Does everybody know something I don’t? – Working with Families to Prevent Maltreatment in Children with Disabilities - Pediatric Grand Rounds-4-3-2026-Meeting Recording

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49m 41s

Calderon, Delia started transcription

Cervantes, Laura L 0:13

Yeah.

Thank you.

Ranch, Daniel 0:34

All right, it's 730, so we'll get started. Good morning, everybody, and thank you for joining UT Health San Antonio Pediatric Grand Rounds. As a reminder, as you log in, please don't forget to mute your devices. Otherwise, it is my great pleasure to introduce Laura Lisa Cervantes for Grand Rounds this morning.

Laura is a certified pediatric nurse practitioner who joined UT Health San Antonio and the Center for Miracles in January 2025. Originally from the Rio Grande Valley, Laura Lisa graduated from Baylor University in 2008 with a Bachelor of Science in Forensic Science before going on to earn her associate's degree in nursing from South Texas College in 2010.

Cervantes, Laura L 0:58

What?

Yes.

Ranch, Daniel 1:14

During her eight years as a NICU nurse, Laura discovered her passion for working with vulnerable pediatric populations and simultaneously earned a Master of Science in Nursing from the University of Texas at Austin in 2018. Prior to joining the team at Center for Miracles, Laura worked as an APRN in a developmental and behavioral pediatric clinic. And now she applies her experience with high-risk NICU graduates

and children with developmental disabilities to advocate for child safety. In addition to her clinical work, Laura Lisa is an active member of the Pediatric Nurse Certification Board Primary Care Update Committee, where she reviews current literature and contributes to continuing education modules. So Laura, thank you very much for doing this. You have the floor.

Cervantes, Laura L 1:52

Thank you so much for having me and good morning, everybody. Welcome. Today I wanted to kick off Child Abuse Prevention Month, or Awareness Month, with just a talk about ways that we can work with families to prevent maltreatment in children with disabilities. Although I think you'll find that a lot of these prevention strategies will be applicable across the board for many of the children that we work with. Just a few objectives for this morning. We'll review current child maltreatment data and discuss a few common types of specific, most common types of child maltreatment. We'll identify some strategies for prevention.

through two brief case studies, as well as understand our role as healthcare providers and how we have a unique opportunity to help prevent maltreatment. And I hope to leave you with a few takeaways to use in clinical practice. So first we'll start off, I want to just quickly touch on definitions of a disability, which is any condition of the body or mind.

that affects A person's day-to-day activities and their ability to interact in the world around them.

We know that approximately one in five children in the United States has special health care needs. And then we also know that maltreatment is approximately 3 times higher in children with disabilities.

And we know that child maltreatment can cause disability and in turn increase risk for further child maltreatment. In 2023, national data showed that 5000, excuse me, 546,159 children were confirmed victims of abuse or neglect. That further breaks down into approximately 64% of that

500,000 experienced A component of neglect specifically, and 10% of that total experienced physical abuse. So we'll be talking about physical abuse and neglect within this presentation. And first, we'll focus on this initial 65 or 64%.

So we're talking about neglect in its simplest terms. Neglect is failure to meet a child's basic needs. We further, you know, break this down into supervision neglect, which is inadequate supervision that places the child at significant risk for harm or

that it results in harm and supervision neglect is the most common form of neglect that most children experience.
We also have physical neglect, which is an inability to meet the basic needs, including food, clothing, and shelter. And then medical neglect is usually the principal concern when it comes to children who are medically fragile or have chronic conditions or disabilities. And medical neglect is defined as a failure to attend to
obvious signs of illness and failure to follow through with medical recommendations after medical advice is sought.
So when we're talking about neglect, I want to highlight, so this is this gray area on the map is what we call Region 8. So this is the area that Bexar County and the surrounding area fall under in terms of CPS, the CPS umbrella. Within Region 8, which we got a total or CPS got a total of 36,692,
reports in 2023, CPS reports. Of those 36,000, 19,081 were screened in and made it to the investigation phase where investigation was completed. And of those completed 19 investigations, the 19,000 of
5,756 were found to have confirmed cases of involving neglect, some component of neglect. So you can see how that, oops, excuse me, you can see how that kind of total plays out and how it breaks up. You can see that neglectful supervision is the most common in our region as well.
So if we, turning to our first case, this is the case of a 12-year-old female with a complex medical history, including Rett syndrome, epilepsy, and failure to thrive. Center for Miracles received the consultation due to concern for medical neglect due to deferment of G-tube placement.
So the information we got from CPS was that this child showed up to a neurology visit due to increased seizure activity. She was found to be severely underweight, less than the 1st percentile, and inpatient hospitalization was recommended to further evaluate her poor weight gain. While she was
in the hospital during her course, she had an EEG, an upper GI, and a swallow study that were completed. And ultimately, as mentioned before, the G-tube was recommended, however, declined by the caregiver. And then the child was ultimately discharged home with mother. Mom was wanting second opinions. And so she was plugged in with some specialists here in town.

