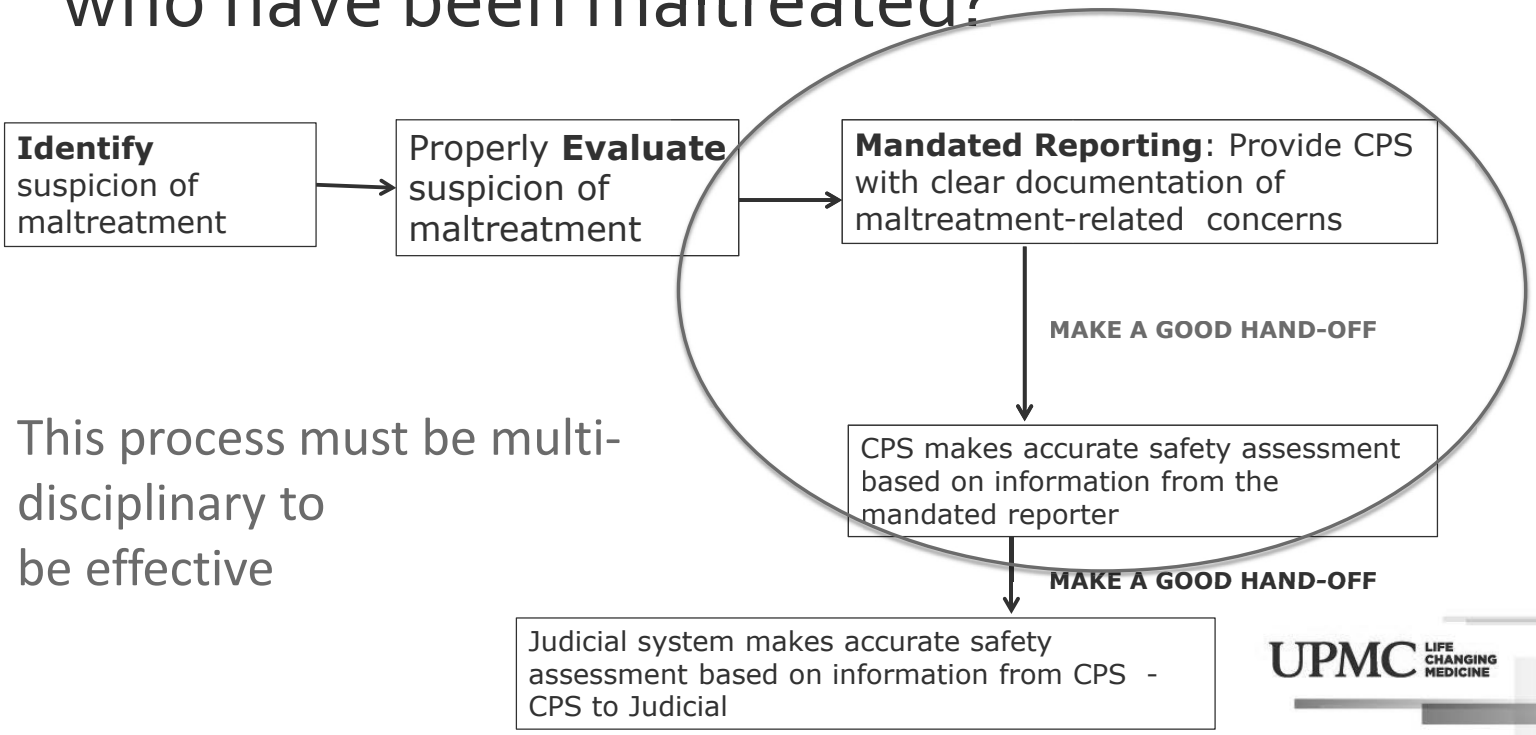
What do we need to do to protect children who have been maltreated?



This process must be multi-disciplinary to be effective

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But often, it is not….

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A sad, but not atypical case…

- 23-mo old reviewed by the county fatality review team
- Child died from an abusive abdominal injury and found to be severely malnourished
- CPS was alerted to the child at 9-months of age when she was seen in a general ED for a humerus fracture
  - Referral made to CPS
  - No skeletal survey was done, referral stated that the parent said the baby had fallen off the bed, no statement about why the report was being made or whether the bed fall was consistent
  - CPS unable to contact the mandated reporter despite multiple attempts
  - Case was unfounded, parent referred for parenting classes

