WHAT'S NEW AND WHO'S DOING IT

Onsite Medical Consultation for New York City Child Protective Services Workers

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New York City's child protective services agency, NYC Children's Services (CS), handled over 50,000 reports of child abuse and neglect from among over 1.5 million city children in 2012. Covering 5 boroughs that are each a separate county, this large city agency is broken down into 16 borough offices with a total of over 1,200 caseworkers in the division that investigates reports of child abuse and neglect (New York City Council, 2013). Offices are further subdivided into zones and units, including specialized prevention and hospital teams and an office to investigate cases within the foster care system. In addition to circumstances leading to a large number of suspected child maltreatment reports made to the state's central child abuse and maltreatment registry, New York City's children face almost insurmountable ecological challenges and alarming health statistics.

In 2000, children in New York City were twice as likely to be hospitalized for asthma as children in the United States as a whole (Garg, Karpati, Leighton, Perrin, & Shah, 2003). The prevalence of diagnosed diabetes has more than doubled, and more than 200,000 additional adult New Yorkers have diabetes but have not yet been diagnosed (Kim, Berger, & Matte, 2006). Several high-profile deaths in the child welfare system have highlighted the need for caseworkers to understand and integrate knowledge about domestic violence, substance abuse, and medical and mental healthcare into their work. In addition to addressing the safety of children during investigations for suspected abuse and maltreatment, caseworkers are also being called upon to meet the ongoing health and developmental needs of the over 15,000 children in foster care in NYC at any given time (Fahim, 2008).

With the documented rise in rates of chronic illness in both parents and children, it has never been more important for child protective services (CPS) to work with medical professionals. When parents neglect the healthcare of their children, there is often more to the story. Many of the city's children and families have complex health and developmental issues, and negotiating the healthcare system can create special challenges for even the most seasoned professionals (Garcia, Collins, Herrera, Nieman, & Walsh Kieninger, 2008). Understanding the presence of medical and developmental conditions is of particular importance because such conditions can leave children more vulnerable to maltreatment and greatly impact their safety and risk. Collaboration between CPS and other professions has been increasing based on the appreciation that a single discipline or profession can not understand a problem as complex and multifaceted as child maltreatment (Lalayants, Epstein, & Adamy, 2011).

Enhancing CPS Access to Medical Services

In addition to recruiting medical providers such as physicians and advanced practice nurses to offer direct services for children, CPS in many jurisdictions has sought expert opinions and consultation of child abuse pediatricians to better determine if a child has been maltreated. Consulting with medical professionals for expert opinions regarding suspected child maltreatment has proven to be valuable in case determination and service planning. In a study from 2011, experts' opinion differed from the initial examining physician and from CPS 43% and 35% of the time, respectively, providing critical information to inform child welfare decision making (McGuire, Martin, & Leventhal, 2011).

Several states have developed programs to enhance CPS access to medical services. Michigan created a statewide medical resource system in 1999 to provide medical evaluations, case reviews, and training (Palusci, 2000). In Massachusetts, child protective services has a Health and Medical Services Team consisting of medical professionals who provide a number of services, including the assessment of healthcare needs of children in CPS care/custody. They recommend appropriate care and placement and work with healthcare providers to ensure that each child in care/custody receives timely medical screening and examination (State of Massachusetts, 2013). Orange County, California, has set up an emergency response program in which CPS staff members can request that a public health nurse accompany them in the field on a visit. These nurses provide a variety of services, including education about health issues, referrals to services, and the review of medical records (Orange County Public Health, 2013). In Florida, the State Department of Children and Families contracts

with local nonprofit organizations for medical consultation and services upon request. These teams provide medical assessment of children, expert testimony, and training (Socolar et al., 2001). Using a different approach, Chicago has a program in which all reports to CPS receive a medical review at intake to assess medical issues and make appropriate referrals to the child advocacy center (National Association of Children's Hospitals and Related Institutions, 2004).