JF **Jane Fried** 6:35
People.

Cervantes, Laura L 6:56

And ultimately, they recommended similar medication regimen that the child had been on previously, and then also recommended GT placement. So I think as we go through this, I'm sure you will be picking up on some patterns here, but the history we obtained that I obtained from mother when I saw the child in clinic,

Jane Fried 7:03

I.

Cervantes, Laura L 7:15

was that child was diagnosed with Rett syndrome at three years old. She began having seizures at approximately 8 years old. Mother's perception was that the child was still able to tolerate food by mouth, specifically soft foods and liquids, and that there was no need for a G-tube. This child began having increased seizure activity requiring hospitalization.

Her mother, she underwent that EEG while she was inpatient and wasn't herself afterwards.

She completed the swallow study. Mother made a point to mention that the swallow study, she felt the swallow study wasn't accurate because the child was not herself after that EEG. Parent declined the G-tube placement. And like I said, child was discharged home with mother. Her physical exam was what you would expect.

For a child with complex medical conditions, she was quite thin, non-ambulatory, total care dependent. She did have poor secretion management. Mom, you know, when she was in clinic, mom was trying to feed her with a spoon and trying to give her water from a bottle and she was coughing.

It's quite the classic picture. She had some contractures, was in a wheelchair, and had some blanchable areas on her skin that made me think that she might not.

be rotated or moved and repositioned as frequently as she needed. And for reference, this is her growth chart, which was quite startling, and she had minimal reserve. When we were able to obtain all of the medical records and review everything, we did see some documented inconsistencies with her prescribed medication regimen.

Jane Fried 8:42
Yeah.

Cervantes, Laura L 8:59
Mom had been altering the doses without medical supervision and discontinuing medication. Mother reported that this was because the medication was causing some undesirable effects when she would give it to the child. We were able to better track that poor weight.
that pattern of poor weight gain and growth. And we also saw that the G-tube had been deferred for at least three years prior to her evaluation at the Center for Miracles.
And then like I was mentioning before, it was deferred because mother was under the impression that child was tolerating pureed foods. And then as also, as you would imagine, her swallow study showed severe dysphasia and really did support the need for the G-tube. And then in the documentation, we also...
noticed that there was some possible barriers. Mother was saying that there was difficulty obtaining the nutritional shakes and supplements that were recommended to help boost her weight for that caloric intake. So we had to delve a little bit deeper into that to figure out if there was any additional resources that we could help with.
So if we go back briefly to this
definition of medical neglect.
I underlined the word obvious because I think that tends to be the biggest part that we, I guess the area that gets the murkiest, right? So it's obvious to us many times as healthcare providers. However, to the parents, oftentimes it's like we're speaking a third language and they don't always quite understand the complexity of things or the importance and significance of why keeping on top of certain things is so important.
When we're talking about medical neglect, there's five common criteria that we usually have to check off as we're going to see if a case meets criteria of war. Medical neglect. The first being if there is harm or risk of harm to the child. In this case, yes, it was very obvious that she was exposed.

Jane Fried 10:48
Yeah.

Cervantes, Laura L 10:59

harmed by the severe malnourishment and poorly controlled seizures.
The second criteria is if the medical recommendations offer any net benefit to the child, again, an obvious yes, that it would optimize, the GT would optimize her caloric intake and that medications would better control her seizures. Is the anticipated benefit greater than the child's morbidity? Again, yes.
And then these last two parts or these last two points is kind of where we have to delve in deeper is whether or not there's access to that health care that is not being used. So in this case, perhaps we know that mom was comfortable seeking out medical care because she would take her to the hospitals frequently for her seizure activity. However, she wasn't receiving her shakes and her supplements.
And then how much does the caregiver actually understand about what's going on? In this particular case, it was unclear. I couldn't quite figure out how mother was under the impression that child was tolerating foods by mouth when she was, you know, struggling to do so.
And.
Sorry, let me go on. So with this first, the first part, when we're talking about access to barriers.
This caregiver, like I said, demonstrated multiple occasions that she was able to seek out medical care. However, we also found out that through, despite going out to seek medical care, she had poor follow through with the diagnostic imaging. So for example, when I was talking to his mother and obtaining the history, what I found out was that
During the child's EEG, she was given a medication that made her very sleepy and made her out of it. You can find in review of the medical record, she was given a dose of Keppra because she was having seizure activity, which I know that that likely was controlling her seizure. And that might have that perception, that disconnect between
becoming more sleepy was likely the child in the postictal state or the medication controlling the seizure and mom seeing that marked a difference in the child's behavior. But I also wonder, you know, when talking to mom, what that perception was on her part, if there was that conversation of how the medications work or this is what it would look like.
I would like to think that, you know, it did occur. However, there was no