- At 12-months of age she was seen by the PCP for bleeding from the ear and a bruise on the helix of the ear
  - Diagnosed with OM - does not appear trauma was considered
  - Provider did not notice that child had had no WCC since 2 month of age and did not review growth chart – which showed drop from 75% to <5% in weight, unclear whether child was undressed
- At 18-months of age, she was seen in an urgent care center for diaper rash
  - There was a referral to CPS for the diaper rash – unclear why it was being referred – no statement about what the concern was or why
  - Does not appear that anyone noticed her weight
  - Referral was screened out
- Next contact with the family was at the time of the fatality

Clearly lots of issues

- Failure to do a complete evaluation at time of the fracture/failure to consider abuse as an etiology of an injury
- Failure to recognize failure to thrive
- Failure of mandated reporter to clearly identify the concern and the level of concern – a poor hand-off
- Lack of collaboration between the CPS system and the medical system including inability of CPS to contact the mandated reporter

Mandated Reporting: The Hand-Off

- Physician education related to child abuse has focused heavily on reporting
  - Which both these physicians did

- Mantra has been “when in doubt report” BUT we never say HOW to report OR what our responsibility is AFTER we report which is often even more important

- When we are in our role as physicians, we spend a lot of time ensuring the quality of our hand-offs

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"Do You Know What I Know?": How Communication Norms and Recipient Design Shape the Content and Effectiveness of Patient Handoffs

Handing Off Safety at the Bedside

BMJ Open Impact of the communication and patient hand-off tool SBAR on patient safety: a systematic review

A Multidisciplinary QI Initiative to Improve OR–ICU Handovers

Making progress on safe patient transfer.

Submitted from BMJ Quality A Quality Improvement Approach to Standardization and Sustainability of the Hand-off Process

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We know what is important in a hand-off for patients' safety and quality of care…

But when we hand-off to CPS, we often don't use what we know in medicine

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What makes for a good hand-off?

- Is synchronous - very important
  - Face-to-face or by telephone so that there is the ability to ask questions
  - Reporting to CPS electronically or having a social worker call in the report are good for workflow, but not for handing off information
- Is given in a standardized way
  - Sign-outs
- Allows for immediate access to the raw data/medical record to confirm accuracy if there is a question
- Includes both facts and clinical decision making and includes assessment of diagnostic uncertainty

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But here are reports made to CPS by physicians

- “Child comes in with femur fracture” (18-month-old)
- “Fell off bed, skeletal survey and head CT negative, believe this is accidental” (9-month-old)
- “9-month-old with bruising to arms, parents say that they were holding his arms while he was standing, skeletal survey negative”

These are actual reports in their entirety…

Each of these cases was screened out by CPS

Each of these children came back with a life-threatening abusive injury

Screening out: What mandated reporters often don’t understand

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How to work with CPS as a colleague

- When you report, provide clear information which tells them what they need to know to quickly decided how to protect a child & do it in standardized way with facts and clinical assessment
    - Why you are 'consulting' them – what are the injuries? the medical issues?
    - How worried you are
    - What you are hoping they can do once they get your report (e.g., bring the child to the ED immediately, make an appointment for an outpt cardiology appointment)
    - Give them a way to easily contact you – cell or backline
- When they 'return your page'/follow-up on your report - talk to them and have a conversation – this is your chance at a synchronous hand-off
    - This is when you can provide information which is not in your report

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How to work with CPS as a colleague

- Recognize they can't do everything you might want – parents have a lot of rights and there are lots of rules and regulations they need to follow
- Respect that they may have more information than you do and that they are using this information to make their decisions
- Know that they have almost no medical knowledge – and use Dr. Google if they don't understand the words you are using
  - They receive no medical training when they learn to be a CPS worker
- BUT also understand that they have a hierarchy like we do
  - Intern, resident, fellow, attending
  - Caseworker, supervisor, clinical leader, regional office director

  Use this understanding to help the children you are most worried about

Yes, all this takes time…more time than making a poor quality report

BUT we can give a child the best medical care in the world and if we don't clearly express our concerns to CPS, the child may be sent back to a violent environment and re-injured or killed and then all of the medical care is for naught

When physicians work with CPS, outcomes are better

Child Abuse & Neglect 33 (2009) 481–489

Contents lists available at ScienceDirect

Child Abuse & Neglect

Is the diagnosis of physical abuse changed when Child Protective Services consults a Child Abuse Pediatrics subspecialty group as a second opinion?

