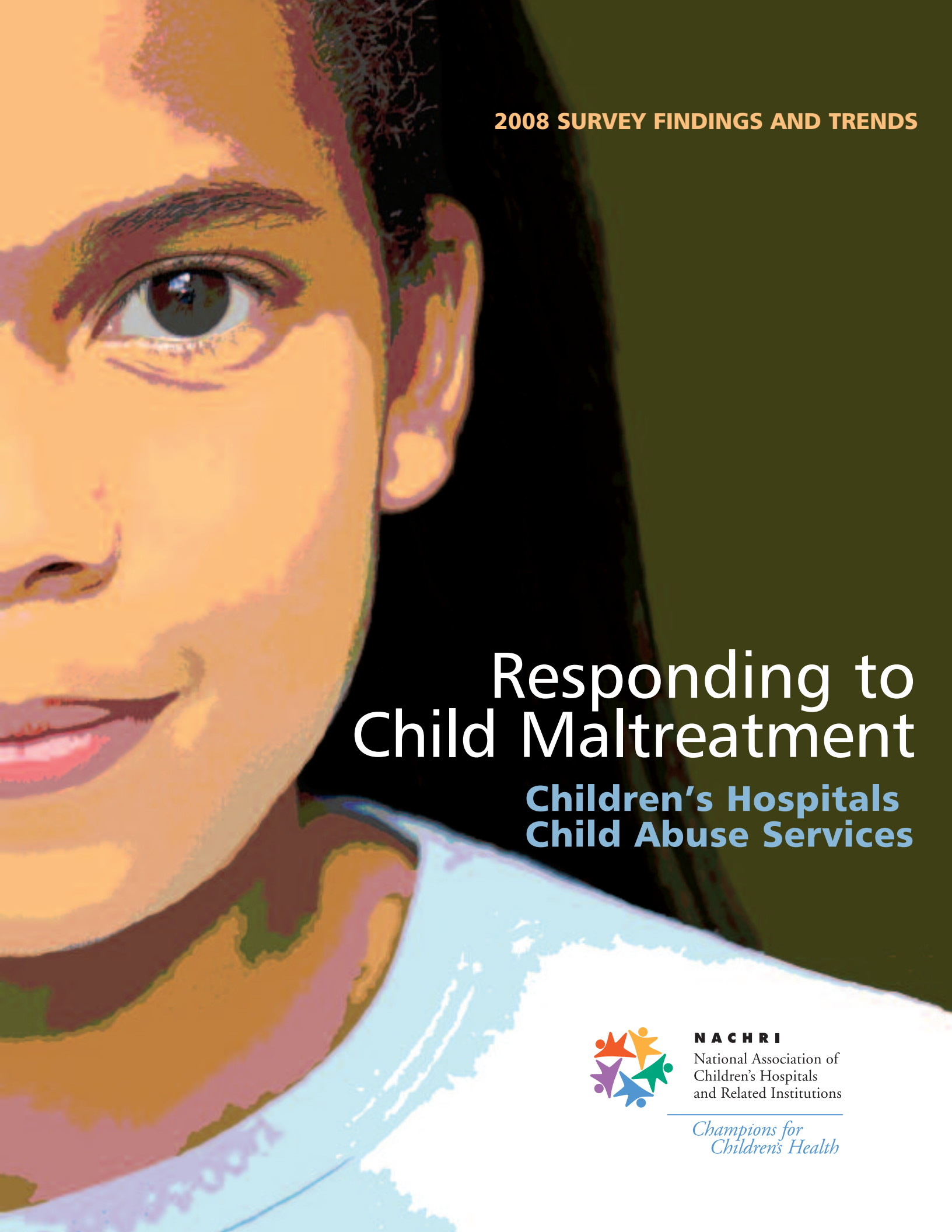


2008 SURVEY FINDINGS AND TRENDS

Responding to Child Maltreatment

Children's Hospitals Child Abuse Services

NACHRI
National Association of Children's Hospitals and Related Institutions
Champions for Children's Health

Introduction

Children's hospitals have exhibited visionary leadership in child abuse treatment and prevention through a highly specialized, multi-disciplinary approach and in partnerships with other community agencies. Weaving together a seamless, timely and effective system of response that provides necessary medical care and emotional healing to children who have been abused and that delivers appropriate justice to offending adults rises as a challenge for every community.

2008 SURVEY FINDINGS AND TRENDS

The National Association of Children's Hospitals and Related Institutions (NACHRI) and children's hospitals are committed to assembling evidence that supports the children's hospital response to child maltreatment. A coordinated response to the societal problem of child abuse is vital because without coordinated effort, more children in need of services will go undetected. Although these services come at a high cost largely absorbed by children's hospitals, they are a critical part of the child advocacy mission of children's hospitals as well as a moral imperative for all communities.

Child abuse and neglect continues to be a pervasive and complex public health problem that can devastate the lives of children, the most vulnerable segment of society. An estimated 3.6 million children suspected of being maltreated were assessed in 2006, with abuse or neglect either substantiated or indicated in almost 30 percent. Over 1,500 children died in 2006 as a result of maltreatment (U.S. Department of Health and Human Services, Administration on Children, Youth and Families, 2008). Death and injury resulting from child maltreatment have staggering financial costs including medical care, lost future earnings and diminished quality of life (Children's Safety Network Economics and Data Analysis Resource Center, 2005). For adult survivors of child abuse, there are persistent, long-term adverse outcomes to the individual, families and society including higher risk of chronic disease (heart, liver and lung disease), unhealthy behaviors (smoking, alcohol and drug abuse, sexual promiscuity), and mental health problems (depression, re-victimization) (Anda).

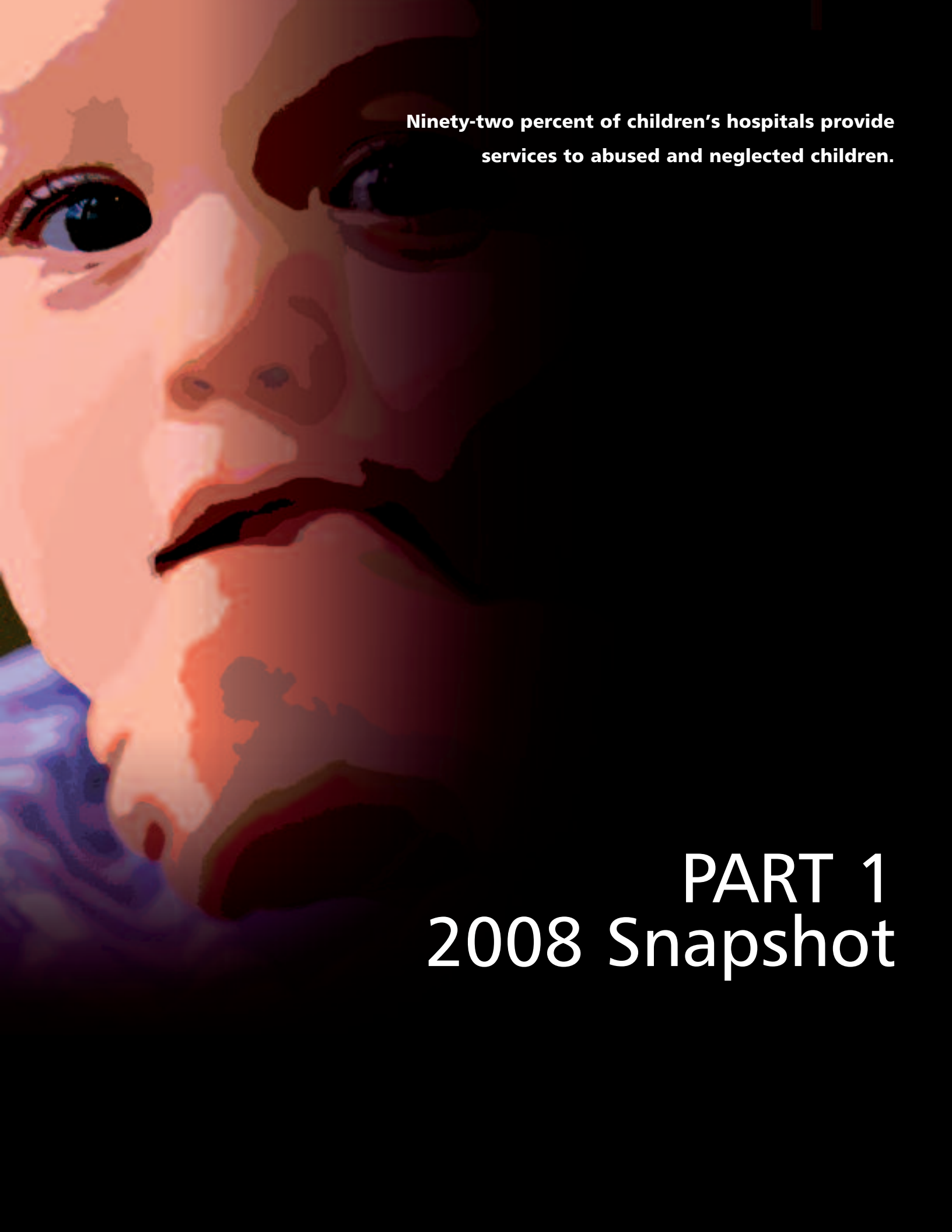
Strengthening the efforts of children's hospitals to treat and prevent child abuse and neglect has been a NACHRI priority since 2001. To better understand the challenge children's hospitals face in providing this indispensible care, NACHRI surveyed members in 2005 to measure the services hospitals provide to children suspected of having been abused or neglected. To bolster the survey findings, NACHRI also developed a companion document, *Defining the Children's Hospital Role in Child Maltreatment*, that creates guidelines for developing, establishing and enhancing abuse services within children's hospitals. It offers thoughtful and comprehensive discussion for assessing the range of services already offered by the hospital and community, guides children's hospitals in determining their role, and lets other partners know the range of services and resources that can be expected from the children's hospital.

This report summarizes the findings of the survey repeated in 2008 and identifies trends emerging from the initial 2005 survey. These tools provide opportunities for both children's hospitals and their partners in pediatric health care to:

- Improve the quality of patient care
- Reach more patients in need of care
- Evaluate the sustainability of programs
- Foster hospital commitment to programs

Combined, the survey data and the guidelines allow children's hospitals to measure their existing child abuse services, with the goals of continuous improvement and meeting the needs of the community.

INDEX OF DATA



Ninety-two percent of children's hospitals provide services to abused and neglected children.

PART 1
2008 Snapshot

METHODOLOGY

The child abuse services survey was first conducted in 2005 with the intent to repeat it every three years.

Procedure

This 2008 survey was collected in May. A Web-based survey tool was used, however, in some instances, respondents submitted a fax response instead. Using the list of those who completed the survey in 2005 as well as child abuse contacts in the NACHRI database, staff attempted to identify a single best respondent at each institution.

Design

An advisory group was convened to inform proposed changes to the 2005 instrument while preserving trend data. The group included one member of the 2005 advisory committee to provide a historical perspective and three new members representing both medicine and social work. Based on the group's feedback, some additions and changes were made to the 2008 survey, however, it closely mirrors the 2005 survey. NACHRI analytics staff also reviewed and commented on the proposed changes.

Respondents

All 226 NACHRI U.S. members were asked to provide data from their 2007 fiscal year. The return rate of 62 percent comprises 140 responses. Surveys were received from member institutions in 41 states, the District of Columbia and Puerto Rico.

A small number of surveys were received from international members; however, this report focuses on data from U.S. members since many of the survey questions are specific to the unique nature of health care structure and financing in the United States.

Table 1 shows the response to the survey compared to the NACHRI membership as a whole (refer to NACHRI membership definitions on page 3). The larger proportion of responses from freestanding children's hospitals is not surprising since these hospitals tend to have established and more well developed child abuse services.

Table 1
2008 Survey Response

NACHRI membership category	Responding to survey	NACHRI membership
Freestanding children's hospitals	39	46
Specialty hospitals	18	40
Children's hospitals within hospitals	47	74
Children's services	23	35
Other	13	31
Total	140	226

Limitations

NACHRI is a voluntary membership association, and the survey data include only responses from NACHRI members.