documentation of it. And I know, you know, with mom, for mom's history, right, the expert in this child who takes care of the primary caregiver of this child, she's telling me that something was off. The other thing is that,
There was no, there was a pattern of missed appointments and no identifiable barriers. They had transportation. They were able to get to where they needed to go. We had mom just saying, you know, I would forget, she would forget, or, you know, nobody's answering the phone. These sorts of hiccups that kind of can be perceived as barriers.
but really, it was much more, as you'll see as we go on. And so in this case, her access was not being utilized as needed. And so that did meet criteria for medical neglect. Caregiver comprehension, when we talk about this, let me lower this down.
So the child was able, or excuse me, the mother was unable to verbalize some of the medical conditions and the care, the anticipated care that was needed for this child, which obviously for me was a big red flag. The perceptions of events during hospitalizations, like I was saying earlier with the EEG and the child not being herself. This family's preferred language was Spanish. This caregiver's preferred language was Spanish, and there was no evidence of any interpreter used. Mom was able to communicate in English. However, I think that there might have been a language barrier that may have prevented her from fully comprehending the situation.
And then in talking to mom, it was very clear that, you know, that she was having, she was overwhelmed. She was a single, she was a sole caretaker of this child and had a second child at home with disabilities and extra medical needs or special care medical needs. And so I think that there may also have been some underlying mental health issues that could have been addressed with additional resources that perhaps Unnoticed or undocumented, or you know, various areas for...
other areas we could have helped with prevention, or at least supporting this family. And then there was also a question that I had just in reviewing everything is whether or not there was an actual discussion about concerns for maltreatment or why we're so concerned. At least when I was going through medical records, it was just brief snippets of
G2 was recommended, you know, three years ago. G2 was recommended by so-and-so, but there was no actual documentation of discussing the concerns, the, you know, if this does not happen, then this may happen. Those risks and benefits that go with with with some of these heavier discussions for medical.
Neglect, and so, ultimately, this child had...

sequential follow-ups with us here at Center for Miracles. She did have her G2 placed a few weeks, I want to say, after we initially started getting involved. And she came back for weight checks, which weren't great. Her weight gain was still not great. We found that
The child was hospitalized shortly after visiting, after being seen in our clinic for fever and likely pneumonia, but in the hospitalization record of that new hospitalization. She was, there was undisputed documentation that mom was still adjusting medications within her hospital stay and still feeding the child by mouth. So now we have a documented pattern of behavior placing this child at risk for harm and continued lack of available use of a test.

jeannine kaufmann 16:58
Oops.
And.

Cervantes, Laura L 17:12
available resources to obtain the recommended formulas and utilize them as needed. So for this particular case in general, she did meet criteria, we did diagnose her with concern for medical and physical neglect, which I'm sure many of you saw coming and could anticipate.
Excuse me. So when we are talking about prevention of maltreatment in medically fragile children, one of the things we think about is, as we all know, all children would benefit from a medical home. The pediatrician, that central hub where communication can come through, where referrals, a family can always go back and request referrals. That's always paramount for the care that we give these children. But it's also, I think, goes a long way with...
having that, being able to build that rapport and seeing the same person, continuity of care, seeing that same provider over and over again that the family can get used to seeing. One of the other things we think about, which I touched on too, is caregiver education, right? Obviously, I think providing education in the same language, the preferred language of the caregiver is important.
But one of the things we'll also mention later on in the presentation is, you know, optimizing the education that we provide in a way that's going to best, I guess, land with the caregiver if there's any learning differences. So being aware of that. Caregiver goals is also very important to keep in mind.