James Anderst[a,*], Nancy Kellogg[b], Inkyung Jung[c]

[a] Division of Emergency Medical Services, Section for Children at Risk, Children's Mercy Hospitals and Clinics, University of Missouri at Kansas City, 2401 Gillham Road, Kansas City, MO 64108, USA
[b] Division of Child Abuse Pediatrics, UT Health Science Center San Antonio, USA
[c] Department of Epidemiology and Biostatistics, UT Health Science Center San Antonio, USA

University of Texas

Child Abuse Consultations Initiated by Child Protective Services: The Role of Expert Opinions

Lindsay McGuire, MD; Kimberly D. Martin, PhD; John M. Leventhal, MD

ACADEMIC PEDIATRICS 2011;11:467–473

Connecticut

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- Evaluated ~400 reports to CPS which were initially evaluated by a physician without training in child abuse pediatrics and then referred to a child abuse pediatrician

- The referring physician provided an assessment of the likelihood of abuse <50% of the time - the poor hand-off

- There were significant differences in opinion about the likelihood of abuse between the child abuse pediatrician and other physicians
  - More frequent for the non-child abuse physician to think it was abuse and the child abuse pediatrician to NOT think it was than the opposite
  - **These difference were felt to be due a combination of expertise, continued information exchange and collaboration**
- This makes a difference for children - Almost 30% of the time when the child abuse pediatrician said it was not abuse, CPS had already removed the child

Many states/jurisdictions have tried to enhance the CPS/medical collaboration

- Connecticut
- Illinois
- Indiana
- Los Angeles
- Maryland
- Missouri
- New Jersey
- N. Carolina
- Ohio
- Oregon
- S. Carolina
- Texas

All collaborate with child abuse pediatricians

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PUBLIC LAWS AND INVESTMENTS INTENDED TO PROMOTE THE USE OF

Medical Expertise in the Diagnosis & Treatment of Child Abuse & Neglect

RESEARCH BRIEF

RACHEL PARDES BERGER
CINDY W. CHRISTIAN
CATHLEEN PALM

THE CENTER FOR Children's Justice
Children's Hospital of Philadelphia
UPMC | CHILDREN'S HOSPITAL OF PITTSBURGH
casey family programs

State or County	Medical Evaluation and Consultation Program Operating	There is Designated Funding for the Program	Specific Injuries or Age of Child Triggers Medical Evaluation	Designated Medical Director
Connecticut	Yes	Yes	No	Yes
Florida	Yes	Yes	Yes	Yes
Illinois*	Yes	Yes	Yes	No
Indiana	Yes	Yes	Yes	No
Los Angeles	Yes	Yes	Yes	Yes
Maryland	Yes	Yes	Yes	Yes
Missouri	Yes	Yes	Yes	No

What are some ways to improve collaboration between CPS and medical professionals?

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Legislatively….In Pennsylvania
Senate Bill 27: Allows and Requires Collaboration

In circumstances which negatively affect the medical health of a child, a certified medical practitioner shall, in a timely manner, provide the county agency with the following information when an assessment…is being conducted or when the family has been accepted for services…

(1) Relevant medical information known to the certified medical practitioner regarding the child's prior and current health.

(2) Information from a subsequent examination.

(3) Information regarding treatment of the child.

(4) Relevant medical information known regarding any other child in the child's household where such information may contribute to the assessment, investigation or provision of services by the county agency to the child or other children in the household.

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Senate Bill 27

- Parental consent is not required for the certified medical practitioner to provide the information under subsection
- You do NOT need to the be the mandated reporter. You only need to be involved in the care of the child who CPS has been tasked with evaluating

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It goes both ways

If requested by the child's primary care physician or a certified medical practitioner who is providing medical care to the child, the county agency…shall provide the following information:

(1) The final status of any assessment… if the report of child abuse is indicated…

(2) Information on an unfounded report of child abuse if the certified medical practitioner made the report as a mandated reporter

(3) If accepted for services, any service provided, arranged for or to be provided by the county agency

(4) The identity of other certified medical practitioners providing medical care to the child to obtain the child's medical records to allow for coordination of care between medical practitioners

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What are other ways in which we can improve collaboration with CPS?

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Approaches in our county which has been a leader in this area

- Through research
  - Allegheny County Family Screening Score (AFST)
- Through clinical programs
  - Child Health Evaluation and Coordination Service (CHECS) program
  - Project MAGICO

