



Defining the Children's Hospital Role in Child SECOND EDITION Maltreatment



Defining the Children's Hospital Role in Child Maltreatment

SECOND EDITION

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Defining the Children's Hospital Role in Child Maltreatment, Second Edition

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BACKGROUND

In 2000, the NACHRI Board of Trustees approved child abuse and neglect as a public health focus. In doing so, they recognized child maltreatment response as a mission-aligned service that benefits children, the community and children's hospitals. Staff work was directed to improve the quality of medical care provided to children suspected of being abused; recognize and reinforce the vital role children's hospitals play in the identification and treatment of child abuse and neglect; and identify the elements hospitals need in place to enhance their position as leaders in the field. The 2006 release of *Defining the Children's Hospital Role in Maltreatment* answered that Board directive. Further, a triennial survey of children's hospitals child abuse services provides critical benchmarking information to accompany these guidelines.

Defining the Children's Hospital Role in Child Maltreatment, Second Edition does not describe clinical parameters, provide assistance in medical decision-making and is not an accreditation document. Its purpose is to help child protection teams assess where they are and augment their strengths while raising awareness of the leadership role that children's hospitals play in responding to, treating, investigating, studying and preventing child maltreatment.

A Three Level System

(Updated)

Defining the Children's Hospital Role in Child Maltreatment, Second Edition outlines what a child protection team at a children's hospital should offer in terms of infrastructure, staffing, functions, and systems to be considered **basic, advanced, or a center of excellence**. Each level builds on the assumption that a growing team meets and will maintain the previous level's recommendations. There will likely be overlap between one level and the next. A child protection team might meet basic recommendations in one category, but be advanced in another. If a team leader cannot check off every single recommendation in a particular level that does not mean the team has not achieved that level. **The three tiers are not a ranking for competitive evaluation; they are a framework for hospital self assessment to set goals for growth and development within the context of its community's needs.**

"I think that set of guidelines was revolutionary. I can't tell you how many people have said to me, 'This is what I go to my hospital administration with and say, 'This is the gold standard. Do you want to be an A, B or a C? Pick your category and let's build something.' And I think that it's had a marked effect on the way we do business. I think it was a wonderful project that has yielded great rewards."

Carole Jenny, M.D., M.B.A., FAAP
Director, Child Protection Program
Hasbro Children's Hospital, Providence, RI

BASIC

All acute care children’s hospitals should, at a minimum, meet the recommendations for a basic response.

In some communities, depending on the other services available, the basic level is exactly the right role for the children’s hospital — not every children’s hospital could or should strive to build an advanced level team or center of excellence. Each hospital should conduct a self assessment in this regard, considering its institutional character and the needs of the community.

In general, at the **basic** level:

- The three functions essential to a child protection response are: medical leadership, administrative coordination and social work services. Each essential function need not be performed by a separate, dedicated staff person.
- Staffing may be limited, but includes, at minimum, a physician who provides the medical leadership and administrative coordination, and social work services provided by staff trained in the field of child abuse.
- Representatives of community agencies routinely participate in child protection meetings.
- If mental health professionals are not assigned to child protection, they should be available from other hospital departments or via referral.

ADVANCED

All acute care children’s hospitals that meet one or more of the following criteria should have a medically directed child protection team that is at either at the advanced or center of excellence level.

- ✓ Have a trauma center designated by the state and/or verified by the American College of Surgeons as a Level I or II adult or pediatric trauma center
- ✓ House an intensive care unit
- ✓ Have an academic residency
- ✓ House a burn unit

In general, at the **advanced** level, in addition to meeting all recommendations for the basic level, the child protection team:

- Is led by a full-time medical director who is board certified in child abuse pediatrics (with few exceptions)
- Generally has additional staff
- Is an administrative unit of the children’s hospital with centralized management and administrative functions
- Meets regularly to present and review child abuse cases
- Coordinates, as appropriate, with community agencies involved in child protection
- Is more likely to serve a broader catchment area, receiving referrals from outlying communities
- May offer an accredited fellowship

CENTER OF EXCELLENCE

Centers of excellence are distinguished by additional educational and research capabilities. In general, in addition to meeting all recommendations for the basic and advanced levels, a center of excellence:

- Features larger child protection teams whose members include additional professionals in the hospital, such as psychologists
- Offers advanced diagnostic and treatment services that often require consultation with hospital medical and surgical subspecialists
- Is likely to offer an accredited fellowship
- May sponsor multicenter trials
- Is a regional and national leader in child maltreatment and related family violence intervention and prevention

“These are incredibly time-consuming cases and they cost money, but when we do it right, the kids are protected, the outside systems work better, and social services are much more likely to make the right decisions. If it’s a criminal case, it is more likely to proceed in an orderly way. And just as important, if we do it right, people who haven’t abused their kids are not going to be accused of abuse and we’re not going to be spending money putting kids in foster care who don’t need to go into foster care.”

Carole Jenny, M.D., M.B.A., FAAP
Director, Child Protection Program
Hasbro Childrens Hospital, Providence, RI

Introduction

The Children’s Hospital Role

All children’s hospitals see child abuse and neglect. It is an unavoidable health problem regardless of whether the hospital has a dedicated child protection team. Whether an abused child shows up in an emergency department or abuse is suspected during a home visit provided by a specialty hospital, all children’s hospitals have a responsibility to provide immediate care. The responsibility is even greater knowing that much of both the inpatient and outpatient populations of children’s hospitals are at increased risk for maltreatment, especially children with special needs and children from impoverished families (Centers for Disease Control and Prevention, 2011).

An unconscionable number of children are affected annually by neglect and physical, sexual, and emotional abuse: 702,000 in 2009 according to the latest federal data. More than 1,700 of those kids died from their injuries, the vast majority under the age of five (U.S. Department of Health and Human Services (DHHS), 2010). A 2011 report from the U.S. Government Accountability Office (GAO) estimates that the true number of deaths is likely much higher: more like 2,400 for 2009 (GAO, 2011). Medical and mental health costs alone for child abuse and neglect are conservatively estimated at \$7.7 billion dollars annually (Wang & Holton, 2007). Further underscoring the severity and expense is the reality that hospitalizations related to child abuse are two times longer, involve twice the number of diagnoses and are double the cost of other pediatric hospitalizations (Rovi, Ping-Hsin, & Johnson, 2004).

Research suggests that child maltreatment is associated with significant long-term adverse health effects. In 1998, researchers at the Kaiser Permanente Health Appraisal Clinic in San Diego and the U.S. Centers for Disease Control and Prevention published the first of more than 50 articles based on the Adverse Childhood Experiences (ACE) Study (Felitti et al, 1998). More than 17,000 individuals undergoing a physical exam completed a confidential survey with detailed questions about their childhood experiences of abuse, neglect, and family dysfunction. Findings have shown an increased risk of poor health outcomes and shortened life expectancy strongly associated with adverse childhood experiences including occurrence of many physical conditions such as heart and liver disease, psychological consequences (depression, anxiety, alcohol and drug abuse), and behavioral consequences such as unemployment and adolescent pregnancy. Recent data presented by CDC conservatively estimated the lifetime economic burden of maltreatment (inclusive of productivity losses and costs related to health care, special education, criminal justice and child welfare) as \$121 billion for 2008 (CDC, June 16, 2011).

While children's hospitals, individually and as a whole, are the undisputed leaders in providing medical care to abused and neglected children, more can be done. With the second edition of *Defining the Children's Hospital Role in Child Maltreatment*, NACHRI makes a new national recommendation to support its members in evaluating and improving the services already in place: children's hospitals with certain depths of resources (status as a Level I or II trauma center, home to an intensive care unit, academic residency or burn unit) should sustain a child protection team at the advanced or center of excellence level. **NACHRI urges other national organizations to likewise pursue and define their role in a complicated and interdependent system of child abuse response and prevention.**

While these guidelines speak primarily to those who are constructing and staffing child protection teams, they also speak to those who manage the budgets and negotiate the choices that enable this work to continue. Child protection activities are in many ways distinct from other hospital services. Intensive cooperation with other professionals is necessary to keep children suspected of being abused safe, both within the hospital, and with child protective services (CPS) and law enforcement professionals in the community. The deep complexity of injuries and circumstances makes healing these children and providing for their immediate safety needs more urgent and more expensive. Evaluation takes longer, requires more resources, and many of the critical services provided, such as forensic interviews, psychosocial assessments, mental health services and court testimony, are poorly reimbursed. All of this makes the budget line stand out. But for a children's hospital, support for child protection is mission-driven.

HIGHLIGHTS

A New Subspecialty

A sea change in the field of child maltreatment has occurred since the first edition of *Defining the Children's Hospital Role in Child Maltreatment* was published. In 2006, child abuse pediatrics was accepted as a subspecialty of the American Board of Pediatrics making a total of 20 subspecialties; the first subspecialists were certified in 2009.

"We are in a very exciting time for our field. The grandfathers (and grandmothers) of child abuse pediatrics laid the groundwork to enable us to formalize and validate this pediatric subspecialty and to offer an academic training environment that will support the next generation."

Phillip V. Scribano, D.O., M.S.C.E., FAAP
Medical Director, Safe Place:
Center for Child Protection and Health
The Children's Hospital of Philadelphia

The subspecialty will enable best practices, foster accredited fellowships, and create interest in research. From a practical standpoint for the role of the general pediatrician, this new subspecialty is like any other subspecialty: to treat, and then refer when necessary.

The contrast in numbers between the nation's first 191 child abuse pediatricians, the majority who work in children's hospitals, and the scope of the problem estimated at 702,000 substantiated cases in 2009, puts the problem into stark perspective. This staggering ratio illuminates the necessity of hospital-based expertise in diagnosis, treatment, research, training and prevention of child abuse. It also underscores the need to undergird the ranks of other allied professionals.

Changes brought via the new subspecialty are incorporated throughout the *Second Edition*. Chief among them is a recommendation that **all child protection teams at the advanced and center of excellence levels have a board certified child abuse pediatrician**, with few exceptions. (See *Chapter 1: Medical Leadership and Chapter 9: Education*).

Community Benefit

Most children's hospitals are tax-exempt because the community services they provide might otherwise become a public responsibility. Since the publication of the first edition, the federal Internal Revenue Service, U.S. Senate and House committees, and state attorneys general are increasingly questioning hospitals' qualification for tax exemption, particularly

"Before we even start doing work in the community, we need to know what the needs of the community are. Community benefit has been a gift because it forces us to get better at what we do."

Ginny Hickman, LMSW-AP
Assistant Vice President of Community Health Outreach
Cook Children's Medical Center, Fort Worth, TX

the validity of hospitals' community benefits reporting. Children's hospitals need to be able to demonstrate the benefits they provide to the community in order to respond to this scrutiny. **The *Second Edition* outlines hospital activities related to child abuse treatment, education and prevention that can be quantified as community benefit.** (See *Special Section: Community Benefit*).

Prevention

Prevention science has advanced since the first edition. Research is uncovering drivers of abuse and revealing cues to prevention. The potential of prevention is made more urgent as researchers are learning about long-term effects that make child maltreatment a far more prevalent public health concern than had ever been realized.

“Prevention is the holy grail of child abuse work; we want to put ourselves out of business.”

Angelo Giardino, M.D., M.P.H., Ph.D., FAAP
Health Plan Medical Director
Texas Children’s Health Plan, Houston, TX

A federal focus on prevention has emerged, evidenced by the \$1.5 billion investment in home visiting programs within the landmark 2010 Affordable Care Act, that has shown promise in preventing abuse and improving child health indicators.

A new chapter in the *Second Edition* outlines how the child protection team contributes to prevention activities in the hospital and community. (See Chapter 6: *Prevention*).

CORE MESSAGES

- Now a subspecialty, child abuse pediatricians should be utilized when their medical expertise is needed. The role of the general pediatrician remains the same: treat and refer, and take ownership when appropriate.
- The opinions rendered by child abuse experts in discerning the manner of injury are essential for the entire response system to work and to determine the next steps taken by protective and criminal justice agencies and the medical community.

RECOMMENDATIONS

1. All acute care children’s hospitals should, at a minimum, meet the recommendations for a **basic** response.
2. All child protection teams at the **advanced** and **center of excellence** levels should be medically directed, in most cases by a certified child abuse pediatrician.
3. All acute care children’s hospitals that meet one or more of the following criteria should have a medically directed child protection team that is at either the **advanced** or **center of excellence** level.
 - Have a trauma center designated by the state and/or verified by the American College of Surgeons as a Level I or II adult or pediatric trauma center
 - House an intensive care unit
 - Have an academic residency
 - House a burn unit

CHILD ABUSE RESPONSE IN NONACUTE CARE SETTINGS

A children's hospital's role in addressing child maltreatment will vary by institutional capacity. For example, some children's hospitals are nonacute care centers providing a specialized range of services aimed at a particular population of children. In dealing with maltreatment cases, these institutions partner with and make referrals to hospitals that support emergency and/or trauma services. Specialty hospitals (long-stay, nonacute care centers) should have a formal relationship that assures the availability of a child abuse pediatrician for consultation and referral.

The role of nonacute care centers should not be minimized. Specialty children's hospitals often bring a unique voice and expertise to the diagnosis and care of children who have suffered particular types of abuse. Equally important is their perspective on the long-term impact of abuse.

When a child who has suffered maltreatment is referred to a specialty hospital, the intake process should facilitate a discussion between the referring and admitting physicians about the nature of the trauma so that they can ascertain the need for further child abuse consultation and plan accordingly.

Certain specialty hospitals (e.g., burn centers and rehabilitation clinics) have a unique and essential role to play in child maltreatment prevention and intervention because of their expertise in particular types of injury that could be intentionally inflicted. These hospitals often do not have an emergency department that would offer exposure to a broad range of abuse cases, and in this case establishment of a child protection team would be inappropriate. Nonetheless, these hospitals need to establish protocols to ensure that medical staff members maintain the necessary skills to diagnose and refer child maltreatment cases when seen, and to act as effective consultants to child protection teams that seek their particular expertise. Hospital policies and training should also incorporate measures to be taken when there is suspicion of medical neglect.

Nonacute care children's hospitals can use these guidelines to define their role in maltreatment-related child advocacy and adapt relevant sections, such as those on policymaking and community collaboration, to suit their circumstances.

GUIDANCE FOR GENERAL HOSPITALS WITH PEDIATRIC PATIENTS

Children's hospitals represent less than 5 percent of hospitals in the U.S. As a result, most suspected victims of child maltreatment will not enter the health care system through a children's hospital. Despite a minority representation of hospitals, children's hospitals are home to a majority of the nation's 191 board certified child abuse pediatricians. This expertise offers consult and referral opportunities for general hospitals that see children. In recognition of the important role and responsibility of general hospitals in caring for suspected victims of abuse, the following recommendations echo and expand on The Joint Commission standards requiring that hospitals have criteria for identification, assessment, referral, staff education, tracking and reporting suspected abuse.

All hospitals that care for children should have:

- Policies and procedures in the emergency department, for inpatients, and for outpatient clinics that provide for identification of suspected abuse.
- Procedures for internal reporting of suspicion of child maltreatment and pursuit of a diagnostic opinion with appropriate consultation and/or support of a child abuse expert.
- Policies and procedures for referral to a child abuse expert when warranted.
- Policies and procedures that strictly comply with state mandated reporting laws. (*See sidebar.*)
- A designated pediatric liaison to act as point of contact for transfers and referrals as well as for law enforcement.
- An internal liaison who has designated responsibility for knowledge of current practice guidelines (e.g., AAP policies) and informs reporting procedures and referrals for suspected abuse and neglect (including medical neglect).
- Social work oversight of the flow of paperwork and communication about disposition.
- Ongoing education for hospital staff on recognition of child abuse.

Compliance With Mandatory Reporting Requirements

All states in the U.S. have statutes identifying persons who are required to report child maltreatment.¹ These mandated reporters typically have frequent contact with children and may include social workers, teachers, physicians and other health care workers, mental health professionals, childcare providers, medical examiners and law enforcement officers. In 2009 almost 60 percent of reports of alleged maltreatment were made by professionals like these (DHHS, 2010). The training these professionals receive from child protection teams at children's hospitals take multiple forms, ranging from basic classroom lectures to extensive hands-on experiences. Child protection staff should work with the hospital's legal staff to develop clear policies for compliance with state law related to mandatory reporting. Medical staff training in mandatory reporting requirements should ensure that potential cases come to the child protection team for screening to confirm or disprove alleged maltreatment. Ideally, a hospital's set of annual required trainings include this child protection responsibility around detection and mandated reporting along with other necessary topics such as infection control and patient privacy.

¹For thorough description of state mandatory reporting requirements visit the Child Welfare Information Gateway sponsored by the U.S. Department of Health and Human Services <http://www.childwelfare.gov/responding/mandated.cfm>.

Section 1

Structure and Staffing



CHAPTER 1: MEDICAL LEADERSHIP

All children's hospital child protection teams require the medical leadership of a physician trained in child maltreatment.

The physician should have broad administrative, education and clinical responsibilities and a correspondingly wide range of skills, knowledge and experience. Whatever the level of a child protection team, the physician should be experienced and trained in child abuse and neglect issues and have up-to-date patient care, examination and diagnostic skills. In addition, he or she should have management skills, be comfortable in a leadership role and with public appearances, collaborate well with other members of the child protection team, hospital colleagues and community partners, as well as have the ability to educate and train a variety of audiences on child maltreatment issues.

At the **basic** level, the medical leader:

1. Must be dedicated and compensated appropriately (but may be part-time).
2. Is a pediatrician, with some exceptions (hospital staff or community-based with hospital privileges).
3. Has education, experience and an interest in child maltreatment (although not necessarily board certified in child abuse pediatrics) and its presentation in the health care system, especially physical and sexual abuse and serious neglect.²
4. Provides direct supervision and review of cases seen by allied health care professionals (who also have specialized interest or training), trainees, students, residents and other hospital staff. When the physician leader is not a pediatrician, a trained pediatrician provides these medical services.
5. Develops protocols for access to and obtaining consultation from board certified child abuse pediatricians when necessary or desired. Circumstances will dictate when consultation is essential. Having this protocol in place will support the medical leader by ensuring access to subspecialty expertise when warranted.
6. Pursues knowledge of the most current practices and research in the field.
7. Organizes medical information, interprets diagnostic data, and communicates level of concern and impressions to non-medical, community-based professionals.
8. Interprets medical information for the legal system and the courts when needed (i.e. court testimony).
9. Effectively participates in and collaborates with multidisciplinary teams within the hospital and the community.
10. Demonstrates leadership for the hospital in meeting the needs of children and families affected by child maltreatment both within the hospital and the community.

