VCHIP CHAMP VDH COVID-19

December 11, 2020 | 12:15-12:45pm Call Questions and Answers*

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Pediatricians in the News

Wendy Davis, MD, VCHIP: Thanks to Dr. Erica Gibson for sharing this article by a group of pediatric senior residents at Mass General Hospital titled "We're Pediatricians in a Pandemic. We Shouldn't Be Taking Care Of Your Grandparents" (available at: https://amp.wbur.org/cognoscenti/2020/12/08/pediatricians-grandparents-covid-19-sam-cohen-anna-handorf-vidhya-kumar-sarah-servattalab-jeffrey-sumner-emily-ziady?fbclid=IwAR0qXwHsLc_lprj_qIKifOX-ECbqowPpS1JGxra36OO7d_GeAD0EE4AIURU). The article has already generated a bit of discussion via email today.

We also want to extend thanks to Dr. Ashley Miller today. We learned Dr. Miller participated just last evening in a panel with Vermont's Coalition of Health Care Provider Associations as part of their 2021 policy proposals. The event included a spotlight presentation with an update from the frontline of COVID-19. We understand Dr. Miller did a fabulous job representing independent physicians, and in particular pediatricians, on that panel. We are grateful Dr. Miller managed to cover all of the topics of great interest to us. Thanks to all of you who continue to put yourselves out there to talk about these topics.

Practice Issues – Update from Vermont DCF Family Services & UVM CH *by Brenda Gooley, VT DCF Family Svcs. Operations Director & James Metz, MD FAAP – Child Abuse Physician, Div. Chief*

Brenda Gooley, *DCF:* I thought I would start out by sharing some of our numbers, and this chart is actually looking over the past decade. Across the bottom, you'll see the years with the categories being types of cases (blue is children and youth in DCF custody). You'll see that in 2015 and 2016, we peaked at around 1,375 kids in care. We do attribute that peak to the opioid epidemic. more recently, our numbers have gone down. We were at 1100 at the time this slide was created. The orange category indicates conditional custody order cases where a child's in the conditional custody of their parent or a relative. The gray category is our family support cases, which are cases where we have ongoing open involvement because of high risk of abuse or neglect occurring, but there's no court involvement. So, what I wanted to emphasize is all three of those categories have decreased in the past couple years and we attribute that to some of our continuous quality improvement efforts. More recently, the impact of COVID-19 has also decreased the number of families that we're involved with.

I also wanted to share the number of children/youth in DCF custody stratified by age group. The number of children ages 0-5 in custody went up to 539 back in 2015 and has since come back down to 389. We've had a slight decrease in the number of teenagers and the children ages 6-11 in custody. We want to emphasize that despite COVID-19, we continue to be committed to the same principles of child safety and wellbeing, using data to inform our practice.

I'd also like to highlight what we're doing with regard to our front end response. What's different with COVID-19 right now is that we have some discretion regarding whether that child safety intervention goes on what's called the assessment track or the investigation track. If it's on the assessment track, we can

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commence virtually. So, lower level allegations of child abuse or neglect or situations involving children that are age 7 and older would go on the assessment track, which would allow us to commence virtually. We're still responding in person to the more serious abuse allegations to younger children. If anyone answers yes to our screening questions, we go through a decision process to determine if virtual commencement is appropriate for assessing if that child is safe. If in-person is necessary, our staff will go out with appropriate PPE.

It's important to stress that for March, April and May, we saw about a 50% decrease in the number of calls of concern to our hotline and a commensurate decrease in the number of calls of concern we responded to. Obviously that's a concern, since folks who typically see children and youth frequently (teachers, child care providers and pediatricians) are a big part of our safety net. We do attribute the decrease in our hotline calls to that decline in interactions with children and youth during the pandemic.

We are required by the federal government to see all children in our open cases face-to-face each month. However, due to COVID-19, the federal government is allowing for virtual contact to count for that standard. So, that is actually what we're doing right now, unless there are safety reasons warranting an in-person response.

With regard to parent child contact, I want to acknowledge we've had some bumps in the road. In the spring when COVID-19 numbers spiked, we moved to virtual parent child contact. When our COVID-19 numbers started going up again in the fall, we tried to move to all virtual parent child contact for the first couple days out of the gate. We very quickly backtracked because the guidance from the American Academy of Pediatrics and VDH clearly indicates there are constitutional liberty implications and trauma considerations when separation occurs. So, that contact is now considered to be essential. The vast majority of the 1131 children and youth in DCF custody today have at least some level of in-person contact in tandem with virtual contact. We have extensive guidance from VDH for how parent child contact can safely occur in light of COVID-19.