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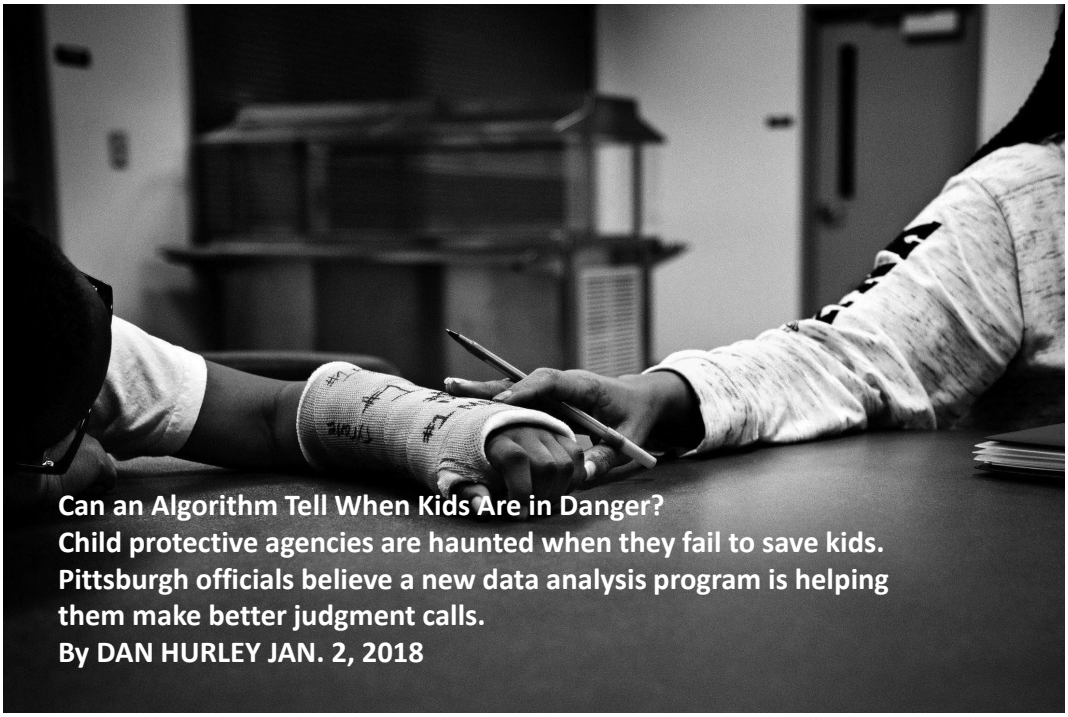
The AFST

- A predictive risk model (PRM) used when a child is referred to Allegheny County Child Protective Services for a General Protective Services referral
  - Helps provides guidance about which 50% of children should be screened out
  - Explicit goal to try and decrease racial disproportionality in the child welfare system
- AFST was built from hundreds of structured fields captured in the county's administrative health and human services records
- Score of 1-20 with a higher score representing a higher risk of being placed in foster care within 2 years
  - Scores distributed along a normal curve: 5% of children with score of 19 or 20

New York Times Magazine



Can an Algorithm Tell When Kids Are in Danger?
Child protective agencies are haunted when they fail to save kids. Pittsburgh officials believe a new data analysis program is helping them make better judgment calls.
By DAN HURLEY JAN. 2, 2018

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AFST Model Validation

JAMA Pediatrics | Original Investigation

Hospital Injury Encounters of Children Identified by a Predictive Risk Model for Screening Child Maltreatment Referrals
Evidence From the Allegheny Family Screening Tool

Rhema Vaithianathan, PhD; Emily Putnam-Hornstein, PhD; Alexandra Chouldechova, PhD; Diana Benavides-Prado, PhD; Rachel Berger, MD, MPH

Objective was to determine if AFST score which we know predicts likelihood of future foster care placement also is associated with hospital injury data

Subjects: 47,305 children referred to Allegheny County CPS for maltreatment concerns 4/1/10-5/4/16

Looked at ED and hospitalizations for these children 2002-2015

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Results:

Children	Injury, encounter (per 1000 and 95% CI)			Cancer (per 1000 and 95% CI)
	Any cause	Abusive	Any suicide and self-inflicted	
All children				
Highest score referral is in top 5%	14.5 (13.1-15.9)	2.0 (1.5-2.6)	1.0 (0.6-1.4)	0.1 (0.0-0.2)
Highest score referral is in lowest 50%	4.9 (4.7-5.2)	0.2 (0.2-0.3)	0.1 (0.1-0.1)	0.1 (0.0-0.1)

Data demonstrate that children reported to CPS and classified as high-risk by AFST were also at increased risk of ED and in-patient hospitalizations for injuries.