² One resource is: "Requirements for Individual Learners" from Ambuel, B, K Trent, P Lenahan, P Cronholm, D Downing, M Jelley, A Lewis-O'Connor, M McGraw, L Mouden, J Wherry, M Callahan, J Humphreys, R Block, Competencies Needed by Health Professionals for Addressing Exposure to Violence and Abuse in Patient Care, Academy on Violence and Abuse, Eden Prairie, MN, April 2011

11. Recognizes available research resources in the community and collaborates with the research efforts of child protection teams at the advanced or center of excellence levels by providing case data.

At the **advanced** level the medical leader's responsibilities increase to include education and training, prevention, advocacy and outreach. In addition to meeting all recommendations for the basic level, at the **advanced** level, the medical leader:

12. Is certified by the American Board of Pediatrics in child abuse pediatrics, with few exceptions.
13. Must be dedicated and compensated appropriately (likely full-time).
14. Informs and ensures appropriate clinical coverage based on community needs and staffing ratios at the hospital.
15. Provides medical leadership for children's advocacy centers (*see Chapter 8: Community Collaboration*), domestic violence prevention and intervention programs, child abuse prevention programs, and other community and advocacy programs as appropriate.
16. Serves as the medical leader for peer review and educational programs coordinated by the child protection team.
17. Mentors other physicians as they learn to manage or consult on child abuse and neglect cases.
18. Enables collaborative multidisciplinary team meetings within the hospital and the community.
19. Directs the improvement of medical services to suspected abused and neglected children in the children's hospital including encouraging quality activities that examine team functions.
20. Helps secure ongoing administrative support and funding.

At the **center of excellence** level the medical leader's responsibilities expand to reflect the program's status as regional leader, education and research center. In addition to meeting all recommendations for the basic and advanced levels, a **center of excellence**:

21. Ensures that medical staffing ratios are based on the volume of abused children seen at the hospital and, where possible, reflect the volume tracked by local/regional child welfare agencies.
22. Plays a key public role in community prevention and advocacy efforts.
23. Serves as a source of peer review locally and regionally and mentors colleagues.
24. Leads research efforts focused on child abuse and neglect and is knowledgeable about associated ethical issues in conducting such research. Encourages and facilitates research by other members of the child protection team.

COLUMBUS, OH - "We need to recognize that child maltreatment is a public health problem which requires public health strategies and partnerships," says Philip Scribano, D.O., M.S.C.E., FAAP, former medical director at **Nationwide Children's Hospital**. This perspective informed the direction of programs under his leadership. According to Scribano, "the physical health and behavioral health implications of maltreatment last a lifetime. There is a growing body of science which addresses this reality in childhood and the outcomes into adulthood. All disciplines dealing with this complex problem will benefit from this knowledge to address the problem at the local level." The leadership needed in his multidisciplinary setting required each party to have a contribution and a voice. Scribano sees the role of medical director as a motivator and collaborator, allowing managers, directors and clinical professionals to present ideas in a group setting. The Partners Council was established in 2005 to bring together all those involved in the team approach to the assessment and treatment of child maltreatment at the hospital. Scribano explains, "the role of the medical director can be very intimidating for some. It is important to attempt to draw others out to solicit various perspectives and identify creative solutions. The forum allows for equal participation and collaboration. No one individual or discipline can accomplish the goals alone." ***For more information, contact Philip Scribano, D.O., M.S.C.E., FAAP, at scribanop@email.chop.edu.***

ROANOKE, VA - Donald W. Kees, M.D., FAAP, of **Carilion Clinic Children's Hospital**, is a pediatric hospitalist who consults on child abuse cases in the Roanoke Valley of southwest Virginia. Kees acts as a consultant and local expert on child abuse cases who testifies in court on behalf of the children. Although Kees is not a board certified child abuse pediatrician, his experience with child abuse has placed him at the center of many cases that occur in the region. He recently led a multidisciplinary team to revise a hospital child abuse policy that has led to better quality review of each case. The revision included creation of a communication tool within the electronic medical record to house vital information about the case including child protective services and police contacts, a list of concerning injuries and the safety plan. Kees has used grand rounds and other lecture formats as a way to educate other medical providers on the identification and treatment of child abuse. "I am a willing advocate for these children," says Kees. ***For more information, contact Donald W. Kees, M.D., FAAP, at dkees@carilion.com.***

LEBANON, NH - Kent Hymel, M.D., FAAP, of **Children's Hospital at Dartmouth**, encouraged a child abuse provider in a local private practice to negotiate with three hospitals who were the primary beneficiaries of her services to expand her practice through their financial support. The Children's Hospital at Dartmouth, through the support of Hymel, created this collaboration between the institutions. According to Hymel, "The chief medical officers were able to talk and recognize the need for her services. Through some novel relationships forged between institutions the practitioner was able to expand her sphere of influence." The child abuse provider became an extension of their programs where the state of New Hampshire is moving to a children's advocacy center model. "It was a matter of how to pool goals into a common goal," says Hymel. ***For more information, contact Kent Hymel, M.D., FAAP, at kphymel@gmail.com.***

CHARLESTON, SC - The Violence Intervention & Prevention (VIP) Division of **The Children's Hospital Medical University of South Carolina** conducts peer review weekly and between scheduled meetings as needed. According to Anne Abel, M.D., FAAP, "peer review is vital in the field of child abuse pediatrics. It assures the highest quality assessments and provides a safeguard against under- or over-diagnosing child abuse or neglect." The process at the VIP Division follows a strict protocol in which records are kept of all cases reviewed. The clinicians, who include three child abuse pediatricians and three nurse practitioners, make modifications of their diagnoses and recommendations as needed and appropriate. The acute sexual assault exam reports and photographic images created by the pediatric sexual assault nurse examiners are also reviewed as part of the process. Any needed corrections on the reports are sent to medical records and to the law enforcement investigator. **For more information, contact Anne Abel, M.D., FAAP, at abela@muscu.edu.**

MILWAUKEE, WI - The topic of addressing and preventing secondary trauma for staff is familiar to all medical professionals. **Children's Hospital of Wisconsin** took a proactive approach to dealing with burnout and secondary stress-related issues for the staff of the Child Protection Center. The TASC Program (Teambuilding, Advocacy, Support and Communication) was developed by Lynn K. Sheets, M.D., FAAP, medical director of the Child Protection Center, initially as the project of a leadership training conference in 2006. Several years later, the TASC Program was incorporated into the center. According to administrative director Mark Lyday, "the program has helped staff become more familiar with hospital resources and allowed staff to talk openly about these issues." Sheets agrees that a "culture change took place within the program" where the issue is no longer hidden. The staff holds monthly meetings to discuss issues related to stress in the workplace with topics suggested by staff members. A recent topic was personal protection, including dealing with hostile patients and caregivers and conflict resolution strategies for de-escalating these situations. **For more information, contact Lynn K. Sheets, M.D., FAAP, at lksheets@chw.org.**

CHAPTER 2: TEAM ADMINISTRATION AND COORDINATION

At the foundation of every child protection team is a clinically oriented coordinator who is committed to high quality assessment and treatment.

The coordinator's training reflects the issues the team will address, from medical assessments to mental health concerns, to interactions between the community-based and hospital teams. From this perspective, the coordinator is able to assess the strengths and clinical challenges facing the team and strive for accountability by guiding both quality assurance and continuous quality improvement efforts.

In many institutions the staff person assigned the coordinator role may be a social worker or case manager; in some cases the duties rotate among team members. If the coordinator is a social worker, adequate resources must be in place to ensure that the administrative and coordination functions can be fulfilled without diverting resources from meeting the clinical social work needs of the team.

There are many ways in which the administrative roles and the people who fulfill them can be organized within an individual hospital. This chapter describes necessary functions regardless of how they are distributed. What is essential is that there is a single person who is ultimately responsible for the administration and coordination of the team and that a functional relationship exists between the medical leader and this person.

At the **basic** level, a number of factors should be considered when developing the coordinator position.

Responsibilities of the hospital:

1. The role of coordinator should be addressed specifically in the hospital job description of the position assigned this role. Through this paid position, the hospital visibly demonstrates its commitment to child maltreatment services.
2. The hospital must allot adequate time for the coordinator to fulfill the responsibilities of the role properly. The amount of time required for this role will vary among hospitals from part-time to full-time based on the size and complexity of the team, including overall case load.

The coordinator should participate, with hospital support, in periodic professional education to increase knowledge about child abuse and program management.

3. Working with the medical leader, the coordinator, directly or through delegation has the following responsibilities. These responsibilities relate to the establishment of operational systems to ensure the effective and efficient management of the child abuse response. In some basic programs, the roles of medical leader and coordinator are fulfilled by the same person. At the **basic** level, the coordinator:

4. Develops policies and procedures for managing suspected child maltreatment cases. This includes hospital policy on the identification of suspected child abuse, evaluation of children, internal and external referral procedures, confidentiality, and the process by which medical information can be appropriately shared with members of the community-based multidisciplinary team.³
5. Ensures core data and tracking functions are performed in a timely manner.
6. Integrates the community-based multidisciplinary team into the hospital's child abuse response as appropriate. In working with the community-based multidisciplinary team, the hospital should be aware of the unique roles and needs of each agency represented on the team, including the distinct differences in the role of hospital social work versus child protection social work.
7. Cooperates with community-based multidisciplinary team investigations. This is an expected function and should not be restricted by other hospital policies regarding privacy and confidentiality.
8. Serves as the contact for referrals from community agencies and community hospitals.
9. Supports collection and documentation of patient history by various providers to achieve an accurate diagnosis. This includes documenting all explanations offered to any hospital personnel by caregivers for injuries being observed and treated by the team. While it is the medical professional's responsibility to take histories, the coordinator ensures this documentation is kept in a well-organized, accurate system that can easily be accessed for case management and investigations.
10. Provides for ongoing case management of abuse and neglect patients to ensure appropriate follow-up and treatment is obtained.
11. Provides basic information to hospital colleagues and community agencies about the medical evaluation of child abuse when requested.
12. Organizes peer review by discipline for hospital/medical personnel. It can take a number of forms, from medical peer review to peer review among child interviewers or mental health practitioners.
13. Manages the budget, contracts and child protection staff.
14. Works with the medical leader to standardize procedures to maximize reimbursement.

³ A community-based multidisciplinary team may include representatives from law enforcement, child protective services, prosecution, medicine, mental health, victim advocacy and children's advocacy centers among others. These professionals work together to gather and share information so that decisions about cases are well informed and the needs of the child and family can be better met. (See Chapter 8: Community Collaboration)

When a child protection team at a children's hospital expands staff and capabilities, moving to the **advanced** level, the responsibilities of the coordinator also grow. In addition to meeting all recommendations for the basic level, at the **advanced** level, the coordinator:

15. Works with the medical leader and hospital fundraising staff to secure ongoing administrative support and funding.
16. Organizes and facilitates multidisciplinary team meetings within the hospital and/or community.
17. Organizes and facilitates extensive internal and/or cross-institutional peer review systems.
18. Identifies gaps in services within the community and communicates those observations and any suggested opportunities for improvement to the medical leader, the hospital administration and/or the leadership of the community-based multidisciplinary team.
19. In the case of a nationally accredited hospital-based children's advocacy center, maintains/coordinates compliance with current National Children's Alliance standards. (*see Chapter 8: Community Collaboration*)

A **center of excellence** is distinguished primarily by a regional leadership role and extensive outreach/advocacy programming, as well as advanced educational and research components. In addition to meeting all recommendations for the basic and advanced levels, at such a highly developed center, the coordinator:

20. Coordinates and supports the center's community advocacy and prevention efforts.
21. Facilitates the center's research program and educational offerings, including the logistical and administrative coordination of fellowships, internships, and residency rotations.
22. Takes a leadership role in local and regional organizations involved in child protection.
23. Seeks out opportunities for recognition of the center within the hospital and in the local community to advance and strengthen its work.
24. Manages grant awards.

SALT LAKE CITY, UT - As administrator of the child protection team at **Primary Children's Medical Center**, Julie Bradshaw, LCSW, sees her role as an interpreter among and between the clinical disciplines, hospital administration, and local agencies. The medical center treats children from a vast geographic area encompassing several states in the intermountain region. Bradshaw believes that translating also means setting standards of care for Intermountain Health Care in all its medical settings. Because of the complexity of working together to provide the best care for the child, it is important to standardize practices. Says Bradshaw, part of her role is to "translate state-speak and laws into the medical arena and also to translate medical-speak to the state." According to Bradshaw, the position of intake coordinator at her hospital fulfills a similar role as a liaison between medical staff and families of children admitted to the hospital for suspected child abuse. "The position has become a tremendous asset to the hospital due to the intake coordinator's background as a former employee/liaison at the Utah Division of Child and Family Services," she says. **For more information, contact Julie Bradshaw, LCSW, at julie.bradshaw@imail.org.**

MADERA, CA - By auditing digital medical records, C. Leanne Kozub, RN, nurse program coordinator of The Guilds Child Abuse Prevention and Treatment Center of **Children's Hospital Central California**, can pull all charts that have the document type "suspected child abuse" for review. The tracking system for suspected child abuse reports was accomplished with no changes in hospital policy. Kozub received approval from the hospital's Institutional Review Board for a retroactive review of all records. She looked at 800 cases to see injury codes and whether other risk factors were involved in the case, such as neglect or substance abuse. Now, her department is tracking records in conjunction with department social workers. "When a whole chart is reviewed, individual visits that may not be a red flag can become a red flag," says Kozub. This project has led to the creation of a pilot interventional prevention program to streamline the tracking system and data collection so missed cases can be identified and all members of the multidisciplinary team can work together. **For more information, contact C. Leanne Kozub, RN, at ckozub@childrenscentralcal.org.**

MEMPHIS, TN - "Developing a working relationship with the clinical teams and other social workers is key to the success of the child protection team, particularly in the management of patients who present with concerns that border on the possibility of child maltreatment," says Susan Steppe, LAPSW, director of social work and the child assessment team, at **Le Bonheur Children's Hospital**. Areas where the responsibilities of the child protection team and the social work team may overlap include cases where patients present with chronic illness and possible medical compliance issues. According to Steppe, "this area of overlap needs to be managed carefully and cooperatively in order to delineate roles and responsibilities and assure that the best interests of the patients are served." The different concerns of the teams might include the hospital staff's focus on clinic appointments, medicine management and rehabilitation. The child protection team is interested in how many appointments were missed and how parents were trained or informed in the care of the child. Another area of coordination includes decisions to report suspected child maltreatment. It is the role of the coordinator to work with hospital staff to establish protocols in the decision making process. "Collaboration and open communication are central to the success of the relationships," says Steppe. **For more information, contact Susan Steppe, LAPSW, at steppes@lebonheur.org.**

CALIFORNIA - The Inter-Agency Council on Child Abuse and Neglect (ICAN) California Hospital Network creates a working system to automate child abuse reports and support hospital case management. The program is housed in the Los Angeles County ICAN National Center on Child Fatality Review (NCFR). ICAN/NCFR began the first child death review team in 1978 and has grown to support child fatality review for all states since 2001 and continues to grow internationally. The California Hospital Network project adds a spectrum of fatal/nonfatal injuries with PICU, inpatient and emergency department cases.

Project components include:

- A statewide hospital directory that connects liaisons in 84 hospitals including **every children's hospital in California**, 32 PICUs, 12 child burn units and a growing number of birth hospitals.
- Information posted on ican4kids.org that allows open and secure sharing of hospital program models for detection, screening, evaluation, reporting and case management.
- An informal national network that provides a forum to share information on automation of child abuse reports.
- Medical specialists in PICU, burn, maternity, emergency medicine, surgery, and radiology who can share experiences and resources with counterparts in other hospitals.
- Computerized data on child abuse reports that are replacing the present system, using injury data under age 3 as a proxy measure to estimate the rate of exposure to possible abuse.
- A computer data system that will automate child abuse reports and connect hospitals to their own reports with a searchable database.
- Standards, protocols and guidelines that are helping develop common language for hospital multidisciplinary teams.
- Encouragement of hospital participation on fatal cases in order to assist the local child death review team.
- Prevention programs that benefit from medical expertise on toddlers, infants and newborn

For more information, contact Michael Durfee, M.D. at michaeld55@aol.com or visit ican4kids.org.

CHAPTER 3: SOCIAL WORK

A child protection team at a children's hospital must offer the services of trained clinical social workers in cases of suspected child abuse or neglect.

Emphasis on appropriate social work coverage provides early detection, assessment, prevention, education and ongoing support for children and families. Social workers are partners and collaborators who contribute a vital function along with the medical and administrative staff of the child protection team.

Clinical social work functions can be performed by social workers dedicated to the child protection team, or by other hospital-based social workers assigned to and trained for these functions. The medical functions of social work are commonly defined as clinical social work, which in many states is associated with a licensure requirement. The level of educational preparation and training of clinical social workers should be appropriate to the roles and responsibilities fulfilled as part of the team. For example, social workers who provide care to inpatients may be forensically trained. The larger and more comprehensive a child maltreatment response, the more likely it is that social workers are assigned and dedicated to the child protection team.

The clinical social worker role is distinct from the therapeutic social worker role. In a hospital setting, therapists may provide ongoing therapy to complement the crisis intervention of the medical team. This function – frequently performed by social workers, psychologists or marriage and family therapists – can support children and families who have passed through the hospital child protection team or have come via direct referral for therapy. The functions performed by social workers on child protection teams may vary according to the type of services that the hospital provides.

Ideally, a **basic** response includes a dedicated full-time clinical social worker. In some cases where a social worker also acts as the administrative coordinator, adequate resources must be in place to ensure that administrative and coordination functions can be fulfilled without diverting resources from the clinical social work needs of the team and the children and families it serves.

At some children's hospitals, staffing and budget limitations may make it a challenge to hire or assign a full-time social worker to child protection. At minimum, one member of the hospital's overall social work staff should be assigned to work with the child protection staff, become familiar with its needs, become an expert in child maltreatment reporting requirements, and consult on cases as needed.

Whether or not the social worker(s) are part of the child protection staff or assigned from the hospital department of social work as needed, at the **basic** level, the clinical social worker:

1. Has training in the dynamics of child abuse and neglect and in assessment and management of abuse within a hospital setting.
2. Participates in history taking and safety assessments in collaboration with other professionals.