Definitions

Respondents were asked to classify their hospitals' services according to specific definitions.

No services: All suspected cases are referred to another community health care institution.

Child abuse services: The hospital provides clinical response to all forms of child maltreatment, either through the emergency department or a designated child abuse specialist. Staff are trained in the field of child abuse to detect, treat and document child abuse cases; policies exist to report suspected cases to appropriate local agencies.

Child abuse team: A dedicated and recognizable child protection team provides medical assessment, referral and diagnostic services for all forms of maltreatment. The team includes, at minimum, a pediatrician, an administrative coordinator trained in the field of child abuse, and social work services. At some children's hospitals, the team medical director also acts as an ad hoc administrative coordinator. The social work team, which is given additional training on child maltreatment, provides services as needed. The children's hospital regularly invites appropriate community members to participate in child protection meetings.

Child abuse program: An administrative unit of the children's hospital with centralized management and administrative functions provides assessment, referral and diagnostic services for all forms of maltreatment. The unit coordinates with community agencies involved in child protection and accesses hospital medical staff and subspecialists available to consult and participate in team functions as needed. The program members meet regularly to present and review child abuse cases.

Other structure: The respondent was asked to describe their hospital services.

NACHRI has five membership categories for hospitals and institutions with criteria in clinical services, recognition as a primary teaching site and governance structure.

Freestanding children's hospitals: Not-for-profit, short-stay, self-governing and independent children's hospitals.

Specialty hospitals: Not-for-profit, self-governing and independent hospitals that treat children with chronic or congenital conditions.

Children's hospitals within hospitals: Not-for-profit medical institutions with integral children's short-stay programs that also serve as primary teaching sites for organized academic departments of pediatrics of Accreditation Council for Graduate Medical Education accredited medical schools.

Children's services: Not-for-profit medical institutions with integral children's programs, a pediatric graduate program affiliated with a medical school, a salaried part- or full-time pediatric director, a minimum daily census of 45 and recognition as a pediatric referral facility.

Other: Profit or not-for-profit institutions and organizations that do not meet NACHRI membership criteria but choose to support and benefit from the Association's activities.

DEFINING HOSPITAL SERVICES

Two clear goals of the 2008 child abuse services survey are to provide a snapshot of current data and to identify trends using the prior survey.

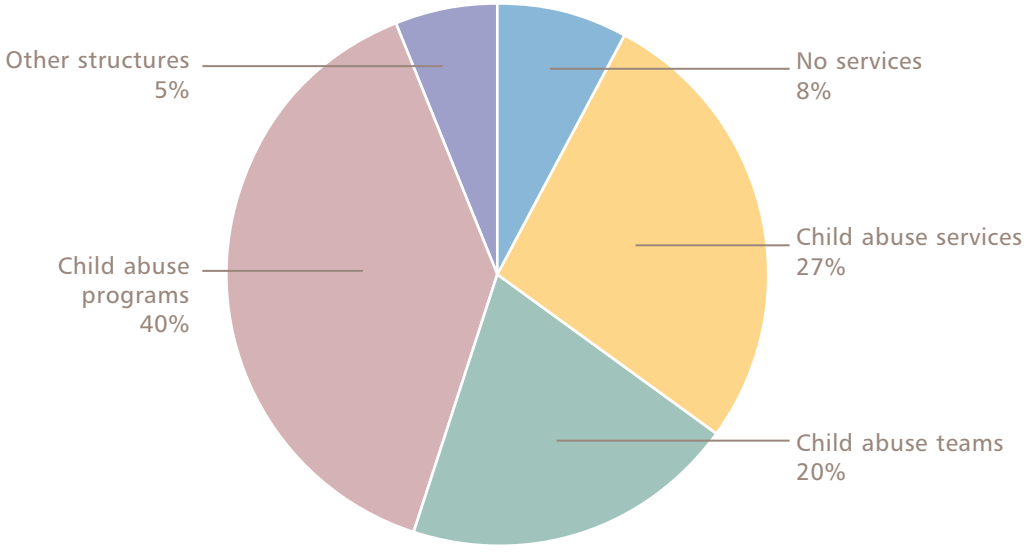
To enhance comparison with the 2005 survey, hospitals not completing the full survey were asked to answer at least the first question. As a result, the response to the first question is greater than the response to the overall survey. In 2008, 87 percent of the U.S. NACHRI membership answered this question:

Which of the following statements best describes your hospital's services?
(See definitions on page 3)
a) No services
b) Child abuse services
c) Child abuse team
d) Child abuse program
e) Other structure

The response determined the next questions applicable to the respondent for the remainder of the survey. Some of the data in this report is stratified according to how respondents classified their hospitals' child abuse services.

Only 8 percent of responding hospitals indicate that they do not provide any child abuse services. Of the 15 hospitals not providing services, nine are specialty hospitals that do not provide acute care services. More than a quarter of NACHRI members state that they provide child abuse *services*, but do not have a more formal *team* or *program*. The remaining children's hospitals—more than half—report either child abuse *teams* or *programs*. Refer to Figure 1.

Figure 1
Defining Children's Hospital Services 2008
n=196



Most child abuse *programs* (82%) reside within either a freestanding children's hospital or within a children's hospital within a hospital. Table 2 shows both the description of hospital services and the NACHRI membership category.

Table 2
Description of Hospital Services by NACHRI Membership Category

NACHRI membership category	Program	Team	Services	No services	Other	Total respondents by membership
Freestanding children's hospitals	32	7	3	0	2	44
Specialty hospitals	1	2	13	9	2	27
Children's hospitals within hospitals	32	15	13	0	3	63
Children's services	9	8	14	0	3	34
Other	4	7	10	6	1	28
Total respondents by hosp. services	78	39	53	15	11	196

Nearly all hospitals (86%) indicate that they provide services in both inpatient and outpatient settings.

Thirty-two hospitals (25%) report housing multidisciplinary children's advocacy centers affiliated with the National Children's Alliance. All 32 identify their response to child abuse as a *program*. More than half of respondents (56%) said their hospitals provide medical services to one or more independent children's advocacy centers. Almost three quarters of those providing medical services to a children's advocacy center are child abuse *programs*.

CASELOADS AND DATA COLLECTION

Sixty-seven percent of hospitals report an overall increase in their child abuse caseloads.

Reasons attributed to this increase include:
- Higher visibility of child abuse teams
- Awareness of availability and the value of specialized services
- More staff and/or increased capacity
- Better recognition and referral by clinicians and partner agencies
- Growing awareness of abuse in the community
- Societal influences such as the worsening economy

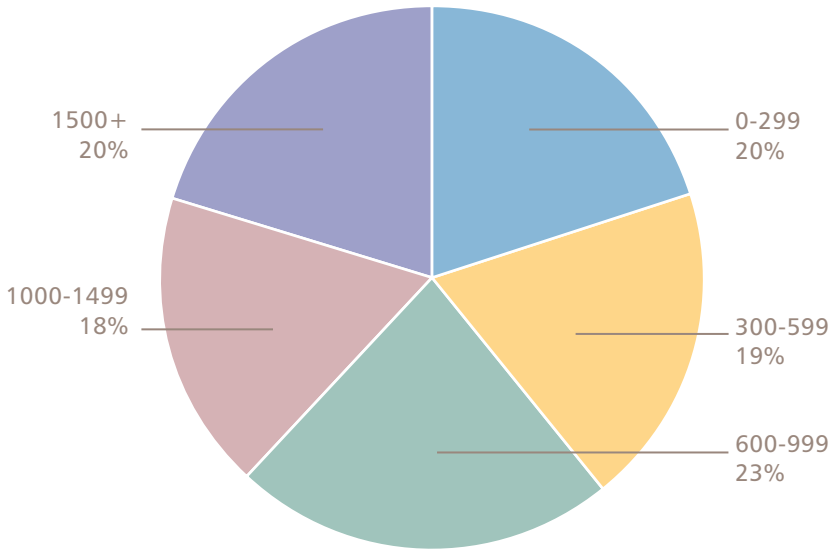
Five percent of hospitals indicate an overall decrease in caseload, while 19 percent report no change. Nine percent of respondents report they do not track caseload information or don't know if there has been a change in caseload. Of those who do not track caseload or don't know, half are specialty hospitals that do not provide acute care. None are child abuse *programs*.

Twenty-six hospitals with child abuse *services* report serving an average of 150 child abuse patients each in FY 2007. The median number of patients seen by those providing child abuse *services* is 100, with a minimum of five patients and a maximum of 500. These hospitals saw approximately 5 percent of total cases reported by survey respondents.

Hospitals with either a more structured child abuse *team* or child abuse *program* treated more than 21 times as many children as those with child abuse *services*. This constitutes an average of 1,061 children per *team* or *program* in FY 2007. *Teams* and *programs* report caseloads ranging from a low of 40 patients to more than 6,000 with a median of 654. Hospitals with *teams* and *programs* account for 95 percent of the total cases seen by survey respondents in FY 2007. Figure 2 shows the varying caseloads of child abuse *teams* and *programs*.

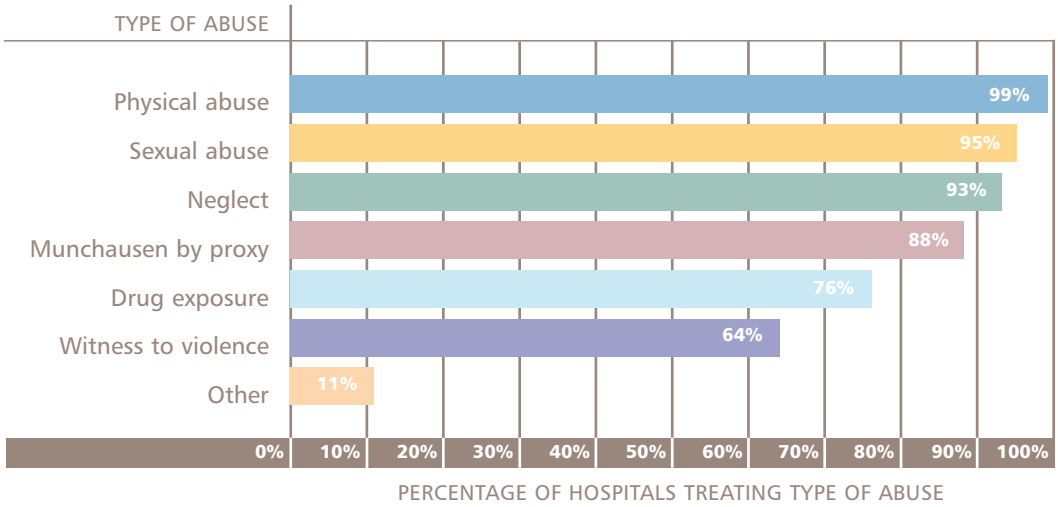
Of the 20 percent of respondents reporting caseloads greater than 1,500 patients, 10 (13%) have caseloads between 1,500 and 2,499, and six (7%), caseloads greater than 2,500.

Figure 2
Caseload for Teams and Programs 2008
n=79



Hospitals encounter many types of maltreatment, but most often treat children for physical abuse (99%), sexual abuse (95%)[1] and neglect (93%). Several hospitals also report treating children for emotional abuse. Refer to Figure 3.

Figure 3
Types of Child Abuse Treated 2008
n=127



[1] In 2005, the choice "sexual abuse" was inadvertently left off the list of possible types of cases treated. While 58% of respondents wrote "sexual abuse" under "other," we believe that the percentage would have been much higher if it had been offered as one of the checkboxes. Therefore, the percentage for 2005 should not be compared against the much higher percentage from 2008 when this oversight was remedied and respondents had the option of selecting "sexual abuse" as one of the choices.

Hospitals were also asked to report on the systems they use to collect data on caseload. Seventy-seven percent of hospitals have data collection systems.[2] Thirty-eight percent collect data using a paper method, and 66 percent use an internal electronic or Web-based system. Fewer than 15 percent use a regional, statewide or national database. Respondents had the option to select more than one method of collecting data. Twenty-three percent report no data collection system at all. It is unclear why some hospitals report caseload data, yet indicate they have no data collection system.

