



DEFINING THE
Children's Hospital Role
in Child Maltreatment



NACHRI
National Association of
Children's Hospitals
and Related Institutions

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Introduction

All children's hospitals see child abuse and neglect cases. Even if a children's hospital does not have a dedicated child abuse program, child maltreatment is an unavoidable health problem. Whether an abused child shows up at an acute care emergency room or child maltreatment is noticed during a home visit provided by a specialty hospital, immediate care needs to be provided.

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. The fact that nearly 3 million cases of suspected abuse and neglect are reported in the United States each year is an urgent call to action for every children's hospital (DHHS, 2005). Further underscoring the urgency 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, 2004). Medical and mental health spending for child abuse and neglect cases reported to child protective services tops \$2 billion dollars annually (NCANDS, 2005).

“Defining the Children’s Hospital Role in Child Maltreatment” is a comprehensive set of guidelines developed by the National Association of Children’s Hospitals and Related Institutions (NACHRI) to help children’s hospitals build, grow and/or improve sustainable child abuse and neglect response programs. The guidelines are the product of more than a year of discussion among leading child abuse experts and administrators from children’s hospitals. These experts were joined by key allies, including the American Academy of Pediatrics, the Association of Medical School Pediatric Department Chairs, the Ray E. Helfer Society and the National Children’s Alliance. The expertise and dedication these child health leaders provided to the project will help evolve the response of all children’s hospitals to our nation’s most vulnerable children.

The first child maltreatment teams in America were established at Children’s Hospital of Pittsburgh and Children’s Hospital Los Angeles during the late 1950s. Since then, children’s hospitals across the country developed programs – from exhaustive efforts of single physicians, to centers of excellence staffed by dozens of experts – that set the standard for medical intervention. As an integral part of community response, children’s hospitals are defined by their medical expertise and perspective of child abuse as a public health problem — not a prosecutorial or law enforcement problem. The challenge is to address the individual medical needs of each victimized child; provide comprehensive medical assessment to a high-risk population often medically underserved; and work on physical and mental healing.

Since child abuse was, until recently, a specialty not recognized by the medical establishment, abuse and neglect programs at children’s hospitals developed without an overarching system to guide efforts or define what communities should expect from these programs. These guidelines outline what a child maltreatment program at a children’s hospital should offer in way of infrastructure, staffing, functions and systems to be considered a “basic” program, “advanced” program or “center of excellence.”

A THREE-LEVEL SYSTEM

Under the rubric of **basic programs**, “Defining the Children’s Hospital Role in Child Maltreatment” sets forth the fundamental capabilities that a comprehensive children’s hospital should have to meet its community’s medical needs regarding child abuse and neglect. What staffing is needed? What policies should be in place? How can the program work with other experts in the community? These kinds of questions, which are particularly important in the establishment of a fledgling or basic child maltreatment team at a children’s hospital, are addressed in this document.

Each children’s hospital is as unique as the community it serves. There are undoubtedly circumstances in individual hospitals and communities that render one or some of the specific elements of a basic program inappropriate or irrelevant. In general, however, the framework for a basic program outlined in these guidelines applies to most children’s hospitals.

At the **advanced program** level there is evolution largely in terms of additional staffing capabilities; programs may add a social worker or engage a full-time medical director whose primary responsibility is the child maltreatment team, for example. Advanced programs are also more likely to serve a broader catchment area, reaching beyond the local community to receive referrals from outlying areas.

Centers of excellence are primarily distinguished by their educational and research capabilities, and their positions as regional and national leaders on child abuse and maltreatment issues. While basic and advanced programs may have some educational or research capabilities, centers of excellence offer fellowships, sponsor multicenter trials, and often take the lead in major child maltreatment prevention or intervention initiatives at a statewide or broader level.

Each level builds on the assumption that a growing program meets and will maintain the previous level's guidelines.

However, there will likely be some spillover between one level and the next. A child maltreatment program might meet basic standards in one category, but be advanced in another. If a program leader cannot check off every single recommendation in a particular level that does not mean the program has not achieved that level. “Defining the Children’s Hospital Role in Child Maltreatment” is not about measuring one hospital program against another. Instead, the guidelines offer a framework in which a children’s hospital can define its child maltreatment program and set goals for growth and development within the context of its community’s needs.

USING THESE GUIDELINES

It is important to make clear what “Defining the Children’s Hospital Role in Child Maltreatment” is not. It is not a set of clinical parameters or medical decision-making pathways. It does not prescribe specific tests, processes or treatment choices. (Practitioners seeking these will benefit from [Appendix A \(see page 47\)](#), which includes a list of clinically oriented resources.) It is not a new accreditation document and NACHRI isn’t establishing a new system of any sort. Rather, this document sets out to define the leadership role children’s hospitals play in responding to, treating, investigating, studying and preventing child abuse and neglect cases and provide a guide for strengthening programs nationwide.

While “Defining the Children’s Hospital Role in Child Maltreatment” is of most use to children’s hospitals, it can also be used as an external tool. As hospitals conduct self-assessments and child protection teams develop and position themselves, this document can provide guidance to other organizations and community groups, helping them understand how children’s hospitals work in the broader, multidisciplinary context of child abuse intervention and prevention.

Clarifying what this document is and is not begs the question as to why NACHRI set forth on this endeavor. In 2000, the NACHRI Board of Trustees approved child abuse and neglect as a public health focus for the Association, with a strategic recognition that this focus would be beneficial to children and children’s hospitals. NACHRI is focused on improving the quality of medical care to maltreated children and enhancing the leadership role children’s hospitals play in the child maltreatment arena. In issuing “Defining the Children’s Hospital Role in Child Maltreatment,” NACHRI seeks to:

1. Make a significant contribution to the field of child abuse and neglect
2. Clarify for children’s hospitals the unique role they play in the field of child abuse and neglect
3. Draw public attention to the role that children’s hospitals play in diagnosing and treating abused and neglected children

CHILD ABUSE RESPONSE IN NON-ACUTE CARE SETTINGS

While most children’s hospitals can build child protection programs like the ones outlined in this document, not all of them should. Some, for example, are specialty hospitals, such as burn centers or rehabilitation clinics. These hospitals 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. However, establishment of a general child maltreatment program would be inappropriate for such hospitals because they often do not have an emergency department through which they would come in contact with a broad range of abuse cases. Nonetheless, these hospitals need to establish protocols to ensure that medical staff maintain the skills needed to accurately diagnose and refer child maltreatment cases when seen, and, conversely, serve as effective consultants to child maltreatment teams seeking their particular expertise.

Non-acute care children’s hospitals can use the recommendations in this document to define their role in child maltreatment and are urged to adapt relevant sections, such as those on policies and community collaboration, to suit their unique circumstances.

UNDERSTANDING COMMUNITY NEEDS

Whether a child maltreatment program is basic, advanced or a center of excellence, it must be founded on principles of community collaboration. Before establishing or expanding a program, a children’s hospital should conduct a comprehensive community needs assessment. A program should recognize and be guided by the needs of the children it serves.

