SENATE BILL 27

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Good morning. Thank you for inviting me to provide testimony for Senate Bill 27, legislation I believe is critical to improving outcomes for maltreated children. My name is Cindy Christian, and I am here this morning in my role as the Medical Director for the Department of Human Services in Philadelphia.

I was honored to serve as an appointee by Governor Corbett to the Pennsylvania Task Force on Child Protection, and I am greatly appreciative of the work the legislature has done in response to the report of the task force. In addition to my part-time role as DHS medical director, I am a board certified child abuse and general pediatrician at The Children's Hospital of Philadelphia, where I have worked for 29 years. Personally, I have cared for thousands of abused and neglected children who have been treated at CHOP. I am a Professor of Pediatrics at The Perelman School of Medicine at the University of Pennsylvania, the Chair of the American Academy of Pediatrics National Committee on Child Abuse and Neglect, and a faculty director at the Field Center at Penn. I have the unique experience of having had a long career working to protect abused and neglected children and the experience of working as the medical director for the largest child welfare agency in the Commonwealth. I understand the benefits of information sharing between Child Protective Services (CPS) and health care providers, the operational challenges that proposed legislation such as SB 27 may have on county children and youth agencies, and the significance of such legislation for doctors who care for children.

I urge you to support SB 27 with some changes that the City of Philadelphia is proposing because this bill will allow for the essential flow of information between child welfare agencies that serve children and the medical practitioners who care for them, both of whom are deeply invested in the health, safety and well-being of children. Improving the legal framework for the exchange of information is critical for many reasons: it will improve the identification of child abuse, it will result in better health care for children, including their long term health, and will enhance the vital partnership between health care providers and child welfare professionals, consistent with federal mandates and the fundamental goal of improving the health, safety and well being of children.

Each day in Pennsylvania, Child Protective Service workers are asked to make extremely difficult decisions about the potential abuse and neglect of children. Some of the reports that are made to county children and youth agencies involve serious injuries- intracranial hemorrhages, fractured bones, complex burns. Others involve what may appear to be minor trauma- a bruise for example- that may in fact herald the abuse of an infant or young child. Some reports involve medical neglect of chronic, serious pediatric health issues like diabetes mellitus or congenital adrenal hyperplasia.

Each day in Pennsylvania, CPS workers do their best to make the right decisions during investigations and throughout the life of a case: many work with doctors who report abuse, reach out to medical providers as a collateral contact, and may collaborate with health care providers to understand the medical issues. But each day, due to legal barriers, CPS workers cannot get all of the information that they need from primary care providers about children who are the subjects of investigations, in the legal custody of county agencies or being supervised by county agencies by court order. And physicians cannot get information about a family's involvement with the child welfare system except in the limited circumstances where they have been contacted for information or are the reporter of abuse. And each day in Pennsylvania, children and families may be harmed because information is not shared, and child welfare workers and health care providers are not allowed to freely communicate under the existing law.

There is a profound need to strengthen the legal framework for information sharing between medical providers who are responsible for children's health and children and youth agencies. Some information sharing already occurs, but it is not enough. With some proposed changes, Senate Bill 27 can help change this, can help improve vitally important decision making, can help improve the safety of children, can help protect innocent families, and can begin to build a more robust collaborative child welfare and health care system for abused and neglected children. The importance of information sharing between professional partners in health and child welfare work cannot be overstated. During investigations, failure to share information can result in incomplete decision making, inaccurate assessments of risk and danger, unnecessary placement of children out of their homes or unwarranted reassurance in keeping children in their homes, and in some instances, ultimately keeps some children in dangerous environments. In the highest risk cases, families often don't share some of the most important information about their social and CPS history with their health care provider, for various reasons, and sometimes this information is vital to keeping children healthy and safe. During treatment, doctors may miss issues because they do not have an accurate understanding of their patient's home environment.

The importance of a CPS worker obtaining information from the child's pediatrician or family physician and sharing information cannot be overemphasized – for children who are not yet in school, the primary care physician is often the only professional who sees a child regularly. This physician may have observed the parent child interaction on multiple occasions and may have significant insight into the family dynamics- in the case of a family practitioner, perhaps over several generations. And sometimes, the primary care physician can tell the CPS worker that the child is behind on immunizations, is not following up with certain medical needs or that he/she has significant developmental concerns about a child.