This is a good opportunity, you know, if we're reviewing caregiver goals for parents and the provider to be on the same page, but also it's a good opportunity for us to better understand rationales for decisions that the caregiver makes that we may not necessarily agree with or think that, you know, it's the best route to take. It's also a good opportunity to correct any misinformation.

jeannine kaufmann 18:56
Okay.

Cervantes, Laura L 19:04
that is, you know, that the caregiver might be under the impression of. We also, one thing that's very common for us here at Center for Miracles in Child Abuse Pediatrics is sibling risk assessments. Because our medically fragile children are not able to, sometimes not able to verbalize or disclose, you know, maltreatment or resource and security and these sorts of things that we're trying to prevent. Many times we'll ask for the siblings, especially if they're three years or younger or also at high risk for maltreatment to be seen in the clinic as well for the sibling risk assessment, where we'll do a complete head to toe assessment, but it also gives us another
aspect and view into the child's social world and what, you know, things might be like at home if there's any other resources or help that we can provide.
And oftentimes, excuse me, going back to the sibling risk assessment, oftentimes that will also allow us to identify any other forms of maltreatment that might be going on that we might not necessarily be seeing in the index child initially. And then lastly, assessing household stressors. You know, are there financial stressors? Is, you know, this a single parent who is working two jobs trying to make ends meet? Perhaps very often we find, you know, they might not be having access to the private duty nursing or to the local support networks that they need. And so trying to kind of attack these little areas where we can can really help to alleviate some of that stress for the caregiver and work to prevent.
maltreatment in some of these children.
So I want to move over to physical abuse. Physical abuse, I think, tends to be what most people associate with child maltreatment. It is defined as the use of physical force that can result in physical injury. I want to point out, I know the slide says intentional use. Here in Texas, DFPS doesn't

recognize intent. So for us, our intents and purposes, it's just, it's the physical, the use of physical force that can result in physical injury, regardless of intent. And that means that injuries that occur outside of routine care and handling would be consistent with child physical abuse as well. So going back to the national data, we'll be focusing here now on this 10%.
of children who experience confirmed cases of physical abuse. Given the same numbers as before regionally here in region 8, you'll see that physical abuse, how it stacks up against neglect, we saw only 679 confirmed cases of physical abuse within our region, which
I felt in, you know, reviewing these stats was quite low. But we also, the literature says that the rate of physical abuse is 3 1/2 times higher in children with disabilities. And it's a certain combination of disabilities that puts the child at risk, which our case study will show here in just a second.
Most specifically, the highest rates of physical abuse are seen in children with mild cognitive disabilities and no motor deficit. So we'll see in our second case here regarding a 10-year-old boy, a 10-year-old male with autism spectrum disorder and learning differences.
Well, the information we got from CPS was that the child arrived to school with a bruise on his cheek. School personnel overheard his sibling telling a peer that the child was hit by a belt. And the child, when interviewed by CPS, told CPS that the injury was sustained from him squeezing his face when he became frustrated. And he demonstrated this sort of motion, pulling his
face down when he was upset or frustrated. And we were told that that was a common thing that he did when he to self-regulate.
In terms of his capabilities, he did require mild to moderate support.
Like I said, diagnosed with autism spectrum disorder. He is capable of walking independently. He speaks in clear sentences and receives accommodations at school.
So in terms of the injury itself, the photos that were provided by CPS show patterned bruises involving the left temple, cheekbone, fleshy part of the cheek. And there were areas of unbruised skin within that injury. So for reference, this is what our injury looked like.
You can see the pattern outline and the distribution of it, and it makes it very unlikely that, you know, he inflicted this injury on his own by squeezing his face. We also know that, you know, injuries that are on the fleshier areas of the skin, like the cheek, have a lower likelihood of being accidental in nature.