Child Health Evaluation and Coordination Service (CHECS) program

- Program developed in 2015 as a collaboration between the CHP CAC and Allegheny County CPS to
  - provide comprehensive health care assessment and care coordination for medically fragile children involved in child welfare by CHP nurses who are embedded in the CPS offices around the county
  - medical education for CPS professionals and families
  - started with 3 nurses & 0.15 FTE physician time
    - now have 8 nurses with 0.40 FTE physician time
    - And have expanded to another county about 100 miles away which has 2 nurses and physician support

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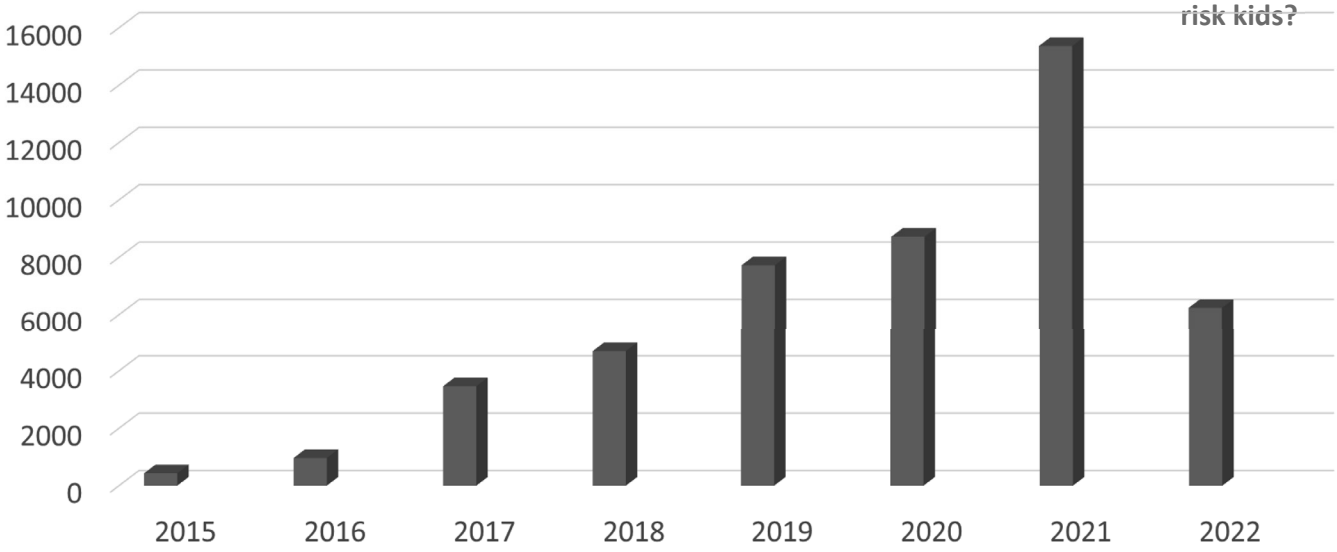
Number of Children with CHECS Involvement

How can we focus on the highest risk kids among all these high-risk kids?



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Project Magico

- **M**edical
- **A**ssessment
- **G**uidelines to
- **I**mprove
- **C**hild
- **O**utcomes

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What is it?

- Program which focuses on medical/CPS collaboration for the subset at HIGHEST risk for fatalities and near-fatalities
- The objective was to ensure rapid accurate medical assessment of injuries and ensure that children were being seen by a PCP. We hypothesized that this would decrease re-referrals, improve overall health and decrease the near-fatalities/fatalities where there had been prior missed opportunities which were medically-focused
  - Age <3 years
  - Specific high-risk allegations
    - chosen because these are the allegations which were the ones most commonly identified in fatality and near-fatality reviews as missed opportunities