To this end, DHS supports the provision that requires health care providers to share relevant medical information with CPS regarding the child's prior and current health status and other relevant medical information. It would be extremely helpful to all county child welfare agencies to have this information and could improve the quality of its investigations to ensure that all licensed medical practitioners are required by law to share medical information with DHS and other county agencies where there is suspected child abuse (not just those who are the reporters of child abuse which is what existing law allows for). In addition, DHS is

recommending that language be added requiring doctors to share this information if a child is in the legal custody of the county or if the county agency is providing court-ordered supervision, not just during an investigation. The counties can better meet the needs of a child in its custody when it has complete medical information regarding a child in its care or under court-ordered supervision, without needing to seek parental consent or a court order.

At the Department of Human Services in Philadelphia, like some other county children and youth agencies across the Commonwealth, we understand the importance of sharing information at the investigative stage. We hold special meetings when children have injuries that have been reported for investigation, and the investigator cannot determine whether the injury represents abuse or, in some cases, who caused the injury. At these meetings, workers, administrators, solicitors and our medical team sit together to analyze both medical and investigative information, so that our decision-making is well informed. I know that decisions are better when we work together, because the information is more complete, complex injury mechanisms and medical diagnoses can be explained, questions can be asked and answered, and alternative interpretations and perspectives can be discussed. But no other county agency has a medical director and few have nurses who are readily available for this type of collaboration.

Pediatricians are charged with improving and maintaining child health- the physical, developmental, behavioral and social health of their patients. And abused and neglected children often have poor health. Physicians can't effectively do their job without knowing whether their patients have been abused, neglected, or are living in unsafe environments. Our present state laws do not allow pediatric providers to know about the child welfare history of their patients. During our work on the recent Pennsylvania Task Force, we heard testimony from primary care pediatricians who care for many maltreated children. Dr. Amy Nevin, a pediatrician in the Pittsburgh area, told us she estimated that about 40% of her patients were involved with child welfare- the problem was, she didn't know which 40%, and had no way of finding out. Dr. Nevin needs to know which of her patients are child welfare involved, as these social problems in families often have permanent, life-long negative effects on the health of children, even into adulthood.

I recall reviewing medical records in a child fatality case a number of years ago- a case in which a child was murdered. The child's pediatrician was a well-trained, competent physician. The fatally abused child had previously been known to child welfare and there was a long history of domestic violence in the family but at some point the case was closed because services were determined to no longer be necessary. When I reviewed the child's medical record, under social history, it was simply noted that the child lived at home with his/her mother and siblings. That was it- nothing about domestic violence, nothing about child welfare, and nothing to indicate that this child was at risk. If the physician had known of the child's social history, perhaps that physician could have counseled the child's mother more effectively related to the domestic violence, child development and safety; provided anticipatory guidance around violence prevention; provided resources for the family; ensured that the child was examined regularly; watched for the behavioral and developmental problems so common in maltreated children; and perhaps he could have provided a safety net when child welfare closed the family's case prior to the child's murder.

While DHS supports the principle of sharing information with medical practitioners even if they are not the reporter of the abuse, DHS believes that the information shared should mirror the information that is currently shared with other mandatory reporters, authorizing the sharing of information about the final status of the child abuse report following the investigation, whether it be indicated, founded or unfounded and any services provided, arranged for or to be provided by the county agency to protect the child. DHS also agrees that it is beneficial to share (as proposed) the identity of other licensed medical practitioners providing medical care to the child to obtain the child's medical records and also to coordinate care with other medical providers. DHS has also added that those practitioners providing emergency treatment may seek information.

DHS's proposed language is preferable to the present language in SB27. Given that this provision appears to allow medical practitioners to receive this information at any point in time, regardless of whether the family is currently receiving services or not, the breadth of the information provided should be limited. This change may also help to alleviate the concerns of those who correctly want to protect the privacy of parents and other adults in the household.