3. Performs biopsychosocial assessments to evaluate for risk and protective factors associated with child abuse and neglect.
4. Provides appropriate intervention (e.g. crisis intervention, advocacy and case management) to families and children when abuse or neglect is suspected.
5. Assists families in navigating complicated bureaucracies, processes and treatments.
6. Thoroughly understands mandatory child abuse reporting laws.
7. Collaborates with the community-based multidisciplinary team (includes CPS and law enforcement) and proactively develops relationships with community agencies.
8. Is knowledgeable of child maltreatment community resources and can be designated as a resource specialist in this area.
9. Participates in case review and presentation.
10. Is knowledgeable of current practices and research in the field, including the interconnection of child maltreatment with intimate partner violence and elder abuse.

At the **advanced** level social workers are dedicated members of the child protection team. In addition to meeting all recommendations for the basic level, at the **advanced** level, clinical social workers:

11. Increase staffing proportionately as the program and responsibilities grows.
12. Are available during all regular child protection clinic/service hours. Are available for 24 hour on-site response for crisis intervention and acute case management (via an on-call system, if not on-site).
13. Support medical follow up of complex, high-risk children and support secondary intervention.
14. Contribute to the education and training of new social work staff in child protection issues.
15. Provide education and training to medical and hospital staff on psychosocial, mental health and legal aspects of child maltreatment.
16. Define expectations and assist in the development of an appropriate training program for hospital staff who are also mandated reporters.
17. Participate in creating hospital-wide and, where appropriate, system-wide, discharge planning policies that address the safety and protection of the patient.
18. Act in a consultative role to other specialists and departments.
19. Provide expert court testimony.

In addition to meeting all recommendations for the basic and advanced levels, at a **center of excellence**, clinical social workers:

20. Advocate for staffing levels that are appropriate to the volume of suspected victims of maltreatment seen at the hospital (including outpatient programs).
21. Serve as a regional resource for social workers in smaller teams and those in communities without medically directed child protection teams.
22. Direct center staff to receive supportive and mental health resources available via the hospital employee assistance program that address such issues as compassion fatigue, vicarious traumatization and secondary traumatic stress.
23. Participate in specialized training and internships for social workers.
24. Participate in research.
25. Participate in the development of quality improvement and quality assurance initiatives.
26. Contribute social work expertise to policy and program development on local, state and/or federal levels.

BALTIMORE, MD - The Therapeutic Foster Care Program at the **Kennedy Krieger Institute** identifies medically fragile, developmentally disabled or emotionally disabled children whose biological family cannot provide for them. Often the children have experienced abuse or neglect due to the biological parents' addictions or mental health issues. Started in 1986, the program actively recruits foster families in the Baltimore area to care for these children. Many of the foster families have a member who has experience in a medical field or working with people with disabilities. The hospital recruits, trains and certifies the families to work with the child along with an assigned clinical social worker to supervise the primary care management and clinical work. Program director Rob Basler, M.S.W., LCSW-C says, "the care is extremely individualized. Each child has very different needs. The level of dedication and commitment that the foster families provide is unparalleled." The program strives to maintain a connection with the biological family as part of a permanency plan. Options for the plan include: 1) child is reunited with the biological parents once they have received treatment and support; 2) child is placed with relatives who can provide care; or 3) child is adopted by the foster family or another family capable of care. **For more information, contact Rob Basler, M.S.W., LCSW-C, at basler@kennedykrieger.org.**

SEATTLE, WA - For over three years, **Seattle Children's** has run a quality improvement project called On Call SCAN Social Work, a consultation service where experienced child abuse social workers provide clinical oversight to other social workers working after hours and weekends. This service has established standards of practice that support hospital family violence policies as well as community protocols. These specialists in child abuse social work provide the needed risk management stability for child abuse and neglect cases given the large number of social workers who work after the child protection team's regular hours. **For more information, contact Jackie Brandt, LICSW at jackie.brandt@seattlechildrens.org.**

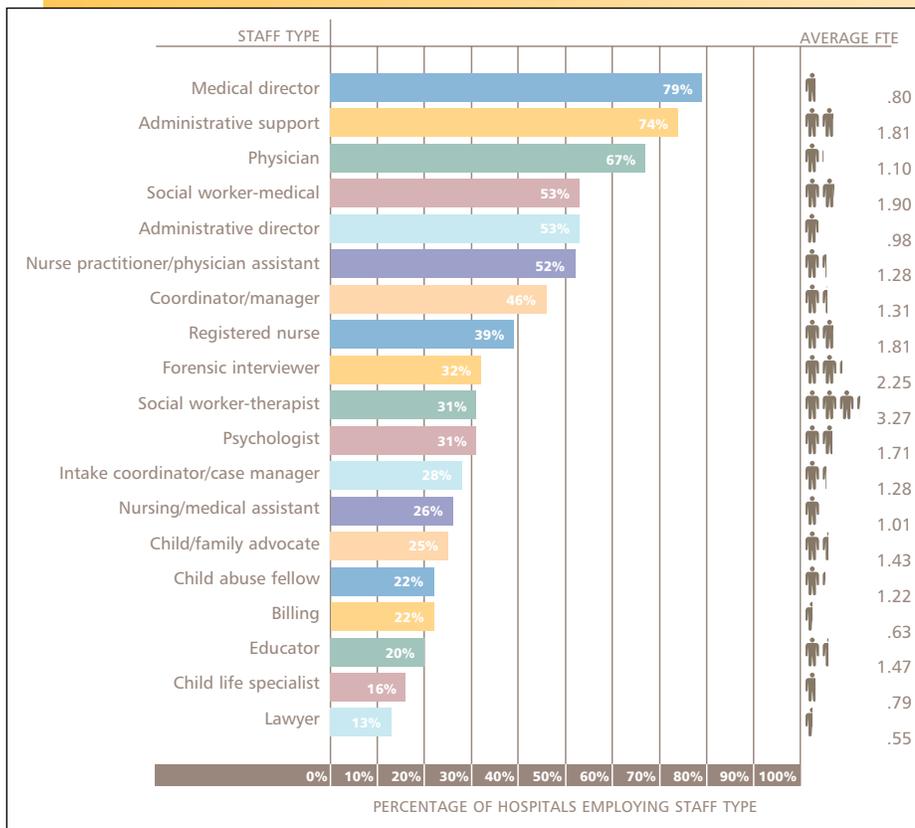
LITTLE ROCK, AR - At **Arkansas Children's Hospital**, the reporting structure for social workers in the hospital is centralized under one director. According to Carol Maxwell, LCSW, ACSW, director of social work, family services and interpreter services, the teaching hospital creates a supportive environment for all social workers, especially those on the child protection team. Says Maxwell, "the social workers feel more connected to the bigger picture of the organization rather than being isolated in their own program." She believes that this model lessens conflict and creates more support for social workers in a stressful work environment. "Social workers need to be the ones leading the way," says Maxwell. **For more information, contact Carol Maxwell, LCSW, ACSW, at maxwellcf@archildren.org.**

LEBANON, NH - At **Children's Hospital at Dartmouth**, the hospital prioritizes family, patient and staff safety when working with families at risk for abuse. Care managers navigate complex care for families, social workers assigned to their units and the child protection team. Kent Hymel, M.D., FAAP, says "the regular multi-team meetings morphed into extremely helpful discussions on solving thorny psychosocial problems." The meetings focus on one or two problems and have become a venue for advice and support for staff who often work with dysfunctional family situations. The "touchy-feely rounds" as Hymel calls them, are a great learning experience for him and staff, and help improve the care they provide. **For more information, contact Kent Hymel, M.D., FAAP, at kphymel@gmail.com.**

OTHER PROFESSIONALS

The structure and staffing of a child protection team have been described in this section as consisting of three essential roles: medical leadership, administrative coordination and social work. However, most teams are enhanced by a variety of other professionals dedicated to the mission of the team. Each team evolves according to the needs of the community it serves and available resources. While the makeup of teams differs, what they have in common is their holistic approach to the health and safety of the individual patient and their families. Data from the NACHRI 2008 Children's Hospitals Child Abuse Services Survey show that child protection teams are comprised of an array of staff. They include other clinicians such as nurses who care for the medical needs of patients; professionals who address the mental health needs of the child and family such as psychologists and therapists; forensic interviewers who humanely collect legally sound data from suspected victims; and others who support the well-being of the family such as child and family advocates and child life specialists.

Figure 4
Staffing for Teams
and Programs 2008
n=85



The mental health needs of the patient deserve particular mention. The importance of mental health providers is hard to overstate given the abundance of research showing the lifelong effects of abuse, cycles of abuse and potential impact on the family and community. A core function of child protection teams is to minimize the impact of these adverse experiences after they have occurred either by referring patients and families to appropriate providers within the institution or community or by providing mental health services. Mental health professionals help patients and families cope with both the immediate aftermath of suspected abuse and the long-term consequences.

The child protection team is enhanced by mental health professionals not just from the mental health services that they provide to the team's patients

NACHRI 2008 Children's
Hospitals Child Abuse Services
Survey, p. 8

and team members themselves, but also from other expertise they bring to the team. For example, a psychologist who is the member of a child protection team expands that team's ability to: educate trainees/fellows in psychology on child maltreatment issues and practices; provide expert testimony in court on such issues as delayed disclosure, recantations, results of trauma testing with valid instruments, and children's memory and suggestibility; conduct and evaluate research; write grants that include sound research design and appropriate statistical analysis; sit on the hospital's Institutional Review Board; and conduct statistically meaningful program evaluation.

WASHINGTON, DC - The mental health component of the child protection team at the Freddie Mac Foundation Child and Adolescent Protection Center at **Children's National Medical Center** has ongoing short- and long-term therapy for a variety of ages. Evidence-based treatment interventions such as trauma-focused cognitive behavioral therapy reduces trauma symptoms experienced by patients as a result of their victimization. According to Allison Jackson, M.D., M.P.H., FAAP, division chief of the center, "we treat kids with a lot of complex trauma, not just from maltreatment but also from trauma experienced at home and in the community." The strong focus on mental health is evident in the early intervention when a patient arrives at the center, and the mental health assessment is paired with the medical assessment of both child and family to determine the need for services. The mental health assessment team consists of three social workers and one psychologist, all who also train mental health professionals through internships in social work and psychology and a rotation of pediatric psychiatry fellows. "The impact on mental health of child victimization is long-term. It really is a public health problem," says Jackson. **For more information, contact Allison Jackson, M.D., M.P.H., FAAP, at amccarle@childrensnational.org.**

BIRMINGHAM, AL - Prevention of secondary trauma is the goal of the caregiver support program at **Children's of Alabama**. According to chief operating officer Tom Shufflebarger, its Children's Hospital Intervention and Prevention Services (CHIPS Center) employs a licensed counselor to assist team members in a "care for caregiver" arrangement. The emotional wellness program was started by Lou Lacey, LPC, director of caregiver services, who saw the need for a program from the position of the child protection team. Shufflebarger believes the position has been well received by clinical staff and hopes that it will help reduce burnout and turnover rates in hospital programs. Another key component of the program has been the introduction of Schwartz Center Rounds at the hospital: informal lunch sessions for staff to talk about job related issues. Recent topics included communicating a poor prognosis, working with patients who are chemically dependent, and caring for children with facial disfigurements. According to Lacey, "we wanted to bring this experience to our employees because it emphasizes the fact that this work can be emotionally taxing and that we are all impacted by our patients." **For more information, contact Tom Shufflebarger at toms@chsys.org. For more information about Schwartz Center Rounds, visit www.theschwartzcenter.org.**

NORFOLK, VA - The child abuse program at **Children's Hospital of The King's Daughters, Inc.** employs pet therapy dogs in its facility to make children less anxious prior to interviews and examinations. According to Jane Hollingsworth, Psy.D., executive director, "one child who arrived at the facility was selectively mute and would not speak with the therapist about her story. She spent time telling one of the pet therapy dogs her story which got her practiced and more comfortable talking to the therapists." The canine assisted therapy program, also known as the Buddy Brigade, began at the hospital in 2005 and was added to the child abuse program in 2008. Trading cards to collect and keep, with photographs and information about the therapy dogs, have been tremendously popular with the children. In fact, they sometimes try to schedule their appointments to coincide with a visit from their favorite dog. The program is in the process of applying for a facility dog for the hospital who will be on-site at all times and will be available during the forensic interview process as well. The facility dog may also attend court and sit in the witness box when children testify, as permitted by various jurisdictions. **For more information, contact Jane Hollingsworth, Psy.D., at jane.hollingsworth@chkd.org.**

Section 2

Functions



CHAPTER 4: CLINICAL SERVICES

The fundamental role of any hospital-based child protection team is to ensure that children suspected of being abused or neglected are diagnosed correctly, receive the best possible and most appropriate medical care and are kept safe.

“Child abuse medicine is not the same as pediatric medicine. My doctors don’t spend 10 minutes with a patient; they spend an hour and a half.”

Julie Bradshaw, LCSW
Director, Center for Safe and Healthy Families
Primary Children’s Medical Center
Salt Lake City

While other elements of child protection are important, providing for a child’s medical and safety needs is essential. Ensuring the immediate safety of the child as part of the provider’s clinical role makes this subspecialty unique.

This responsibility of child protection is more comprehensive than just medical diagnosis and treatment. The team also facilitates multidisciplinary assessment within the hospital and community, integrating the needs of the patient, including the needs and stability of the family, to formulate a workable plan for long-term management. Beyond strictly medical needs, this may include placement in foster care, prosecution of an abuser, or provision of services to a neglectful household. In all of the tasks of the child protection team, the most important treatment priority is ensuring the health and safety of the child.

At the **basic** level, child protection staff members:

1. Offer suspected victims of child maltreatment in the hospital and the hospital’s affiliated outpatient clinics a comprehensive medical evaluation that includes a complete history and assessment of the child’s safety and stability needs.
2. Provide medical evaluations based on specific criteria developed by skilled medical providers.
3. Are available for consultation on suspected cases of child maltreatment. A system is in place that ensures the medical leader reviews all child abuse cases in a timely manner, but review may at times occur after the child has left the hospital.
4. Develop standards for response that are medically appropriate and reflect the urgency of the case.
5. Document all explanations offered to any hospital personnel by caregivers for injuries being observed and treated by the team. (Inconsistency between medical findings and the history is a key diagnostic factor in assessing non-accidental trauma. It is common for an abusing caregiver to offer multiple and evolving explanations for injuries and for any delay in seeking medical treatment.)
6. Use internal or external trained forensic interviewers to augment history obtained by medical staff.
7. Provide psychosocial assessments and mental health referrals.

8. Coordinate care within the hospital and make recommendations to cooperating agencies on next steps and long-term care.
9. Make reports of suspected abuse to CPS and law enforcement as appropriate.
10. Document findings. Capacity exists for photo documentation of injuries.
11. Provide expert testimony when required.
12. Refer for timely sexual abuse examinations with a local or regional children's advocacy center if expertise in child sexual abuse examination is not available through child protection staff (*see Chapter 8: Community Collaboration*).
13. Assist families in navigating complicated bureaucracies, processes and treatments.

In addition to meeting all recommendations for the basic level, at the **advanced** level, the child protection team:

14. Increases staffing levels and overall hours of coverage. A team member is on call every day.
15. Offers all children suspected of having been abused a comprehensive medical evaluation conducted by a board certified child abuse pediatrician, or a physician consulting with a board certified child abuse pediatrician, with few exceptions.
16. Staffs with regular hours a program, clinic or center for the evaluation of alleged or suspected child abuse.
17. Is consulted for inpatient and outpatient suspected victims of child maltreatment and oversees the medical evaluations. A policy is in place to ensure this consultation (*see Chapter 5: Policies*).
18. Is available for consultation and referrals throughout the allied health system and from elsewhere in the local and outlying community.

In addition to meeting all recommendations for the basic and advanced levels, a **center of excellence**:

19. Has staff on call 24/7.
20. Provides additional clinical services, such as mental health care and counseling.
21. Has a procedure for developing reports that state recommendations in the best interest of the child. The procedure includes representatives from other disciplines involved in cases and considers many opinions.

22. Has other specialists and subspecialists, (such as pediatric neurologists, ophthalmologists, and orthopedic surgeons), specifically knowledgeable in child abuse, available for regular clinical consultation and participation in multidisciplinary conferences as needed.
23. Has a procedure for regular hospital and community-based multidisciplinary team meetings to provide program oversight and quality assurance.
24. Offers regional consultation and receives regional referrals. May provide consultation via telemedicine.
25. May provide medical services to children in foster care or to other high risk and/or medically underserved populations of children.