James Metz, MD, UVMMC: Initially, we were trying to figure this out case by case, which did work for a little bit. I think it helps provide some overarching themes for how we think about these children in the welfare system. In September, this guidance came out from the American Academy of Pediatrics, which just reiterates the bedrock or the essential pieces to visitation (linked here: https://services.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/clinical-guidance/guidance-for-children-and-families-involved-with-the-child-welfare-system-during-the-covid-19-pandemic/). The guidance reinforces that in-person visitation is preferred whenever possible. I think VDH and DCF have heard this and done as much as possible to abide by this and be creative in ways to adhere to this, which is reassuring. I've been consulting with Drs. Lee and Raszka on cases where there are underlying conditions (child or the foster family) to consider with regard to risk. Those cases are more of an exception than a rule.

Brenda Gooley, DCF: I'd like to briefly highlight questions about our process when children or youth placed in foster homes or residential programs get COVID-19. The resounding message we're trying to reinforce in the field is that we want everyone to stay put. We really want to do everything we can to support the current setting to quarantine or isolate as they need to. There is not a recovery center in Vermont for children and youth recovering from COVID-19. It does not exist. There are for adults, but neither of those sites are places where children or youth could go.

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Breena Holmes, MD, VCHIP & VDH: I just wanted to remind my pediatric colleagues that VDH district offices have public health nurses who have a role in connecting medical homes to DCF staff in districts. I think what the chat is reminding me is there's some systemic back and forth and concerns that have existed for a long time with our pediatric medical homes. So, we are going to pilot a VCHIP project with a couple of communities, which I don't think are finalized yet, where we'll be sort of looking at communication and systems because busy pediatricians want someone to call them, but the DCF family, support staff and social workers in the districts are swamped and busy as well. I just can feel that ongoing need to work this out because the doctors can call back to see what happened with the case but I do think that's cumbersome as well, so let's keep talking. We have built capacity for years and years in VDH district offices to try to be the conduit between our busy pediatric health care folks and our DCF workers. That effort is called fostering healthy families. Each one of your district offices has a representative. It's almost always the maternal child health nurse, but if that person is not well known to you, then I continue to really want to improve that system.

Wendy Davis, MD, VCHIP: As Dr. Metz pointed out, this is an area of great national concern through the AAP as well. I'm excited the area of health care for children in custody and foster care is the life passion of our new AAP President-elect, Dr. Alaji Moira Szilagyi. I know this will be an area of great focus for her as she moves into this year as President-elect and then her year as President. It will be particularly poignant following up on what will no doubt be the long-term fallout from the pandemic and the additional trauma burden it's placing on our children, families and state colleagues working in this arena. I feel like we have identified a couple of areas for ongoing exploration, which we should take back and figure out the best communication channels.

Questions/Discussion

Q: My current frustration with DCF is that we are making reports that aren't being accepted because we don't know details. I was always taught that when a patient discloses, we were supposed to make them feel safe and heard, right down the details they do give you, but not ask any further questions as we didn't want to be accused of asking leading questions, and that DCF/CACs were trained to do this questioning, and would try and do it in a safe place, with police present as well if necessary, so the child didn't have to go through it more than once. Further conversation would be great, because I thought after we reported, those questions were asked by DCF to determine if a case would be opened. I did not think they determined if they should open a case just based on what we said.
A: Brenda Gooley, DCF: That's a hard spot to be in in terms of whether that's too leading. I think that is quite a bind to be in. I think in terms of a call of concern, some of it may be helpful just to go into our policies and I'm happy to share afterwards the definitions of physical abuse, sexual abuse. When that call of concern comes in, we need enough detail to be able to determine based on how the definition of that category of abuse is written in policy and statute, you know it doesn't meet criteria, and if it does, then we can open and we can interview. If it doesn't, then we can't. So we need enough detail to know that we have a valid allegation of abuse, but not so much detail that you're actually interviewing the child and that may require further conversation, which I'm happy to engage in perhaps in addition to this presentation. We have to determine whether to accept or not based on what is reported. We cannot talk to the child unless it is accepted.
A: James Metz, MD, UVM Medical Center: I think you raise a good point but I usually tell providers when there is a concern for, specifically sexual abuse, but abuse in general, is that some providers feel that they have to end the conversation immediately, when the disclosure is made, and I would say that that's a little bit overstated. I would just say that what I recommend is that you, as you would do with any child, you would ensure that they are safe and if they are wanting to talk or make more disclosures then that is fine

and what I encourage people to do, is ask very open ended questions, whether it physical abuse or sexual abuse, and if they don't respond then you don't push the issue and you don't keep prodding them. IF they do make a disclosure or further disclosures you write it down, and you thank them for being open with you. I think that disclosures you know in children is a whole other topic, and they come in very different flavors and different forms, but I think that if they provide that amount of information, it is helpful for DCF so that they can decide whether they're going to open the case or not.
A: Stephanie Mozzer: I have shared the same experience. My understanding was that it is the mandated reporter's responsibility to bring forward concerns and DCF would investigate.