And the fact that it was unilateral was quite telling as well. And so we did express concern for physical abuse. Also, I think probably a obvious outcome for most. But what I wanted to focus on was when we're talking about mild cognitive delays is many times the conditions that come to mind are your autism spectrum.
disorder, attention deficit disorder, and mild intellectual disabilities, which they're a little bit different. These disabilities are a little bit different than our children with complex medical needs, because they're a bit like invisible disabilities in the sense that they may not be evident. You might have to spend a little bit more with the child, a little bit more time with the child to see some of these cognitive deficits, right?
social differences. Many of these children, if we review some of the criteria for these diagnoses, many of these children have processing differences that include all five senses, right? They're interacting with the world and perceiving the world that's around them very differently than typically developing children. They oftentimes have differences in emotional awareness. Sometimes these children don't realize that they're in trouble or that they shouldn't be doing something until there's a huge change in tone of voice. They may not pick up on the mom stare, as we like to, you know, joke about, or different subtle ways of trying to redirect them. They don't always respond to traditional discipline.
I think this is probably the biggest, I guess, barrier or area where we see these children at risk for physical abuse because, you know, putting them on timeout isn't necessarily going to work unless the child has the capability to reflect on what they've done and think about it.
in general. So we also have emotional dysregulation where they feel big feelings all the time, very intensely, and don't know how to turn it down or regulate themselves. And so that can often lead to increased stress in certain situations. We also, these kiddos have
impulsive behaviors, right? We have to remember that they...
our only focus on what's in front of them at that moment, right? The consequences aren't crossing their minds, the potential dangers aren't crossing their minds. It's just, oh, let me see what I can do with this here. And, you know, then chaos can ensue. And finally, we also have to remember with these children, there is
more often than not a mismatch in caregiver expectation versus the child's limitations and the child's capabilities. Because like I said, these sorts of disabilities aren't something that you can look at a child and right away tell that they process

things a little bit differently internally. More often than not, families, they're always going to be able to
tell you the quote unquote bad things, right? He won't sit still. He doesn't listen. He doesn't do these things. But what people don't realize is those times that caregivers have to sit there and repeat themselves endlessly or physically show the child, oh, you have to do first this and then this and then this and have to show them and model it.
step by step. Many people don't realize that those are symptoms of these conditions as well. It's just displayed a little bit differently. And that's the child's day to day. That's not, those are the symptoms that you see in situations that might not be as highly stressful where the kiddo is trying to regulate themselves, like when they're running around or won't sit still or having these emotional breakdowns. And it often goes unrecognized by many people and can lead to increased risk for maltreatment. These children is also important to remember that they're at an increased risk for emotional abuse. Bullying at school because of their processing differences or social differences,
as well as bullying at home due to whether it's sensitivity, increased emotions, cognitive differences that might be.
deemed inappropriate from a family dynamic standpoint, from a cultural standpoint. You know, these differences, if they're not well understood by caregivers and families, can be a real difficulty for some of these children. But going back to these sort of key points and features in these conditions, it's really important to remember that in
uncomplicated cases where there's no underlying genetic issue or reason or syndromic reason for these children to be exhibiting global developmental delays. More often than not, when we're talking about mild cognitive disabilities, the apple never falls far from the tree. Usually, at least it's been in my experience, if the child has some sort of mild cognitive
difficulty, the parent usually has some sort of, whether it's a learning difference or maybe ADHD themselves that's gone unnoticed. And so it's very often that we'll see situations where the child is overstimulated, the parent becomes overstimulated, often for similar reasons and neither one of them realizes.
that there's an overlap there. There's ineffective communication because everybody's screaming at each other.
Everybody's triggering everybody in the home because everybody's got the same

buttons that are being pushed. There's no structure to re-regulate. And then we get a knee-jerk reaction, right, where somebody hits somebody or, you know, something happens and there's a, you know, explosion. And so one way that we can work with this, I think in
When I used to work in development, something we used to do was take a lot of time to kind of explain some of these diagnoses and then change what we do in our clinical practice to kind of see if we can't better individualize and accommodate some of these caregivers so that we can also
obtain the information that we need while still working with what they have to offer. I think one of the easiest ways to do this, and I think we're all aware of this and have had practice in this, is how we phrase the questions, right? Asking direct questions and smaller questions, not making them too complicated, using
the appropriate vocabulary for some of these families to get, you know, the information we need. Another thing that we can do, I used to do quite frequently is use big calendar milestones to help build timelines. You know, did this occur before or after Christmas? Was it before school started or after school started? A lot of times when we're dealing with neurodiversity, there's a
big component of time blindness that it's just very easy for days to mesh together. And so using tangible milestones like that can be helpful. And then using what they know to get back the information that we need. That can be as simple as using the notes app to jot down your, you know, blood glucose that you're tracking or your blood pressures or what have you.
Utilizing the CDC has a great app for child wellness and immunization reminders. So using these sort of technologies to our advantage that the families are aware of.
In terms of the physical exam.
It's always helpful to verbalize normal and abnormal findings. I say normal findings because often we think about, the one that always comes to mind for me is your CDMs, the birthmarks. Sometimes those bluish purple birthmarks, we do get consulted quite frequently about those, whether or not they're bruises, because they do resemble bruises.
Because sometimes if we're documenting these sorts of normal physical exam findings and making the family aware of them, then, you know, that can be very helpful as well. Because sometimes parents don't realize, you know, that the child has a birthmark. And then obviously abnormal findings to draw attention to what we'll be monitoring for the family as well.