ST. PAUL, MN - The Midwest Children's Resource Center (MCRC) is a hospital-based child advocacy center and subspecialty consultation service at **Children's Hospitals and Clinics - St. Paul**. The facility evaluates 1,200 – 1,400 patients per year for physical, sexual and medical child abuse and neglect in both inpatient and outpatient settings. The hospital is a referral center for the entire region and it is within this framework that MCRC provides regional child abuse expertise which frequently involves direct patient care. For example, when a young infant was airlifted from a small town in Wisconsin with a skull fracture and severe brain injury, MCRC was rapidly notified by the PICU attending physician. MCRC responded immediately and began the medical evaluation for suspected child abuse by obtaining and documenting a detailed presenting history that included a fall from a couch. Medical director Carolyn Levitt, M.D., FAAP, provided the diagnostic expertise that is often critical to child protection and law enforcement. Levitt explained the medical findings and their significance to the detectives at the start of the investigation. They were able to rapidly and confidently refute a number of implausible potential explanations for the infant's injuries. Ultimately, a caregiver confessed to abusing the child. At other times, MCRC provides case consultation for children who are not evaluated in the clinic or hospital. In one recent case, law enforcement electronically transferred pictures of a child reported to have abusive bruises. The physician provided an opinion based on the distribution and pattern of the bruises and the age of the child, that the injuries could well be accidental. The opinion spared the child and family the stress of an investigation. **For more information, contact Jane Braun at jane.braun@childrensmn.org.**

MILWAUKEE, WI - **Children's Hospital of Wisconsin** has conducted medical screenings of foster children since the mid-1990's at its child advocacy center, The Child Protection Center. According to Mark Lyday, M.S.W., LCSW, administrative director, "every kid who goes through the court system is screened within five days." The screenings include comprehensive medical and developmental evaluations including tuberculosis testing and immunizations (if consent is given). "Many of these children have not been screened for physical signs of abuse or neglect and it is not uncommon to see injuries in these children when they come in for an evaluation," says medical director Lynn K. Sheets, M.D., FAAP. The Child Protection Center has started a pilot program to provide on-site, urgent, comprehensive developmental testing of some children entering foster care, mainly young children. The program has a large network of child advocacy centers located across the state of Wisconsin that provide services to almost 6,000 children annually. **For more information, contact Lynn K. Sheets, M.D., FAAP, at lsheets@chw.org.**

BRONX, NY - "Statistics indicate that children with disabilities are at least twice as likely to be physically abused, sexually abused and/or neglected when compared to typical children," says Karel R. Amaranth, M.P.H., M.A., executive director of the J.E. and Z.B. Butler Child Advocacy Center at **The Children's Hospital at Montefiore**. The vulnerability of these children is further complicated by the challenges of identifying abuse in children with disabilities, the lack of prevention programs that are accessible and appropriate for children with disabilities, state laws that deter prosecutions, and the prevailing public attitude that such abuse is unthinkable. The Moving Mountains project fuels efforts at the Butler Center to assure that services are available, appropriate and comfortable for all children, including those with physical, cognitive and communication disabilities. Recognizing there is no one "silver bullet" in accommodating children with special health care needs and disabilities, Moving Mountains employs a variety of tactics to improve availability and accessibility of services. Staff training is specific to understand differences/sensitivities and adapts the typical forensic model, employing multiple interview techniques to account for physical or cognitive disabilities. Collaborative relationships exist with local disabilities centers at Columbia University and Einstein College of Medicine to consult with and support staff when working with children with disabilities. All interview rooms are not only compliant with the Americans with Disabilities Act but are designed to consider behavioral variances and comforts underscoring the physical adaptability of the space. Prevention strategies for children with special health care needs and disabilities focus on recognition of abuse and sensitivity to the unique vulnerability of the child. These and other efforts are overseen by a multidisciplinary advisory board. **For more information, contact Karel Amaranth, M.P.H., M.A., at kamarant@montefiore.org.**

ATLANTA, GA - At **Children's Healthcare of Atlanta**, telemedicine is used to connect child abuse-trained providers in Atlanta to hospitals in its network, primarily Coffee Regional Medical Center (Sadie's House CAC), A Child's Voice CAC, and Synergy Health. The use of telemedicine in clinical care allows for child abuse doctors to assist with assessments of children in rural areas where there may be limited access to pediatric specialists. According to Stephen Messner, M.D., FAAP, lead physician at the child protection center, Children's Healthcare of Atlanta conducts regular telemedicine appointments three days a week. Children's Advocacy Centers of Georgia recently received a grant from the governor's office for updated equipment including a webcam to stream images that will be used to connect even more providers in the state. Another use of the telemedicine technology is "store-and-forward" where images or other medical data can be transmitted to a doctor or specialist for review offline. It doesn't require the parties to be available at the same time. "The technology is also used for long-distance learning, lectures and webinars where information can be streamed to many sites," says Messner. **For more information, contact Stephen Messner, M.D., FAAP, at stephen.messner@choa.org.**

CHAPTER 5: POLICIES

All health care providers, regardless of the setting, are state mandated reporters of suspected child abuse – even when there is no designated child protection team at the hospital.

In addition, all hospitals accredited by The Joint Commission follow standards for identification of suspected abuse, assessment, referral, education of hospital staff, tracking and reporting suspected cases. Moreover, basic policies that detail how these standards are followed (e.g. how suspected child abuse is reported, appropriate channels for reporting from all hospital departments and clinics, the documentation of such reports) are essential at any hospital that sees children. (*See Introduction: Guidance for General Hospitals with Pediatric Patients for a list of these policies.*) Ideally, a hospital's set of annual required trainings (such as infection control and patient privacy) include this child protection responsibility around detection and mandated reporting.

A child protection team of any scope or size requires a clear set of policies in place to guide internal and external collaboration. Child abuse and neglect cases often involve complex interactions not only among a variety of disciplines within the children's hospital, but with external agencies, such as law enforcement and CPS, as well as with the court system. These policies should cover several broad areas, including how referrals are made to the child protection team, how cases are evaluated, how information is shared with external agencies and how costs are allocated. Child protection team members should contribute to the development of these policies as appropriate.

Before launching a child protection team, leaders should consult appropriate hospital staff and external partners to develop a clear set of fundamental governing policies that build upon existing policies related to mandatory reporting and internal procedures.

At the **basic** level, policies include:

1. A directive that allows for referrals to child protection staff to be made by any hospital staff member.
2. Procedures in the emergency room, for inpatients, and in outpatient clinics for referral to the child protection staff or another appropriate organization.
3. Guidelines and protocols for the medical evaluation and/or referral of suspected child maltreatment. Specific criteria for medical evaluation are developed to include histories, examinations, documentation, reporting, radiographic imaging and consultation of the child protection staff.
4. Protocols for access to and obtaining consultation from board certified child abuse pediatricians when necessary or desired.

5. Strict compliance with all state laws governing the reporting of suspected child abuse, with all necessary measures to ensure staff is familiar with these laws. How to access updated state laws and the proper mechanism of reporting in that state (such as centralized hotlines) are well known to child protection staff.
6. Guidelines for collaboration between the children's hospital child protection staff and community agencies such as police, CPS and prosecutors.
7. Guidelines for visitation in instances where maltreatment is suspected.

In addition to meeting all recommendations for the basic level, at the **advanced** level, policies include those that:

8. Outline protocols for hospital providers and specialists who are not members of the child protection team who receive child abuse referrals from community hospitals.
9. Designate a hospital liaison who serves as a consistent, reliable contact person for both referrals from within the hospital and external referrals. Not necessarily a physician, the liaison should be knowledgeable about child maltreatment and the child protection team's policies, and should communicate effectively with physicians and other medical personnel.
10. Fulfill successful and positive outreach to community agencies, such as video recording of interviews, joint interviews, availability of hospital staff for court proceedings and consultation by the child protection team.
11. Advance awareness, education and zero tolerance for violence or inappropriate behavior within the hospital and its health care settings.
12. Promote a safe hospital environment for patients, families and staff (e.g. safe sleep, safe child consults for medically intensive cases who may be families at risk for abuse, domestic violence support for staff to request help anonymously).
13. Describe capacities and procedures for diagnostic video (covert) surveillance if hospital is a referral facility for suspected medical child abuse cases.
14. Are developed between the hospital's risk management department and child protection team on issues of potential threat to children's safety within the hospital setting.

In addition to meeting all recommendations for the basic and advanced levels, policies at a **center of excellence** may expand to include:

15. A proactive crisis response developed in concert with the hospital's public relations and risk management staff (e.g. a missed diagnosis of abuse).
16. Recognition that center staff members are at significant risk for secondary traumatic stress with strategies for prevention and mitigating its effects.
17. Description of capacities and procedures for diagnostic video (covert) surveillance for suspected medical child abuse cases.

CHICAGO, IL - Mandatory screening for every child under the age of 3 is the standard of the burn and child protection protocol at **Comer Children's Hospital at University of Chicago Medical Center**. Jill Glick, M.D., FAAP, medical director of child protective services, explains "all kids in this age group are photographed and the images are uploaded into the hospital server for access by essential medical personnel." When Glick is on call, she can view a photograph from her home computer to assess whether the hospital needs to file a report with the Department of Family Services and initiate an investigation. The Multidisciplinary Pediatric Education and Evaluation Consortium (MPEEC), started by Glick, created the policy. The MPEEC program is now considered the standard response for all children in this age group in Chicago. The MPEEC consortium includes three hospitals in the Chicago area: Comer Children's Hospital at University of Chicago Medical Center, Children's Memorial Hospital at Northwestern University There are 11 board-certified child abuse pediatricians between the three MPEEC hospitals available to identify and evaluate child abuse cases in the Chicago area.

"Child abuse needs to be treated the same way as other injuries and illnesses that come into the hospital ICU," says Glick. Creating mandatory practices for child abuse care has allowed practitioners to eliminate bias. "Most parents and doctors realize that they benefit from this practice. Parents don't get mixed messages and doctors can focus on what is best for the child's treatment." This team approach to treating possible child abuse uses a protocol that makes children safer when pediatric doctors alone aren't able to provide time and expertise required to determine whether a case is an accident or abuse. "Negative diagnosing an accident is just as important as diagnosing abuse," says Glick. "MPEEC has made a huge change in Chicago and is a reproducible model for many hospitals." **For more information, contact Jill Glick, M.D., FAAP, at jglick@peds.bsd.uchicago.edu.**

ANN ARBOR, MI - **C.S. Mott Children's Hospital**, part of the University of Michigan Health System, created a set of guidelines to promote a healthy hospital environment where violence is not tolerated. Modeled after a few key programs in the country, Mott decided to establish a "No Hitting Zone" to further the mission of patient safety and to educate employees on techniques for intervention against threats, threatening behavior and violence through a supportive family-centered approach. Maria Thomas, M.A., M.P.A., advocacy director, says, "the guidelines provide greater clarity for staff and faculty to respond in a supportive way and provide resources and practical skills." The initiative has received a positive response from staff and faculty for its proactive stance to families who are already experiencing stress with sick children in the hospital setting. **For more information, contact Maria Thomas, M.A., M.P.A., at mariatho@med.umich.edu.**

MINNEAPOLIS, MN - At **University of Minnesota Amplatz Children's Hospital** protocol dictates that the child protection team at The Center for Safe and Healthy Children must be consulted for all injuries where the possibility of abuse exists. According to Rich Kaplan, M.D., M.S.W., FAAP, medical director at the center, "it was very easy to develop support for the protocol" since the surgeons and emergency room physicians were involved in drafting it. As part of the protocol, Kaplan and his team do their own photodocumentation of injuries in the emergency room to make the most thorough diagnosis available. **For more information, contact Rich Kaplan, M.D., M.S.W., FAAP, at kapla111@umn.edu.**

CHAPTER 6: PREVENTION

Given the scope of the problem and the lifelong consequences of maltreatment to individuals and communities, advances in and commitment to prevention is ultimately the only solution to protecting children from abuse.

Through a common mission, all children's hospitals work to enhance the health and well-being of children in their communities. By targeting the root causes and social determinants of abuse, unintentional injury, illness and chronic conditions, children's hospitals contribute meaningful improvements to the health of children and their families.

A hospital's prioritization of health promotion and preventative investments is often enterprise-wide and visible in its mission and culture. As such, child abuse prevention is often more than the solitary purview of the child protection team. Rather, preventing child abuse is informed by the team's expertise and integrated into the hospital's broader child health advocacy mission.

There are many related and interwoven risk factors that may contribute to child maltreatment such as poverty, generational violence and lack of community supports, making the prevention of maltreatment complex at best. While the research base is growing, there is much that is unknown as prevention science continues to evolve. Children's hospitals, like other organizations contributing to prevention, must balance advocacy and science by investing limited resources in prevention efforts that appear to be the most promising, and by basing those efforts on community needs.

At a **basic** level, child protection staff members:

1. Monitor universal and targeted prevention efforts in the community. They partner with at least one local or regional child abuse prevention organization and participate in their efforts to the greatest extent possible.
2. Encourage basic screening efforts (e.g. domestic violence screening) in primary care clinics.
3. Train medical and other hospital staff in child abuse recognition and referral protocols. This training is also provided to medical students and residents who rotate through the hospital. Staff members have protected time to develop and implement such curricula.
4. Are knowledgeable about current prevention strategies.
5. Collaborate with local child fatality review committees.
6. Promote child abuse prevention within the hospital, including participation in the development of organizational policies that contribute to the safety of patients and staff.

In addition to meeting all recommendations for the basic level, at the **advanced** level, the child protection team:

7. Has policies that include a commitment to and involvement in community and regional prevention programs.
8. Increases its participation in hospital and community prevention activities.
9. May provide training in the recognition and referral of child abuse to community-based pediatricians and to nonmedical partners, such as professionals in child protective services and law enforcement.

In addition to meeting all recommendations for the basic and advanced levels, a **center of excellence**:

10. Contributes content expertise in the hospital and to community partners for the development, implementation and maintenance of child abuse prevention efforts. In some cases, the center may lead these efforts.
11. May provide prevention skills education for staff at neighboring hospitals.
12. Collaborates on proposals for funding prevention efforts.
13. Prioritizes measurement of the effectiveness of the center's prevention efforts.
14. Is committed to informing regional, state and national prevention efforts, research and policy development.
15. Promotes the use of evidence-based principles in prevention efforts.
16. May expand focus on universal and targeted prevention to consider indicated prevention (aimed at families where abuse has already occurred) to prevent recidivism and reduce sequelae.
17. May host or provide space for conferences or meetings on prevention (such as for statewide multidisciplinary groups).
18. Considers prevention when determining research priorities.
19. Promotes and informs prevention content as a key component of medical education programs, fellowships and other training initiatives, such as continuing education.

ALBUQUERQUE, NM - Para Los Ninos (PLN) is the primary 24-hour on-call service for pediatric sexual abuse at **University of New Mexico Children's Hospital**. PLN provides free medical evaluations for children and adolescents who have been sexually abused or assaulted. Renee Ornelas, M.D., FAAP, director and professor of pediatrics, directs a bilingual staff providing emergency and scheduled evaluations, forensic medical evaluations, crisis counseling and adolescent sexual assault follow-up, and the Segura y Fuerte (Safe and Strong) class. Started by Ornelas in 2002, Segura y Fuerte takes place at the Albuquerque Family Advocacy Center near the hospital. According to Ornelas, "the kids who were coming in for treatment had very limited resources and many needed therapy and education about their behaviors beyond the visits to the hospital." The classes provide information on sexuality, domestic violence, rape crisis survival, self-defense and emotional and mental health. Two ten-week sessions are offered at the center during the spring and fall. The girls range in age from 13 to 18 and many come from difficult family situations where there is physical or substance abuse. The class is an example of tertiary prevention where there is a focus on rehabilitation and minimizing risk of recurrence. **For more information, contact Renee Ornelas, M.D., FAAP, at ronelas@salud.unm.edu.**

HOUSTON, TX - The PREVENT Institute (PREventing Violence through Education, Networking and Technical Assistance), a component of the National Training Initiative for Injury and Violence Protection, offers an intensive program of education, networking and technical assistance in a three-part series. It is hosted by University of North Carolina at Chapel Hill Injury Prevention Research Center. The first part includes three days of on-site coursework and team-based activities; the second part has a six-month home-based team project with an experienced coach; and the third part includes three days of on-site courses and team presentations. Angelo Giardino, M.D., Ph.D, M.P.H., FAAP, health plan medical director at **Texas Children's Health Plan**, gathered a multidisciplinary team to take part. He and his five-member team of academics from Baylor College of Medicine, the University of Texas, School of Nursing and Medicine and Texas Women's University received intensive training in prevention science with an emphasis on leadership. The result of the training will be a Houston-based PREVENT program for a community coalition with the support of grant funding. According to Giardino, "Prevention needs to be community-based with a broad and multidisciplinary approach." **For more information, contact Angelo Giardino, M.D., Ph.D, M.P.H., FAAP, aggiardi@texaschildrens.org. or visit PREVENT Institute online at www.prevent.unc.edu.**

MEMPHIS, TN - **Le Bonheur Children's Hospital** recognizes that children are among the most vulnerable in a community over-burdened by poor birth outcomes, poverty and high child abuse and neglect rates. In its efforts to promote the health and well-being of children, Le Bonheur became a Nurse-Family Partnership (NFP) implementation site in 2009. Le Bonheur's Nurse-Family Partnership Program was initially composed of one nurse supervisor and four nurse home visitors with a program capacity of 100 families. Leveraging Le Bonheur Children's Hospital's quality reputation in the community, NFP reached capacity in less than seven months. The program has received additional funding to increase capacity by fifty families who will be served by two nurse home visitors. After more than a year of service, no families in the NFP program have been reported for suspected child abuse or neglect. Le Bonheur's Nurse-Family Partnership is part of the Early Success Coalition, a broad-based collaborative of public and private agencies and groups committed to improving the lives of families with young children. **For more information, contact Sandra M. Allen, M.S.S.W., director, Le Bonheur Center for Children and Parents, at allens@lebonheur.org.**

NEW ORLEANS, LA - Stacie LeBlanc, J.D., M.Ed., executive director of the Audrey Hepburn CARE Center at **Children's Hospital** and New Orleans Children's Advocacy Center, is a former prosecutor who believes teenagers and their parents need to understand the laws regarding teen sexual activity as it pertains to consent, age, alcohol, Internet, texting, sexting and pornography. This is the message behind an innovative program titled "Teens, Sex and the Law" at the CARE Center. Working with the Tulane School of Health, the targeted education and intervention program uses evidence-informed research to create a curriculum based upon laws that affect teenagers in Louisiana. Le Blanc states, "most teenagers who have been through the program were clueless that their consensual sexual activity could be illegal. Teens know that 'no means no', but they have no concept that 'yes' can also be a 'no' in certain situations." The program is always administered by two trainers of different genders, at least one of whom is college-aged to better relate to the teen audience. **For more information, contact Stacie LeBlanc, J.D., M.Ed., at sleblanc@chnola.org.**

LEBANON, NH - At **Children's Hospital at Dartmouth** the child advocacy protection care manager is on the unit every day visiting families who are undergoing significant stress. The care manager asks every family about background issues that can inform a case such as substance abuse in the family and other possible risk factors. An example of a successful intervention in the hospital occurred with a child who arrived at the emergency rooms multiple times and failed to thrive. Suspecting possible child maltreatment, the care manager pieced together patterns of growth failure based upon times the child was solely in the mother's care. Using gentle persistence, the manager challenged the findings of a well-regarded subspecialist to bring the case to the attention of the ethics committee and the hospital attorneys to temporarily remove the child from the mother. After doing so, the child began to thrive. According to Kent Hymel, M.D., FAAP, "the care manager finessed an institution-wide response to the case. Saving the child is always the focus." **For more information, contact Kent Hymel, M.D., FAAP, kphymel@gmail.com.**