Bringing Medical Consultations Into CPS Offices

To bring medical services into CPS offices, NYC CS designed a formal collaborative system with other disciplines to better understand and provide services for their cases. In 2002, New York City CS implemented the Clinical Consultation Program (CCP). CCP is designed to enhance decision making and case outcomes through use of consultation teams with specialized knowledge in the areas of mental health, domestic violence, and substance abuse. The consultants are not child welfare caseworkers but are obtained through contracts with social service agencies in the community. Teams are organized in each of the 16 offices under a single agency umbrella, each with a team coordinator and consultants addressing specific disciplines. Caseworkers contact one or more of these consultants on a voluntary basis as they see fit during their investigation and could consult both informally and formally with the creation of a written report, which would be available to the caseworkers and supervisors of the child welfare team, but kept separate from the child welfare case file. Although the need for consultation regarding medical issues was considered, the development of a medical clinical consultation program was delayed due to budget restrictions.

After an open bidding process in 2007, NYC CS contracted with NYC Health and Hospitals Corporation's Bellevue Hospital Center to provide the medical consultation component of CCP. Bellevue Hospital is a public facility affiliated with New York University School of Medicine. It houses a child advocacy center that is staffed by three board-certified child abuse pediatricians. The initial program model consisted of 12 full-time nurse practitioners (NPs), either pediatric nurse practitioners or family nurse practitioners with a strong background in pediatrics, acting as onsite medical consultants to CS staff. Nurse practitioners were chosen based on their experience in functioning independently, knowledge of primary care and health systems, and ability to provide health education. The medical consultants joined the preexisting CCP multidisciplinary teams in NYC CS offices but had separate supervision from the rest of the CCP team. Each medical consultant (MC) was assigned to collaborate with one of the three child abuse pediatricians (1.5 FTE) who serve as senior medical consultants and trainers for the program. These physicians review every consultation write-up and are available by phone to provide guidance with cases. A full-time social worker functions as the project coordinator to assure contract compliance, provide guidance, and liaise with CS administration. Additional program staff initially included a part-time developmental pediatrician and an administrative assistant.

Adding Value to Children's Services

The collaboration between CPS and the medical community is a familiar concept, but the Medical Clinical Consultation Program in NYC introduces an innovative model. In this city, medical professionals are located onsite, not to provide clinical care or case management but instead to provide case specific guidance, training, referrals, and recommendations with the goal of improving CPS decision making. In this model, caseworkers are the consultant's client, and no clinical care is provided at any time.

The medical consultants provide a number of services, but a majority of their time is spent providing case consultation directly to frontline caseworkers. A consult consists of meeting with a caseworker on a one-to-one basis, reviewing the initial report and case investigation, and discussing any medical and/or developmental issues. Medical issues can be present in any household member, be it the subject child, siblings, parents, or other caregivers. A consultation can include education about the disease process, information about the standard of care for that condition, and how the condition could affect parenting and school attendance, navigating the healthcare system, and making referrals to community services.

Medical consultants also model for CPS how to best ascertain medical information by joining caseworkers in their home visits and case conferences. The consultant helps caseworkers navigate the healthcare system and makes recommendations about what information should be requested from providers to help CPS form an assessment. The consultant also helps CPS explore the caregiver's resources and parenting capacity and whether an allegation of medical neglect, for example, could be due to cultural issues, parental cognitive delay, lack of appropriate resources, or the possibility that medical information was not explained to the family in the family's preferred or first language.

Medical consultants can assist CPS with obtaining relevant health information by joining CPS during home visits and case conferences with parents, providers, or both. When present, the MC can model for CPS how and what questions to ask. When taking part in a home visit, the purpose would not be to provide care but, again, to model for CPS what to ask and what to observe in the home. For example, when visiting the home of someone with poorly controlled asthma, the MC would help CPS identify possible environmental triggers, such as smoke, pets, roaches, and so forth. Onsite trainings are conducted by the medical consultants, be they nurse practitioners and physicians or medical providers from the community. These trainings are about medical and developmental topics on a one-to-one basis, in small group settings, or in large group lectures, depending on the need of the particular worker, unit, or CPS office.

Case Examples

Case example 1. A case is called in by a healthcare provider involves an adolescent female with type 1 diabetes who is noncompliant with appointments and doesn't take her insulin. The medical consultant provides the following to the CPS worker:

(1) Education about type 1 diabetes with emphasis on the health risks associated with noncompliance;

(2) Education about child development and how adolescence may be a factor in noncompliance;

(3) Guidance to caseworkers about what medical information should be requested as well as where information should be sought (hospital, office, provider), how this can be obtained, and what to ask;

(4) Methods to efficiently get information from healthcare providers caring for the child and family. The medical consultant may call the provider directly while sitting with the caseworker, giving an opportunity for the MC to model how to best interview providers and obtain relevant medical information;

(5) Recommendations regarding health-related services;

(6) Questions about family resources and parenting capacity;

(7) Ways to inquire about the health of others in the home.