STAFFING

Along with greater caseload, hospitals also report an increase in child abuse staffing.

Seventy percent of hospital respondents indicate an increase in full time equivalent staff (FTE) since the establishment of the child abuse *program*, *team* or *service*. The majority attributes this growth to both increased volume and expanded services. Almost 10 percent were able to increase capacity relying on funding from grants. In contrast, the 10 percent reporting a decrease in staffing and 20 percent reporting no change attribute this to lack of funding and budget constraints.

Institutions with less formal child abuse *services* employ an average of one FTE physician devoted to child maltreatment. More than two-thirds of physician time is dedicated to providing direct patient care, and just over 15 percent of physician time is spent on administrative tasks. Eleven percent of time is dedicated to education and training, and little time (5%) is devoted to research. Of the 31 hospitals reporting child abuse *services* and completing the entire survey, only 10 responded to this question.

By definition, a child abuse *team* or *program* comprises dedicated, multidisciplinary staff. Children's hospitals with a child abuse *team* or *program* were asked to provide detailed information about the types of staff and amount of time devoted to providing services to children suspected of having been abused or neglected. Of the 85 hospitals providing staffing information, medical directors, administrative support, physicians, medical social workers, administrative directors and nurse practitioners/physician assistants are the most frequently reported personnel. Fewer than 10 percent of hospitals report psychiatrists, home visitors, clergy and parent educators as part of the child abuse *team* or *program* staff. Figure 4 shows those positions reported by 10 percent or more of hospitals.

[2] The answer choices for the question on data collection were changed on the 2008 survey and should not be compared to the 2005 survey.

Figure 4
Staffing for Teams and Programs 2008
n=85

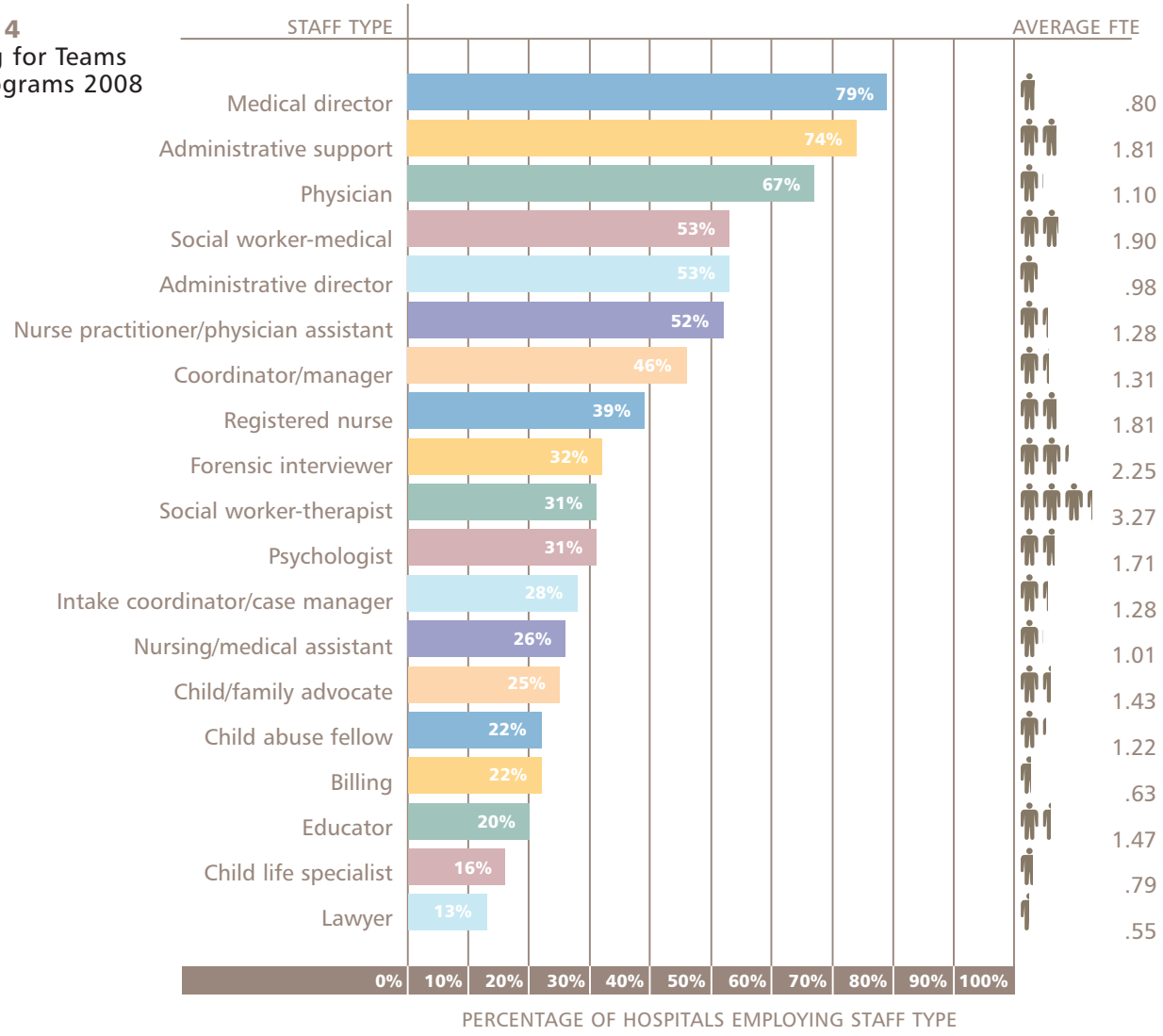


Figure 5 illustrates the percentage of professional time dedicated to four primary functions:

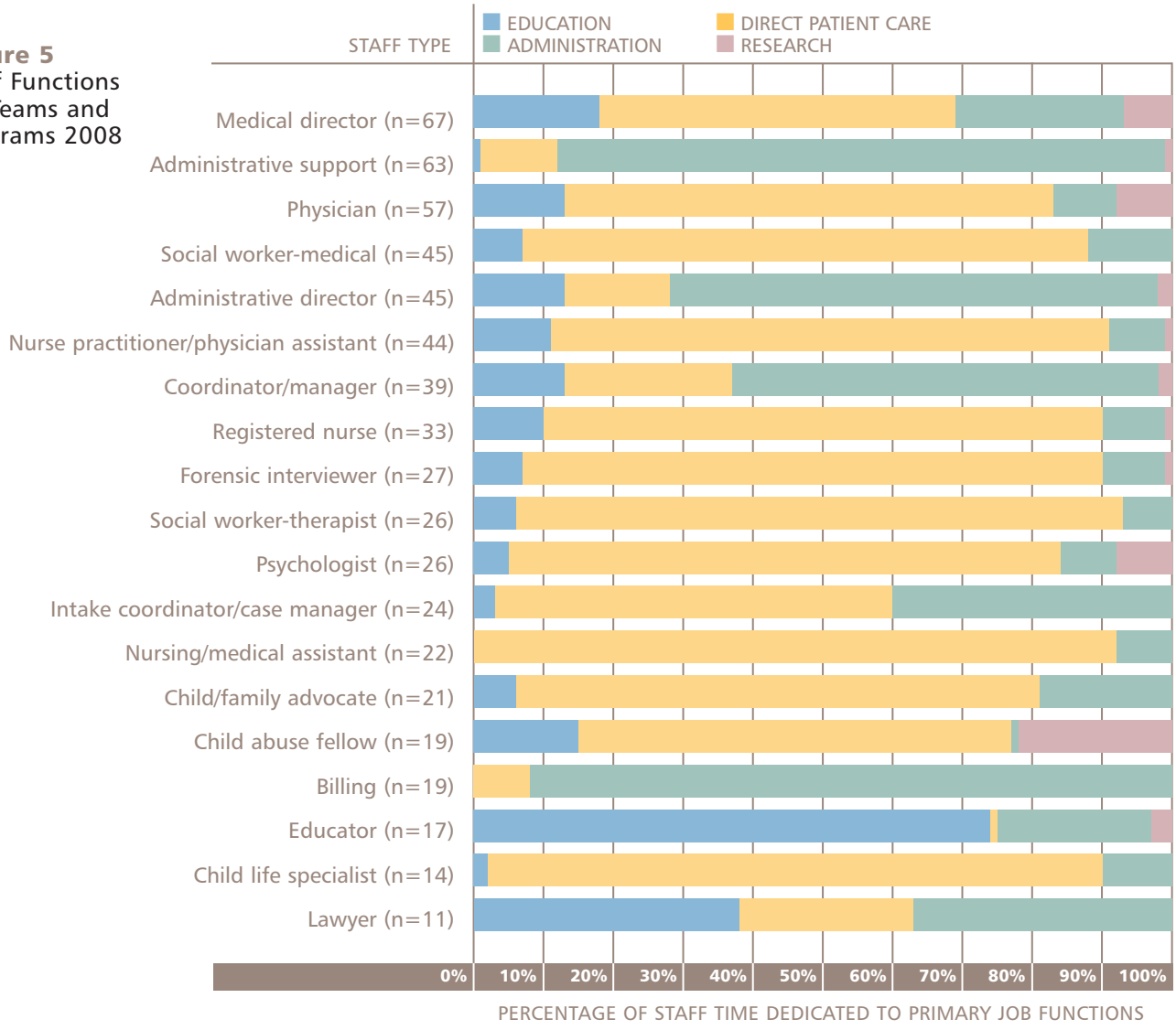
- Direct patient care
- Education and training
- Research
- Administrative functions

As one might expect, clinicians spend the majority of their time in direct patient care while administrative staff is usually dedicated to administrative functions; however, none of the positions devotes time exclusively to one activity. This is most notable for the medical director who, more than any of the other positions, has responsibilities widely distributed across each of the four functions.

Sixty-four percent of *teams* and *programs* that completed this matrix conduct some child abuse research. Child abuse fellows spend the most time on research—an average of 22 percent according to 19 hospitals employing fellows. Physicians, psychologists and medical directors spend between 5 and 10 percent of their time on research.

Among child abuse clinicians, the percentage of time dedicated to education is minimal. Medical directors report spending 18 percent of their time on education, followed by child abuse fellows (15%) and physicians (13%).

Figure 5
Staff Functions for Teams and Programs 2008
n=80

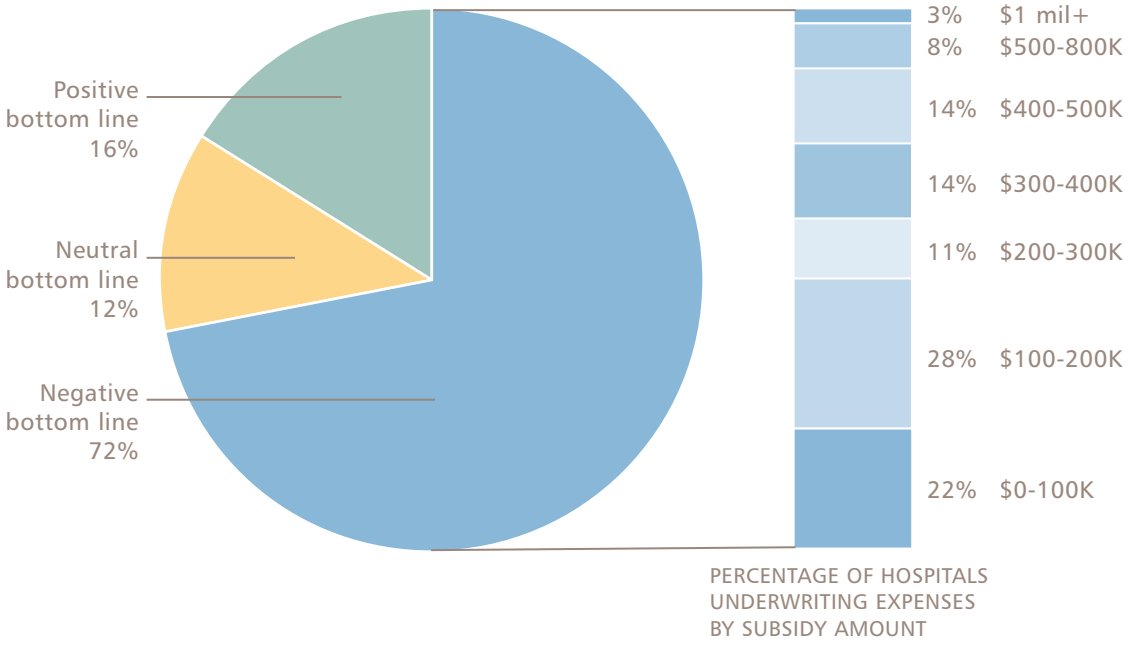


Hospitals report substantially underwriting the expenses of child abuse services.