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Conduct by a parent that places a child at risk	General Protective Services-Conduct By Parent, Caregiver, or Household Member That Places Child At Risk Or Fails To Protect The Child From Others
Inadequate Physical Care	General Protective Services-Inadequate Physical Care
Delay in seeking medical care	General Protective Services-**Delay/Denial In Healthcare** General Protective Services-Medical Neglect General Protective Services-**Refusal to Obtain Medical Attention** **Physical Neglect**-Medical Neglect (Resulting in a Physical Condition) Medical Neglect Causing Serious Physical Neglect Of A Child-Failure To Provide Medical Treatment/Care
Inappropriate Discipline	Inappropriate Discipline
Per Se Act	Engaging In Per Se Acts-Kicking Engaging In Per Se Acts-Interfering With The Breathing Of A Child Engaging In Per Se Acts-Throwing Engaging In Per Se Acts-Cutting Engaging In Per Se Acts-Unreasonably Restraining/Confining Engaging In Per Se Acts-Forcefully Slapping A Child < 1 Year Of Age Engaging In Per Se Acts-Leaving Child Unsupervised With A Tier 2 Or Tier 3 Sexual Offender Engaging In Per Se Acts-Forcefully Shaking A Child < 1 Year Of Age Engaging In Per Se Acts-Biting Engaging In Per Se Acts-Forcefully Striking A Child < 1 Year Of Age Engaging In Per Se Acts-Leaving Child Unsupervised With An Individual Determined To Be A Sexually Violent Predator Engaging In Per Se Acts-Burning Engaging In Per Se Acts-Causing Child To Be Present At A Meth Lab Location
Physical Abuse	Causing Bodily Injury To Child Through Recent Act/Failure To Act-Beating Causing Bodily Injury To Child Through Recent Act/Failure To Act-Causing Causing Bodily Injury To Child Through Recent Act/Failure To Act-Hitting/Punching Causing Bodily Injury To Child Through Recent Act/Failure To Act-Scratching Causing Bodily Injury To Child Through Recent Act/Failure To Act-Providing Alcohol Causing Bodily Injury To Child Through Recent Act/Failure To Act-Pushing Causing Bodily Injury To Child Through Recent Act/Failure To Act-Other Causing Bodily Injury To Child Through Recent Act/Failure To Act-Slapping/Striking Causing Bodily Injury To Child Through Recent Act/Failure To Act-Failure To Act Causing Bodily Injury To Child Through Recent Act/Failure To Act-Kicking Causing Bodily Injury To Child Through Recent Act/Failure To Act-Providing Drugs Causing Bodily Injury To Child Through Recent Act/Failure To Act-Cutting Causing Bodily Injury To Child Through Recent Act/Failure To Act-Dropping Causing Bodily Injury To Child Through Recent Act/Failure To Act-Interfering With Breathing Causing Bodily Injury To Child Through Recent Act/Failure To Act-Burning/Scalding Causing Bodily Injury To Child Through Recent Act/Failure To Act-Stabbing Causing Bodily Injury To Child Through Recent Act/Failure To Act Causing Bodily Injury To Child Through Recent Act/Failure To Act-Biting Causing Bodily Injury To Child Through Recent Act/Failure To Act-Shaking Causing Bodily Injury To Child Through Recent Act/Failure To Act-Shooting Causing Bodily Injury To Child Through Recent Act/Failure To Act-Poisoning Causing Bodily Injury To Child Through Recent Act/Failure To Act-Exposing Causing Bodily Injury To Child Through Recent Act/Failure To Act-Submerging

What is the program?

- Every day, the CPS data system develops a list of children who are eligible for Project Magico
  - Started in 2 of the 5 CPS regions and currently in all 5
- Cases reviewed by an MD and the CHECS nurse within 24 hours of the referral Sat-Th and within 72 hours for referrals Fri-Sat
  - What is the acute allegation? Does the child need a medical evaluation, by whom and when (emergent, urgent in a few days)?
  - Child Health: Is the child UTD with WCC? Are there unmet medical needs?
  - Family Health/Needs: Are there siblings with needs?

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Medical Communication Form to be completed by CPS, parents and medical provider

In order to properly evaluate your child, a medical provider needs certain information. It is important that he/she knows your concerns and Child Protective Services' concerns. If you have any photos of injuries which are you concerned about, please share these with the doctor or nurse practitioner.

DEMOGRAPHICS AT TOP

For the parent to complete:

What are your concerns? Why are you bringing your child to the doctor?

For the CPS worker to complete:

What concerns would you like the doctor to address?

Are there specific questions you would like the doctor/nurse practitioner to answer?

Caseworker name: _____ Caseworker phone number:

Supervisor name: _____ Supervisor phone number:

MEDICAL PROVIDER DOCUMENTATION:

- PE:
- Weight/height/OFC appropriate for age? Yes/ No _____
- Development appropriate for age? Yes/ No _____
- Next WCC: ____/ _____/_____
- Immunizations up to date? Yes/ No _____
- Any follow-up appointments needed or scheduled?
- **MEDICAL PROVIDER: AFTER YOU COMPLETE YOUR DOCUMENTATION, PLEASE FAX THIS FORM**

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Our PM program evaluation period - 10/1/19 – 7/22/20

COVID-19 started half-way through just when caseworkers were getting used to the algorithm

- Required changing the algorithm
  - Can’t bring children to a PCP which is closed
- Saw a marked decrease in CPS referrals overall
- Very little medical neglect for a few months
- Inability to see some families in person
- Families very resistant to hospitals or clinics for health care

What did we find?