Because children’s hospitals are the medical experts in treating, evaluating and crafting medical opinion in cases of suspected child abuse, they work closely with an array of other professionals — law enforcement, social services, mental health specialists, Children’s Advocacy Centers and domestic violence experts to name but a few. Children’s hospitals that are non-acute care centers often work collaboratively with hospitals that provide emergency medical care.

A needs assessment conducted with these allies will determine what agencies and organizations are already responding to child abuse, and how a children’s hospital, in its role as medical expert, can best integrate into or improve the existing network.

ADDITIONAL RESOURCES

In addition to the broad parameters defining three general levels at which children’s hospitals can take on a leadership role in child maltreatment, “Defining the Children’s Hospital Role in Child Maltreatment” provides additional resources. Throughout the text, examples from a variety of children’s hospitals illustrate the implementation of specific recommendations. Appendixes to the document offer additional supporting materials, including a reference list of additional publications, planning tools and guidelines.

Section 1:
Structure and Staffing of the
Children's Hospital Child
Protection Team

Maltreated children need a variety of health-related services from a children's hospital and from partner agencies with which that hospital works. Services for these children are most comprehensive and best integrated with community services when children's hospitals have multidisciplinary child protection teams. A centralized, dedicated child protection team ensures that services are as supportive as possible to a child, the child's family and the medical staff (Bross, 1998; Palusci, 2003).

The overall structure of a child protection team varies significantly at each children's hospital. In broad strokes, however, all teams should be able to perform the same basic functions and have the same core capabilities. Whatever the size or scope of a child protection team, it does not "take over" the care of a child suspected of being abused or neglected from that child's primary treatment team. Rather, the team provides consultation to these medical professionals, offering expert diagnostic opinion, forensic medical evidence collection, interview guidance, and assistance in dealing with the family and outside agencies. Referrals to child protection teams typically come from social service agencies, law enforcement, emergency departments, newborn nurseries, inpatient pediatric wards, burn units and primary care clinics such as pediatrics, family medicine and prenatal care. It is important that members of a child protection team have good working relationships with these referral sources.

At a hospital with a **basic program** or child protection team, staffing may be limited. The team has, at minimum, a pediatrician who provides medical leadership, administrative coordination and social work services through staff trained in the field of child abuse. While each of these functions is essential to a child protection program, they need not be performed by a separate, dedicated staff person. For example, at some children's hospitals the team's medical director also acts as an ad hoc administrative coordinator. Social work is often provided on an as-needed basis by the hospital's overall social work team, which is given additional training on child maltreatment ([see Chapter 3, Page 13](#)). In addition, the children's hospital invites appropriate community members to participate in child protection meetings and functions on a regular basis.

An **advanced program** establishes its child protection team as an administrative unit of the children's hospital, with centralized management and administrative functions. The team meets regularly at a recurring time and place to present and review child abuse cases. The team also coordinates, as appropriate, with community agencies involved in child protection.

A **center of excellence** has a larger, more comprehensive child protection team that includes other health professionals, such as psychologists or social workers. (Programs not at this tertiary level should still have access to mental health and social work services, either from other hospital departments or via referral if they do not have such professionals assigned to the child protection team.) In addition, the advanced diagnostic and treatment capacities of center of excellence teams often require hospital medical and surgical subspecialists to be available for consultation.

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, educational and clinical responsibilities and a correspondingly wide range of skills, knowledge and experience. Whatever the level of a child maltreatment program, 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 should have management skills, be comfortable in a leadership role and with public appearances, as well as have the ability to educate and train a variety of audiences on child maltreatment issues.

In a **basic program**, medical direction is provided, with few exceptions, by a pediatrician (hospital staff or community-based with hospital privileges; optimally board-certified in general pediatrics) who takes initiative in the field of child maltreatment. In a basic program the medical director:

- Pursues knowledge of the most current practices and research in the field
- Organizes medical information, interprets diagnostic data and communicates level of concern and impressions to non-medical, community-based professionals
- Provides direct supervision and review of cases performed by allied health care professionals (who also have specialized interest or training), trainees, students, residents and other hospital staff. When the physician leader of the team is not a pediatrician, a trained pediatrician provides these medical services.
- Interprets medical information for the legal system and the courts when needed
- Demonstrates competence in participating in multidisciplinary teams and effectively collaborates with other health care professionals and team members in the community
- Has comprehensive training in child maltreatment and its presentation in the medical care system (in the absence of formal child abuse training), especially physical and sexual abuse and serious neglect ([see Appendix A, Page 47](#)).
- Provides leadership for the hospital as to how it should address the needs of children and families in the hospital and community regarding child maltreatment
- Knows about available research resources in the community and collaborates with the research efforts of more extensive child maltreatment programs by providing case data

Within **advanced programs**, the responsibilities of the medical director expand. These growing programs have larger auxiliary components, such as education and training, advocacy and outreach, and prevention. At this level the medical director:

- Ensures appropriate clinical coverage for child maltreatment cases based on community needs and staffing ratios at the hospital
- Serves as the medical leader for peer review and educational programs coordinated by the child protection team ([Hospital Example 1](#))
- Provides mentoring for other physicians as they learn to manage or consult on child abuse and maltreatment cases
- Encourages quality assurance efforts that examine team functions
- Enables collaborative team meetings
- Directs the improvement of medical services to abused and neglected children in the children's hospital ([Hospital Example 2](#))
- Helps secure ongoing administrative support and funding

A **center of excellence** often seeks a medical team leader in the field or a pediatrician who received fellowship training in child abuse and neglect. In coming years, many centers of excellence will choose a physician leader who is board-eligible or certified in child abuse pediatrics by the American Board of Pediatrics after the certification becomes available and sufficient time has passed for physicians to achieve the designation.

At a center of excellence, the program's status as a regional leader, educator and research center is added to the medical director's responsibilities. At such centers, 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. The team's medical director:

- Encourages and facilitates research into child abuse and maltreatment issues by members of the child protection team, and conducts and/or co-investigates such research
- Plays a key public role in community advocacy and prevention efforts ([Hospital Example 3](#))
- Provides medical leadership for Children's Advocacy Centers, domestic violence prevention and intervention programs, child abuse prevention programs, and other community and advocacy programs as the child protection team's services expand
- Serves as a source of peer review locally and regionally and mentors colleagues
- Leads research efforts focused on child abuse and neglect and is knowledgeable about the steps needed to protect patients when conducting such research

1 Although the Regional Child Protection Center at **Blank Children's Hospital** in Des Moines, IA, is relatively new, the academic credentials of its medical director, Rowan Shah, M.D., gave it a strong educational component from the beginning. As a faculty member at the University of Iowa, Shah sponsors a one-month rotation at the center for pediatric residents. The center also provides training for community health care workers and others likely to encounter drug-exposed or abused children. Training, says Shah, is an excellent public relations tool. "Blank Children's Hospital provides me the opportunity and resources to travel and present educational workshops to professionals from various disciplines in urban and rural communities. Now in many of those communities, when they have a case identified and want an evaluation, they know we're the source." For more information, contact Chaney Yeast at yeastc2@ihs.org; <http://www.blankchildrens.org>; or download "Confronting Child Abuse and Neglect: Portraits of Child Abuse Teams" at <http://www.childrenshospitals.net>.