So they're aware of it. Something else that I would do quite frequently is use developmental screenings as teaching tools for these caregivers. We're talking about development and cognition that can be very abstract for these families to kind of grasp sometimes.
And sometimes using those developmental screens, that scoring page, that last page is a very easy way to say, you know, ideally we want all these bubbles to be in the white area. And I can see that, you know, baby might be in the gray or in the black. And this is why I think he might need some speech therapy or physical therapy or what have you. And then utilizing those screening tools, almost like
a growth chart where you can repeat the same, the same screening at the next visit to demonstrate the progress that the child has made to help the family better visualize, you know, how they're developing.
I know I've briefly mentioned documentation. It's something that we that is also super important when we're talking about verbalizing normal findings, including typical normal behaviors or abnormal behaviors in the documentation. So this is particularly important with children who have self-injurious behaviors, right? The kiddos who bite themselves or scratch themselves.
or head bang, that would be helpful to be able to track, you know, when we're consulted about, oh, the child who squeezes his face, right? Obviously that we knew that that's not what happened, but these sorts of ways that they self-sue that might be a little bit atypical would be beneficial to have in documentation.
We also want to document normal variants, like I was talking about CDMs earlier, subconjunctival hemorrhages in newborns is also another big one that we're consulted on that would be good to have in the documentation. And then as well as any animal findings that put the child at risk for
injury. So osteopenia, perhaps bleeding disorders, and these sorts of things that are useful to know as well to have a baseline for. Photo documentation is always, always a good thing to have. I think with Epic, that's helped a lot with having us be able to view an injury immediately and give some feedback or give recommendations and our impression.

Nolan, Robert J Jr 34:16
Skip.

Cervantes, Laura L 34:30

Of course, with photo documentation, we always encourage taking the photo from a good angle, not overexposing with too much light or brightness and flash, but, you know, making it to where I want to be able to see what you're seeing in front of you, right? That would be the most helpful so that we can give an accurate assessment. And then patient education, which we've touched on a bit. So it's really important to provide disability specific guidance and resources. So if we're talking about a child with who's nonverbal, who has autism, right? Perhaps our anticipatory guidance is regarding elopement or part of it is regarding elopement.
how to, you know, improve childproofing the house, locking the doors, these sorts of things to make it a little bit more meaningful for the family so that they really feel like they have a good takeaway from these visits. And then utilize or utilizing different manners of education to give these caregivers what they need. I know often I used to give
There used to be like a specific YouTube link to an autism video on YouTube from one of the universities that would explain it. This is what it is. This is how we're, you know, the child processes things. For my visual learners, I would hand that out a lot because a lot of times I know that handing my family's after visit summaries wouldn't necessarily
you know, it would just get lost in the paperwork from everything we gave them at checkout. So really tailoring some of the patient education to.
help the families meet families where they're at. And then tangible goals for their next visit. That was always something that went over really well. It was something that a mentor of mine taught me from the very beginning, but something that I found over and over again that's gone over very, very well with families is if you give them one thing to work on, whether it's, hey, I just need you to wake up in the morning and get her on the bus.
Or maybe I just, I need you to work on just how many time, three, four times a day, or whatever your recommendation is. You can give one thing for them to just like grab on and work on to follow up on at the next visit. And it's a really good way to get parents to do buy-in, to get buy-in and to really become involved and understand some of the
the things a little bit better of what we're looking for. And the other most unique position that we're in is modeling some of these things for families. We know that kiddos model adults, right? That's why we always tell parents, watch what you say around children, or, you know, be careful what you do or how you say, because they