Case example 2. A case is called in because a 9-year-old child has missed 30 days of school. Upon investigation, CPS discovers that the child has been staying home from school to take care of her mother, who is obese and has a serious cardiac condition. The child assists her mother with food preparation and bathing, and she seems fearful to leave the mother alone. The medical consultant provides the CPS worker with the following:

(1) Education about that cardiac condition;

(2) Assistance in reaching out to the cardiologist and recommending what questions to ask. The medical consultant and CPS could make the call together;

(3) Assistance in reviewing medical records from emergency room visits;

(4) Suggestions about possible safety plans for if/when the mother is admitted to the hospital and for permanency planning if appropriate;

(5) Suggestions about additional services, such as a visiting nurse or a home health aid to assist the mother;

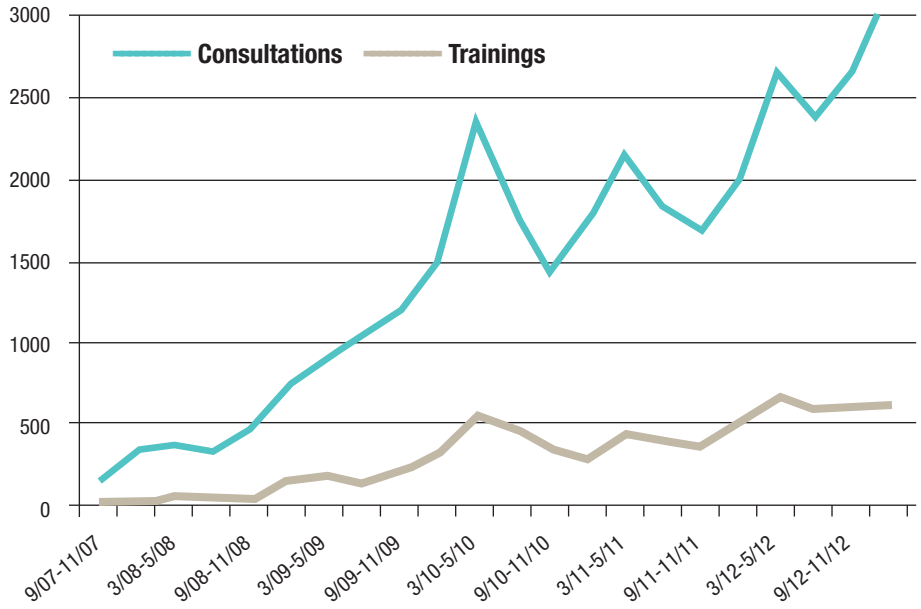
(6) Questions to ask about the child's health and medical care, such as about the child's growth, development, screening tests, and immunizations.

Program Progress

The Medical Clinical Consultation Program began in 2007 with two part-time child abuse pediatricians, four medical consultants, a coordinator, a part-time developmental pediatrician, and an administrative assistant. In FY 2013, it is staffed with 12 medical consultants covering the 16 CS offices. After 5 years in the CPS offices, the program has steadily increased utilization of consultations and trainings, and each MC now averages over 100 consults each per month (Figure 1). Staffing levels have varied greatly over the past 5 years as a result of variations in city funding, with significant decreases during 2010–2011 as the recession took hold in NYC. Though home visits have declined dramatically due to the time required, the number of conferences attended has been closely tied to NP-staffing levels (Figure 2). Following a high-profile fatality of a 4-year-old child in 2010, NYC CS policy was changed to require medical consultation when it is suspected that a child may have special medical needs (Associated Press, 2012).