Underwritten Expenses

The budget deficit was calculated by subtracting the operating budget from revenue. Approximately three-quarters (72%) of respondents show a negative bottom line with an average deficit of $283,000. The amount underwritten by the hospital ranges from $10,000 to $1,293,000 with a median deficit of $186,000. Six respondents (12%) show neutral budgets (broke even) and eight (16%) show positive bottom lines. Refer to Figure 6.

Figure 6
Budget Deficits
2008
n=50

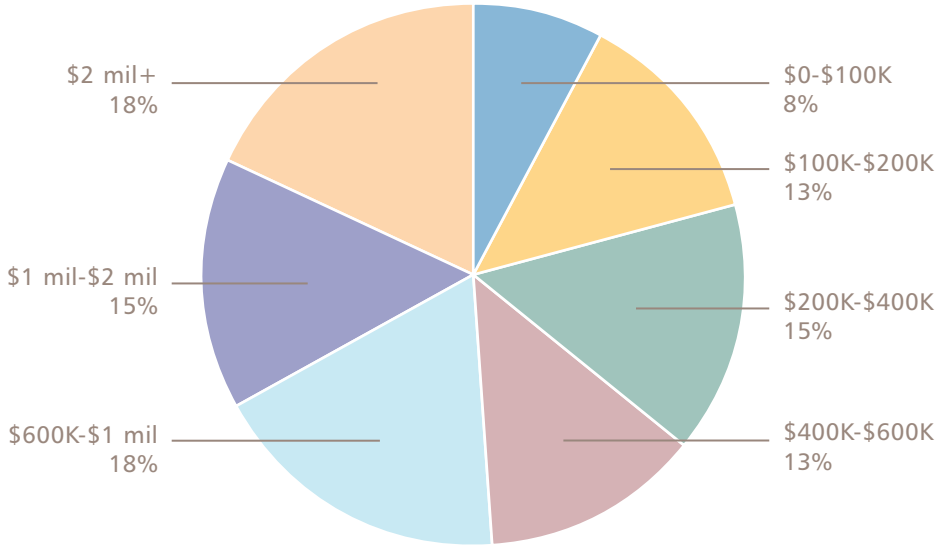


Operating Budget

Of the 115 children's hospitals responding to this question, 45 (39%) disclose having no budgetary allowance for child abuse for their 2007 fiscal year. Lacking a dedicated budget does not necessarily mean that no child abuse services are available. Conversations with members outside the survey structure indicate some hospitals employ alternate funding structures or are affiliated with other funding organizations in addition to the children's hospital (e.g., child abuse services are funded through an affiliated medical school).

Of the 70 children's hospitals with a dedicated budget, 61 (87%) provide specific information about operating budgets. Total expenses range from a low of $30,000 to a high of more than $8.5 million with a median budget of $600,000 and mean of $1,044,000. Ninety-five percent report an operating budget of less than $3,000,000 with a mean of $818,000. Figure 7 shows the range of reported operating budgets.

Figure 7
Operating Budgets
2008
n=61



Overhead is an important consideration when assessing the costs of any program. The 2008 survey includes a new question that asks if the reported operating budget includes allocated overhead or indirect expenses. While overhead encompasses a broad range of expenses, this question attempts to gain a rough understanding of whether or not indirect expenses are part of the budget calculation.

Of the 65 children's hospitals answering this question, 27 (42%) report that overhead is included in the operating budget. Twenty of these hospitals provide the dollar amount of overhead ranging from a low of $4,300 to a high of $830,000 with a median of $37,500 and a mean of $133,400. On average, overhead accounts for 11 percent of the operating budget for these 20 hospitals.

Fifty children's hospitals report revenue with a minimum of no revenue, a maximum of $7,442,000 and a median of $445,000. The average revenue for these respondents is $909,000.

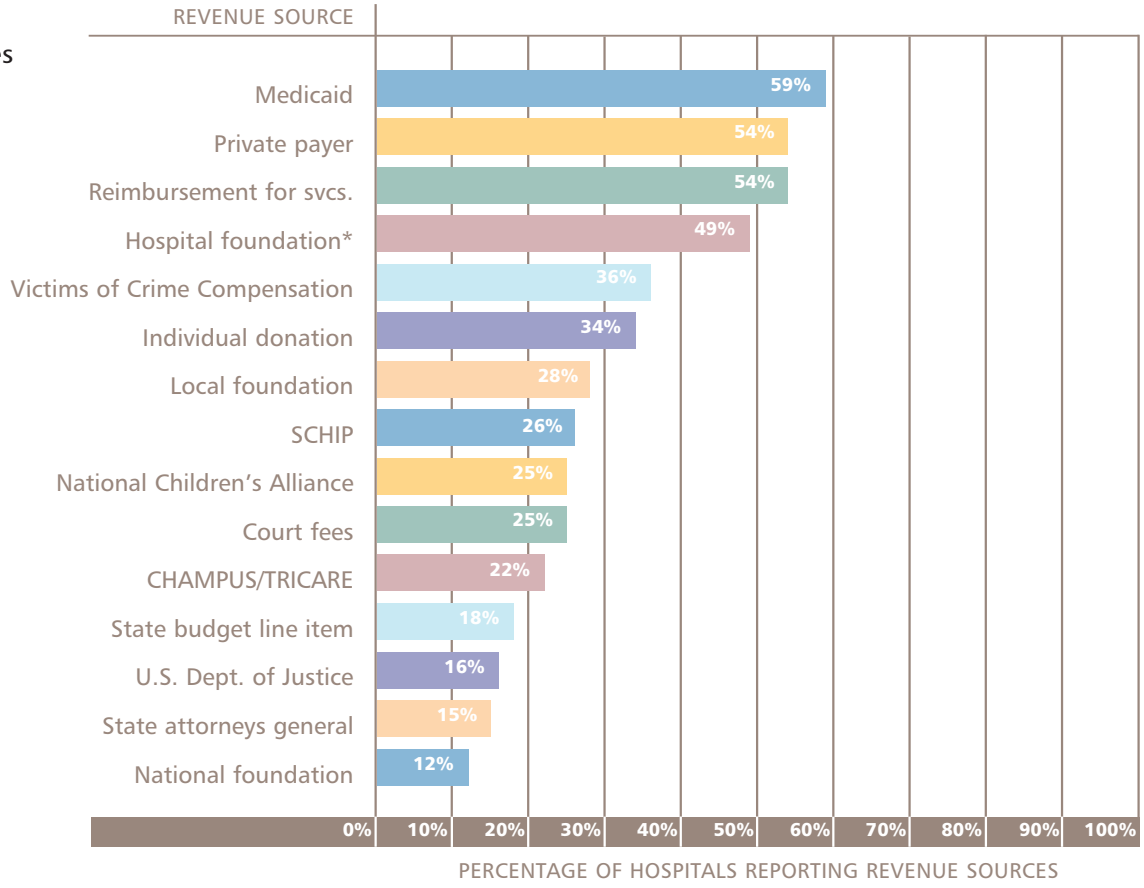
Revenue Sources

Institutions were asked to identify and rank revenue sources for funding child maltreatment programs and services for FY 2007. The most common revenue sources are those that also provide the most total dollars:

- Medicaid
- Reimbursement for services provided to local, county or state agencies
- Private payer
- Hospital foundation

Figure 8 shows revenue sources reported by 10 or more hospitals.

Figure 8
Revenue Sources
2008
n=85



*Different than operating budget subsidized by the hospital

Fewer than 8 percent of respondents indicate they receive funding from the following revenue sources: Substance Abuse and Mental Health Services Administration, Centers for Disease Control and Prevention, National Institutes of Health, Title 19 of the Social Security Act, U.S. Department of Health and Human Services and U.S. Department of Housing and Urban Development.

REIMBURSEMENT FOR SERVICES

Most hospitals must substantially underwrite their child abuse services because they receive only partial or no reimbursement for them.

Clinical and Non-clinical Services

Respondents were asked to complete two tables that asked if a particular service is provided and whether it is reimbursed.[3] One table represents contracted services and the other, non-contracted services. Ninety-three respondents completed both tables; seven more respondents completed the table for contracted services than completed the table for non-contracted services. Refer to figures 9 and 10.

[3] This data should not be compared to the 2005 data. In 2008, respondents were only able to select one reimbursement level while in 2005 respondents were able to select multiple levels of reimbursement.

Reimbursement

As one would expect, more respondents indicate that they are either fully or partially reimbursed for the common clinical and non-clinical services listed in Figure 9 if provided under contract.

Services Provided

Over half of respondents provide the following clinical services, regardless of whether the service is contracted or not and whether the service is reimbursed:

- Inpatient medical care
- Medical exam
- Phone consult
- Psychosocial assessment
- Second opinion medical consult
- Written expert opinion

A majority of respondents also provide two non-clinical services: court testimony and prevention/public awareness regardless of whether or not the service is performed under contract and whether or not the service is reimbursed.