In addition, DHS has some concerns about the provisions requiring the county agency to provide information on the condition and well being of the child, protective service records and the service plan developed for the family. This provision, as written, would create massive logistical and operational issues for county agencies, potentially interfere with family privacy by sharing family service plans, and not necessarily result in better outcomes for children. To highlight the operational challenge, in 2013, The City of Philadelphia's DHS conducted approximately 3,831 CPS investigations and 9,371 GPS assessments. That means that DHS would need to identify and contact over 13,000 primary care physicians as well as any other ongoing medical practitioners serving these children. These numbers only address the initiation of assessment and investigation requirement above. Moreover, county children and youth agencies are already accomplishing the goal of sharing information with medical practitioners in many cases, following best practice as allowed by existing law and policy. In addition, it is unclear to what end county agencies would be required to repeatedly notify multiple medical practitioners multiple times (i.e. during the investigation and then again when services are provided, and possibly when additional services are provided) of children and youth agency involvement.

The proposed legislation as written goes too far regarding what information is being shared. A family service plan contains detailed information not only about the child but about the parents as well including mental health and drug and alcohol treatment information. This is personal information that should not be provided to all doctors in all cases where there has been the initiation of an assessment, investigation or the provision of services. Physicians and other health care providers do not require actual child welfare records and do not need family service plans: they need to know that there are child welfare concerns about their patients that are being addressed by CPS, need to know that they can share health care information and their concerns with the child welfare worker and know that they can have a meaningful conversation with the worker about the safety and health of their patients. The child's physician should be a resource for the CPS worker and the CPS worker should be a resource for a concerned physician.

Finally, DHS believes there is no need to add an additional requirement to consult a doctor at the outset of an investigation because county agencies should already be reaching out to

medical providers as part of their investigations in cases where it is appropriate as required by state regulations. To the extent that current practice does not already comply with existing law, county children and youth agencies must prioritize best practices in this area, given the high stakes involved.

The City of Philadelphia proposes that the legislation be amended to include a requirement for the county agency to notify a child's primary care physician when he/she is the subject of an indicated or founded Child Protective Services Report or where a General Protective Services report has been accepted for service where there is a child age five or under in the family. This requirement would serve as an alert to the primary care physician that their patient was a victim of abuse or where a child five or under is in a family in need of general protective services. In my work over many years, it is clear that infants and young children who sustain the most terrible outcomes- including fatal abuse- have often been known to child welfare prior to a final, tragic event. Most of these cases involved prior concerns of neglect, referred to child welfare under the GPS, not CPS law. If we have any chance to reduce morbidity and mortality from child maltreatment in Pennsylvania, we need information sharing in GPS cases that involve young children. The other provision of the legislation would allow the physician to inquire and receive information about the services that a child was receiving and the identities of other medical providers working with the child. Finally, DHS is also proposing that the implementation date be 180 days from the date that the legislation is signed into law as given the size of our system, it will take time to develop policies and systems to implement these changes.

DHS is in fact already sharing information with and consulting with medical providers in many cases, under the confines of existing law and regulation. Currently, I serve as DHS's medical director and oversee a staff of ten nurses who serve every day as liaisons between DHS and our medical community. DHS has a policy in place that requires mandatory consultation with nurses in all cases involving medical and other related health issues. This collaboration is the good result that can come from notifying the primary care physician that the child is a victim of abuse, and developing relationships between the child welfare and health care communities.

Finally, I should note that sharing information with the goal of improving health outcomes for children can have long-term benefits. Although child abuse is considered a social and legal problem, it is also a public health problem with life-long health consequences for survivors. There is accumulating medical evidence that early adverse childhood experiences including abuse and neglect are strong contributors to many adult diseases. Adults who were maltreated as children have poor health outcomes and early mortality, and their health care costs billions of dollars annually. A child's early life environment profoundly influences their biological health, and these influences are inheritable from one generation to the next. It is not enough for physicians to work in their practices, ignorant of the social and family problems that can so greatly affect their patient's health- and it is not possible for CPS workers to evaluate and try to improve a child's well-being without partnering with the child's health care provider. Exchanging information between health care providers and CPS workers is necessary to improve the well-being of children and their long-term health outcomes.

Our goal should be that children leave the child welfare system healthier than they arrive. It is only through collaboration and critical information sharing within a legal framework that this will be accomplished. I urge you to support SB 27 with our proposed changes, as it is

necessary legislation that will result improved health, safety, and well-being for children in the Commonwealth. Thank you.