In June 2005, the American Board of Pediatrics (ABP) approved a petition to create a new subspecialty in child abuse pediatrics. In turn, ABP submitted a petition to the American Board of Medical Specialties. The approval process at this level includes a comment period of one year. Approval is anticipated by fall 2006. At that point, work will commence on establishment and accreditation of fellowships and on a certifying examination. A "grandfather" period will follow, allowing pediatricians currently working in the child abuse field an opportunity to sit for the examination.

2 Advanced child abuse response programs work effectively with departments such as trauma, emergency and neurosurgery to improve the overall care of abused children in the hospital. At the Kempe Children’s Center, affiliated with **The Children’s Hospital**, Denver, the child protection team is collaborating with the hospital’s trauma, neurosurgery and public affairs departments to develop an educational program on shaken baby syndrome (also referred to as abusive head trauma). This effort will educate parents on the risks of shaking. *For more information, contact Andrew Sirotnak, M.D., at sirotnak.andrew@tchden.org; <http://www.thechildrenshospital.org>; or download “Confronting Child Abuse and Neglect: Portraits of Child Abuse Teams” at <http://www.childrenshospitals.net>.*

3 At the Kempe Children’s Center, affiliated with **The Children’s Hospital**, Denver, Medical Director Andrew Sirotnak, M.D., provides training on child abuse issues to a number of different community organizations and works closely with Denver County’s Court Appointed Special Advocates (CASA) program. When Sirotnak goes to events on behalf of CASA or trains CASA volunteers, he’s also serving as an ambassador for the center and hospital. He is showing the program’s commitment not only to addressing child abuse in a hospital-based program, but in the broader community. *For more information, contact Andrew Sirotnak, M.D., at sirotnak.andrew@tchden.org; <http://www.thechildrenshospital.org> or; download “Confronting Child Abuse and Neglect: Portraits of Child Abuse Teams” at <http://www.childrenshospitals.net>.*

CHAPTER 2: TEAM ADMINISTRATION AND COORDINATION

At the foundation of every child protection team is a clinically oriented coordinator who is committed to quality assessment and treatment. The coordinator’s training provides an orientation to the issues the team will address, from medical assessments to mental health issues, to interactions between the community-based and hospital teams. The team coordinator assesses the strengths and clinical challenges facing the program and guide continuous efforts to improve service delivery quality.

In many institutions the staff person assigned the coordinator role may be a social worker or a nurse case manager; in some cases the duties rotate among team members. The child abuse team requires clinical social work support in the assessment and management of individual cases ([see Chapter 3, Page 13](#)).

In creating a **basic program** or child protection team, a number of factors should be considered when developing the team coordinator position:

- The role of team 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 abuse services.
- The hospital must allot adequate time for the team 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 a program, including overall case load.

- The team coordinator should participate, with hospital support, in periodic professional educational efforts to increase his knowledge about child abuse, best practices in hospital-based child abuse response programs, and effective and efficient ways to implement the institution's child abuse response program.

The child protection team coordinator establishes operational systems to ensure the effective and efficient management of the child abuse response program. Working in concert with the medical director, the coordinator, directly or through delegation:

- 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 team. ([see Chapter 5, Page 20](#))
- Ensures core data and tracking functions are performed in a timely manner
- Develops and integrates the community child abuse team into the hospital's child abuse response program as appropriate. In working with the community-based 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.
- Cooperates with community child abuse team investigations. This is an expected function and should not be restricted by other hospital policies regarding privacy and confidentiality. ([Hospital Example 4](#))
- Serves as a point person for referrals from community agencies and community hospitals
- 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. Inconsistency between medical findings and the history offered is often a key diagnostic factor in assessing non-accidental trauma. It is important to collect all histories provided as it is not uncommon in child abuse cases for an abusing caregiver to offer multiple and evolving explanations for the cause of the injuries and for any delay in seeking medical treatment. While it is the medical professional's responsibility to take such histories, the coordinator ensures this documentation is kept in a well-organized, accurate system that can easily be accessed for case management and investigations.
- Provides for ongoing case management of abuse and neglect patients to ensure appropriate follow-up and treatment is obtained
- Provides basic information to community agencies about the medical evaluation of child abuse
- Organizes peer review by discipline for hospital/medical personnel. Peer review in a child abuse team can take a number of forms, from medical peer review to peer review among child interviewers or mental health practitioners.

When a child protection team at a children’s hospital expands staff and capabilities, moving to an **advanced program** level, the responsibilities of the team coordinator also grow. At such institutions, the team coordinator:

- Works with the team director and hospital fundraising staff to secure ongoing administrative support and funding
- Organizes and facilitates multidisciplinary child protection team meetings within the hospital and/or community-based team meetings
- Organizes and facilitates extensive internal and/or cross-institutional peer review systems
- Identifies gaps within the community child abuse response system and communicates those observations and any suggested opportunities for improved team operation to the medical director, the hospital administration and/or the leadership of the community-based team

Child protection **centers of excellence** at children’s hospitals are distinguished primarily by their regional leadership roles and extensive outreach/advocacy programming, as well as their advanced educational and research components. At such highly developed centers, the team coordinator:

- Coordinates and supports the child protection team’s community advocacy and prevention efforts (see [Chapter 6, Page 23](#)) ([Hospital Example 5](#))
- Facilitates the team’s research program and educational offerings, including the logistical and administrative coordination of fellowships, internships and residency rotations ([Hospital Example 6](#))
- Takes a leadership role in local and regional organizations involved in child protection
- Seeks out opportunities for recognition of the child protection team within the hospital and in the local community to advance and strengthen the program ([Hospital Example 7](#))

4 The power of a child protection team is often in direct proportion to the quality of communication among team members. At **Blank Children’s Hospital** in Des Moines, IA, investigators from child protective services and law enforcement attend each appointment so important child safety and investigative decisions are made in a timely manner based upon the medical, psychosocial and forensic interview information gathered by the team. Chaney Yeast, manager of the Regional Child Protection Center at Blank Children’s, regards the professionals the program deals with as “customers,” and regularly checks in with them to find out what helped a particular case go smoothly. Asking these questions gives the program the information it needs to improve and lets community team members know their opinions are valued. *For more information, contact Chaney Yeast at yeastc2@ihs.org; <http://www.blankchildrens.org>; or download “Confronting Child Abuse and Neglect: Portraits of Child Abuse Teams” at <http://www.childrenshospitals.net>.*

5 St. Joseph's Children's Hospital of Tampa in Tampa, FL, takes child abuse prevention education to an unlikely forum — jail. Hospital staff considered the myriad of audiences they could reach with targeted education about child abuse (shaken baby syndrome in particular) and identified single, teenage fathers as an appropriate audience. Along with prevention education, other topics are offered, such as typical child development, positive discipline and home safety. The goal of providing this range of information is to promote bonding and encourage an active role for the young fathers in the lives of their children. *For more information, contact Melanie Hall at melanie.hall@baycare.org; <http://www.stjosephschildrens.com>.*