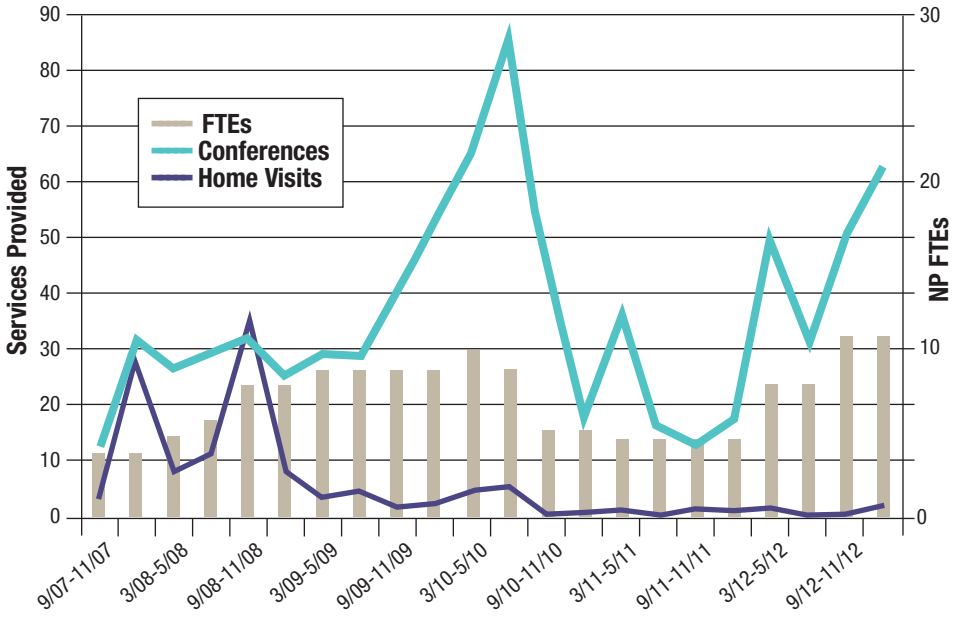
The contract between NYC CS and Bellevue Hospital Center requires that caseworkers and their supervisors be given the

Figure 1. Medical Clinical Consultations and Trainings, by Quarter, 2007–2012



Source: Bellevue Medical Clinical Consultation Program (Nieman's personal unpublished information, May 2013).

Figure 2. Medical Clinical Consultation Conferences and Home Visits, NP FTE, by Quarter, 2007–2012



Source: Bellevue Medical Clinical Consultation Program (Nieman's personal unpublished information, May 2013)

opportunity to complete performance evaluations following services. A performance evaluation tool was developed by NYC CS for all of the consultants (medical, domestic violence, substance abuse, and mental health) and is now available online. The survey consists of six questions using a 5-point Likert scale, with a rating of 1 being the least helpful and 5 being the most helpful. Evaluations of medical program services have been uniformly positive over the past 5 years; 2,888 evaluations were completed between September 2007 and February 2013 with an average overall rating of 4.7 (Table 1). The ratings have been consistently high during 2007–2012, ranging from 4.5 to 4.9 over time for the various services, their value, and the response time of the medical consultants.

Research Findings in the Program

Several research projects have been carried out to assess the nature of the cases and needs of the ACS workers in the program. The majority of medical issues identified in cases have been found to revolve around common pediatric conditions and medical conditions affecting family members, rather than specific issues with injuries and conditions directly resulting from child abuse and neglect (Table 2). CS workers have increasingly become aware of medical issues in families that contribute to maltreatment. The most common medical conditions encountered have been diabetes, asthma, failure to thrive, and issues related to obesity, including high blood pressure and sleep apnea. The medical consultants frequently consult on cases involving HIV, autism, and other developmental disabilities, as well as answer questions about medications and their side effects. Even though usually not the primary reason for a child welfare investigation, these medical issues can be found during the investigation for any form of abuse or maltreatment, including medical care and educational neglect.

A variety of medical issues have been identified in children and families, with 50% or more of consultations including requests for basic medical information concerning routine pediatric health supervision visits and immunizations and common chronic conditions such as asthma or lead exposure. Cases with complex conditions (such as mental retardation, developmental delays, autism, and physical disability) comprise an additional 25% of consultations. Questions regarding the mechanism of specific injuries identified in the active investigation were noted in 20% of consultations. Recommendations made by the NPs include referral for the need for additional medical evaluation of the child (75%), provision of additional services and therapies for children with special medical needs (25%), and the need to obtain additional medical information to better evaluate the active ACS investigation (30%). In many cases, the interpretation of medical information concerning the parents has been critical to assist the CS worker's understanding of their ability to care for a child (McHugh, Legano, Nieman, & Palusci, 2008).