Figure 9
Contracted Services 2008
n=100

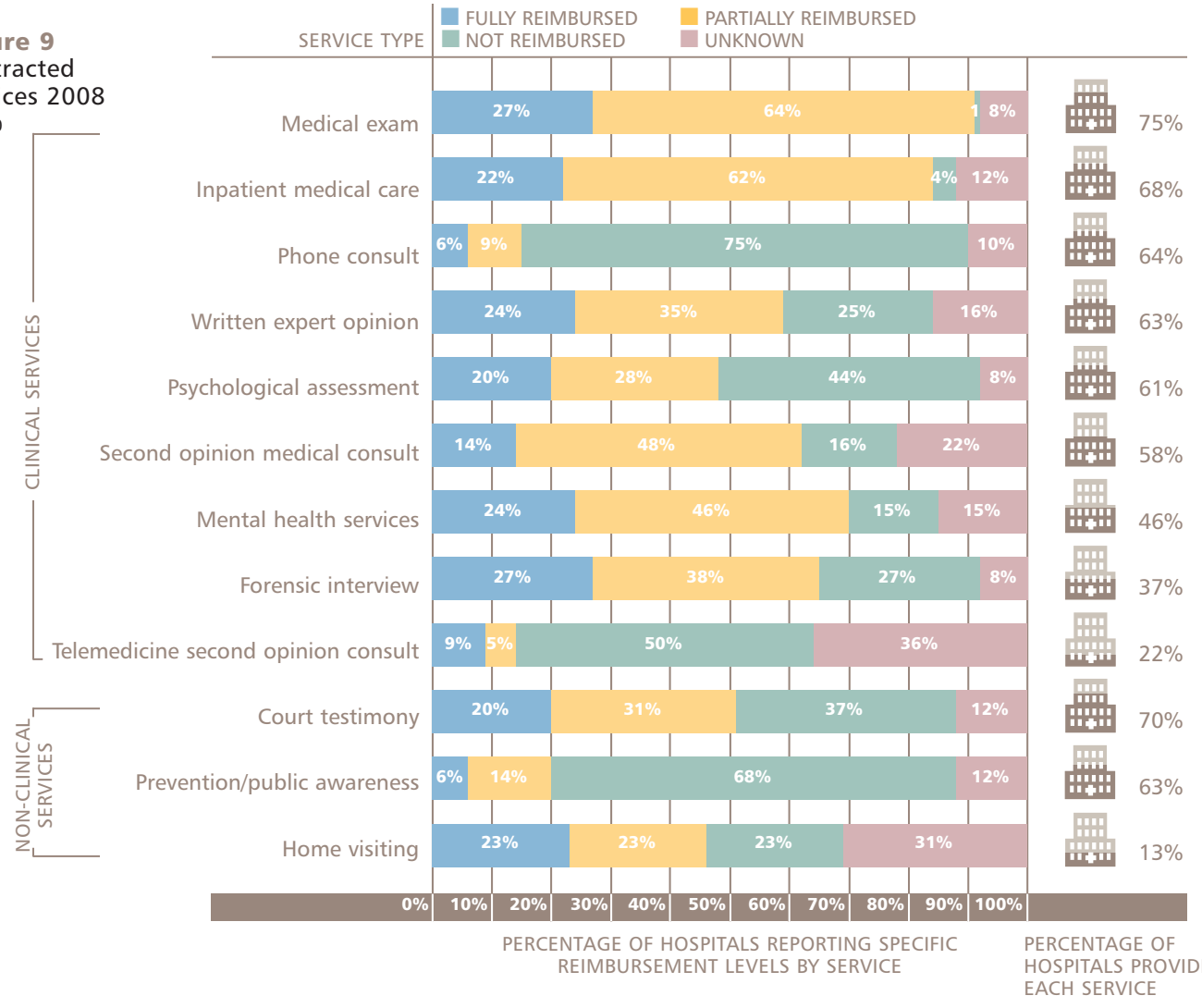
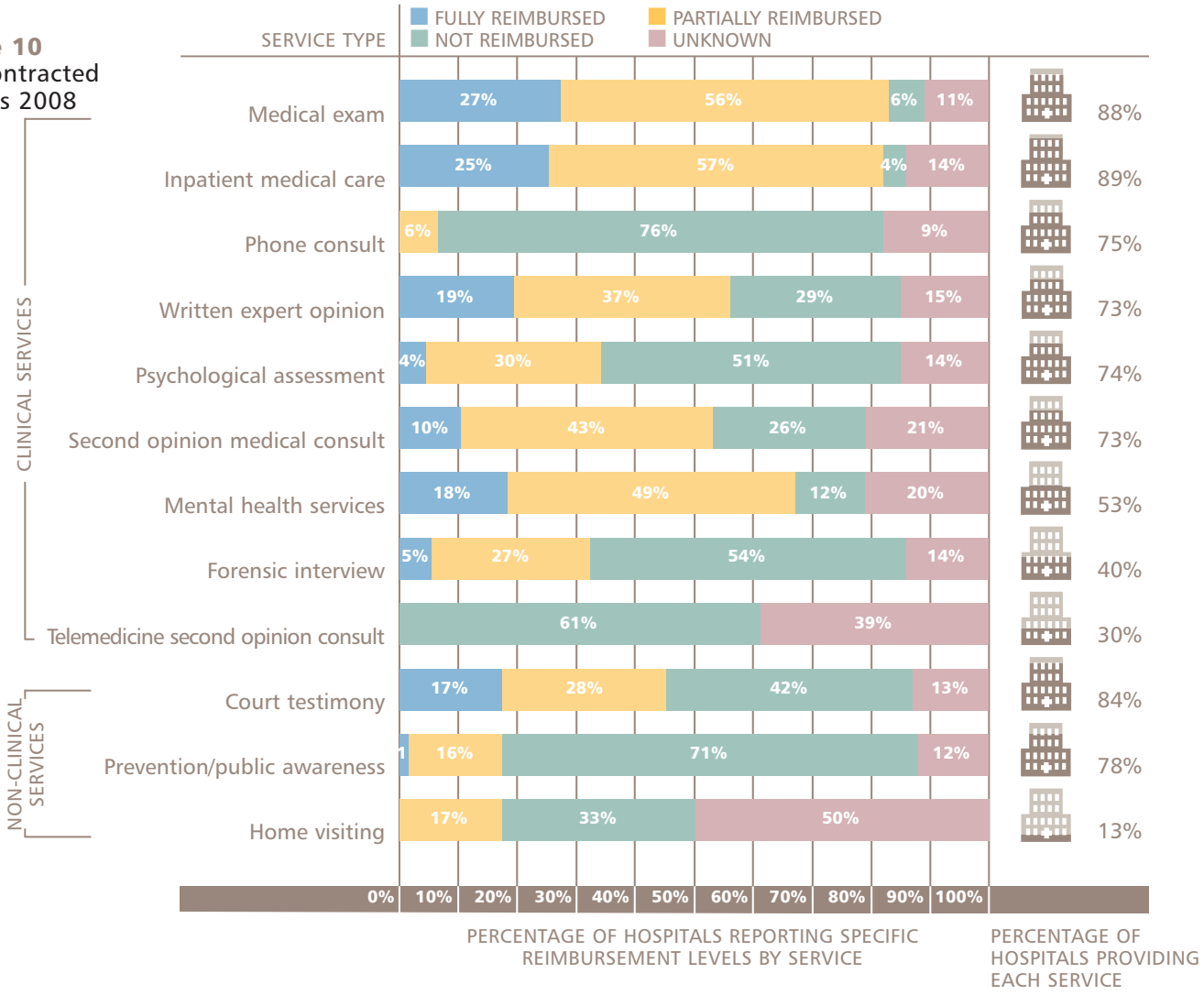


Figure 10
Non-contracted Services 2008
n=93



EDUCATION AND TRAINING

The majority of survey respondents (63%) report providing training to a variety of clinicians and community partners, although much of this training is not funded, either partially or fully.

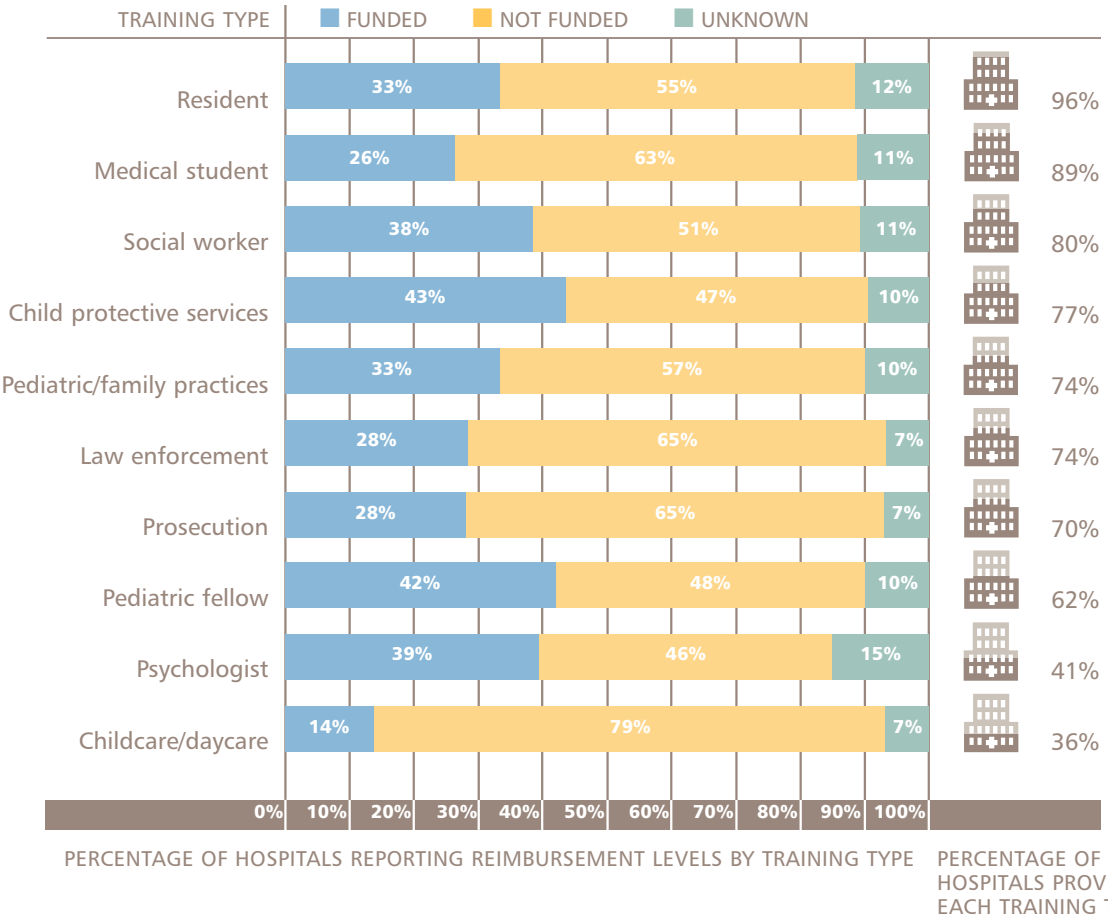
All of those providing training are child abuse *teams* or *programs*. Hospitals report providing training to residents (96%), medical students (89%) and social workers (80%) whether or not the training is funded.

For all types of training listed in Figure 11, at least half of respondents report either no funding or the funding status is unknown. With the approval of child abuse as a pediatric subspecialty, we cautiously anticipate that funding streams for fellowship training will become more available in the years ahead. (See Sidebar on page 16)

Training most frequently either fully or partially funded:

- Child protective services (43%)
- Pediatric fellows (42%)
- Psychologists (39%)
- Social workers (38%)

Figure 11
Funding for Education and Training 2008
n=81



Child abuse pediatrics was approved as a subspecialty by the American Board of Pediatrics in 2006. Beginning in 2010, one must successfully complete an accredited child abuse pediatrics fellowship program to be eligible to sit for the certification exam. The first programs will be accredited by the Accreditation Council for Graduate Medical Education (ACGME) in early 2010. Several questions were added to the 2008 survey to gauge the existing number of fellowship programs and obtain information on leadership and plans for future fellowships. In 2011, when this survey is conducted for the third time, we will be able to measure growth in this dynamic field.

Twenty-one existing child abuse fellowships are reported by 119 respondents (18%) at their institutions. From publicly available sources, we know that this represents nearly all existing fellowship programs.

Medical directors have practiced an average of 15 years (ranging from 5 to 38 years) in the field of child abuse. Most of the medical directors have a primary specialty in either general pediatrics or family practice. Ten of the existing fellowship programs (48%) are led by a medical director trained in a child abuse fellowship program.

Thirty-three of 91 (36%) respondents intend to establish a fellowship in the future. Plans range from fellowships that will open as soon as 2009 to those tentatively planned for 2018 and beyond.

RESEARCH

Few respondents indicate that the child abuse research conducted at their hospitals is funded.

In addition to the matrix showing staff time spent time on research (see page 9), the survey asks in the form of a yes/no question if hospitals conduct child abuse research. Fifty-four of 124 (44%) child abuse *programs*, *teams* and *services* responded affirmatively.

Areas of research currently conducted by survey respondents include:

- Abusive head trauma
- Skeletal fractures in infancy
- Perinatal methamphetamine exposure
- Improving outcomes after abuse
- Prevention
- Domestic violence

The two datasets from 2005 and 2008 have enabled us to measure change in efforts by children's hospitals to address child maltreatment.

PART 2
Trend Data 2005-2008

METHODOLOGY: TREND DATA

The methodology for the trend data mirrors that of the 2008 snapshot except where noted below.

Respondents

Sixty-seven NACHRI U.S. members provided data for both the 2005 and the 2008 surveys. This represents 30 percent of the membership, from 30 states and the District of Columbia.

The trend data reflects a smaller percentage of *services* and *teams* and a larger percentage of *programs* than the responses to the 2005 and 2008 surveys individually.

Table 3
Trend Data Response

NACHRI membership category	Responding to 05 & 08 surveys	NACHRI membership
Freestanding children's hospitals	28	46
Specialty hospitals	4	40
Children's hospitals within hospitals	23	74
Children's services	6	35
Other	6	31
Total	67	226

Limitations

In some instances, different individuals from one hospital completed the survey in 2005 and 2008. The two viewpoints could account for a different classification for the hospital response to child abuse as either a *service, team* or *program*. Individual respondent bias was also occasionally apparent in how caseload was assessed in 2005 and 2008.

NACHRI membership changed somewhat between 2005 and 2008 and limits the ability to trend data.

Definitions

Definitions of the services hospitals offer in response to child maltreatment and NACHRI membership categories are on page 3 at the beginning of the report.