6 When developing a baseline for tracking the success of its abusive head trauma prevention program, Prevent Child Abuse Ohio, based at **Children's Hospital**, Columbus, OH, found that the abusive head trauma code was not consistently used. Researchers isolated approximately a dozen diagnosis codes that could indicate abusive head trauma and pulled data for children under age 3 from 1997-2003. A physician who helped develop the program reviewed all relevant medical records to develop good historical baseline data and a framework for assessing future cases. *For more information, contact Philip Scribano, D.O., at scribanop@pediatrics.ohio-state.edu; <http://www.childrenscolumbus.org>; or download "Confronting Child Abuse and Neglect: A Simple Model, A Vital Purpose: Preventing Shaken Baby Syndrome" at <http://www.childrenshospitals.net>.*

7 At the CAARE Diagnostic and Treatment Center and California Medical Training Center at **University of California Davis Children's Hospital** in Sacramento, CA, Marilyn Peterson, director, seeks ways to get public recognition for the hospital based on the CAARE Center's programs. When *The Sacramento Bee* had an annual contest naming best workplaces in the area, Peterson nominated the hospital, which won in its category based in part on the child abuse response program. The center's annual golf tournament, a successful fundraising event, has also proven a useful public relations tool. Hospital administrators play golf with executives from large companies, gaining the hospital additional recognition among corporate leaders. Peterson also submits all newsworthy happenings at the center to the hospital's electronic newsletter, and invites heads of state and federal agencies to visit the center. *For more information, contact Marilyn Peterson at marilyn.peterson@ucdmc.ucdavis.edu; <http://www.ucdmc.ucdavis.edu/children>.*

CHAPTER 3: OTHER PROFESSIONALS

A child protection team at a children's hospital should offer the services of trained clinical social workers who can participate in history taking with other professionals, provide support to families and children when abuse or neglect is suspected, and perform psychosocial assessments to evaluate for risk factors of abuse.

Social work functions can be performed by a dedicated social worker on the child protection team, or by other hospital-based social workers tapped and trained for these functions. The larger and more comprehensive a program, the more likely it is that the child protection team has its own staff of social workers.

Ideally, a **basic program** includes a social worker as an assigned member of the dedicated child protection team. Indeed, some child protection teams have a social worker as their administrative director. (In such cases, 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 the team serves.)

At some children's hospitals, staffing and budget limitations may make it a challenge to hire or assign a full-time social work staff member to the child protection team. At minimum, one member of the hospital's overall social work staff should be assigned to work with the team, become familiar with its needs, and consult on cases as needed. ([Hospital Example 8](#))

Whether or not the social worker is part of the child protection team or assigned from the department of social work as needed, they:

- Have training in the dynamics of child abuse and in identification of abuse in a hospital setting
- Collaborate with the community-based team
- Are familiar with mandatory child abuse reporting laws
- Are knowledgeable of child maltreatment community resources and can be designated as a resource specialist in this area
- Participate in case review and presentation
- Ensure that the emotional and other needs of the family requiring services are met, including crisis intervention

Within **advanced programs**, social work staffing increases proportionately as the program grows. Social workers on the team or assigned to cover its needs:

- Are available during all regular child protection clinic/service hours
- Are available via an on-call system for after-hours emergent cases
- Participate in case review and presentation
- Contribute to the education and training of new social work staff in child protection issues
- Provide education and training to medical staff on the needs of social workers

At a **center of excellence**, the team has an enhanced case management function. ([Hospital Example 9](#)) Within such programs social workers:

- Serve as a regional resource for social workers in smaller programs and those in communities without medically based child protection teams
- Address the mental health of professionals handling serious child abuse cases.
- Participate in specialized training and internships for social workers ([Hospital Example 10](#))

8 Founded in March 2003, the child protection team at **St. Christopher’s Hospital for Children** in Philadelphia is one of the nation’s newest. From its inception, staff included a social worker, in addition to a medical director and a nurse. In order to provide 24-hour consultation, other social workers are recruited as needed from the hospital’s main social work department. Social work took a leading role in the child protection team from the beginning. The hospital’s director of social work partnered with Angelo Giardino, M.D., the team’s founding medical director (now at Texas Children’s Hospital in Houston), to convene the early meetings that led to the creation of the team. *For more information, contact Angelo Giardino, M.D., at apgiardi@texaschildrenshospital.org; <http://www.stchristophershospital.com>; or download “Confronting Child Abuse and Neglect: Portraits of Child Abuse Teams” at <http://www.childrenshospitals.net>.*

9 The CAARE Diagnostic and Treatment Center and California Medical Training Center at **University of California Davis Children’s Hospital** in Sacramento, CA, has five social workers, including a licensed clinical social worker and a case manager, on its staff of 120. The psychosocial services these professionals provide include psychosocial intakes, crisis counseling for children and families, patient advocacy and case management, referrals for mental health services provided within the center, and referrals to other agencies and services. *For more information, contact Marilyn Peterson at marilyn.peterson@ucdmc.ucdavis.edu; <http://www.ucdmc.ucdavis.edu/children>.*

10 The **University of California Davis Children’s Hospital** CAARE Diagnostic and Treatment Center in Sacramento, CA, trains two second-year Masters of Social Work students each academic year in partnership with California State University – Sacramento’s School of Social Work. Interns work with experienced social workers and other multidisciplinary staff on the child maltreatment team, learning clinical and medical social work skills under the supervision of a licensed clinical social worker. Interns are trained in mandated child abuse reporting laws, legal and ethical issues of child abuse and neglect, cognitive behavioral therapy and parent-child interaction therapy, and gain experience in providing direct services to children and families. *For more information, contact Marilyn Peterson at marilyn.peterson@ucdmc.ucdavis.edu; <http://www.ucdmc.ucdavis.edu/children>; or download “Confronting Child Abuse and Neglect: The Future of Education and Training” at <http://www.childrenshospitals.net>.*

Section 2:
Functions of the
Children's Hospital Child
Protection Team

The dedicated child protection team at a children’s hospital is charged with supervising all hospital-based child maltreatment functions, ranging from core services, such as diagnosis and treatment, to more extensive programming, such as outreach, education and research. The team provides medical assessment and consultation services to inpatient, emergent and other hospital clinics, recommends internal or external referrals, provides medical opinion on child abuse cases and helps develop hospital policy and procedures regarding child abuse. In some cases, the “team” may be one person – a pediatrician with training and interest in child abuse – who provides clinical services and works with other hospital staff as needed to coordinate these services.

The more extensive the program, the broader the functions and services of the child protection team, as this section explains. Basic programs offer a core of clinical services, documentation and coordination with community partners, while larger and more advanced programs may host a Children’s Advocacy Center, lead professional training opportunities and incorporate other services, such as domestic violence prevention.

CHAPTER 4: CLINICAL SERVICES

The fundamental role of any child protection team at a children’s hospital is to ensure that children suspected of being abused or neglected are diagnosed correctly and receive the best possible and most appropriate medical care. While other elements of child protection programs are important, caring for a child’s medical needs is essential.

Non-acute care centers may refer some portion of these services out (if they are the first to intervene), or may provide only some of these services through referral from an acute care facility.