Among 527 consultations in the first quarter of 2009, 19.2% were found to have allegations of educational neglect. There was a variety of chronic medical conditions, including asthma, diabetes, neurologic impairment and chronic pain syndromes which were offered as possible causes of missed school. Approximately one third of these cases had parents who were affected by a medical condition causing their child to miss school. The issues surrounding healthcare neglect included inadequate medical treatment, lack of adherence to treatment, lack of access to care, and no primary care provider to coordinate care. There were also several cases where a parent or caseworker incorrectly believed that the disease interfered with the child's ability to attend school (Legano, McHugh, & Palusci, 2009).

As part of a community nursing school rotation, 27 nursing students were placed at an NYC CS office for one semester with one of the nursing consultants and nursing school faculty during

Table 1. Program Evaluation by CPS Workers, 2007–2013

Question	Mean Score*
In general, how helpful did you find this service?	4.6
How helpful, was this service in acquiring new information, resources, understanding, etc.?	4.6
How was the response time?	4.8
How helpful did you find the service in your making decisions about the case?	4.6
How helpful was the service in locating appropriate referrals?	4.6
How helpful would the service be to your co-workers?	4.7
0verall	4.7

***1=Not Helpful; 2=Somewhat Helpful; 3=Helpful; 4=Very Helpful; 5=Extremely Helpful**

Source: Bellevue Medical Clinical Consultation Program (Nieman's personal unpublished information, May 2013).

Table 2. Specific Diagnoses Noted in Consultations, 3 Months, 2009

Diagnosis	N=527	%
General pediatric care/health supervision	191	36.2
Child abuse/neglect	112	21.3
Chronic medical problem	108	20.5
Dental problem	20	3.8
Development/failure to thrive	5	1.0
Genitourinary	52	9.9
Medication information	15	2.8
Substance abuse	6	1.1

Source: McHugh, Legano, Nieman, & Palusci, 2008.

2010–2011. Nursing students learned about NYC CS and were tested on their knowledge of abuse identification and reporting before and after the rotation. Posttests showed they were better able to identify and report child maltreatment in case scenarios. Additionally, the nursing students provided education for NYC CS caseworkers on health topics and surveyed them regarding their own health information and stressors. They identified several worker issues, including lack of sleep, illness, changes in appetite and weight, smoking, headaches, back pain, and hypertension (Ince, Geary, Pawlowicz, & Palusci, 2010).

Conclusions and Future Directions

The Medical Clinical Consultation Program highlights the need for basic medical information among caseworkers and supervisors and the value of case consultation and training given by medical providers in child welfare offices. Medical consultations from the program are well received and increasing in volume as caseworkers accept and utilize the medical consultants more frequently.

There are a number of challenges and potential barriers to replication that could be addressed by those wishing to implement a similar program in CPS offices. One area is the consultation initiation process. Unlike in Chicago, where there is active surveillance and cases are assigned for medical services, NYC CS must initiate a medical consultation with the nurse practitioner by formally requesting a case consult, training, or attendance at a meeting or home visit. Certain diagnoses that identify the child as medically fragile are supposed to require medical consultation, but implementation varies from office to office and relies on caseworkers, supervisors, and managers to assure that it occurs. It is our perception that, despite changes in policy requiring consultation for special medical needs children, there are still a number of children and families that do not receive medical consultation because the case is not flagged and/or the caseworker does not seek consultation.

Likewise, using a medical model, the medical consultant provides recommendations but does not make directives or provide supervision to the caseworker. While the medical consultant gives CS a consultation write-up documenting what transpired during the consult, any recommendations or referrals, and links to educational resources and handouts, it is CS workers and supervisors who decide whether a consult is needed and whether to follow one or more of the recommendations. Specific to the implementation of medical CCP, having medical consultants join preexisting CCP teams with domestic violence, substance abuse, and mental health consultants has had its benefits and challenges. While the other disciplines had a team structure, had laid the groundwork for the program, and had already provided CS staff with a good understanding of the consultation process, the other consultants worked for different agencies and had already developed procedures that often did not take medical issues into account. For example, consultation write-ups are not part of the CS record system and are kept separate from the CS record. Creating a system integrating consultation reports across disciplines as well as with CS information would be invaluable for the CS worker in addition to the medical consultant, especially as additional cases are opened over time or the family moves and cases are transferred to different workers and consultants.