Q: If we have time, I would be interested in hearing what Brenda referred to re: the details of what "safe, in-person contact" looks like.
A: Brenda Gooley, DCF: It has been incredibly challenging balancing the safety and health of everyone involved in parent, child contact, and we know typically we're involving four different households, because there's a household of the person who is supporting the contact, the household of where the parent is, the household where the child and sometimes foster parent is so we know we are absolutely mixing households as part of our parent child contact. And we're saying this is essential that's court ordered. We must provide this service, this essential service. So in that context, we have screening questions that we ask. We have protocols in place with regard to ensuring that we're sanitizing. We do have what we call shared parenting meetings where we bring parents and foster parents together ahead of time to talk about any health concerns that people have…are there individuals who are members of households that are high risk that could be impacted by this parent-child contact occurring, and if so what measures can we take to mitigate that risk. So it's really hard because there's the staff safety issues and there's the trauma of the child and parents from separation and really trying to ensure that we're providing that constitutional liberty, in terms of parent-child rights, right to parent-child contact.

Q: Has there been a change in qualifying criteria that is leading to decreased #s of accepted cases?
A: Brenda Gooley, DCF: No, same criteria, just fewer calls. It is back to a more similar level now. It was dramatically decreased last spring when schools were closed.

Q: What are current caseload #s of DCF SWs?
A: Brenda Gooley, DCF: Yes, I am actually pleased to share that our caseload count is 14.7. That means 14.7 families per ongoing worker, which is the lowest it's been in years. That assumes that all of our social worker positions are filled with experienced workers, and of course, that's not true. So if you are talking to one of our workers, they may say how that can be, I've got a caseload of 25. That is also true. But the measure that we use has been the same over the past many years, and so we know that the number of families per worker overall has decreased. The ratios there are good. We have guidance regarding our parent-child contact, which we call family time, that I can share with you and we have taken a deeper dive into our front end reporting data broken down by category of mandatory reporter and we compare this year to last year side-by-side each week and each month. We analyze the factors and how those have changed. We analyze what percentage by each category of mandatory reporter. So we've got some robust data there that we can share.

Q: Would be interesting to dig into data from spring more: Was reduced report rate due to fewer reports from schools only or also from other reporters, i.e., pediatricians, as there was less contact with families in other settings as well?
A: Brenda Gooley, DCF: I have data regarding reporting that I can share as well as parent child contact guidance.

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C: James Metz, MD, UVM Medical Center: Here's the link to Dr. Lewis First's child safety video: https://www.youtube.com/watch?v=Od-Zw15O5UI

Q: A small request: could DCF please generate clean copies of their standard releases of info sent out to offices? They are so distorted from replication, often nearly illegible. Thanks for all you do.
A: Brenda Gooley, DCF: Many of our staff have moved to fillable PDFs on their iPhones, and others have not. There's kind of a range of what's happening out there in terms of comfort level with technology, so that is probably a great area to do some follow up.

Q: I am still having challenges with getting information from DCF if they have investigated and have opened a case. It would be so helpful to know after I make report that it was accepted to be investigated.
A: Jenn Reges: You can call back within 24 hours to learn if accepted for investigation.
A: Kristy Trask, RN, Care Manager, Primary Care Pediatrics: DCF assigns a case number and you can call back with that number to see if the case was accepted.
A: Brenda Gooley, DCF: That is exactly right. So we screen the call of concern within 4 hours and it's within 1/2 day of when that call of concern comes in. So yes, you absolutely can call back the next day to find out if it was accepted or not. If it was accepted, they will tell you which district office staff it's been assigned to. Typically it's a 60 day period of time that that child safety intervention is open. So then you could follow up with that worker if you have immediate information you can share with them at any point, but if you want to know if it was substantiated or not, you should get a letter letting you know at the end of the 60 days. And of course, sometimes they are not something that you know is wrapped up in 60 days, so that could be a problem. Even then, making that call to the local district office to get that information should get you where you need to go.
A: Shannon Hogan, DO, UVMCH Pediatric Primary Care: I think that it would be better for DCF to follow up with the providers. Often they ask us for a lot of information, but don't report back. Communication needs to go both ways.

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