In **basic programs**:

- All children who are suspected victims of child maltreatment are offered a comprehensive medical evaluation. Medical evaluations are provided based on specific criteria developed by skilled medical providers. ([Hospital Example 11](#))
- The child protection team physician is available for consultation. A system is in place that ensures a pediatrician reviews all child abuse cases in a timely manner. Response should be medically appropriate and reflect the urgency of the case. Standards for response are developed by the child abuse response team.
- Medical staff obtains a history that is medically complete and assesses the child’s safety needs.
- If expertise in child sexual abuse examination is not available through the child protection team, the hospital has experts available to refer for timely sexual abuse examinations with a local or regional Children’s Advocacy Center.
- Internal or external trained interviewers are used to augment historical information obtained by the child protection team.
- Psychosocial assessments and mental health referrals are provided.

Within **advanced programs**, the difference in clinical services is often seen in staffing levels and overall hours of coverage. Ideally there is an outpatient clinic for child protection services with regular visiting hours, but some advanced programs do not have established physical “clinics.”

In advanced programs:

- A policy for timely notification of suspected cases of child maltreatment to the hospital’s child abuse response team is in place.
- A program, clinic or center is staffed by child protection team members for the evaluation of alleged or suspected child abuse. ([Hospital Example 12](#))
- The child protection team is consulted for inpatient and outpatient suspected victims of child maltreatment and oversees the medical evaluations. Someone from the team is on call every day. ([Hospital Example 13](#))

At a **center of excellence**, the primary difference in clinical services is that a specialist in child maltreatment is the clinician providing the physical examination to all children in suspected abuse cases ([Hospital Example 14](#)). At other centers, these physicians may not always be available and may act as consultants to the primary examining physician for some cases.

At a center of excellence:

- All children suspected of having been abused receive a comprehensive medical evaluation conducted by a clinician who specializes in child maltreatment.
- The hospital has staff capability to obtain detailed medical histories, or can provide patients with access to trained forensic interviewers available through a partner such as a Children’s Advocacy Center. Policies are set in place for a reasonable response time for interviews.
- The child abuse program outlines a procedure on how to develop a consensus report that states the team’s recommendations as to what is in the best interest of the child.
- Additional clinical services, such as mental health care and counseling, are provided.
- Other specialists and subspecialists, such as pediatric neurologists, ophthalmologists and orthopedic surgeons, who have been educated in child abuse issues by the primary child maltreatment team, are available for regular clinical consultation.

11 Many children who have been abused and/or neglected may have never had a comprehensive medical examination, says Jill Glick, M.D., assistant professor of pediatrics at the **University of Chicago Comer Children’s Hospital** and a forensic pediatrician with extensive training and experience in child abuse cases. When a child protection team at a children’s hospital is called in on a case, there is a window of opportunity to assess the general health history and current medical needs of the child. “The majority of these children haven’t had good medical care and it’s important to look at their past history – in particular their growth and development – and parents compliance with established criteria for ongoing preventive care,” Glick says. A comprehensive examination provides the opportunity for referrals for other health care needs, be they emergent, chronic or developmental. *For more information, contact Kristen Bilka at 773/702-4900; <http://www.uchicagokidshospital.org>; or download “Confronting Child Abuse and Neglect: Mandated Medical Expert Review for Chicago Children” at <http://www.childrenshospitals.net>.*

12 All children in Chicago who are reported to Child Protective Services because of suspected abusive head trauma, fractures or intestinal injuries are evaluated by one of three Multidisciplinary Pediatric Education and Evaluation Consortium (MPEEC) teams, two of which are based at children’s hospitals: the **University of Chicago Comer Children’s Hospital** and **Children’s Memorial Hospital** at Northwestern University. The third team is based at Cook County Hospital. The MPEEC central office receives each suspected abuse report and assigns a child abuse medical expert from one of the three institutions to the case. The expert is provided with information about the medical team treating the child and the child protection specialist and law enforcement personnel involved with the case. The medical team and the investigators – physicians, police officers and social workers – share information and discuss their portion of the investigation with the MPEEC child abuse medical expert. “We receive copies of case notes from the Department of Family Services, and share our medical findings with the police officers who are investigating,” says Emalee Flaherty, M.D., assistant professor of pediatrics at Northwestern University’s Feinberg School of Medicine and medical director of the protective services team at Children’s Memorial. The medical expert reviews the record, the history and all available information, going over imaging studies with radiologists or neuroradiologists. The expert then provides a comprehensive and definitive medical opinion report to the state with an opinion as to whether the child was maltreated. For more information, contact Emalee Flaherty, M.D., at e-flaherty@northwestern.edu; <http://www.childrensmemorial.org>; or download “Confronting Child Abuse and Neglect: Mandated Medical Expert Review for Chicago Children” at <http://www.childrenshospitals.net>.

13 The child protection team at **St. Christopher’s Hospital for Children** in Philadelphia was launched in 2003 with a three-phase development plan. During its first two years, the center operated with only three staff members: a medical director, a full-time social worker and a nurse. The team recruited support as needed to provide 24-hour consultation coverage in the emergency department and through the social work department. In early 2005, the hospital launched the second phase, an independent screening clinic for child abuse and neglect that conducts follow-up appointments for the hospital’s emergency department. Now entering the third phase, the clinic is working toward conducting its own evaluations in emergent and non-emergent cases referred by law enforcement and other agencies, as well as directly from the hospital’s emergency department. *For more information, contact Ifye Ford at ifye.ford@tenethealth.com; <http://www.stchristophershospital.com>.*

14 The Kempe Children’s Center, affiliated with **The Children’s Hospital**, Denver, has one of the longest-running child protection teams in the nation. Every year, the center provides an average of 800 medical consultations. The center’s additional programs average 1,500 psychological treatment sessions and 2,230 treatment days to children and their families. The child protection team’s medical director, Andrew Sirotnak, M.D., estimates that about 300 of these 800 medical consults involve sexual abuse, another 200 involve severe physical abuse and the remainder are outpatient or psychological therapy visits. The child protection team operates like any medical department within the hospital, Sirotnak explains. The team consists of two full-time physicians, including a child abuse fellow; one full-time pediatric nurse practitioner; a full-time child health associate/physician’s assistant; a part-time psychologist; and a hospital social worker who is assigned to cover the child protection team, the emergency department and trauma services. Patients are referred predominantly by the children’s hospital, which in turn receives cases through law enforcement, social services, community organizations and family self-referrals. The team provides medical and psychological examinations, but does not conduct forensic interviewing. Interviews are conducted in well-established community Children’s Advocacy Centers. For more information, contact Andrew Sirotnak, M.D., at sirotnak.andrew@tchden.org; <http://www.thechildrenshospital.org>; or download “Confronting Child Abuse and Neglect: Portraits of Child Abuse Teams” at <http://www.childrenshospitals.net>.

CHAPTER 5: POLICIES

As health care providers, children’s hospitals and their staffs are mandated reporters of child abuse — even when there is no designated child abuse response program at the hospital. Basic policies governing how suspected child abuse is reported, appropriate channels for reporting from all hospital departments and clinics, and documentation of such reports are essential at every children’s hospital.