NEW ORLEANS, LA - Darkness to Light (D2L), a program for the prevention of child sexual abuse, provides organizations nationwide with educational materials, training, public awareness campaign strategies and support for community prevention initiatives. The Audrey Hepburn CARE Center at **Children's Hospital** made prevention a primary mission for 2011 and offers all levels of the D2L program. Stacie LeBlanc, J.D., M.Ed., executive director of the CARE Center and the New Orleans Children's Advocacy Center, believes that the program has been very successful at changing the ways parents protect children from sexual abuse. In fact, LeBlanc states, "it changed the way I protect my own children and I have been in this field for 21 years. The program gives parents and all adults simple steps to truly protect children from sexual abuse." **For more information, contact Stacie LeBlanc J.D., M.Ed., at sleblanc@chnola.org or visit Darkness to Light online at www.d2l.org.**

SIOUX FALLS, SD - Prevention of abusive head trauma (AHT) is a priority in the NICU at **Sanford Children's Hospital** as well as at Sanford Health's maternity hospital, Birth Place. The AHT prevention program was developed by Monica Maurer, RN, program coordinator at Child's Voice (the hospital-based child advocacy center) and a team of concerned nurses. Maurer attended a national shaken baby conference in 2004/2005, wrote a grant to fund the project, and the team rallied support in the hospital for implementation. The program is implemented during the discharge planning process with education given to parents/caregivers of newborn babies and infants who are discharged from the NICU. The hospital-based program uses a video, pamphlets and a pledge form for parents to sign stating that they will inform others caring for their baby about the dangers of shaking infants and small children. Because the hospital believes that even one child injured from abusive head trauma is too many; an abusive head trauma task force has been formed with membership from all areas of the hospital that deal with parents and children. The task force has physicians, nurses and social workers dedicated to educating and increasing awareness to all staff, parents and to the community about the dangers of shaking an infant or small child. **For more information contact Monica Maurer, RN at monica.maurer@sanfordhealth.org.**

Prevention Resources

Selected national organizations with information and resources on prevention:

The Centers for Disease Control and Prevention, Division of Violence Prevention website includes definition of child maltreatment, data sources, risk and protective factors, consequences, prevention strategies and lists of publications and resources. www.cdc.gov/violenceprevention/childmaltreatment/

Doris Duke Charitable Foundation is a grant making organization that has three goals for its child abuse program: to build the repertoire of prevention strategies, to increase the number of effective and innovative methods for preventing abuse and neglect, and to develop capacity of existing systems. www.ddcf.org/child-abuse-prevention/

National Alliance of Children's Trust and Prevention Funds provides training, technical assistance and peer consulting opportunities to state Children's Trust and Prevention Funds and strengthens their efforts to prevent child abuse. www.ctfalliance.org

The Pew Center for the States Home Visiting Campaign promotes and advances smart state and federal policies and investments in high-quality, home-based programs for new and expectant families. www.pewcenteronthestates.org/initiatives_detail.aspx?initiativeID=52756

Prevent Child Abuse America is a national advocacy organization that works with its state chapters to provide leadership to promote and implement prevention efforts at both the national and local levels. www.preventchildabuse.org

United States Department of Health and Human Services, Administration for Children and Families, Child Welfare Information Gateway, Preventing Child Abuse & Neglect provides information and resources on supporting families, protective factors, public awareness, community activities, positive parenting and prevention programs. www.childwelfare.gov/preventing/

Selected Articles and Publications that Provide a Prevention Overview

American Professional Society on the Abuse of Children (APSAC). (2010). *Integrating prevention into the work of child maltreatment professionals*. <http://www.apsac.org>

Flaherty, E., Stirling, J., & the Committee on Child Abuse and Neglect. (2010). Clinical report – the pediatrician’s role in child maltreatment prevention. *Pediatrics*, *126*(4), 833-841. doi: 10.1542/peds.2010-2087

Pew Center on the States. (2011). States and the New Federal Home Visiting Initiative: An Assessment from the Starting Line. Retrieved from http://www.pewcenteronthestates.org/uploadedFiles/assessment_from_the_starting_line.pdf

Preventing Child Maltreatment (Theme Issue, Fall 2009). *The Future of Children*, *19*(2). <http://www.futureofchildren.org>

Scribano P. (2010). Prevention strategies in child maltreatment. *Current Opinion in Pediatrics*, *22*(5), 616-620. doi: 10.1097/MOP.0b013e32833e1688

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U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children’s Bureau. (2010). *Child Maltreatment 2009*. See Chapters 6: Services and 7: Reports, Research and Capacity Building. <http://www.acf.hhs.gov/programs/cb/pubs/cm09/index.htm>

Zimmerman, F., & Mercy, J. (2010). *A better start: child maltreatment prevention as a public health priority*. Washington, DC: Zero to Three: National Center for Infants, Toddlers and Families. Retrieved from <http://www.zerotothree.org/maltreatment/child-abuse-neglect/30-5-zimmerman.pdf>

CHAPTER 7: ADVOCACY IN THE HOSPITAL AND COMMUNITY

With the child maltreatment expertise found in children’s hospitals comes a responsibility to be a voice for the safety of all children — both within the hospital and the community.

As a hospital’s child protection team grows, so too should its investment in advocacy. As the medical experts in child maltreatment and prevention, child protection teams at children’s hospitals have important advocacy roles to play in supporting families, educating communities and influencing policymakers. The advocacy tactics a hospital and its child protection team choose to employ in fulfilling these roles are a reflection of staff capacity, expertise, political climate and public opinion, or a confluence of several of these factors.

“Child abuse has been the leading cause of trauma deaths at Children’s Hospital Colorado every year since 2003, with several kids admitted every month who have been shaken, one of the most deadly forms of child abuse. The staff and hospital leaders realized that we had to do something about these preventable tragedies. Our hospital made a firm and public commitment to reduce the incidence of shaking through better education of our community and its leaders. Our hospital is viewed as a believable messenger on child health issues which put us in a position of leadership to advocate for the safety of children.”

James E. Shmerling, D.H.A., FACHE
NACHRI/CHCA Board of Trustees Member
President and Chief Executive Officer, Children’s Hospital Colorado

Although the physicians, coordinators, social workers and others who make up a child protection team at a children’s hospital are neither public relations specialists nor lobbyists, their medical expertise makes them uniquely qualified to speak persuasively about shaping personal behavior, informing public attitudes and changing governmental priorities. This function of “expert influencer” is powerful and should be cultivated both within the hospital and beyond.

A hospital’s public relations staff is an essential resource to the child protection team and all advocacy communications efforts should be coordinated through this department. These experts can craft and communicate messages to the public and policymakers

and help integrate child abuse intervention and prevention messages into outreach initiatives. Public relations staff members are aware that high profile child abuse cases offer the opportunity for hospital child abuse experts to be spokespersons, thereby projecting the hospital as a leader in the community.

Likewise, the child protection team can advance child abuse initiatives locally and statewide by strategically aligning with the hospital government relations staff. These public policy professionals can consult on influencing a public official’s opinion or vote on initiatives, funding, or regulations that could impact child abuse and neglect services or prevention initiatives. All public policy advocacy needs to be coordinated through the hospital government relations staff, who can clarify the hospital’s lobbying policies.

At the **basic** level child protection staff members:

1. Help families navigate complicated bureaucracies, processes and treatments.
2. Actively cultivate their position as child abuse experts within the hospital.
3. Support and contribute to the development of internal policies that promote a safe hospital environment for patients, families and staff.

4. Contribute to community advocacy initiatives focused on child maltreatment (such as Child Abuse Prevention Month activities) and advocate for community collaboration to the greatest extent possible.
5. Establish a relationship with the hospital's public relations department and make themselves available to support this department in responding to local events and media inquiries.
6. Seek to enhance skills as public spokespeople through available training.
7. Advocate for legislative reform and systems improvement regarding child protection, by speaking at public events and meeting with legislators and community officials when possible.

In addition to meeting all recommendations for the basic level, at the **advanced** level, the child protection team:

8. Includes members (e.g. medical director, coordinator, social workers and other staff) who serve on community boards that influence awareness and understanding of the prevention and treatment child abuse.
9. Educates the public about all forms of child maltreatment and its prevention through presentations, educational information and other outreach efforts.
10. Works with the hospital's public relations staff to secure news coverage that highlights the children's hospital role in responding to and preventing all forms of child maltreatment.
11. Allots specific time and resources to legislative advocacy.

In addition to meeting all recommendations for the basic and advanced levels, a **center of excellence**:

12. Works to include information about child abuse intervention and prevention and relevant public policy issues in internal and external hospital publications.
13. Acts in positions of organizational leadership for community advocacy programs. Leadership at this level is often regional as well as local.
14. Establishes a liaison relationship with specific staff members in the hospital's government relations, public relations and other outreach offices who can specifically focus on promoting the center's staff members as experts for consultations, interviews and legislative hearings.
15. Establishes a system to track legislation and regulations relevant to child protection in partnership with the hospital's government relations office.

TEXAS - The NACHRI child abuse program guidelines were key elements of a forward-looking Texas initiative that is developing regional networks of child abuse prevention and treatment programs. In 2007, the Texas legislature called for a multidisciplinary committee to investigate establishment of centers of excellence in child abuse prevention and treatment across the state. When the Pediatric Centers of Excellence Advisory Committee (PCOE) reported its findings, they cited *Defining the Children's Hospital Role in Child Maltreatment* and reported that the committee had been able to fine-tune the NACHRI model in accord with available resources in Texas. The legislature agreed to establish a grant program to fund regional initiatives. Eight hospitals that met PCOE criteria for centers of excellence or advanced programs were funded. Each now has a mentoring relationship with a designated outlying hospital.

"We don't have enough money to create a statewide system," Bryan Sperry, president of the Children's Hospital Association of Texas explained, "but we wanted to stabilize and build the centers of excellence and advanced programs. So we decided that to get grant money, you had to mentor at least one other program in an outlying area. Each of the programs got some grant money and they all partnered with another place to help development. So Texas Children's Hospital has reached out to CHRISTUS Hospital – St. Elizabeth in Beaumont, for example," and Dell Children's Medical Center has reached out to Providence Health Center in Waco.

The eight hospitals that make up the Texas child abuse prevention leadership are:

- Children's Medical Center Dallas
- CHRISTUS Santa Rosa Children's Hospital, San Antonio
- Cook Children's Medical Center, Fort Worth
- Dell Children's Medical Center of Central Texas, Austin
- Driscoll Children's Hospital, Corpus Christi
- Texas Children's Hospital, Houston
- The University of Texas Health Science Center at Houston
- Children's Hospital at Scott & White, Temple

"The [NACHRI] manual gives a framework that we could look at and then adapt to our state's situation," Sperry said. "Some states are smaller and maybe have one children's hospital; they can think about what one children's hospital does and how that relates to a whole state. But for us, it was how do we move to a better statewide system and how do we build that system?"

We used the manual for that." **For more information, contact Bryan Sperry at bryansperry@childhealthtx.org.**

PORTLAND, OR - When shaken baby syndrome (SBS) admissions doubled during one year in 2004, pediatric hospitalists and members of the child abuse prevention team earned the support of the executive leadership at Legacy Health to implement a system-wide SBS prevention and education program. Sandy Nipper, RN, child safety program coordinator at **The Children's Hospital at Legacy Emanuel**, led the effort to create a multidisciplinary task force on the issue and secure grant funding for a program developed using patient satisfaction and other quality data. A year later, the program was launched system-wide within the maternity and pediatric services. A mandatory skills day training for 400 obstetric care registered nurses included a 30-minute session on SBS and a viewing of the Period of PURPLE Crying® DVD/booklet and now new staff members are trained as part of their unit orientation. Nipper's passion for SBS prevention is informed by her personal experience as the mother of an inconsolable baby 25 years ago. Her personal story helps to raise awareness that parents are not alone and there are resources to help them cope with crying. **For more information, contact Sandy Nipper, RN, at snipper@lhs.org.**

JACKSON, MS - The NACHRI publication, *Defining the Children's Hospital Role in Child Maltreatment*, was the guide for Elizabeth Hocker, J.D., to do when she developed the Children's Justice Center (CJC) at the **Blair E. Batson Hospital for Children**. Hocker, former executive director of the center, used the publication to guide training, clinical services, outreach and all levels of providing care. According to Hocker, it was "the bible" for transitioning her program in 2005 from a nonprofit providing forensic medical examinations at the hospital to a legislatively mandated Center of Excellence funded by the state legislature. The publication provided the statutory language used in drafting a bill outlining the medical care abused and neglected children need and deserve. The former chair of the department of pediatrics at University of Mississippi Medical Center, Owen B. Evans, M.D., FAAP, used the NACHRI document to validate and support the creation of the Children's Justice Center. "The NACHRI document articulated exactly what we needed to do," says Hocker. "Because of the hospital support and the clear language of the publication, the Children's Justice Center became a reality." **For more information, contact Scott Benton, M.D., FAAP, medical director, at sbenton@umc.edu.**

AURORA, CO - The Kohl's Shaken Baby Syndrome Prevention Campaign, executed in partnership with **Children's Hospital Colorado** and The Kempe Center, aims to prevent shaken baby syndrome (SBS) through a range of grassroots community outreach, education and advocacy efforts. The campaign outreach efforts include sophisticated social media efforts, national, state-wide and local presentations, and an awareness campaign internal to the hospital. At the core of the campaign is a hospital-based bedside education program designed to educate new parents about infant crying, coping strategies and prevention of shaken baby syndrome. Staff within the Children's Health Advocacy Institute dedicate time to track educational and advocacy accomplishments in order to quantify campaign exposure and reach. At the same time, the hospital is engaged in research to study the effectiveness of the education delivery, change in caregiver knowledge, ease of use by nurse educators, and comparative effectiveness to current educational practices. **For more information, contact Theresa Rapstine, B.S.N., RN, at theresa.rapstine@childrenscolorado.org.**

CHAPTER 8: COMMUNITY COLLABORATION

Child protection teams at children’s hospitals are not lone rangers.

They are one component of, and must coordinate with, what ideally should be a strong network of community agencies and organizations, including law enforcement, CPS and advocacy groups. Community collaboration is essential to thoroughly address suspected abuse — for the health and well-being of the child and family, and for appropriate prosecution when it is found that a crime has taken place — and for its prevention.

In all of its collaborative efforts with community partners, a children’s hospital should clearly maintain its role as a provider of medical care. While the hospital may work with other agencies to provide referrals and support for other types of services, such as shelter and legal aid, it should always be clear that the medical needs of the child are the hospital’s — and the child protection team’s — most urgent responsibility. When it comes to investigating suspected abuse, the role of the children’s hospital is not to be a finder of fact or an independent investigator, but to provide expert medical opinion and ensure nonmedical professionals understand the medical issues.

While the primary role of children’s hospitals is as medical expert in child maltreatment and prevention, they can also fill in other gaps in community services. However, hospitals should not duplicate services that are adequately provided by another agency. Conducting an assessment of available community services is an important first step in the process of developing or expanding a child protection team at a children’s hospital. Once a community’s multiple stakeholders are identified, and their various roles and interactions defined, a children’s hospital can determine how it, as the source of medical expertise in the treatment and prevention of child abuse and neglect, can work best within this network. In some areas, existing memoranda of understanding, institutional agreements or state statute may define these relationships.

To engage in community collaboration at the **basic** level, child protection staff members:

1. Collaborate with and assist CPS and law enforcement in their investigations.
2. Identify, and in some cases partner with, existing local child abuse evaluation and treatment centers, including children’s advocacy centers and their partners.
3. Promote among community partners a designated child protection staff person as the appropriate point of contact for the hospital. This internal liaison can assist community agencies in handling procedural issues and coordination of services for the suspected victim.
4. May refer investigators to a team at the advanced level or a center of excellence when necessary or desired.
5. Monitor universal and targeted prevention efforts in the community. Partner with at least one local or regional child abuse prevention organization and participate in their efforts to the greatest extent possible.

In addition to meeting all recommendations for the basic level, at the **advanced** level the child protection team:

6. Engages in regular, face-to-face contact with CPS and law enforcement. This will improve understanding of the medical needs of children who have been abused or neglected, and facilitate gathering medically relevant information during investigations. What's more, the different members of a multidisciplinary community team, such as prosecutors and detectives, are most motivated to come together and interact when they can benefit from medical expertise. Frequently this happens as part of the children's advocacy center case review and interactions.
7. Works with CPS to assign dedicated, "primary" social workers to liaise with the hospital, and:
 - ✓ Requests that these primary social workers have advanced training.
 - ✓ Considers offering desk space to the primary social workers to facilitate the relationship.
 - ✓ Realizes that this collaboration is subject to case volume and budget constraints.
 - ✓ In the case of a partnership between the hospital and CAC, this primary social worker should sit on the multidisciplinary team.
8. Works with the police department to assign dedicated, "primary" detectives to liaise with hospital, and:
 - ✓ Requests that these primary detectives have advanced training.
 - ✓ Considers offering desk space to the primary detectives to facilitate the relationship.
 - ✓ Realizes that this collaboration is subject to case volume and budget constraints.
 - ✓ In the case of a partnership between the hospital and CAC, this primary law enforcement person should sit on the multidisciplinary team.

Maximizing community and hospital response

As a children's hospital considers its approach to child maltreatment, team leadership should ask:

- What currently exists in our community's approach to child maltreatment? How can it be enhanced? What is missing?
- Where could the response to and investigation of abuse and neglect cases benefit from medical expertise and medical leadership?
- What are our hospital's capabilities (and limitations) in addressing these needs?
- Where might advanced capabilities, like education and research, contribute to the efforts of our community partners? What data can we provide? (By sharing its own mortality and morbidity data with other data sources in the area, such as child death review teams or coroner's offices, a children's hospital can help develop a more complete picture of child abuse in its community.)
- How can our hospital and child protection team work with community partners to ensure that abused and neglected children are protected and that cases of suspected abuse are evaluated in a medically appropriate way?

9. Establishes, as appropriate, a monthly meeting of all hospitals in the community or region. Through this connection, physicians serving child abuse victims in any emergency department or hospital are aware of consult and referral opportunities at the children's hospital.
10. Outreaches to and establishes relationships with emergency medical services that bring children from outlying areas to the children's hospital in response to suspected child abuse or neglect (in accordance with any existing protocols or memoranda of understanding). The entry point for these children may be at the children's hospital directly, or may come via referral from general/community hospitals.
11. Coordinates with forensic interviewers, who are key components to child sexual abuse cases. Forensic interviewers may be a part of the hospital-based team, contracted by the hospital to do evaluation in an outpatient setting, or coordinated through a CAC.
12. Creates and signs collaborative agreements when working with a community-based multidisciplinary team such as with that of a CAC.
13. Assumes some of the responsibility for contributing to maintenance of a healthy and productive collaboration.