NYC CS consists of 16 borough offices, which are located within different communities. While each office under NYC CS follows the same set of policies, each office has its own culture and potentially different procedures. The sheer numbers of workers, fami-

lies, and children is daunting. It is estimated that each medical consultant serves roughly 100 CPS staff in one or two offices. Perhaps it would be helpful to have medical consultants assigned to each zone to allow them to get involved earlier in the case, be involved in more cases, and provide more modeling while helping to obtain crucial medical information. With more time, for example, medical consultants could sit with the CPS caseworker while he or she makes calls to medical providers, joins them in case conferences, and spends more time talking with families.

It can be a challenge for medical professionals to work in a large city agency where staff is dealing with high levels of stress and trauma. Large child welfare agencies have historically high staff turnover that results in an ongoing need to repeat trainings and to re-educate CPS staff about situations that would warrant a medical consult. It would be beneficial to the child and family to contact medical consultants earlier in a case if any medical or developmental conditions are mentioned in the mandated report. This would allow the MC to provide CPS with some basic fact-finding questions to begin the investigation and to use when speaking with families and medical providers early in the investigation.

In addition, as a governmental program, CCP has suffered from changing funding levels and office staffing, which have slowed full implementation. The number of funded positions has varied dramatically, and support for administrative assistance, particularly in program support and statistics, would be helpful for the medical component and for CCP overall. As currently designed, CCP does not have a funded evaluation component, and it would be invaluable to conduct research that can look at the potential improvements in case outcomes from the consultation process.

Hiring appropriate staff has been difficult. NPs are in high demand to provide clinical services in our community, and it is a challenge to find qualified NPs who are interested in working in child welfare in a nonclinical position full-time. Working in a nonmedical, child welfare environment can be isolating because being the only medical professional in an office can be challenging for a young or inexperienced clinician. Given the complex nature of the cases and the need to provide training for nonmedical professionals, nurse practitioners need to be experienced clinicians and have experience with the child welfare system to be most effective as medical consultants. Furthermore, salaries are lower than other agencies and hospitals can offer for clinical positions, affecting NP recruitment and retention.

Overall, the Medical Clinical Consultation Program has provided a level of medical expertise and direct case involvement that can occur only when medical professionals are available on a daily basis to child protective services workers and can work within the child welfare system for children and families. It is our perception that this has changed the culture within CPS to value the role of medical providers and to actively seek their opinion for their cases. They have taken ownership of the process and are actively reintegrating medicine into child welfare. Medical CCP has also given medical providers a unique understanding of the problems and stresses within CPS, enhancing our ability to respond to nonmedical as well as medical issues that affect children and families. The program has developed a cadre of experienced clinicians who are knowledgeable about our child welfare system and who are able to help others understand and be more effective advocating for children and families within the community. While the barriers may seem insurmountable, implementation of a program using healthcare providers in CPS offices offers children, families, and the child welfare system unique, accessible resources to promote the health and welfare of the community.

Acknowledgments

The medical component of the Clinical Consultation Program is being provided through a contract between Bellevue Hospital Center and the New York City Children's Services. We wish to thank Jacqueline McKnight, Deputy Commissioner of NYC CS Family Support Services, Angel V. Mendoza, Jr., former Assistant Commissioner

of NYC CS Child and Family Health, Sharon Cadiz, Director of NYC CS CCP, and Andrea Goetz, Assistant Commissioner of NYC CS Clinical Practice and Support, for their participation and assistance with the program.

We'd also like to thank all of the nurse practitioners who have participated in this project: Memoudou Abalola, Annette Ardire, Nila Bragg, Saribel Garcia Ceballos, Margaret Collins, Christine Garcia, Theresa Griffith, Tracey Healy, Eileen Herrera, Mary Huang, Helene Ince, Diana Kong, Ursina Mercado, James Rempel, R. Christy Schmitt, Mary Beth Snyder, Robin Thomas, Betsy Villavicencio, Geraldine Walsh, and Chris Weidt.