Clear governing policies become even more important and require more detail when child abuse response programs are established. Child abuse and neglect cases often involve complex interactions not only among multidisciplinary medical teams within the children’s hospital, but with external agencies, such as law enforcement and social services, as well as with the court system. Child protection teams of any scope or size require a clear set of policies in place to guide these collaborations. These policies should cover several broad areas, including how referrals are made to the child maltreatment team, how cases are evaluated, how information is shared with external agencies and how costs are allocated.

Before launching a basic child abuse response program, 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 ([see Chapter 11, Page 43](#)).

Basic program policies include:

- Referral policies to the child protection team or another appropriate organization
- A mandate that allows referrals to the child protection team to be made by any member of the hospital staff
- Guidelines and protocols for the medical evaluations of suspected child maltreatment including histories, examinations, documentation, reporting, radiographic imaging and consultation of the child protection team
- Strict compliance with all state laws governing the reporting of 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 – should be well known to child protection team staff.
- Guidelines on how to choose the timing, location and provider of the medical examination so that skilled evaluation is conducted, acute injuries (as well as evidence of old or chronic injuries, such as healed fractures and scars) are documented and forensic specimens are preserved. A trained screener can determine the need for an emergency evaluation and where non-emergent examinations should be conducted.
- Guidelines for collaboration by the children’s hospital and the child protection staff with community agencies such as police, social services and prosecutors
- Visitation guidelines in instances where non-accidental trauma is suspected ([Hospital Examples 15 and 16](#))
- Adequate procedures to maximize reimbursement for child maltreatment cases ([see Chapter 10, Page 39](#))

Advanced program child protection teams often receive referrals from a wider array of sources and a larger catchment area. Their protocols should reflect this, creating clear channels of communication and lines of decision-making.

Advanced program policies include:

- Internal policies to advance awareness, education and zero tolerance for violence or inappropriate behavior within the hospital and its health care settings ([Hospital Example 17](#))
- Surveillance policies and capacities if the hospital serves as a referral for suspected Munchausen by proxy syndrome cases ([Hospital Example 18](#))
- Protocols for consultants and specialists who receive child abuse referrals from outlying community hospitals and for shepherding referrals through a liaison who serves as consistent, reliable contact person. This screener does not need to be a physician, but should be knowledgeable about child maltreatment and the child protection team’s policies, and able to communicate with physicians and other medical personnel.
- Ways to 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 ([Hospital Example 19](#))
- Protocols between the hospital’s risk management department and child protection team on issues of potential threat to children’s safety within the hospital setting ([See Chapter 11, Page 43](#))

At the **center of excellence** level, the extent and detail of policies are likely to be largely the same as those incorporated within advanced level programs. However, the center also develops a crisis communications plan in concert with the hospital’s media relations/communications staff to be put in place before a crisis arises (e.g., allegations of abuse by a hospital employee or a missed diagnosis).

15 Protocol at **UCSF Children’s Hospital** in San Francisco permits the medical team to limit or totally restrict visitation by a caregiver it believes may jeopardize the safety of the patient. This protocol is used in the most extreme cases where the department of child protective services has not provided the hospital with necessary visitation guidelines, or a perpetrator has not yet been identified. Further, it is hospital policy that any patient admitted for non-accidental trauma be placed in a monitored room near the nursing station. *For more information, contact Rebecca Gates at rebecca.gates@ucsfmedctr.org; <http://www.ucsfhealth.org/childrens>.*

16 At **The Children’s Hospital at the Medical Center of Central Georgia** in Macon, a “sitter” is routinely ordered for inpatients until abuse is ruled out by the department of family and child services and the agency determines that the child is safe with his appointed guardian. The policy went into effect after an unobserved parent abused a hospitalized child. The cost of the program is born by the hospital – as opposed to a local department of child protective services – and is shared among the units that care for maltreated children. *For more information, contact Cyndee Adams at adams.cyndee@mccg.org; <http://www.mccg.org/childrenshealth>.*

17 **The Children’s Mercy Hospital** in Kansas City, MO, developed the Creating an Attitude for a Responsive Environment (CARE) Program to make the hospital a safe and healthy environment for children and families. The child abuse prevention program educates families about positive parenting strategies and trains hospital employees and volunteers to identify and intervene when families in the hospital are under stress and whose actions may degenerate into abuse. The hospital developed a handbook for the CARE program that outlines hospital policies and provides training tools and examples. The handbook is available to other hospitals for a nominal fee. *For more information, contact Alice Kitchen at akitchen@cmh.edu; <http://www.childrens-mercy.org>.*

18 **C.S. Mott Children’s Hospital University of Michigan Health System** in Ann Arbor receives frequent referrals for Munchausen by proxy syndrome cases. Two rooms are equipped with video surveillance. Procedure first calls for an inpatient evaluation without the suspected perpetrator present to attempt an objective assessment. If the suspected perpetrator refuses to leave, covert video surveillance is considered after a multidisciplinary team meets and agrees that there is sufficient concern for pediatric condition falsification. *For more information, contact Elaine Pomeranz, M.D., at 734/763-0215; <http://www.med.umich.edu/mott/>.*

19 Close, well-defined relationships with external partners such as police, Children’s Advocacy Centers, district attorney offices and social services can facilitate appropriate referrals and make the jobs of all child protection team members easier. For example, says Lori Frasier, M.D., medical director of the Center for Safe and Healthy Families at **Primary Children’s Medical Center** in Salt Lake City, UT, the center’s good relationship with the local legal community helps ensure that appearances in court are not an excessive burden for the physicians testifying. “Attorneys know that our doctors have urgent cases and can’t sit all day in a courthouse, so together we’ve developed ways to facilitate communication so that a subpoena that says 8 a.m. doesn’t cause a problem.” *For more information, contact Lori Frasier, M.D., at lori.frasier@ihc.com; <http://www.primarychildrens.com>.*

CHAPTER 6: PREVENTION AND ADVOCACY

As the medical experts in child maltreatment, child protection teams at children's hospitals have an important role to play in educating communities, influencing policymakers and engaging in other advocacy efforts designed to boost awareness and understanding of child abuse issues and garner support for related programs.

The advocacy tactics a hospital or its child protection team choose to employ are a reflection of staff capacity, expertise, political climate and public opinion — or a confluence of several of these factors. This chapter explores six different types of advocacy efforts:

1. **Internal advocacy** – positioning the child abuse response program and services internally before key hospital stakeholder groups to raise visibility, understanding and institutional support ([Hospital Example 20](#))
2. **Case advocacy** – helps parents and children deal with complicated bureaucracies, processes and treatments relevant to their child's circumstance ([Hospital Example 21](#))
3. **Public education advocacy** – engages the public on all forms of child maltreatment and its prevention through presentations, educational information and other outreach efforts ([Hospital Example 22](#)) and ([Hospital Example 23](#))
4. **Public policy advocacy** – influences 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, which can clarify the hospital's lobbying policies ([see Appendix B, Page 51](#)) ([Hospital Examples 24, 25, 26](#))
5. **Private policy advocacy** – influences or changes a corporation or private organization's policy or behavior regarding child abuse and neglect ([Hospital Examples 27, 28, 29](#))
6. **Media advocacy** – secures news coverage that positions the children's hospital role in responding to and preventing all forms of child maltreatment before a strategic audience of opinion leaders. All advocacy communications efforts should be coordinated through the hospital's public relations/marketing staff. ([Hospital Example 30](#))

Advocacy goes hand-in-hand with prevention at most children's hospitals; the central message child protection teams want to spread in their communities is how to keep child abuse and neglect from occurring. Just as cardiologists seek to educate the public about heart-healthy lifestyles to prevent cardiovascular disease, physicians and other health professionals with expertise in child abuse work to educate the public about how to prevent child maltreatment and promote positive parenting.