DEFINING HOSPITAL SERVICES: TREND DATA

The 2005 survey established a baseline of the mix of structures within children's hospitals that provide services to children suspected of having been abused or neglected.

Respondents had the choice of describing their hospitals' responses to child abuse as:
- No services
- Child abuse services
- Child abuse team
- Child abuse program
- Other

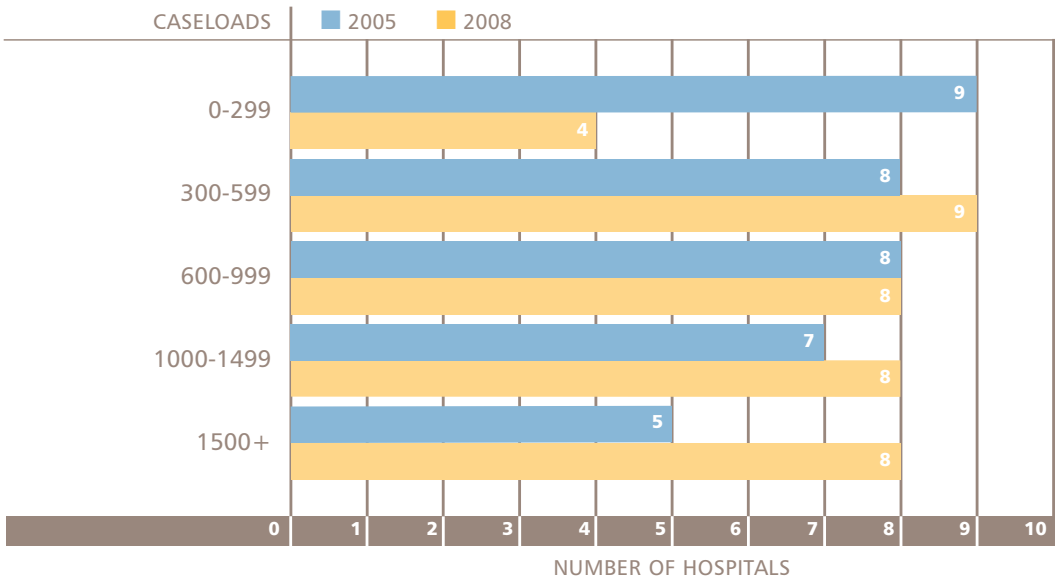
Given the small sample size of 67 hospitals, the differences between descriptions from 2005 and 2008 do not reliably represent significant change. It should be noted that change in descriptions move in both directions: toward a more evolved response to child abuse and also toward a lesser response to child abuse, than was reported in 2005. Case studies may be a more appropriate vehicle to describe change in how a hospital responds to child abuse.

CASELOADS AND DATA COLLECTION: TREND DATA

Caseloads increased by 21 percent over the last three years as reported by 37 child abuse *teams* and *programs*.

The average caseload increased by 195 patients from 945 in 2005 to 1,140 in 2008. Figure 12 illustrates a drop in those hospitals with the smallest caseload and growth in those hospitals reporting the largest caseloads.

Figure 12
Caseload for Teams and Programs: 2005 and 2008
n=37



Reports show a decrease in use of any data collection system from 88 percent in 2005 to 86 percent in 2008. Only those hospitals using either a regional/statewide database or national database are trended due to a change in the question about type of data collection system on the 2008 survey.

- A net gain of three institutions (six total) currently uses a regional or statewide electronic database bringing that rate to almost 10 percent of hospitals of the trend dataset that use such a tracking system.
- Those using a national database grew more than threefold from two hospitals in 2005 to seven in 2008.

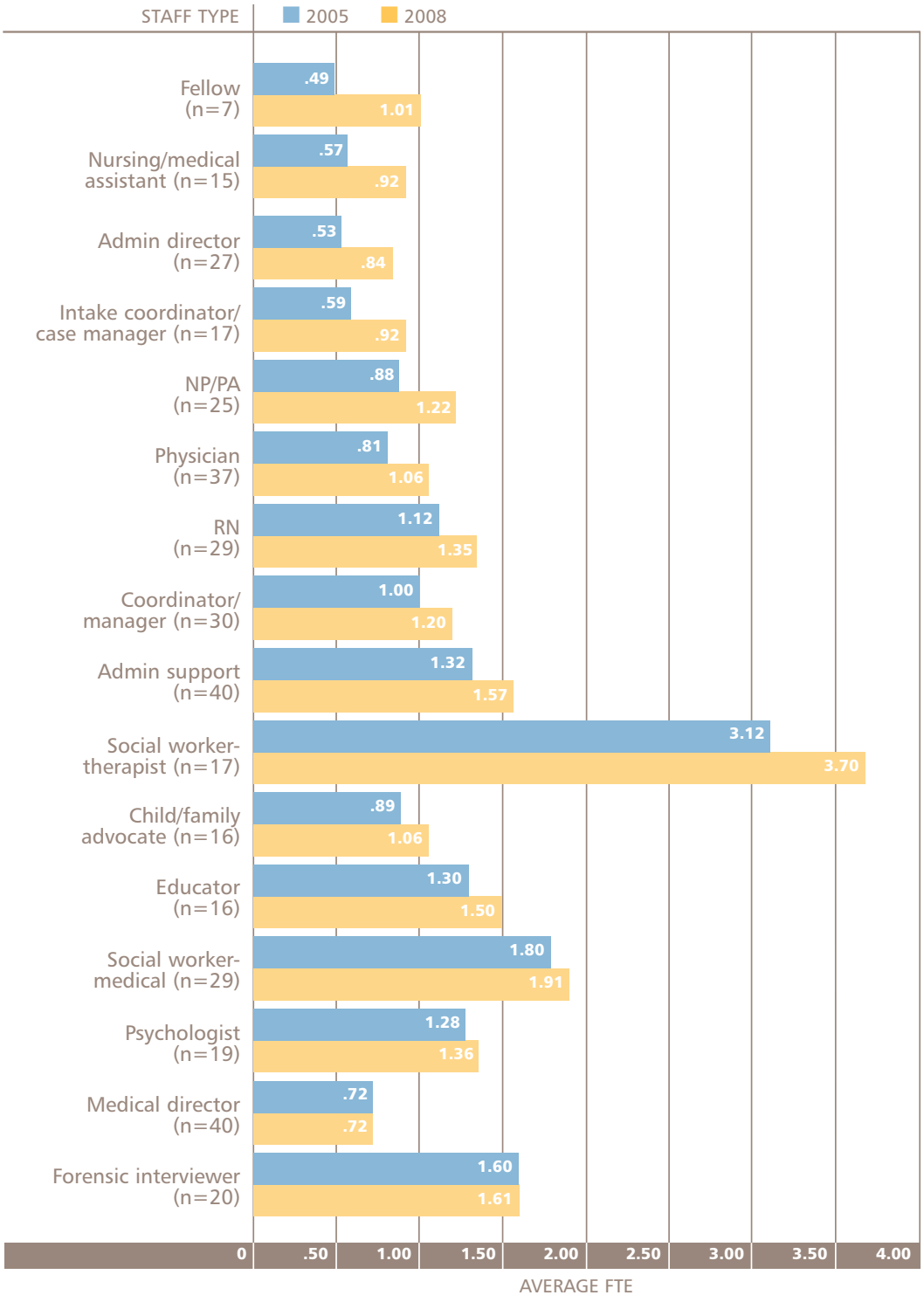
STAFFING: TREND DATA

Time dedicated to almost all positions increased over the last three years.

The most dramatic increases were for child abuse fellows where FTE doubled. The FTE for nursing/medical assistants, administrative directors and intake coordinators/case managers increased by more than 50 percent each. The FTE for medical directors stayed flat at 0.72 FTE.

Forty-two of 67 hospitals give specific staffing information for their child abuse *teams* or *programs* in 2005 and 2008. Depicted in Figure 13 are those positions for which 15 or more hospitals report in both years, listed in order of greatest change in FTE to least change.

Figure 13
Staffing for Teams and Programs: 2005 and 2008
n=42



Not pictured on Figure 13 are positions for which fewer than 15 hospitals report in both years: billing, child life specialist, lawyer, psychiatrist, home visitor, clergy and parent educator.

Overall, hospitals underwrite their child abuse programs by almost $120,000 more in 2008 than in 2005—an increase of 59%.

Underwritten Expenses: 2005 and 2008

While the average subsidy is up, the number of hospitals with a negative bottom line is down and there is a net increase in hospitals with positive and neutral bottom lines. In 2008, 26 percent of respondents operate in the black, as opposed to only 10 percent in 2005. None of the same programs reports a positive or neutral bottom line in both 2005 and 2008. The amount of hospital subsidy required to cover the budget shortfall of the child abuse *program*, *team* or *service* was calculated by subtracting the operating budget from the revenue. Refer to Figures 14 and 15.

Figure 14
Budget Deficits: 2005 and 2008
n=31

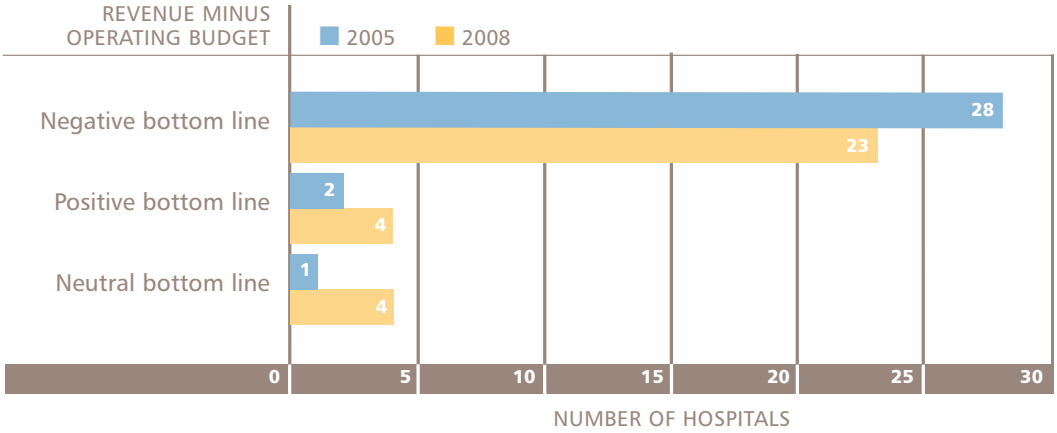
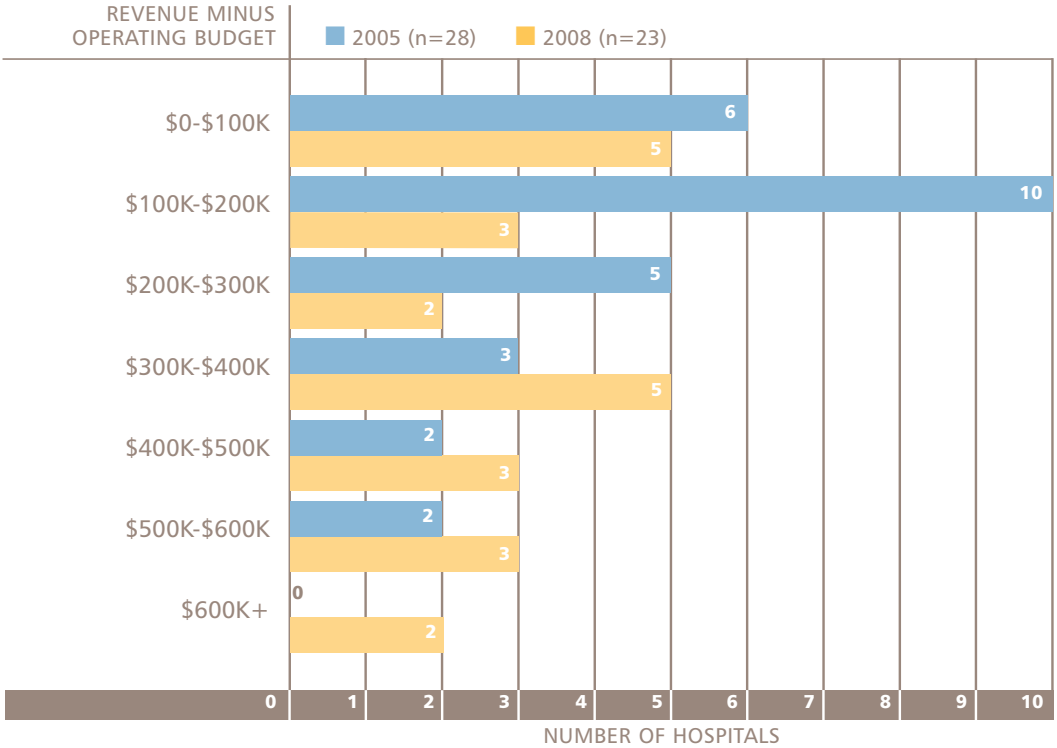