pick up everything. They're little sponges.
But one thing that we can do within our visits as well is model those appropriate adult-child interactions. Oftentimes we have to remember these families, normal for them is, you know, just what's normal for them, but it's not normal for whether it's the rest of us or societal norms or what have you. They're only kind of used to what's going on within their home. So the more exposure that they have in
in visits with us where we can show what is quote unquote normal can be really helpful because these parents ultimately do end up modeling us what they see us do with the child at home. So this comes in to be really helpful when we're trying to show parents, hey, it's okay if the child doesn't want to do that right now. You know, this is how we can be flexible to do things.
Easy ways to do that during our visit is with the physical exam, right? If it doesn't go in the exact order, head to toe that we need it to go in, that's okay. Let's show the parents how we can deviate from that, but still get what we need done. Preparing the children for transitions, that's a hard one for parents. And sometimes that's an easy way for us to kind of show, hey, maybe we can try this at home, right? If we're going to be transitioning from
I don't know, the waiting room to the exam room or the exam is complete and we're going to be wrapping up the appointment. These are all very good points, touch points where we can show parents how to help prepare the child with the transition. And that can be as simple as, you know, visual timers so that the child can see colors running out of the timers rather than, you know, in 5 minutes, this is what's going to happen.
because we all know kids don't have any concept of time or, you know, letting them know, you know, enforcing boundaries, how to model enforcing boundaries. You know, if you, we're not going to hit, if we hit one more time, you know, we're going to take the toy away. Whatever the example is, it's good for us to be able to model that. And then most importantly, modeling developmentally appropriate disciplinary techniques.
or even just interactions with the children being developmentally appropriate, that's going to go over really well with the families. Unique challenges for children with disabilities. Now, it's important to keep in mind before I go down this list is that CPS involvement, I want to highlight CPS involvement and Center for Miracle Involvement doesn't always result in removal.
Often, about 50% of the time, roughly, that's a huge estimate, but 50% of the time,

we find that we're not concerned for abuse. And so instead, we'll offer resources to some of these families, whether it's support, you know, specific support groups or resources here in the city. But it's important to remember that when these children are removed, something that
we have to keep in mind is that children with disabilities are at a higher re-referral rate to CPS. They get called, cases get opened more frequently in children with disabilities. In the instances where they are having to be removed, they're placed in foster care more frequently. And then they tend to experience a higher rate of placement instability.
I think this usually, I worry about this in our children with those mild cognitive disabilities who may not be kind of seen as medically complex. Oftentimes, if you think about, so when children are placed with foster families, usually if we have a medically complex child, a foster family has to be adequately trained to take that child in and to meet their medical needs.
That's not necessarily the same with a child who has autism or severe ADHD or emotional dysregulation. Sometimes those sorts of invisible disabilities don't meet the threshold for CPS and oftentimes they're placed with, you know,
not as adequately prepared foster family. And I can recall many times during visits where, you know, caregivers will have told me, you know, his behavior is just so, we don't know what else to do. It's so overwhelming. And it results in this huge instability for children who already have a low threshold
for change. And so I think that really working to get these disabilities recognized, these sort of the autism, ADHD sort of things recognized would be really helpful to helping these kids. Of course, that's
It's kind of a side topic, but just to keep that in mind, the placement instability can be really disruptive overall. These children do experience higher adoption disruptions and then are less likely to be unified with family or any sort of kinship reunification.
So just to leave you with a few takeaways of what we touched on today, obviously, there's no place like home. So our medical homes are vital for children with disabilities, whether it's a complex care clinic or just, you know, your regular pediatrician. All children should have a medical home to act as that communication hub.
and referral hubs so that the family has a place to go back to and seek care when needed.
Get to know the child's inner circle, right? Ask about sibling, who all lives at home.

The younger they are, the more at risk for maltreatment that they are. So we, you know, just to be really acutely aware of what's going on in the child's inner circle. And then also engage with the non-medical team members of that child's team. So speech therapists, OT, PT,
aides at school who maybe have eyes on the kid a little bit more frequently. If we're needing more information, these are really good opportunities or really good people to reach out to to establish a better baseline for children whose normal is a little... It's a little abnormal. Is there normal?
very typical of those, they're normal. Get creative with patient education. Tailor that anticipatory guidance to the child's needs, the caregiver's needs, optimize information for learning differences in caregivers. That can all be very helpful. And then looking at the big picture, assessing for
household stressors, being aware of our personal biases, which I, you know, I think we all, we're all aware of that and able to feel that rear its head every once in a while. And then reasonable
Actually, I've got a window that I can't see over there. Oh, having reasonable expectations for the caregivers, as just as much as we want the caregivers to have reasonable expectations for the child, we also have to have reasonable expectations for caregivers and what they can accomplish or what they may be capable or what their limitations are as well. And then most importantly,
If you see something, say something. So I wanted to provide just the information for CPS to make a report for immediate danger. Phone reports are preferred for that for serious injuries, injuries to children under five years old. Anything that needs action within the first, within 24 hours,
would be recommended to be reported by phone. Anything else can be online. And the only caveat for that, I think, is if there's imminent danger where, for example, the parent and the child are at risk for disappearing and the child's at risk in that case, you also have the option to make a CPS report, excuse me, a CPS, a law enforcement report for more immediate and urgent concerns.
And then of course, we're always available, Center for Miracles. This is our on-call number. We do ask that if a CPS report is going to be filed, that you do give us a call so that we can be looped in. That way we can help discuss some of these cases with CPS and
help translate some of the medical communications with them and better help

facilitate the investigation along the way. And that is all I have for you. If anybody has any questions, I'm happy to take them.