Although the physicians, nurses and social workers who make up a child protection team at a children's hospital are neither lobbyists nor public relations specialists, their medical expertise makes them uniquely qualified to speak persuasively about changing governmental priorities and shaping personal and public behavior.

While a **basic program** may not have the staffing levels necessary to provide dedicated time to organizing advocacy efforts, the protection team:

- Participates in child abuse prevention efforts and contributes to community advocacy initiatives focused on child maltreatment (such as Child Abuse Prevention Month activities) to the greatest extent possible

- Advocates for community collaboration, legislative reform and systems improvement regarding child protection
- Positions the child maltreatment team and its medical leadership as child abuse experts to be consulted in public discussions of child abuse intervention and prevention
- Establishes a relationship with the hospital's public relations/marketing department and ensures that the hospital integrates the child abuse prevention message into outreach initiatives. Outreach staff is aware that high profile local or national child abuse cases offer the opportunity for hospital child abuse experts to be positioned as expert spokespersons to discuss prevention and trends.
- Ensures that the child maltreatment team's medical director and/or staff has training or guidance in serving as a public spokesperson and makes members of the child maltreatment team available, when possible, to speak at public events related to child abuse and meet with legislators and community officials
- Promotes child abuse prevention within the hospital

As a hospital's child protection team grows, so too should its investment in advocacy and prevention efforts. Increased staffing and capabilities allow greater involvement in specific initiatives focused on shaping public policy regarding child abuse and/or projects aimed at spreading the prevention message.

In an **advanced program**:

- The child protection team allots specific time and resources to legislative advocacy and public education efforts around child abuse prevention.
- The team's medical director, coordinator and other staff (such as social workers) serve on relevant community boards that can influence public policy, awareness and understanding of child maltreatment issues.
- The team broadens its advocacy and prevention portfolio. For example, issues such as domestic violence and foster care are closely intertwined with child abuse. The team speaks out on the need for more domestic violence shelters and helps incorporate domestic violence prevention and intervention measures into the hospital's protocols.

Centers of excellence play a key local and regional role in advocacy for prevention programs, legislative reform, funding and the improvement of child protection systems.

A center of excellence:

- Places child protection team members in positions of organizational leadership for community advocacy programs; leadership at this level is often regional as well as local
- Establishes a system for the tracking of legislation and regulations relevant to child protection in partnership with the hospital's government relations office
- Establishes a liaison relationship with specific staff members in the hospital's government relations, public relations, marketing and other outreach offices who can specifically focus on promoting the child protection team as experts for consultations, interviews and legislative hearings
- Hosts and/or provides facilities, in conjunction with the hospital, for prevention conferences, child abuse task force meetings and other events surrounding child maltreatment

- Works to include information about child abuse prevention and relevant public policy issues in internal and external hospital publications
- Ensures prevention is a key component of medical education programs, fellowships and other training initiatives such as continuing education
- Devotes a segment of the team's research portfolio to prevention

20 At **Rainbow Babies and Children's Hospital** in Cleveland, OH, the child protection team prepares an annual report for the department chair, the division chair and the hospital chief executive officer to engage leadership and promote the team's work. The report summarizes how the team served its patients, the hospital and the community. The report itemizes child abuse and neglect statistics, including: number of reports, nature of maltreatment, age and gender of the child, county of residence and referral source (see sample in [Appendix C, Page 54](#)). For more information, contact Lolita McDavid, M.D., at lolita.mc david@uhhs.com; <http://www.rainbowbabies.org>.

21 **Children's Hospital and Health Center** in San Diego established a parent aid program in 1977 to support non-offending parents. In the 1990s that program evolved into a nurse/home visitor team model of family support working with overburdened families throughout San Diego County. The center also developed formal advocate positions in 1991 to support families struggling with domestic violence. Today those advocates work hand-in-hand with therapists to help non-offending parents meet basic needs and negotiate the complex system designed to help them. With the support of the advocates, the non-offending parent can better focus on the needs of the children. A "Kids in Court" program supplements these services for children called to testify in court about their abuse or violence they witnessed. The program works closely with court officials to reduce the stress children face when going into court as witnesses. For more information, contact Charles Wilson at cwilson@chsd.org; <http://www.chsd.org>.

22 Due to its severity and high rates of morbidity, many children's hospitals are engaged in shaken baby syndrome prevention education. A coordinated, hospital-based, education program targeting parents of all newborn infants was developed by pediatric neurosurgeon Mark Dias, M.D., while at the **Women and Children's Hospital of Buffalo** in Buffalo, NY. In this program, the children's hospital partners with birthing institutions to provide bed-side education to mothers (and fathers when available) during their post-partum hospital stay. Basic elements of the program include: "Portrait of Promise: Preventing Shaken Baby Syndrome," an eight-minute educational video; an informational card about shaken baby syndrome from the American Academy of Pediatrics that teaches parents how to handle prolonged infant crying; and an educational session with a trained hospital nurse. Parents are asked to acknowledge that they received and understood the information. In the May 2005 issue of *Pediatrics*, Dias demonstrated a 47 percent decrease in the incidence of abusive head injuries in New York while this program was in place. For more information, contact Kim Smith at smith@kaleidahealth.org or Kathy deGuehery at kdeguehery@kaleidahealth.org; <http://www.chob.edu/index.asp>.

23 **Children’s Hospital and Regional Medical Center** in Seattle creates child abuse prevention educational tools with parents and other caretakers in mind. A series of print and video resources can be shared by parents with others who care for their young children. Videos such as “Have a Plan,” available in Spanish and English, normalize the fatigue, stress, anxiety and frustration parents of newborns experience as part of the parenting process. Using real-life examples, the video urges parents to have a plan in place to deal with these predictable emotions. *For more information, contact Carol Jenkins at carol.jenkins@seattlechildrens.org or haveaplan@seattlechildrens.org; <http://www.seattlechildrens.org>.*

24 In 2004, the Regional Child Protection Center, located at **Blank Children’s Hospital** in Des Moines, IA, worked with other centers in the state to convince state legislators to appropriate \$100,000 to be distributed among the four Children’s Advocacy Centers in the state. A year later, the hospital was ready to secure a larger and more reliable source of state funding. Blank Children’s employed a grasstops strategy — engaging an influential member of its board of trustees to use his contacts within the governor’s office to advance a funding proposal prior to the legislative session. The hospital convinced the governor to increase the line item amount in the first draft budget from \$100,000 to \$300,000. Once the session began, hospital staff lobbied to retain the governor’s \$300,000 line item request. When the bill came out of the House unscathed, Senate-side supporters successfully pressured to increase the appropriation to \$1,000,000. The \$1,000,000 line item funds existing Children’s Advocacy Centers and supports expansion of the model across the state. *For more information, contact Kathy Leggett at leggetkm@ihs.org; <http://www.blankchildrens.org>.*