In addition to meeting all recommendations for the basic and advanced levels, a **center of excellence** is likely to be a regional as well as local collaborative partner, and:

14. Takes a broader leadership role in the community.
15. Provides more extensive training and consultation to partners such as CPS and law enforcement.
16. Serves as a regional medical resource that provides facilitation and coordination for various investigative agencies from outlying communities.
17. May house a CAC as a program of the hospital.
18. Offers support to other physicians and health care providers in the community regarding the management of alleged or suspected maltreatment.
19. Provides leadership and facilitation for regular multidisciplinary meetings of all agencies involved in the identification, treatment and prosecution of child abuse cases, such as juvenile court, law enforcement agencies, child abuse evaluation and treatment centers (including children's advocacy centers), CPS, district attorneys, sexual assault centers, judges and other community hospitals.
20. Reaches out to key community stakeholders not regularly included in the multidisciplinary team and in doing so, positions the role and expertise of the children's hospital.

Partnering with children's advocacy centers

According to 2008 NACHRI survey data, 32 children's hospitals report housing a children's advocacy center (CAC) and 78 children's hospitals report providing medical services to one or more independent CACs (National Association of Children's Hospitals and Related Institutions, 2009). There are more than 750 CACs in the U.S. **Children's advocacy centers** are modeled on the simple but powerful concept of coordination between community agencies and professionals involved in the intervention system. A children's advocacy center is a child-focused, facility-based program in which representatives from many disciplines, including law enforcement, CPS, prosecution, mental health, medical and victim advocacy, and child advocacy, work together to conduct interviews and make team decisions about investigation, treatment, management and prosecution of child abuse cases. The combined professional wisdom and skill of the multidisciplinary team approach results in a more complete understanding of case issues and the most effective child- and family-focused system response possible. National Children's Alliance provides training, support, technical assistance and leadership on a national level to local children's advocacy centers. **For more information, visit www.nationalchildrensalliance.org.**

PORTLAND, OR - CARES Northwest is a community-based consortium for child maltreatment among four of the region's health systems: **The Children's Hospital at Legacy Emanuel, Doernbecher Children's Hospital at the Oregon Health Science University**, Kaiser Permanente and Providence Health & Services. The consortium includes two adult and two children's hospitals with a single centralized hospital-based children's advocacy center. Kevin Dowling, M.A., program manager at CARES, believes the collaborative arrangement works well for a number of reasons, including: 1) in the mid-1990s in Oregon, legislation was passed that provided funding for child abuse services; 2) there is greater efficiency in having child abuse experts all in one location; 3) cooperation makes more effective use of hospital resources and expertise; and 4) there is increased community commitment to provide services and respond to child abuse allegations regardless of families' ability to pay. According to Dowling, "child abuse providers from hospitals in the consortium work on-site and have the opportunity to be around other child abuse providers. They can then take this expertise back to their health systems." Dowling acknowledges that child abuse work often can be very isolating and centralizing care makes their program stronger and creates camaraderie among the providers who work there.

Jean Rystrom, regional practice director of pediatrics at Kaiser Permanente Northwest, describes the arrangement, "the governing board, which includes an administrator representative from each hospital/health system, benefits from the unique perspective and expertise of each individual and each organization. When we come to the Governing Board we collaborate on the child abuse program, period. That means putting aside the fact that our organizations have multifaceted relationships with each other, including competition. I have found the CARES Northwest collaboration to be immensely rewarding, and have used the CARES Northwest model to foster cross-organization collaboration in completely different areas of work." **For more information, contact Kevin Dowling, M.A., at kdowling@lhs.org.**

TULSA, OK - Collaboration is the key to the success of the child abuse program at **The Children's Hospital at St. Francis**. The child protection team from the child advocacy center is based outside the hospital walls but its members work as consultants and experts on identifying and treating child abuse victims. The team is made up of faculty members from the University of Oklahoma School of Community Medicine's department of pediatrics. These faculty are consulted on a case-by-case basis for expertise in child abuse diagnosis and treatment. According to Robert Block, M.D., FAAP, "one advantage of not relating only to the hospital is that the child advocacy center staff is available to provide consultations with other community hospitals in the Tulsa area." The team at the child advocacy center includes a not-for-profit community agency "core" and social workers, child protection professionals, a law enforcement team and district attorneys, in addition to the medical team. According to Block, the collaborative approach with the staff doctors at the children's hospital along with the advocacy center creates an environment where "there is no need to duplicate in the hospital what is accomplished via collaboration with the team from the center." ***For more information, contact Robert Block, M.D., FAAP, at robert-block@ouhsc.edu.***

OMAHA, NE - For the last 22 years, the children's advocacy team meeting at **Children's Hospital & Medical Center** has included representatives from social work, nursing, child life, pastoral care, and behavioral health and is led by a dedicated medical director. Frequently, child protective service workers and law enforcement officers attend when they have active cases in the medical center. The multidisciplinary group enables a comprehensive assessment of child abuse cases, focusing on the medical condition of the child and safety issues for the family. Mary Bennett-Schulte, LCSW, manager of social work and interpreting services, says the main intent of bringing the team together is to create a good summary of cases that are brought forward for discussion. According to Bennett-Schulte, "the team members come to represent their disciplines and areas of expertise. It creates a sense of closure when everyone gets to hear the immediate next steps for a particular case." Participation of the different agencies and disciplines is central to creating a good summary of these cases. Bennett-Schulte admits that this approach works well in a smaller children's hospital such as Children's of Omaha. "When we had a case where a surgeon was key to the treatment, he came to the meeting to enhance the summary," she says. "It benefits everyone to hear and contribute to the conversation." ***For more information, contact Mary Bennett-Schulte, LCSW, at mbennett@childrensomaha.org.***

CHAPTER 9: EDUCATION

Children's hospitals continue to set the standard for the specialized training of medical professionals and others who work in the complex field of child maltreatment.

In October 2009, the first 191 pediatricians were certified in child abuse pediatrics, the twentieth and most recent subspecialty of the American Board of Pediatrics (ABP). For context, numbers of ABP subspecialty diplomates range from 5,142 neonatologists/perinatologists (established in 1975) to 40 medical toxicologists (established in 1994) (American Board of Pediatrics, 2011). The size of this first group of certified child abuse pediatricians is in keeping with the first cohorts of other subspecialties. This newly certified cohort has undergone specialized training or has extensive experience in the field of child abuse beyond training as pediatricians. After Jan. 1, 2013, one must successfully complete an accredited three-year fellowship to be eligible for board certification. NACHRI approximates that more than 60 percent of child abuse pediatricians are affiliated with children's hospitals.

In 2009, an estimated 3.3 million referrals, involving the alleged maltreatment of approximately 6.0 million children, were received by CPS agencies (DHHS, 2010). While not all of these children require expert medical services, a sizeable number of these reports require thorough assessment by a child abuse pediatrician before cases can either be indicated for or substantiated as maltreatment. Clearly the need from the medical community for this expertise is overwhelming the resources currently in place (Giardino, Hanson, Hill, & Leventhal, 2011). As of summer 2011, 12 fellowships had been accredited and several others are in various stages of planning and operation. The hospitals that are home to these fellowships are to be commended for their vision as they expand the workforce of child abuse pediatricians to meet the demands for clinical service, teaching and research.

While it is indisputable that more child abuse pediatricians are needed, part of the role of these specialists is to support *all physicians* in their decision-making in the diagnosis and management of child abuse. Hospital investment in fellowship programs to educate more child abuse pediatricians will also expand child maltreatment education to greater numbers of other clinicians and professionals in the hospital and community, in turn reaching greater numbers of children who need them. In 2009, almost 60 percent of reports of alleged maltreatment were made by professionals like social workers, teachers, physicians and other health care workers, mental health professionals, childcare providers, medical examiners, and law enforcement officers (DHHS, 2010), all of whom may benefit from the training from a children's hospital-based child protection team.

At the **basic** level, child protection staff members:

1. Train hospital staff so that the child protection staff will be consulted by other hospital professionals efficiently and effectively, including core training in child abuse recognition and referral protocol. This is the fundamental education and training component of a basic response.

2. May also provide education for medical students and residents, but at this level may be more in the “classroom” rather than through hands-on experiences.
3. Are ideally allotted protected time to permit staff to develop effective curricula for these groups.
4. Participate in continuing medical education activities so that the recognition and diagnosis of child abuse will be based on the best available medical evidence, best practices and expert opinion available in the community. These activities are supported by the hospital.

In addition to meeting all recommendations for the basic level, at the **advanced** level, the child protection team:

5. Becomes a coordinator, if not the leader, of child maltreatment educational efforts that reach out into the broader community, including pediatricians, CPS, law enforcement and other community stakeholders.
6. Provides more extensive and diverse hospital-based education, such as elective rotations with the child protection team, to residents, students and other trainees. Pediatric residents, in particular, have increased opportunities for training in child maltreatment issues.
7. May build and maintain an accredited fellowship.

In addition to meeting all recommendations for the basic and advanced levels, a **center of excellence**:

8. Strives to have all the components necessary to establish an accredited fellowship. It should be noted that for some centers of excellence an accredited fellowship is not possible (e.g. lack of medical school affiliation).
 - The support of a fellowship reflects the center’s dedication to the contemporary needs of children such as safety and well-being, which should be one of the primary objectives of any center of excellence.
 - The development and sustainability of fellowships represents a public health investment by the hospital. The next generation of child abuse pediatricians will provide services in the prevention and treatment of child abuse and advocate for the safety and support of children and families.
9. Gives students, residents, and fellows (when applicable) the opportunity to participate in research and pursue research funding.
10. Trains students, residents, other health and allied professionals in advanced multidisciplinary topics related to child maltreatment. For example, studies at centers of excellence may include in-depth instruction and experience in the interpretation of advanced neuroimaging studies.
11. Provides regional and even national training opportunities and peer review via distance education technology.

Accreditation Requirements and Benefits

The accreditation of fellowships by the Accreditation Council for Graduate Medical Education in child abuse pediatrics will require a substantial commitment of time and resources, most notably:

- Accredited fellowships are required to have two board-certified child abuse pediatricians staffing the training program.
- Fellows are required to complete a scholarly project within a three-year program.

Despite the required investment, hospitals can anticipate these benefits to come from establishing an accredited fellowship:

- Creation of the next generation of child abuse pediatricians and faculty armed with the additional training and distinct certification that will ensure children suspected of having been victims of abuse and/or neglect receive expert care.
- Development of a workforce of certified child abuse pediatricians to serve as subspecialists in children's hospitals (and comparable academic medical centers) and mitigation of the impact of an aging workforce in addressing a perennial public health care need.
- Engagement of young physicians in research that expands the scientific understanding of child abuse treatment and prevention.
- Migration of clinical expertise, training, and research into regional centers of excellence that will be a hub for referral and drive excellence in care.
- Evolution of a next generation of practice models that with greater visibility and recognition generate enhanced financial and administrative support and are better equipped to meet fiscal and economic challenges that compromise sustainability.

PROVIDENCE, RI - **Hasbro Children's Hospital** has had a fellowship training program in child abuse pediatrics since 1996. At that time, state agencies working with children identified a lack of expertise in child abuse in the state, leading to the recruitment of nationally recognized child abuse expert Carole Jenny, M.D., M.B.A., FAAP, who then developed the Child Protection Program at Hasbro Children's Hospital. Since its inception, the program has graduated 18 fellows, and currently has three fellows in training. The fellowship program received ACGME accreditation in 2011, one of 12 programs currently accredited in the U.S. Christine Barron, M.D., FAAP, a former fellow of the program and now the fellowship director, says the new fellowship program requirements will be beneficial to the field of child abuse pediatrics. "All programs will have a backbone and framework for training experts in the field." Funding is always a challenge for fellowship programs. Hasbro has dedicated funding for its three fellows (each completing three years of training). Outside funding for the fellows' required research projects is difficult to procure, so most fellows complete unfunded research projects. Despite the challenges, Barron believes the research is an extremely important part of the fellowship training. "Information from the fellows' research projects helps the field to move forward," she says. **For more information, contact Christine Barron, M.D., FAAP, at cbarron1@lifespan.org.**

SYRACUSE, NY - Since 1997 the primary goal of the Child Abuse Medical Provider (CHAMP) program has been to strengthen and standardize prevention and treatment efforts by educating medical providers who are physicians, physician's assistants and nurse practitioners. Before then, children traveled more than 200 miles to the hospital for evaluations for child sexual abuse. According to Ann Botash, M.D., FAAP, professor of pediatrics and vice chair for educational affairs at **Upstate Golisano Children's Hospital** and founder of the program, "the focus of the program is on education — basic knowledge of child abuse — to make sure children are evaluated, treated and referred appropriately." Currently 67 medical professionals practicing throughout 33 counties have become CHAMP providers by successfully completing the self-study course and a face to face skills observership. The champprogram.com website hosts continuing learning resources including suspected child abuse practice recommendations, "what to do" checklists, coursework, case reviews and webcast events. CHAMP offers eight CME-granting webcasts and educational case reviews a year. These programs are free of charge to participants. Weekly conference calls and case reviews with the mentors keep the educational programs strong. **For more information, contact Ann Botash, M.D., FAAP, at botasha@upstate.edu.**

INDIANAPOLIS, IN - Two pediatric hospitalists who were interested in developing a basic child abuse program at Peyton Manning Children's Hospital St. Vincent Health approached **Riley Hospital for Children at Indiana University Health** for training. The staff at Riley agreed to train and consult with them during the year of the program. Each hospitalist spent two months in clinical rotations and participated in weekly sexual and physical abuse case reviews. The hospitalists still maintain an ongoing relationship with the child abuse pediatricians at Riley for consultations. According to Roberta Hibbard, M.D., FAAP, professor of pediatrics and director of child protection programs at Riley, "although it was not a fellowship, it was a really intense and practical learning experience that gave the hospitalists the skills to develop a basic child abuse program in their own institution." Says Hibbard, "We have a strong presence as consultants for child protection services across the state. It is extremely helpful when St. Vincent can manage well the child abuse issues that present to its facility. Our ongoing collaboration serves children, families and the community well." **For more information, contact Roberta A. Hibbard, M.D., FAAP, at rhibbar@iupui.edu.**

NORFOLK, VA - The child abuse program at **Children's Hospital of The King's Daughters** has a unique dual fellowship to facilitate specialized training in child maltreatment. In addition to the child abuse pediatrics medical fellowship, a mental health fellowship provides post-graduate training in the field and enables cross-training among fellows. This focus on evaluation, diagnosis, intervention, and research produces professionals who are knowledgeable in evidence-based practices and can provide expertise to the community as well as the legal system. For the hospital's children, this means improved access to both medical and mental health experts in the evaluation and treatment of child abuse and neglect. **For more information, contact Suzanne Starling, M.D., FAAP, at suzanne.starling@chkd.org.**

CHAPTER 10: RESEARCH

Physicians and other medical professionals in the field are looking to children's hospitals to expand research into the diagnosis, treatment and prevention of child maltreatment.

This calls for a strong commitment from children's hospitals to medically oriented, rigorous, epidemiologically strong research — advanced diagnostic tools, trends, evaluation and more — into the various factors surrounding child abuse and neglect and its prevention. Now that child abuse pediatrics is a subspecialty, research is a required component of accredited fellowships (*see Chapter 9: Education*), thereby increasing child abuse research capacity. Here, children's hospitals have a dual role: to advance their own research, and to teach future physicians and pediatric subspecialists the skills necessary to conduct research as they progress in their careers.

One component of research, data collection, gives hospitals the foundation on which to conduct quality assurance and quality improvement activities. Examination of current performance and identification of gaps in services are expectations for hospital leaders, departments and units, and are applicable to all hospital services, including child protection teams. Child protection at all levels should address some feature of quality⁴ as part of their function, utilizing institutional quality programs and tools for measuring and improving processes and work flow with goals of better service and patient care. Quality of evaluations, referrals, teamwork, outcomes and other aspects of child abuse work can be measured if the right data are collected. Both quantitative and qualitative outcomes of service and patient care are key to demonstrate the value and relevance of child protection and maintain funding, especially in smaller institutions.

It may be difficult at the **basic** level to establish a research agenda as staff priorities are focused on the diagnosis and treatment of suspected child maltreatment. However, at the **basic** level, relatively simple initiatives can be undertaken that can build a foundation for future research and evaluation and can facilitate the research of larger child protection teams at other institutions.

At the **basic** level, the child protection staff members:

1. Have a working knowledge of the relevant research and literature on child abuse and prevention, both classic literature and new findings.
2. Have the capacity to collect data for cases on which they consult. This is a requirement of state child abuse reporting laws and should be a part of general policies, but the design of any data collection system can be maximized for research purposes.
3. Participate in hospital cross-departmental and/or multicenter studies headed by other institutions by contributing data.

⁴ One resource is IOM Crossing the Quality Chasm, which includes 6 domains of quality care: Safe, Effective, Patient-Centered, Timely, Efficient, and Equitable. Committee on Quality Health Care in America, Institute of Medicine. (2001). Crossing the quality chasm : a new health system for the 21st century. Available from www.nap.edu

In addition to meeting all recommendations for the basic level, at the **advanced** level, the child protection team:

4. Medical director or other appropriate medical staff keeps team members regularly updated on new developments in the child maltreatment literature.
5. Initiates smaller research studies such as single-center studies, case studies and pilot studies, in addition to participating in and contributing data to the research of larger institutions. In doing so, a research infrastructure is established that will enhance the child protection team's future research capacity.
6. Seeks out research funding recognizing that much of child abuse research is unfunded. The team is challenged to think creatively about strategies for adapting existing infrastructure for research.
7. Supports, as appropriate, the research requirement of an accredited fellowship.

A **center of excellence** is distinguished, in part, by the multidisciplinary research components and by the leadership role it takes in advancing research on child abuse and neglect. In addition to meeting all recommendations for the basic and advanced levels, a **center of excellence**:

8. Informs the Institutional Review Board on issues unique to studying child maltreatment and champions the necessity and approvability of child maltreatment research.
9. Allots protected time to center staff members to participate in research.
10. Initiates major research initiatives, including multicenter studies, and engages other centers in research.
11. Trains medical students, residents and fellows (each to the degree appropriate to their level of education) in research.
12. Serves as a local and regional resource on the evolving body of research on child maltreatment.
13. May engage in collaborative quality improvement efforts such as telemedicine, case and peer review, and shared data system collaboratives to test quality improvement changes.