Figure 15
Hospital Subsidy: 2005 and 2008

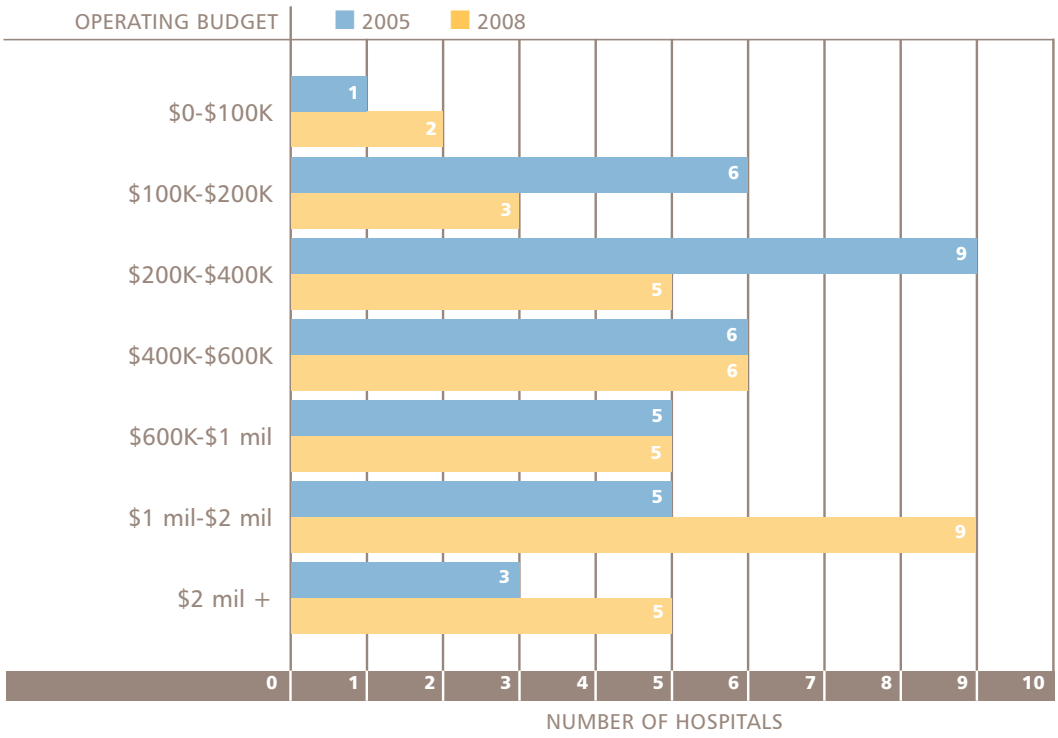


Operating budgets increased by 34 percent over the last three years as reported by 35 hospitals that provided specific budget figures in both 2005 and 2008.

Operating Budget: 2005 and 2008

Of these, over 80 percent are child abuse *programs*. The mean operating budget rose from $880,200 in 2005 to $1,175,400 in 2008. The largest decline in budget is $574,700 and the greatest increase is $2,350,000. Figure 16 shows an increase in those hospitals reporting budgets of over $1 million and a decrease in those with budgets between $100,000 and $400,000.

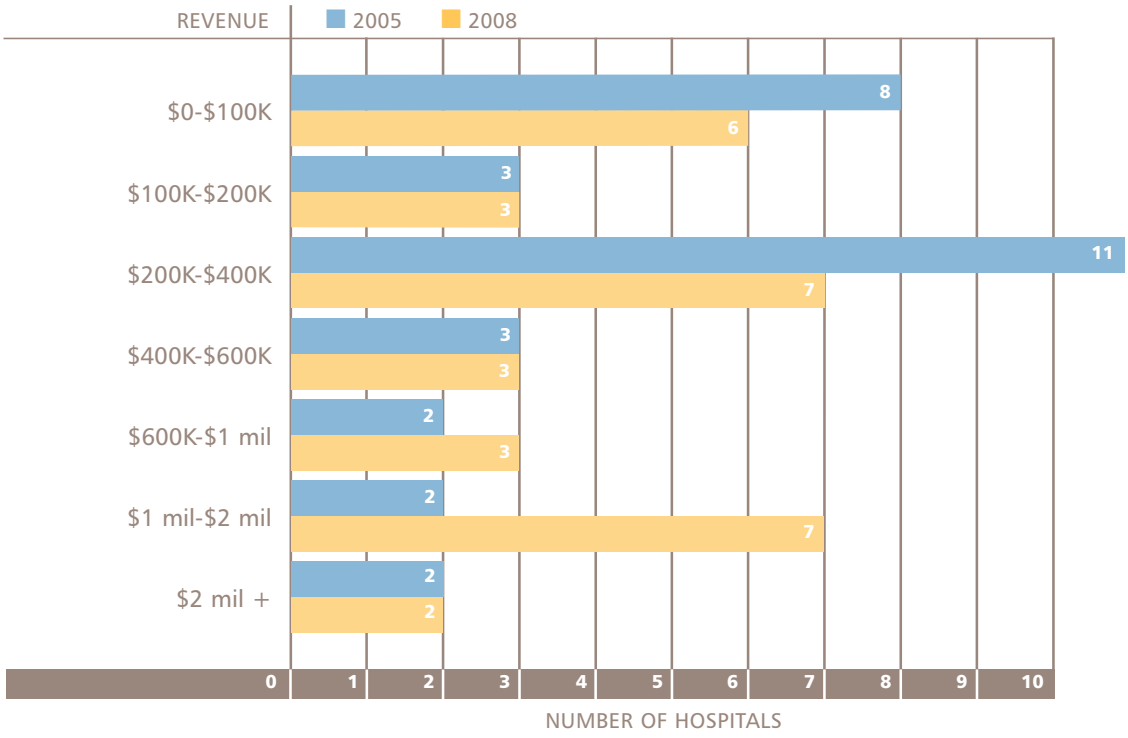
Figure 16
Operating Budget: 2005 and 2008
n=35



Overall from 2005 to 2008, the number of hospitals reporting "no budget" stayed the same at 16. Eleven hospitals report no budget both years; eight of these describe their response to child abuse as child abuse *services*. Three hospitals reporting no budget in 2005 report having budgets in 2008, while two hospitals reporting budgets in 2005 report having no budget in 2008.

Average revenue increased for the 31 hospitals providing this information from $644,300 to $830,600, an increase of 29 percent from 2005. The largest decline in revenue was $454,500 and the greatest increase was $1,262,600. Figure 17 shows an increase in hospitals with revenue in the range of $600,000 to $2 million and a decrease for hospitals that receive between $0 to $100,000 and $200,000 to $400,000 in revenue.

Figure 17
Revenue:
2005 and 2008
n=31

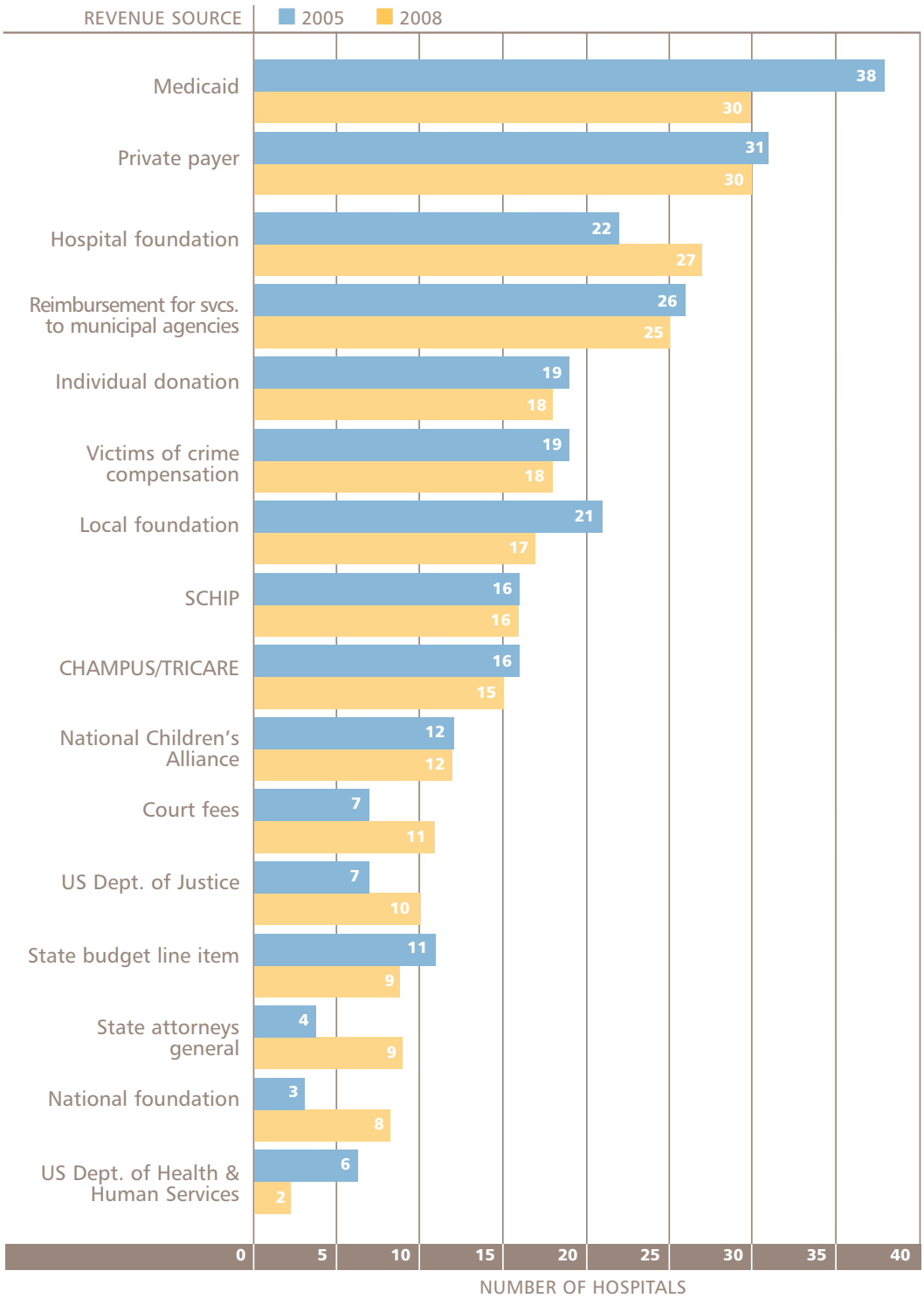


Medicaid is the biggest payer for child abuse programs, but the trend data show a 21 percent drop in programs reporting Medicaid as a revenue source along with a 19 percent decrease in local foundations, while 23 percent more respondents are receiving funds from hospital foundations.

Revenue Sources: 2005 and 2008

The total number of revenue sources selected in 2005 and 2008 stayed flat, possibly representing a shift in revenue sources rather than a net loss. Forty-four hospitals identify multiple revenue sources for funding child maltreatment programs and services in both 2005 and 2008. Change in most frequently selected revenue sources from 2005 to 2008 is depicted in Figure 18.

Figure 18
Revenue Sources: 2005 and 2008
n=44



Not displayed in Figure 18 are revenue sources reported by fewer than five hospitals in both years: Substance Abuse and Mental Health Services Administration (SAMHSA), Centers for Disease Control and Prevention, National Institutes of Health (NIH) and Title 19 of the Social Security Act. No hospitals reported U.S. Department of Housing and Urban Development as a revenue source either year.