- There were 586 referrals which met these criteria during the 9½-month period (10/1/19 – 7/22/20)
- There are about 5,000 referrals annually in children <3 so these represent 15% of all the referrals in this age group
- Mean (SD) age 16.5 (10.4) months
- 47% female
- 39% white, 43% black, 15% multi-racial, 3% other
- >50% of the referrals are made by medical professionals
  - Hard to calculate because social workers are listed as the mandated reporter for MANY of these

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What did we find?

- 92% (537/586) of children were referred once during the 9½ months
- 8% (49/586) were referred more than once for a PM allegation during the 9 months
  - There were 6 children who were referred 3 x (n=4) and 4x (n=2)
- 20% (119/586) already had an open case at the time of the referral
  - This is identical to the rate in all children <3 yr of age referred to CPS
  - These 586 children had already had a total of 576 referrals between 12/26/16 and 9/30/19

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What are children being referred for?

- The number of allegations ranged from 1-11
- 70% General Protective Services (GPS) – most common types:
  - 23% Domestic Violence
  - 18% Medical Neglect
  - 13% Inappropriate Discipline
- 25% CPS
  - 20% Causing bodily injury
- 5% CPS and GPS allegations

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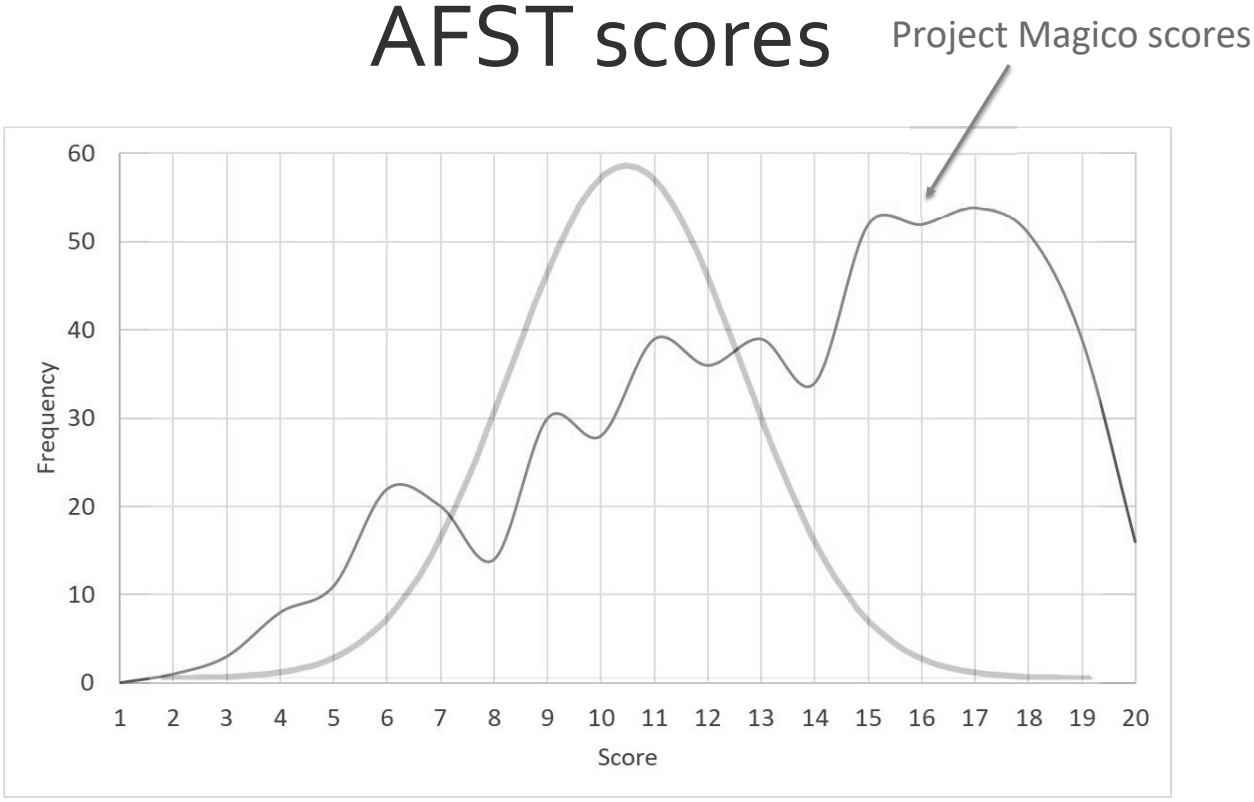
What happened to these case?