References

Associated Press. (2012, June 7). Prison term for mother of a girl, 4, found dead. *New York Times,* p. A22. Retrieved from: **http://www.nytimes.com/2012/06/07/nyregion/mother-gets-prison-term-in-marchella-pierces-death.html?ref=marchellapierce&_r=0**

Fahim, K. (2008, November 12). Mother gets 43 years in death of child, 7. *New York Times,* p. A33. Retrieved from: **http://www.nytimes.com/2008/11/13/nyregion/13nixzmary.html?ref=nixzmarybrown&_r=0**

Garcia, C., Collins, M., Herrera, E., Nieman, M., & Walsh-Kieninger, G. (2008, March 24). Families on the mend in New York City. *Nursing Spectrum Magazine*. Retrieved from: **http://news.nurse.com/apps/pbcs.dll/article?AID=/20080324/NY02/80321004**

Garg, R., Karpati, A., Leighton, J., Perrin, M., & Shah, M. (2003). *Asthma facts, second edition.* NYC Childhood Asthma Initiative. New York: NYC Department of Health and Mental Hygiene. Retrieved from: **http://www.nyc.gov/html/doh/downloads/pdf/asthma/facts.pdf**

Ince, H., Geary, K., Pawlowicz, D., & Palusci, V. J. (2010, May 19). *Teaching undergraduate nursing students about child abuse and neglect.* Poster presented at NYU School of Medicine 6th Annual Joseph Dancis Pediatric Research Day, New York.

Kim, M., Berger, D., & Matte, T. (2006). *Diabetes in New York City: Public health burden and disparities.* NYC Department of Health and Mental Hygiene. Retrieved from: **http://www.nyc.gov/html/doh/downloads/pdf/epi/diabetes_chart_book.pdf**

Lalayants, M., Epstein, I., & Adamy, D. (2010). Multidisciplinary consultation in child protection: A clinical data-mining evaluation. *International Journal of Social Welfare, 20*(2), 156–166.

Legano, L. A., McHugh, M. T., & Palusci, V. J. (2009, May 11). *Understanding medical issues in educational neglect*. Poster presented at New York University School of Medicine 5th Annual Joseph Dancis Pediatric Research Day, New York.

McGuire, L., Martin, K., & Leventhal, J. (2011). Child abuse consultations initiated by Child Protective Services: The role of expert opinions. *Academic Pediatrics, 11*(6), 467–473.

McHugh, M. T., Legano, L. A., Nieman, M., & Palusci, V. J. (2008, May 12). *Medical consultations for Child Protective Services cases*. Poster presented at the New York University School of Medicine 4th Annual Joseph Dancis Pediatric Research Day, New York.

National Association of Children's Hospitals and Related Institutions (NACHRI). (2004, March). *Children's hospitals at the frontlines confronting child abuse and neglect: Mandated medical expert review for all Chicago children.* NACHRI Profile Series. Chicago: Author. Retrieved from: **http://pediatrics.uchicago.edu/chiefs/documents/nachrimpeecarticle.pdf**

New York City Council. (2013). *Child welfare indicators annual report 2012.* New York: Author. Retrieved from: **http://www.nyc.gov/html/acs/downloads/pdf/City_Council_Report_2012_Annual.pdf**

Orange County Public Health Website. (2013). *Emergency response (ER) public health nursing*. (2013). Orange County, CA. Retrieved from: **http://ochealthinfo.com/phs/about/phn/specialized/er**

Palusci, V. J. (2000). Medical resources system. *MiPSAC Newsletter, 4*(1), 1.

Socolar, R. S., Fredrickson, D. D., Block, R., Moore, J. K., Tropez-Sims, S., & Whitworth, J. M. (2001). State programs for medical diagnosis of child abuse and neglect: Case studies of five established or fledgling programs. *Child Abuse & Neglect, 25*(4), 441–455.

State of Massachusetts, Executive Office of Health and Human Services (EOHHS), Department of Children and Families Health and Medical Services Team (HMST). (2013). *DCF Health and Medical Services Team*. Retrieved from: **http://www.mass.gov/eohhs/consumer/family-services/medical-services/dcf-health-and-medical-services-team.html**

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