REIMBURSEMENT: TREND DATA

The questions pertaining to reimbursement for clinical and non-clinical services were changed on the 2008 survey for clarity. As a result, trend data are not available.

EDUCATION AND TRAINING: TREND DATA

Full or partial funding for almost all types of training decreased over the last three years.

Respondents had the choice of indicating "funded" (partially or fully), "unfunded" or "unknown" for each type of training. Figure 19 shows fewer hospitals reporting funded training in 2008 while figure 20 shows a corresponding increase in the number of hospitals reporting that the same types of training are not funded. The exception is that support for child protective services training and pediatric practices has increased.

Figure 19
Funded Education and Training: 2005 and 2008
n=63

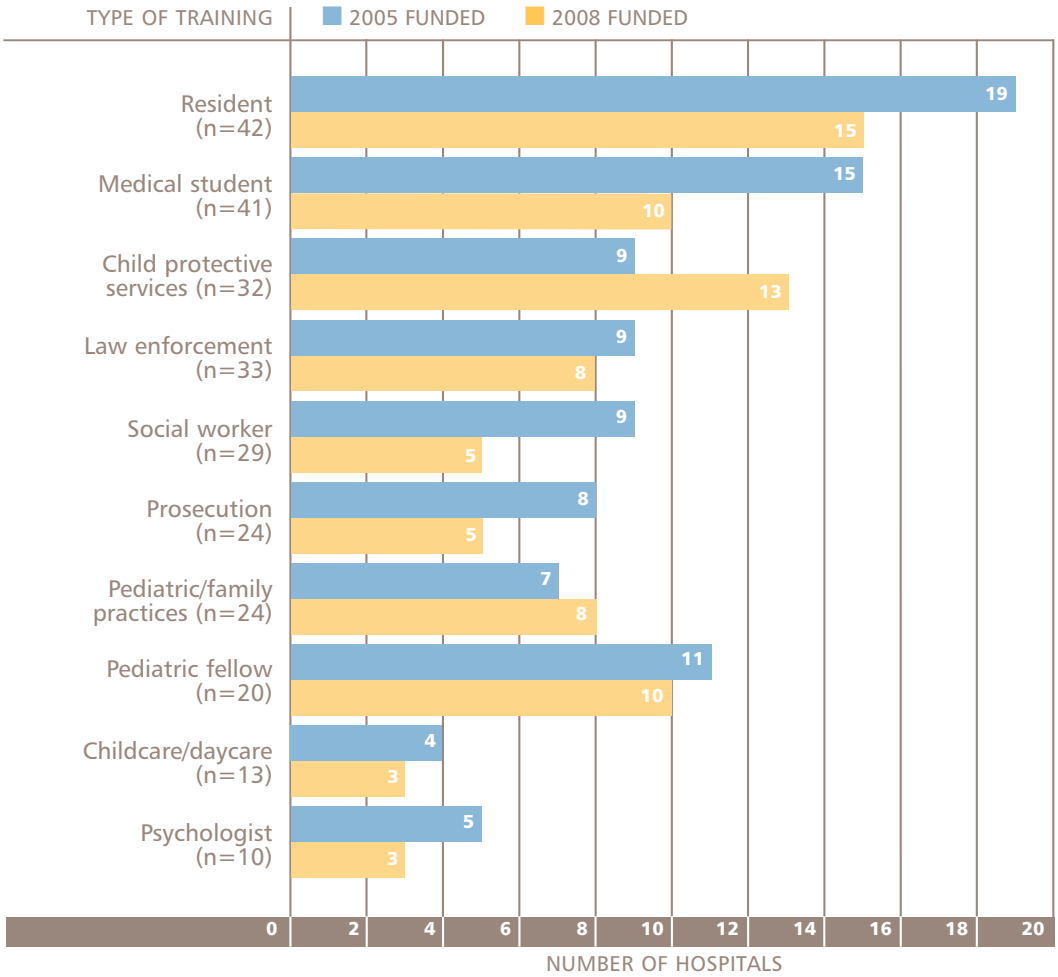
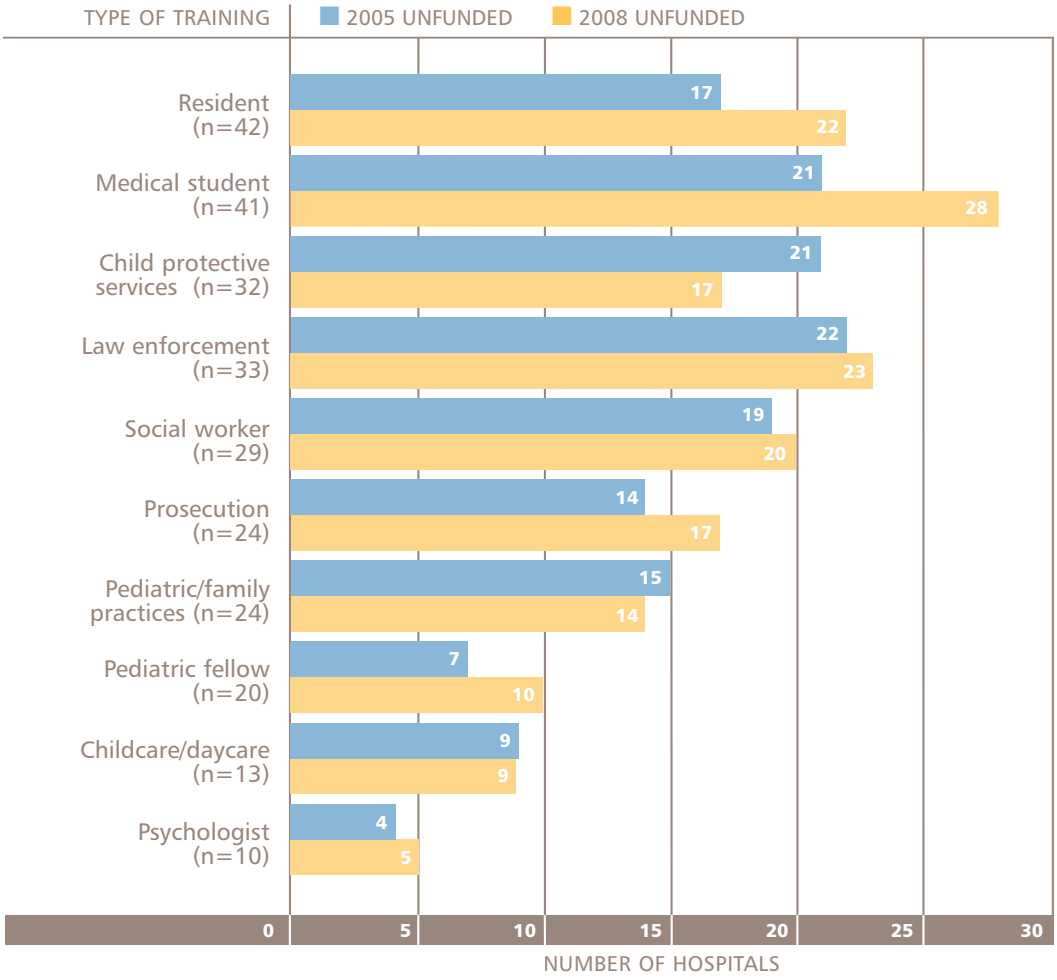


Figure 20
Unfunded Education and Training: 2005 and 2008



Respondents had the option on both the 2005 and the 2008 surveys to indicate that a type of training is not provided: Fewer exercised this option in 2008.

RESEARCH: TREND DATA

Of the 59 responses to the question "Do you conduct research?", 51 percent responded affirmatively in 2005 compared to 59 percent in 2008 —an increase of 8 percent.

Summary

Nearly all children's hospitals provide some services in the area of child maltreatment, but the depth and scope of those services vary greatly. NACHRI is committed to identifying common characteristics of a successful and sustainable response to child abuse. This commitment is anchored in the belief that children's hospitals are and can be transformational in the identification, treatment and prevention of child abuse and neglect within their communities.

This report forms the evidence base for a strong institutional response to child abuse, resulting in better access and improved outcomes for children. Three years ago NACHRI published *Defining the Children's Hospital Role in Child Maltreatment,* establishing guidelines for the hospital's response to child abuse and neglect in its community. The data from the 2005 and subsequent 2008 surveys support the hospital's position as a coordinating hub of child abuse services.

Growing Caseload and Staffing

Federal data underscore the observations of respondents that increased caseload does not appear to be a result of increased incidence of child maltreatment (U.S. Department of Health and Human Services, Administration on Children, Youth and Families, 2008). Rather, it is attributable to better recognition of both abuse and the value of child abuse professionals, as well as improved coordination with partners in the community.

It is reasonable to expect caseload and staffing will continue to grow as the first child abuse pediatrics fellowship programs are accredited in 2010. Talent and resources will gravitate toward those institutions where the hospital is investing in an accredited fellowship program and has a robust treatment and prevention program. NACHRI has championed the evolution of this subspecialty along with support for The Helfer Society's committee of fellowship program directors. Specialized care will reach more children in need of services and result in higher quality, comprehensive care.

Sustainability

It is clear from the data that most children's hospitals provide comprehensive child abuse services at a significant financial loss. The expense of underwriting child abuse programs has grown dramatically over the last three years, perhaps in part from enhanced services and better recognition and consistent with the increase in both caseload and staffing. While the majority of programs collect at least some revenue, in most cases, it is not enough to offset a shortfall. Further, the decrease in Medicaid revenue for child abuse services over the last three years and a shift to increased reliance on support from hospital foundations are alarming and not sustainable. Additional study of those programs that either broke even or had a positive bottom line in 2008 should be emphasized and shared with the larger community of children's hospital-based child abuse services. Integration of this data set with data from other NACHRI benchmarking programs could expand the picture to include overall hospital capacity and resources in relation to child abuse services.

All well developed child abuse programs provide an array of clinical and non-clinical services to not only treat the immediate medical needs of children suspected of having been abused, but also to coordinate with law enforcement and other community agencies that prosecute offenders. Yet, only a small portion of services are reimbursed. With increased scrutiny on the not-for-profit tax status of children's hospitals, child abuse services are an indispensible community benefit that needs to be fully accounted for by the hospital.

Education of Future Providers

Even as demand for those with expertise in child abuse rises, training is generally not well reimbursed. Child abuse is a grave and persistent public health threat that requires a coordinated network of response by a variety of agencies and individuals trained in the recognition, appropriate referral and treatment of children suspected of having been abused. Health care professionals across disciplines have a mandate to contribute to the education of the next generation of providers.

Formalization of child abuse pediatrics as a medical subspecialty fosters greater knowledge to improve care for children suspected of having been abused or neglected. This educational initiative is expected to encourage the proliferation of child abuse pediatricians and to expand their reach to more children who need this level of care. NACHRI is hopeful that dedicated funding for child abuse fellowship programs will become available to hospitals as programs are accredited.

Research

Despite a modest gain in child abuse research over the last three years, academicians and experts in the field would argue there exists a deficit of research to drive innovation and best practice in the field. That said, there is room for optimism. New requirements for high quality, accredited fellowship training programs will mandate a third year of training to what is now typically two years, thus allowing more opportunity for research. Further, as the field evolves to matriculate next generations of board-certified pediatricians, it is anticipated that many will gravitate toward academic medical centers where they can continue research interests sparked as fellows.

Next Steps

These findings and trends along with *Defining the Children's Hospital Role in Child Maltreatment* are comprehensive resources for children's hospitals, child abuse experts and their community allies. NACHRI staff is available to generate customized reports for the purpose of benchmarking data. Next steps include developing case studies based on the trend data to describe the evolving sophistication of individual programs from 2005 to 2008 and creating profiles of typical child abuse program structures. The next Child Abuse Services Survey will be conducted in 2011. At that point, three data sets will be available to measure and evaluate change in child abuse services at children's hospitals over six years.

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About NACHRI
The National Association of Children's Hospitals and Related Institutions is a not-for-profit membership association of 214 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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