Ranch, Daniel 45:05

All right, thank you very much for that wonderful presentation. We can open up to questions. You can place your questions in the chat or feel free to raise your hand and unmute yourself.

While we're waiting, I can start off. So in, say like in my field, nephrology, where we're dealing with patients who we're basically caring for through their entire lives until they go into adulthood, sometimes situations come up where you do have to call CPS, but at the same time, you're trying not to destroy that long-term relationship and that rapport. So any tips on

Cervantes, Laura L 45:39

Open.

Ranch, Daniel 45:42

how to navigate that process.

Cervantes, Laura L 45:46

I always opt for, I think, as I think most of us, most of us realize it's, you know, transparency. So I kind of do it in a stepwise fashion. So in order to not destroy that rapport, right, that we've built, so worked so hard to build, I kind of review, just make sure that I have that patient under or that caregiver understanding, right? How well do they understand? Do they have access? Kind of tick off those boxes.

And then have that transparent discussion. Look, this is my concern. I'm concerned that, you know, whatever the case is, that something bad might really, really happen. And I think we need to maybe engage in additional resources. I tend to refer to CPS as a resource sometimes because they do offer resources. They'll take a better look at everything from a big bird's eye view to make sure that we have access to things. And I kind of approach it from that kind of way.

Ranch, Daniel 46:37

Thank you for that. We have a question from Dr. Williams.

Williams, Janet F (Dr.) 46:41
Thank you for that very interesting presentation. I wanted to comment on...
partly what you just said about the parents understanding, but the sophistication of parenting in itself. And you use the example of timeouts and that the child had to be able to contemplate, be introspective about
what they did and change their behavior. But the parent has to be, has to understand the point of time out and be able to give them thoughtful, kind guidance about what went wrong and what to do differently.

Cervantes, Laura L 47:15
Mhm.
Yeah.

Williams, Janet F (Dr.) 47:30
And I think both contribute in many of the things that you're talking about, that the parent may not have that sophistication and dealing with that is a critical part of what you're saying.

Cervantes, Laura L 47:44
Mhm.
Thank you for bringing that up. Oftentimes, not 100% of the times, but sometimes I will say parents, like it never occurs to them, right, that that mismatch happened. So sometimes it can be as simple as mentioning it, right? He's not in an age where he can understand, you know, what he's done and sit there and think about it. And sometimes it just takes mentioning it and it

Williams, Janet F (Dr.) 47:56
Yeah.

Cervantes, Laura L 48:08
kind of clicks and you can see it and they're like, oh, I've never considered that, right? Other times it takes a little bit more where you'll have to give them a more concrete example of, well, maybe if, you know, we don't want him to throw a cup across the room, maybe we remove the cup, right? If we see that he's done, we'll remove it or

give them the actual tangible action to take.
That, that's leading up to some of the, you know, bigger punishments like timeout. But oftentimes, it's just making sure that they're understanding in blatant terms that, hey, this is, you know, he's just not capable of that.

Williams, Janet F (Dr.) 48:36
Thank you.

Ranch, Daniel 48:56
Looks like a quiet bunch this morning.

Cervantes, Laura L 49:00
Yeah.
Well, thank you all for listening, for sitting in this morning, and it's a pleasure talking to y'all.

Ranch, Daniel 49:03
Okay.
Same here. Well, I guess without any more questions, I'll end it here. Thank you very much, Laura, again, for presenting Grand Rounds for us at UT Health San Antonio.
For the audience, please, the attendance code is in the chat if you haven't already entered it. Also, please don't forget to complete your post Grand Round service. That really helps out our speakers and our programs.
Otherwise, thanks again, Laura, and everybody have a great weekend.

Cervantes, Laura L 49:32
Thank you. Have a great day. Bye bye.

Williams, Janet F (Dr.) 49:34
Thank you.

◉ **Calderon, Delia** stopped transcription