- 29% (169/586) were screened out
  - Screen out rate lower than the overall rate of 38% in children <3 yr referred to CPS
- 40% (165/417) of the remaining were ultimately accepted for service
  - 47% of these were connected to case which was ALREADY open
  - Significantly higher than the overall acceptance rate of 25%

AFST scores


Project Magico scores
60
50
40
30
20
10
0
Frequency
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20
Score

Some lessons learned…

- Respect for the job CPS workers are expected to do
  - Day-to-day ‘life at CPS’ is
    - Like flying an airplane while you are trying to make repairs
    - And then having another airplane almost hit you
- The level of violence in children’s lives is almost unbelievable
- There are a lot of children with a lot of risks
- The same children keep coming back
- Research in this population is really, really hard

Some lessons learned which we can impact…

- A LOT of time is spent trying to make contact with/find families
  - Accurate phone numbers and addresses of the patient/family are often missing especially from medical reporting sources
  - Information often outdate – registrars not confirming addresses (are you still at the same address vs what is your current address), phone numbers not accurate (intentional?)
- A LOT of time is spent trying to reach and get information from mandated reporters, EDs and PCPs
  - A direct phone number to reach the mandated reporter would improve this immeasurably
  - Training of front desk personnel about how to respond – the report cannot be the end…It needs to be the start

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But the most important finding….

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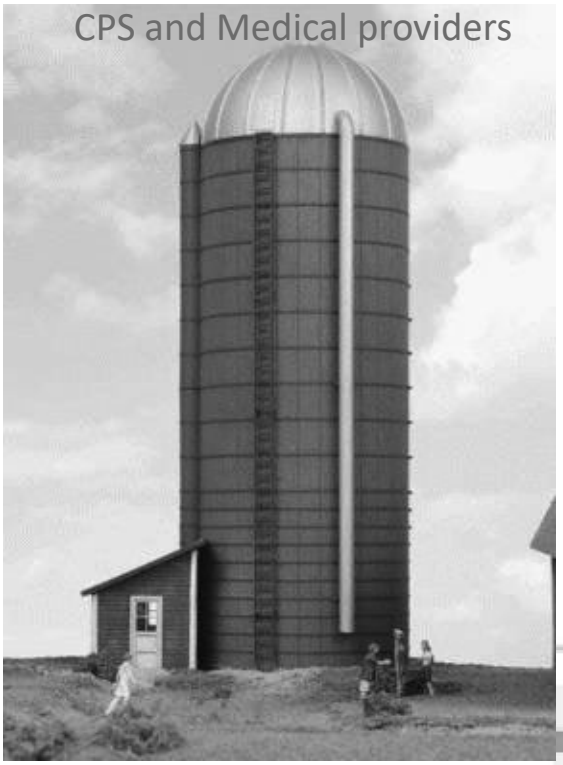
CPS
Medical providers


CPS and Medical providers

Example

- 3-month-old involved in a domestic dispute
- Report by someone at scene was that baby had a mark on his face – unclear if related to the event
- Caseworker went to the home – infant not there, went to second address, infant not there, finally found at a grandparent's home
- CW noticed a small "scratch" to face but otherwise looked well
- CW knew that this high-risk and brought the infant to our ED where she was found to have a subconjunctival hemorrhage, a tongue laceration, bruise to the left hand and a healing rib fracture.

What did CPS think about PM?

- PM has “elevated concerns that may have previously been overlooked due to caseload/time constraints.”
- PM is a “mechanism that allows for enhanced oversight of a highly vulnerable population. The program has allowed for Clinical Managers and Supervisors to have a more targeted discussion during routine supervision.
- The PM algorithm “influenced safety assessment thinking which caused a very dangerous situation to be uncovered…We are convinced that, but for the supervisor following the PM flowchart given the presenting circumstances, the full scope of the child’s injuries would never have known.”
- PM has helped in “honing our awareness of the circumstances which might need priority medical assessment in order to assure child safety.”

What is next for PM?

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Conclusions

- The number of children who die from maltreatment every year in the US is a national crisis
- Making a report to CPS when you have concerns about a child is a first step, but your job cannot end there
- The QUALITY of your report is as important as the report itself
- CPS workers are our colleagues and partners as we all try to protect children and change the trajectory of their lives – treat them as you would your colleagues
- The laws protect your ability to talk with CPS when they are investigating a case - even if you didn't report it

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Conclusions

- There are specific actions you can take to improve the ability of CPS to respond to your concerns
  - Be clear & precise in your concerns and reasonable in your expectations
  - Give CPS a cell phone or a back line to help communication
  - Confirm family's address and phone number (preferably numbers)
  - You can reach out to CPS if you don't hear back after you make a report
  - Try to put yourself in their shoes

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Thank you!

Questions?

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