SAN DIEGO, CA - The California Department of Social Services chose the Chadwick Center for Children and Families at **Rady Children's Hospital - San Diego** in conjunction with the Child and Adolescent Services Research Center to develop the California Evidence-Based Clearinghouse for Child Welfare (CEBC). The CEBC's mission is to provide information on evidence-based practices to child welfare and related professionals including statewide agencies, counties, public and private organizations, and individuals. The goal of the clearinghouse is to identify best practices in serving abused and neglected children and their families. The CEBC provides information in an online format for easy access to research evidence chosen by a scientific panel comprised of internationally known experts in the field. The project is funded by the California Department of Social Services, Office of Child Abuse Prevention. **For more information, contact Charles Wilson, M.S.S.W., senior director, Rady Children's Chadwick Center for Children and Families, at cwilson@rchsd.org or visit www.cebc4cw.org.**

BALTIMORE, MD - A Safe Environment for Every Kid (SEEK) is a model for identifying and addressing common psychosocial problems in families, such as a mother's depression, that may lead to child maltreatment. SEEK was developed for pediatric primary care, focusing on children ages 0 to 5. Developed by Howard Dubowitz, M.D., M.S., FAAP, professor of pediatrics and head of the division of child protection at **University of Maryland Hospital for Children**, SEEK includes: training for health professionals, a parent screening questionnaire, collaboration with social workers, and parent handouts on targeted risk factors that jeopardize children's health, development and safety. Says Dubowitz, "the program offers something valuable in pediatric care — a systematic social history. Knowing something about the family of a child in pediatric practice is often missing." SEEK was funded by the U.S. Department of Health and Human Services Administration on Children and Families, the Centers for Disease Control and Prevention and the Doris Duke Charitable Foundation. Two randomized controlled trials have been conducted: the first in pediatric resident continuity clinics serving a very low income urban population and the second in 18 suburban private pediatric practices with more than 100 pediatricians and pediatric nurse practitioners and a mostly low risk population. The results have been encouraging, showing reductions in child maltreatment and harsh parenting. Dubowitz acknowledges that the whole process of change is a big challenge and that some pediatricians are not comfortable asking questions about domestic violence and drug use. But, "family well-being helps the child's well-being," says Dubowitz **For more information, contact Howard Dubowitz, M.D., M.S., FAAP, at hdubowitz@peds.umaryland.edu.** (see Chapter 7: Prevention for additional examples of children's hospitals prevention efforts).

ALEXANDRIA, VA - The VPS system is a clinical database dedicated to standardized data sharing and benchmarking among pediatric ICUs. VPS^{4c} represents a partnership between NACHRI, **Children's Hospital Los Angeles**, and the National Outcomes Center, **Children's Hospital and Health System**, Milwaukee, WI. A research group at **Kosair Children's Hospital** studied data from 95 patients to identify discriminating bruising characteristics for abusive versus accidental trauma. Characteristics predictive of abuse were bruising on the torso, ear, or neck for a child 4 years of age or younger and bruising in any region for an infant under 4 months of age. The group used the findings to develop a decision tool for screening children at high risk for abuse. The study, *Bruising Characteristics Discriminating Physical Child Abuse From Accidental Trauma*, was published in *Pediatrics* Vol. 125 No. 1 Jan. 1, 2010, and can be accessed for free at pediatrics.aappublications.org. **For more information about the VPS system, visit portal.myvps.org.**

NEW YORK, NY - Vincent J. Palusci, M.D. M.S., FAAP, chair of the Child Protection Committee at **New York University Langone Medical Center**, is leading a project to decrease the number of reports not accepted by New York's State Central Registry. Although reports of suspected child maltreatment are legally mandated, they can negatively affect the family when not accepted by the State Central Registry. Committee members from medicine, nursing, social work, and administration closely review all unaccepted reports to understand the case characteristics and systems issues involved and report their findings to the Pediatric Services Committee and Medical Board. Palusci says that they have already discovered several steps that staff members can take when a report is not accepted, and he believes that through staff training these issues can be resolved and the number of unaccepted reports decreased or eliminated. "While not research in the traditional sense, a quality assurance project concerning child abuse reports at a large medical center is teaching us a lot about how these issues are best handled at the medical center and what we can do in our interactions with community agencies to protect children and fulfill our legal mandate while respecting families and promoting their best hospital experience." **For more information, contact Vincent J. Palusci, M.D., M.S., FAAP, at vincent.palusci@nyumc.org.**

FARMINGTON, UT - Period of PURPLE Crying[®], created by Ronald Barr, M.D.C.M., and developed by the National Center on Shaken Baby Syndrome (NCSBS), is based on research showing that crying is the most common stimulus for shaken baby syndrome. PURPLE is an acronym for: peak of crying, unexpected crying, resists soothing, pain-like face, long lasting, and evening crying. From 2003 – 2007 parallel studies were conducted on the PURPLE program through randomized controlled trials in Seattle, Washington and Vancouver, B.C., Canada. The research, published in *Pediatrics* and in *Canadian Medical Association Journal* in 2009, found that the intervention materials were effective in changing both knowledge and behavioral characteristics that are likely to be important in reducing shaken baby syndrome. The program is currently being tested through a partnership with the University of North Carolina Injury Prevention Research Center, made possible through funding provided by the Centers for Disease Control and Prevention, the Doris Duke Charitable Foundation and the Duke Endowment, to determine if it can reduce shaking. The program is being provided to an estimated 95 percent of the parents of approximately 130,000 infants born in the state each year and the goal is to reduce the incidence by 50 percent. The program is also currently being evaluated in British Columbia where it has been implemented province-wide since January 2009. The BC Ministry of Child and Family Development and a variety of provincial agencies are supporting this implementation and evaluation through active and passive surveillance of infant abuse, parent and nurse quality improvement surveys as well as public health nurse surveillance for the delivery of program materials. Across North America, the PURPLE program has been implemented in more than 900 hospitals (including 29 children's hospitals) and organizations in 49 states, eight Canadian provinces and one territory. "Parents and caregivers continue to send messages expressing their appreciation for information that helps them cope with this normal crying phase and also that it is easy to share with others caring for their babies," says Julie Price, director, international prevention program, Period of PURPLE Crying, for the NCSBS. **For more information, contact Julie Price at jprice@dontshake.org or visit www.dontshake.org and www.purplecrying.info.** (see Chapter 7: Prevention for additional examples of children's hospitals prevention efforts)

Section 3 Administrative Investment



CHAPTER 11: FUNDING AND REIMBURSEMENT

Two unique aspects of child abuse medicine contribute greatly to the economic burden of a hospital housing a child protection team: poor reimbursement and the amount of time involved to ensure the health and safety needs of every child are met.

A child suspected of being maltreated, like any child who is injured or sick, needs and deserves a comprehensive medical response. But unlike a child who sustains an unintentional injury, when abuse is suspected, there are other services beyond evaluation and treatment that must be provided as part of a thorough medical response, such as forensic interviews, psychosocial assessments, mental health services and court testimony. These services are generally poorly reimbursed, if at all. Suspected child abuse patients also take more time for case review, work up, and consultation with other child protection team members, other medical specialists in the hospital, and community partners like CPS and law enforcement.

“My fellows and I did a time study and we found that to do a sexual abuse case: to see the patient, talk to the family, talk to the social worker, do the colposcopy, dictate the chart, and contact the outside agencies, was about 4 to 5 hours of work, for one patient, and if you're getting paid \$60 for that, that is not going to be very good. Even \$200 is not very good. For a complex physical abuse case, the average was more like 17, 18, or even 20 hours of actual physician time that it takes to coordinate the care, interpret all the medical results for the outside system to make sure the child is safe, and to make sure the appropriate work up is done.”

Carole Jenny, M.D., M.B.A., FAAP
Director, Child Protection
Hasbro Children's Hospital, Providence, RI

Because of low levels of reimbursement, children's hospitals are typically forced to heavily subsidize child protection teams. NACHRI survey data show that the expense of underwriting child protection teams has grown 59 percent to \$322,000 since 2005, perhaps in part from enhanced services and better recognition and consistent with an increase in both caseload and staffing. On average, the operating budgets for these teams was \$1.15 million in 2008. While the majority of teams collect at least some revenue, in most cases, it is not enough to offset a shortfall (NACHRI, 2009).

Like all children's hospitals, child protection teams rely heavily on reimbursement from Medicaid, the joint federal-state program that is the single largest health insurer for children in the United States. On average, Medicaid pays for 50 percent of the care provided at children's hospitals and child protection teams are no different. Respondents to the 2008 child abuse services survey report Medicaid as the top source of revenue for the child protection team. Teams face the same issues when it comes to being reimbursed by Medicaid as other clinical services in the hospital: reimbursement rates are substantially below costs. Additional strain is placed on the team when Medicaid does not reimburse at all some services integral to caring for a child who is a suspected victim of abuse, such as forensic interview and psychosocial assessment. Trends from the NACHRI data show a drop in teams reporting Medicaid as a revenue source. At the same time, the data show an increased reliance on supplemental hospital foundation support, which is not sustainable.

Despite the financial strain of supporting a revenue losing unit, children’s hospitals prioritize proper identification and treatment of abuse, knowing it will make an enormous difference in the life course of children and their families. While the most recent federal data show maltreatment declining nationally, many question whether this is a complete assessment of the scope of the problem (GAO, 2011). Several years of economic decline have adversely impacted families (Sell, Zlotnik, Noonan, & Rubin, 2010) and poverty is known to be a major risk factor for maltreatment (DHHS, n.d.). Some experts in the field hypothesize that in light of the economy their communities are experiencing an increase of the most severe forms of child abuse such as abusive head trauma (Berger et al, 2011). Another study reports that increased unemployment is linked to a similar increase in child maltreatment approximately one year later (Sege, 2010). The continuing child health and public need for services addressing child maltreatment and prevention remains clear.

Hospital subsidies can be minimized if children’s hospitals take an aggressive, creative and multifaceted approach to funding. Approaches vary widely based on the attitudes of state legislatures and attorneys general, the size and scope of local foundations and other charitable funders, and other available resources. There is no “one size fits all” formula. Some children’s hospitals have successfully secured ongoing funding for their programs by relying on one or two major outside sources alone or in combination with hospital subsidies, while others piece together a patchwork quilt of support that includes a dozen or more sources.

Enhancing Financial Stability

Consider the following practical points that can help or hinder financial stability:

- Hospital administration and the child protection team should collaborate to build a program that both meets community need and is sustainable in the context of the hospital mission and service.
- Teams should be strategic about long-term viability and cognizant of the true costs associated with the program.
- Team leaders should recognize the relationship between advocacy and funding by building alliances with internal and external decision makers.
- The medical expertise children’s hospitals contribute is necessary for the larger community response system to work. Knowing this, consider potential cost-sharing relationships with agencies that have a stake in the treatment and prevention of child abuse and the prosecution of offenders.

To ensure that services can be offered and sustained, at the **basic** level, child protection staff members:

1. Establish an accurate coding system for child maltreatment services to ensure optimum reimbursement from third-party payers for the clinical functions performed in treating a child who is suspected of having been abused.
2. Assign a cost center(s) specific to the child maltreatment services to facilitate tracking expenses.
3. Assess the availability of common noninsurance revenue sources for basic child abuse medical services (e.g. Victims of Crime Act funds offset costs associated with medical exams, psychosocial assessments and a variety of mental health services (although these funds might not be available in all cases, for example intrafamilial abuse)).
4. Partner with other organizations or hospitals to seek grants and other funding that may be more accessible to cooperative groups than a single organization.

In addition to meeting all recommendations for the basic level, at the **advanced** level, child protection teams may develop additional sources of revenue that include:

5. Contractual relationships with law enforcement, CPS, state attorneys general and other referral agencies. An advanced team functioning on a statewide or regional basis likely has dozens of contracts with law enforcement and referral agencies in each of the jurisdictions the hospital serves.
6. One or more grants of varying sizes from local, state and/or national organizations focused on multiple aspects of child abuse and neglect.
7. Targeted funding aimed at specific aspects of child health and safety. For example, domestic violence programs are a growing part of many evolving child protection teams at children's hospitals. Teams with such specialized services often seek out focused state or foundation funding.
8. Graduate medical education funding when the hospital is home to an accredited child abuse pediatrics fellowship.

In addition to meeting all recommendations for the basic and advanced levels, a **center of excellence** boasts a diversified funding and reimbursement base. Additional sources may include:

9. Multiple research grants that support particular research projects and the time of some of the center's medical staff.
10. State funding from criminal proceeding fees, or, in the most sophisticated scenario, a stable appropriation or budget line item from the state.

NEW JERSEY - "The key to growth is providing a product that the state finds valuable," explains Martin A. Finkel, D.O., FAAP, director of the Child Abuse Research, Education & Service (CARES) Institute and professor of pediatrics at the University of Medicine and Dentistry of New Jersey-School of Osteopathic Medicine, in speaking about New Jersey's Regional Diagnostic and Treatment Centers (RDTC). RDTCs are the statewide networks that offer a multidisciplinary approach to the investigation, evaluation and treatment of suspected child abuse. Finkel spearheaded the passage of the legislative initiative in 1998. The legislation created a sense of permanency for the child abuse centers and elevated the importance of this resource as an asset to the state's child protection services. Although there has been no further appropriation, the centers have become more integrated into the fabric of how child protective services do business. According to Finkel, "the RDTCs have developed stronger contractual relationships since the funding is no longer reliant on a line-item appropriation." This arrangement also allows the RDTCs to be at the table with local, regional and state leaders in the child protection services. Finkel believes that program leaders need to enhance their connectedness by reaching out to important decision makers in their communities and states and make themselves known. "No one knows the value of what they are doing better than the people who are doing it," says Finkel. **For more information, contact Martin A. Finkel, D.O., FAAP, at finkelma@umdnj.edu.**

MADERA, CA - In 2009, C. Leanne Kozub, RN, child advocacy nurse coordinator at **Children's Hospital, Central California** drafted a strategic plan at the request of the chief executive officer to present to the hospital board and the Guilds of Children's Hospital showing several cases of child abuse that might have been prevented if they had funding for prevention programs and increased staffing. The presentation convinced the guild to fund the program through a \$5 million endowment for five years. Funds will provide permanent support for the newly renamed The Guilds Child Abuse Prevention and Treatment Center. Kozub also was able to quantify how much it cost the hospital by not initially recognizing and treating abuse: \$1 million per year for follow-up for one case of shaken baby syndrome. **For more information, contact C. Leanne Kozub, RN, at ckozub@childrenscentralcal.org.**

BRONX, NY - "Funding a child advocacy center is a constant challenge and search for opportunities," says Karel Amaranth, M.P.H., M.A., executive director of The J.E. & Z.B. Butler Child Advocacy Center at the **Children's Hospital at Montefiore**. One way she has created opportunity is through cultivated partnership building with foundations, government grants, donors, board members and the center's famous neighbors, the New York Yankees. Amaranth believes that "reporting and sharing our success as well as our challenges serving children" has strengthened their support. The creative fundraising strategies for the center include the support of Christopher Meloni of the TV program, "Law and Order Special Victims Unit" and his wife, Sherman; and a board member-sponsored annual dinner party, "The Beefsteak." In addition, the New York Yankees have provided grants, a video center for the waiting room, and have hosted a game each year with donated stadium tickets and suites. **For more information, contact Karel Amaranth, M.P.H., M.A., at kamarant@montefiore.org.**

ST. PAUL, MN - Roughly half the expenses at the children's advocacy center (CAC) at the **Children's Hospitals and Clinics of Minnesota** are supported by the generous donations of several loyal private foundations. Carolyn Levitt, M.D., FAAP, medical director, advises "it is really important to have a relationship with your children's hospital foundation." The Children's Hospital Association (CHA), a private group of volunteers that fundraises to support the hospital and community, has featured the CAC at an annual fundraising ball with an auction of donated items from local businesses. Many members of the CHA Board of Directors have become very dedicated to the CAC's work and provide strong and consistent financial and emotional support. They also are influential in the community and contribute fundraising ideas. Levitt is "buoyed by the support of the CHA board members" and the sustainability that they provide. CHA and the Fred C. and Katherine B. Anderson Foundation, as well as other foundations that annually support the CAC, have donated more than \$4 million to the program since it was founded in 1986. ***For more information, contact Carolyn Levitt, M.D., FAAP, at carolyn.levitt@childrensmn.org.***

CHAPTER 12: RISK MANAGEMENT

A strong and effective child protection team helps shield a children’s hospital from liability that can arise from the failure to identify and/or report a case of child abuse or neglect.

Such errors, which occur when staff have little expertise or training in the issue, can lead to legal problems for a hospital and cause serious damage to its public image.

“I do think that failure to diagnose child abuse often arises when the signs are more subtle. Educating physicians about these signs is an important risk management tool, and I have found our child protection team to be invaluable in this aspect.”

Joan Flynn
Vice President, Risk Management, Lifespan
Providence, RI

Conversely, developing expertise in the medical aspects of the investigation of child abuse cases can place a hospital in the middle of complex and volatile legal situations. These situations can expose the hospital to added risk. The hospital and child protection team should be aware of this possibility, and should use the team’s policies and educational components to ensure all staff involved in child protection activities have clear and consistent guidelines to follow in all aspects of their duties.

At the **basic** level, child protection staff members:

1. Use the expertise of their medical director to guide and set standards for the hospital’s participation in its state’s mandatory child abuse reporting program. The availability of the medical director’s expertise will free other physicians with less training in the subject from the responsibility of making medical judgments that will later be used in child abuse investigations.
2. Develop an organized plan for demonstrating compliance with The Joint Commission standards requiring that hospitals have criteria for identifying abuse and that staff be educated in abuse issues.
3. Implement some component of educating the hospital’s emergency medicine physicians in detecting the more subtle signs of abuse. Risk management should be proactive in trying to prevent future abuse. Claims may arise when there are repeat visits to the hospital, and the first visit, in retrospect, shows that there were subtle signs of abuse.
4. Educate the hospital’s legal counsel on child protection services and policies, and seek legal input on a general basis and in the event a problem arises.
5. Have timely availability of competent legal advice (in-hospital or external) unrestricted by financial or access barriers.

In addition to meeting all recommendations for the basic level, an **advanced** child protection team:

6. Develops a specific plan for addressing instances in which accusations of abuse or inappropriate behavior are leveled at staff. Recognizes potential perception of conflict of interest and considers an affiliate agreement with another expert agency to conduct a non-biased investigation.
7. Trains hospital physicians and other community professionals not part of the child protection team, but who may encounter child abuse cases, on how to identify and/or report suspected cases of child abuse, particularly the more subtle signs of abuse.

In addition to meeting all recommendations for the basic and advanced levels, a **center of excellence**:

8. Provides substantial physician coverage that offers expert assessment as needed. With a child abuse medical expert available to be paged 24/7, errors in evaluating a case of suspected child abuse can be prevented.
9. Uses educational seminars, rounds and case presentations to periodically cover hypothetical or actual cases in which the hospital may be exposed to risk or controversy during the handling of a case of suspected child maltreatment, and provides training in appropriate ways of managing these situations.

SAN DIEGO, CA - While little data exists documenting the frequency of child abuse occurring within hospital settings, what is commonly understood is that any child-serving agency – including a children’s hospital – is at increased risk of attracting pedophiles. The extent of risk came to bear in spring 2006 at **Rady Children’s Hospital – San Diego** when “lightening struck twice” as characterized by the hospital’s then chief executive officer, Blair Sadler. In the span of one month, two hospital employees were under separate investigation, and later convicted, of child pornography and child molestation of multiple hospital patients. One, a respiratory therapist, and the other, a registered nurse, worked at the convalescent and main hospitals, respectively.

The dual crisis cast the hospital’s vulnerability under intense scrutiny and drove the creation of heightened vigilance to a series of protective practices and policies to safeguard patients and deploy crisis management response. Practice changes included restrictions on doctors, employees and volunteers from being alone with a child in a private area without a “second set of eyes” from a family member or staff, limits on cell phone use, higher visibility curtains, restrictions on patient photography, real-time audits of all hospital computers and ongoing safety rounds, among others. Policy and security changes included enhanced ongoing background checks for employees, greater scrutiny of non-professional aspects of all employment applicants, internet access restrictions, expanded video surveillance and a building a culture of awareness and vigilance. **For more information, contact Charles Wilson, M.S.S.W., senior director, Rady Children’s Chadwick Center for Children & Families, at cwilson@rchsd.org.**

HOUSTON, TX - Michelle A. Lyn, M.D., FAAP, director of child protection, section of emergency medicine, **Texas Children's Hospital**, and a multidisciplinary team of specialists at the hospital created a program in 2009 to educate medical professionals in identifying caregiver abuse within the hospital setting. Inspired by the presentation "When Lightning Strikes Twice" by Blair Sadler of **Rady Children's Hospital – San Diego**, the program at Texas Children's aims to raise awareness of the possibilities of inappropriate behavior by caregivers and ensure a safe environment for patients. A grant allowed Lyn and an administrative task force to review all aspects of the problem and to create a DVD to present to physicians, first and second year residents, and nurses. The DVD shows three scenarios that explore the "gray areas" where behavior would spark discussion among employees. Lyn says, "we wanted to look at boundaries more than anything else. When does behavior cross the established boundaries?" Lyn admits that it is often difficult to strike a balance between raising awareness and vigilantism, the other extreme. "The fact is pedophiles can be anywhere," says Lyn. Feedback from the program has been extremely positive. There are plans to create a second DVD with scenarios taking place in an outpatient clinical setting. **For more information, contact Michelle A. Lyn, M.D., FAAP, at malyn@texaschildrens.org.**

DETROIT, MI - The fast-changing environment of new media demands an evolving set of hospital policies and practices to protect the privacy and safety of patients and visiting minors. The **Children's Hospital of Michigan** – Detroit Medical Center utilizes social media outlets to target to parents only, not to share content with children. However, recognizing that children (particularly current and former patients, siblings and their friends) may still follow the hospital on social media sites, the hospital includes ground rules for appropriate behavior on the sites and reserves the right to remove any posts that do not follow these ground rules. The hospital has also recently developed a web-based forum for posting and responding to questions and information on various pediatric topics. Currently in the early stages of development, the hospital marketing team is exploring how to engage patients in online support groups that can use the forum to engage with both clinical experts and each other. The hospital will have the option to password protect the support group forums for specific patient groups and would require parents to sign a release/consent form for their children to participate. The groups would be monitored by a staff person to ensure appropriate posting guidelines are followed. Clinical staff will be trained to facilitate forum discussions so that they do not compromise the privacy or safety of the youth participants. Currently, hospital communications staff members monitor daily all postings on the forum and in social media channels to ensure appropriateness of content and respond to posts that require follow-up or acknowledgement. The health care system's IT staff monitors the firewall. A universal employee social media policy addresses patient privacy and safety but as Lori Mouton, vice president of marketing, communications and community relations warns, "hospitals should prepare for the burden of enforcement of their social media policies". **For more information, contact Lori Mouton, M.S., at lmouton@dmc.org.**

Special Section Community Benefit





Children’s hospitals grew out of community need and share a common mission to serve all children by promoting health and wellness and by ensuring every child receives the health care necessary to reach his or her full potential, regardless of ability to pay.

This common mission to serve all children drives a children’s hospital to perform multiple roles as: a community hospital providing preventive and primary care; a safety net hospital for uninsured and underinsured children; and a teaching and research hospital providing complex and specialized care while advancing medical knowledge.

Since 2008, a confluence of perennial state and federal budget deficits paired with heightened desire for transparency in tax-exempt organizations fueled public scrutiny of the community benefit provided by not-for-profit hospitals. Children’s hospitals are challenged on multiple fronts – by congressional and local leaders, tax authorities, courts and the media – to articulate their charitable purpose and prove their worthiness of tax-exempt status. Charged by the Senate Committee on Finance, the Internal Revenue Service issued new federal reporting requirements via the Form 990, Schedule H for Hospitals, that must be completed by tax-exempt hospitals to illustrate their community benefit and provide related data supporting tax-exempt status. In addition, the Affordable Care Act, passed in March of 2010, added new requirements for tax-exempt hospitals to assess health needs in their communities and to adopt implementation strategies for addressing those needs.

Community benefit helps hospitals fulfill their mission to serve their communities. It is part of the overall mission of providing quality service to children, expressed uniquely in the mission statements of each hospital. Through community benefit, there is now a regulatory framework for how hospitals engage in and account for these activities. **The children’s hospital role in child maltreatment response is important to its mission – it is also an important component of a hospital community benefit program.** In establishing a child maltreatment response and engaging in prevention and advocacy, the hospital (1) responds to an identified need, (2) performs an essential service, and (3) enhances the health of the community.

What is Community Benefit?

Community benefits are commonly defined as programs or activities that address a community health need and accomplish at least one of the following objectives:

- Provide treatment or promote health and healing as a response to identified community needs by improving access to health care services.
- Enhance the health of the community.
- Advance medical or health care knowledge that provides public benefit.
- Meet needs that would otherwise need to be addressed via government or other community efforts (The Catholic Health Association of the United States, 2008).

Planning for community benefit requires that the hospital or health system build a community benefit infrastructure that is mission and culturally aligned, and is sustainable. One part of that infrastructure building is to ensure adequate staffing and budget, and develop necessary policies. The child protection team can assist in laying such groundwork by articulating the connection between child abuse response and hospital mission; by serving on internal community benefit workgroups; and by promoting community partnerships commonly a part of the child abuse multidisciplinary team and critical to community benefit programs.

In addition to developing an infrastructure to support the community service of child protection, the child protection team can contribute to the hospital’s community benefit program by working with community partners to assess community need; helping to identify child protection as a priority for the hospital and the community; and planning, participating in and evaluating community-wide interventions to protect children.

At its most basic level, the child protection team can positively contribute to a hospital's community benefit program by accurately tracking the cost to care for children suspected of having been abused. Children's hospitals underwrote an average budget deficit of \$283,000 in 2008 for child protection teams (NACHRI, 2009), driven chiefly by subsidized services. The child protection team can also track monies invested in education, training, research, prevention and advocacy activities. The team administrator should be in regular contact with the community benefits program of the hospital or system to promote an accurate understanding of the scope of subsidized service and community benefit investment made by the hospital in child maltreatment response.

Understanding Community Needs

Whether the child maltreatment response is at the basic, advanced or center of excellence level, it must be founded on principles of community collaboration. **Before establishing or expanding a program, a children's hospital should conduct a comprehensive assessment of community health needs and available resources in order to recognize and be guided by the needs of the children it serves.**

Children's hospitals are home to medical experts in treating, evaluating and crafting medical opinion in cases of suspected child abuse, who work closely with an array of other professionals – law enforcement, CPS, mental health specialists, children's advocacy centers and domestic violence experts to name but a few. Children's hospitals that are nonacute care centers often work collaboratively with hospitals that provide emergency medical care. A needs assessment engaging these allies may determine what agencies and organizations are already responding to child abuse and neglect, and how a children's hospital and its role in providing medical expertise, can best integrate into or improve the existing network of response.

The principle of community collaboration that drives the multidisciplinary team is a hallmark of child protection. Collaboration as a core construct is in direct keeping with federal government's expectation that community health needs assessment and implementation strategies drive community benefit activities. In fact, collaboration is called out as a requirement for community health needs assessments in the Affordable Care Act, which requires tax-exempt hospitals to:

- Conduct a community health needs assessment at least every three years.
- Take into account input from persons who represent the broad interests of the community.
- Take into account input from persons with special knowledge of, or expertise in, public health. (In the case of child abuse these are members of the child protection community such as law enforcement and CPS.)
- Make the community health needs assessment widely available to the public.
- Adopt a written implementation strategy to address community needs.

Community health needs assessments rooted in a collection of public health data may not typically identify child abuse and neglect as a community need. The community benefit program and child protection team should work with community members and partners to identify data sources – perhaps atypical to many community health needs assessments – that commonly track trends in child abuse and neglect and other forms of family violence. Data sources could include CPS, foster care, child death review and the National Incidence Study of Child Abuse and Neglect.

Needs Assessment Requirements

The Catholic Health Association of the United States identifies key elements a hospital should consider while awaiting clear federal guidance as to what constitutes compliance with the provisions of the Affordable Care Act below.

Process

- ✓ When possible, conducts the assessment in collaboration with other hospitals and/or community partners.
- ✓ Forms assessment team/advisory committee that includes key staff within the organization and community representatives.
- ✓ Collects community input using one or more of the following methods: community forums, focus groups, interviews, and/or surveys.
- ✓ Seeks community input that reflects the racial, ethnic and economic diversity of the community.
- ✓ Analyzes data collected and reviewed using comparisons with other communities and with federal or state benchmarks and, when available, trends within the community.

Content

- ✓ Defines its community to include primary and secondary service areas and the types of patients the hospital serves (age, gender, conditions treated).
- ✓ Bases the assessment on review of public health data collected by government agencies and other authoritative sources.
- ✓ Includes the following types of information: demographics (age, income, race) health indicators (leading causes of death and hospitalization), health risk factors (tobacco use, obesity), access to health care (rates of uninsured, availability of primary care), and social determinants of health (education, environmental quality, housing).

Reporting

- ✓ Develops a summary of the child health needs assessment that includes:
 - ◆ Definition of the community
 - ◆ Description of how the assessment was conducted
 - ◆ Who the organization worked with (identified by community affiliation and public health expertise)
 - ◆ Health needs identified
 - ◆ Existing health care facilities and other resources within the community available to meet needs
 - ◆ Makes a summary of the assessment available on its website, upon request, and in other ways to ensure public availability

In addition to the community health needs assessment, the IRS instructions for Schedule H (Form 990) offer further guidance on how community need can be demonstrated:

- A request from a public agency or community group was the basis for initiating or continuing the activity or program.
- There was involvement of unrelated, collaborative tax-exempt or government agencies as partners in the activity or program.

As noted, typical community health needs assessments may not readily identify child abuse and neglect as a community need, therefore, these alternate means to substantiate community need are particularly helpful when addressing child abuse and neglect as a community benefit activity. The need is evidenced in the volume of referrals from public agencies, such as CPS, that request expert medical opinion and treatment from the hospital-based child protection team.

What Counts as Community Benefit?

Schedule H (Form 990) instructions describe specific categories of community benefit activities and further define community-building. The categories are:

- Charity care
- Medicaid
- Other means-tested government programs
- Health professions education activities/programs
- Subsidized health services
- Research programs
- Cash and in-kind contributions
- Community benefit operations
- Community building activities
- Community health improvement services (requires community needs assessment)

A Guide for Planning and Reporting Community Benefit, 2008 Edition, published by The Catholic Health Association of the United States (CHA), provides a nuanced understanding of IRS requirements; offers practical guidance; and integrates the collaborative thinking of the Veteran’s Hospital Administration, the American Medical Association and NACHRI, and the experience of individual hospitals and tax-exempt health care systems. The following is an adaptation of the table, “Determining What Counts as Community Benefit,” available for download at www.chausa.org/guideresources. Here, the examples of activities and programs that should and should not be counted as community benefit are specific to the child maltreatment response at a tax-exempt hospital.

ACTIVITY	REPORT	EXAMPLE RATIONALE
Community Health Improvement Services		
Health education regarding the dangers of shaking and abusive head trauma	Yes	Public health need
Marketing to drive referrals to the hospital’s child protection team from primary care practitioners	No	Marketing focus benefits the hospital more than community
Health Professions Education Activities/Programs		
Grand rounds in child abuse detection for community physicians	Yes	Accessible to all qualified physicians in the community
CME support for hospital staff preparing for certification in child abuse pediatrics	No	Restricted to hospital’s medical staff
Subsidized Health Services		
Child abuse program, including diagnostic and screening services, operated at a loss	Yes	Provides access for all patients in need including uninsured or low-income
Non-offender parent support group with low enrollment and retention	No	Not an established need and may reflect poor business decision
Research Programs		
Research on the effectiveness of home visiting as a child abuse prevention intervention	Yes	Public health need
Quality assurance study on adherence to recommended child abuse screening protocols, for use of the hospital alone	No	Finding used solely by the hospital
Cash and In-kind Contributions		
Donation of colposcope to community-based children’s advocacy center	Yes	Enhances access to care
Value of staff time volunteering during Child Abuse Awareness Month Walkathon	No	Benefit provided by the staff, not the hospital
Community Benefit Operations		
Fundraising for community-based family support programs for high risk mothers	Yes	Related to community need
Fundraising for NCA n.e.t. (a national continuing education and peer review program for multidisciplinary team professionals associated with children’s advocacy centers) or comparable technology/infrastructure need	No	Related to the operation of the child protection team and the hospital
Community Building Activities (Reported in Part II of IRS Schedule H, Form 990)		
Physician recruitment in child abuse pediatrics as a fledgling, medical shortage area	Yes	Response to community need and increased access
Advocacy for enhanced reimbursement for child abuse exams	No	Benefits the hospital

What Doesn't Count as Community Benefit?

Hospitals should be aware of activities or programs which may not be reported as community benefit to the IRS. Specifically, disregard activities that (1) are primarily for marketing purposes, or are conducted for the benefit of the hospital rather than the community; (2) are required for licensure or accreditation; or (3) are restricted to people affiliated with the hospital. A reasonable measure should be if, according to CHA, a “prudent layperson” would question whether the program truly benefits the community – in other words, “a laugh test.”

Measuring Community Impact

Often, measuring the impact on community health is difficult when weighing community health improvement programs and public health initiatives for children. Measuring community health outcomes is not currently demanded by the IRS Schedule H, but is a common expectation of hospital administration, policymakers, funders and the communities children's hospitals serve. As such, measuring impact is good practice and should be a hospital priority.

The hospital is responsible for evaluating the overall community benefit strategy, approach and effectiveness. The child protection team contributes to this process by conducting individual program evaluation of its health education, outreach and advocacy activities. Recognizing that program evaluation is a fundamental part of program planning will create an environment that supports mid-course correction consistent with ongoing implementation evaluation. This foundation enables impact evaluation that measures short-term, intermediate or long-term impact of the child abuse program.

Summary

The public health toll of child maltreatment is indisputable and children's hospitals are uniquely positioned to provide skilled medical diagnosis and treatment and inform prevention efforts rooted in evidence. The cost of child abuse and neglect in the United States exceeds 95 billion dollars annually when accounting for such factors as direct medical care, loss of future earnings and quality of life lost. The prevention of child abuse and neglect as a calculable community benefit is perhaps most clearly demonstrated by the \$3.5 billion spent annually by public/government programs such as emergency response, social services and victim assistance (Children's Safety Network, 2009).

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CONCLUSION

The first edition of *Defining the Role of Children's Hospitals in Child Maltreatment*, published in 2006, signaled a definitive commitment from NACHRI leadership. The three-level framework introduced then was a roadmap tailored to local resources. Children's hospitals with a basic response saw the steps they could take to become advanced; those at the advanced level could plot a path to center of excellence status. Centers of excellence could identify opportunities to strengthen and expand their reach. This system was designed as an effort to ultimately improve the quality of medical care provided to children who have been maltreated.

The *Second Edition* reinforces and builds on the foundation of that early vision. In recognition of the success of these guidelines, it makes recommendations that will further strengthen the response of all children's hospitals to maltreatment:

1. All acute care children's hospitals should, at a minimum, meet the recommendations for a **basic** response.
2. All child protection teams at the **advanced** and **center of excellence** levels should be medically directed, in most cases by a certified child abuse pediatrician.
3. All acute care children's hospitals that meet one or more of the following criteria should have a medically directed child protection team that is at either at the **advanced** or **center of excellence** level.
 - ♦ Have a trauma center designated by the state and/or verified by the American College of Surgeons as a Level I or II adult or pediatric trauma center
 - ♦ House an intensive care unit
 - ♦ Have an academic residency
 - ♦ House a burn unit

While children's hospitals have long been leaders in maltreatment intervention, prevention and education, the hard work is far from over. As the medical establishment more actively supports the specialized research and teaching efforts child abuse requires, children's hospitals have the extraordinary opportunity to develop a better coordinated and quality health response to one of the nation's most complex and confounding public health issues.

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The National Association of Children's Hospitals and Related Institutions is a not-for-profit membership association of more than 220 children's hospitals. The Association promotes the health and well-being of children and their families through support of children's hospitals and health systems that are committed to excellence in providing health care to children. It does so through education, research, health promotion and advocacy.



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