25 Working with coalition partners, Primary Children’s Center for Safe and Healthy Families at **Primary Children’s Medical Center** in Salt Lake City, UT, helped bring home the message about the impact of child abuse in a visual way during Child Abuse Prevention Month 2004. The partners placed 911 pairs of children’s shoes on the steps of the state capitol; each pair of shoes represented one of the children who had been a victim of abuse in the state during that month. Utah’s then-governor Olene Walker told the Deseret News that at first she thought the number of shoes was too high for a year — let alone one month. *For more information, contact David Corwin, M.D., at david.corwin@ihc.com or Julie Bradshaw at julie.bradshaw@ihc.com; <http://www.primarychildrens.com>.*

26 In 1998, Blair Sadler, president and CEO of **Children’s Hospital and Health Center** in San Diego proposed a “national call to action to end child abuse.” Over the next five years, Sadler led a national movement supported by NACHRI, American Medical Association, National Children’s Alliance, American Academy of Pediatrics and a host of other national organizations interested in prevention of child abuse. As part of this effort, Children’s San Diego launched “Authentic Voices,” a campaign that continues to help adults touched personally by abuse advocate for social change and the financial resources needed to bring it about. Through this effort, Children’s San Diego was called upon to testify before Congress and to brief congressional and administrative staff. *For more information, contact Charles Wilson at cwilson@chsd.org; <http://www.chsd.org>.*

27 Phoenix Children’s Hospital developed the Supporting a Family-Friendly Environment (S.A.F.E.) program to help employers and retailers build environments that promote appropriate parent-child interaction while in situations away from home. Frustrated and stressed parents can interact inappropriately with their child in any number of public settings; watching a child being mistreated by an out-of-control adult can be uncomfortable for everyone around them. Through the S.A.F.E. program, the hospital trains community agencies, employers and retailers in sensitive and effective ways to resolve and reduce such incidents. *For more information, contact Marcia Stanton at mstanto@phoenixchildrens.com; <http://www.phoenixchildrens.com>.*

28 Rainbow Babies and Children’s Hospital in Cleveland, OH, declared itself a “No Hitting Zone”— a campaign aimed at stopping the use of physical discipline, which in some cases may tread near the line of abuse, by stressed-out parents while in the hospital. Educational sessions detailing the policy, introducing the family to educational materials and demonstrating a variety of practical approaches to intervening in abusive or disruptive discipline situations were provided for doctors, nurses, child life, secretaries, social workers, therapists, and lobby and waiting room receptionists. Eye-catching posters were placed in patient rooms, public bathrooms, by elevators and entrances, and in waiting rooms. Brochures and handouts addressing a host of discipline issues were created for free distribution to parents. *For more information, contact Lolita McDavid, M.D., at lolita.mcdavid@uhhs.com, or Lauren McAliley at lauren.mcaliley@uhhs.com; <http://www.rainbowbabies.org>.*

29 In March 2001, with the help of a three-year, \$575,000 grant from the federal Health Resources and Services Administration, The Children’s Mercy Hospital in Kansas City, MO, developed a screening initiative for domestic violence entitled “It’s Time to Ask.” Combining a two-question universal screening protocol with training for emergency department staff, the program has since tripled to quadrupled the number of referrals the hospital makes to domestic violence intervention programs and the number of shelter placements. *For more information, contact Denise Dowd, M.D., at ddowd@cmh.edu; <http://www.childrens-mercy.org>.*

30 The Shaken Baby Association of Wisconsin, in partnership with the advertising agency BVK and Children’s Hospital of Wisconsin, Milwaukee, WI, launched a powerful advocacy communications campaign in 2001 after an increasing number of shaken baby syndrome cases at the hospital culminated in four infant deaths in eight days. The campaign’s goal was to create a public service announcement that would cause people to feel, in some small way, the sense of frustration a person experiences before they shake a baby. The hospital created “Radio Roadblock,” a radio spot featuring the sound of an infant incessantly crying, which aired simultaneously on 18 radio stations. Radio listeners could not escape the irritating cries of that baby no matter where they turned their radio dial. The hospital and the ad agency worked in advance to issue press releases to radio stations and to line up a series of interviews focusing on shaken baby syndrome and its prevention. *For more information, contact Jennifer Hammel at jhammel@chw.org; <http://www.chw.org>.*

CHAPTER 7: COMMUNITY COLLABORATION

Child protection teams at children's hospitals do not operate in a vacuum. They are a key component of, and must coordinate with, what ideally should be a strong, community-based network of agencies and organizations, including law enforcement, child protective services and advocacy groups. While the primary role of children's hospitals in child maltreatment is a medical one, they can also fill in other gaps in community services. However, the hospitals should not duplicate services that are adequately provided by another agency.

For far too long, child abuse was not placed in its appropriate context within medicine and public health. It was addressed largely within the criminal justice and social service systems; medical providers were viewed as peripheral to the issue. Now, child abuse experts in the medical field, particularly in children's hospitals, have come to the forefront of efforts to intervene in, prevent and treat the results of child abuse and neglect. Working with community partners, the children's hospital child maltreatment team is ideally positioned to improve public understanding of child abuse as a public health problem, rather than simply a social welfare or criminal problem.

Conducting an assessment of available community services is an important first step in the process of developing or expanding a child maltreatment team at a children's hospital. Once a community's multiple child protection agencies and entities are identified, and their various roles and interactions defined, a children's hospital can determine how it, as the source of medical expertise in child maltreatment, can work best within this network.

Not all children's hospitals are the same of course and not every institution can or should take on the same role in addressing child maltreatment. Some children's hospitals are non-acute care centers, providing a specialized range of services aimed at a particular population of children. In dealing with maltreatment cases, these institutions must partner and make referrals to hospitals that support emergency and/or trauma services. The role of non-acute care centers should not be minimized, however. Specialty children's hospitals, such as rehabilitation hospitals and burn centers, often bring a unique voice and expertise to the diagnosis and care of children who have suffered particular types of abuse, as well as an important perspective on the long-term impact of abuse and the need for prevention.

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

- What is missing in our community's approach to child maltreatment?
- 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 maltreatment 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? ([Hospital Example 31](#))

In all of its collaborative efforts with community partners, a children's hospital should clearly maintain its role as the 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 crystal clear that the medical needs of the child is 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 on the team understand the medical issues.

A children's hospital's expertise in the unique medical needs of children becomes particularly important when dealing with children who are medically fragile, have disabilities, mental illness or other special needs. These children are at a greater risk of abuse than other children because of the additional stress their caregivers face. At the same time, these children may be less able to communicate their abuse to investigators or be understood and listened to when asking for help. Most children's hospitals deal frequently with children with special needs, and the insights of these institutions can be useful to all members of a multidisciplinary community child protection team as they seek to help these vulnerable children.

To engage in community collaboration, **basic programs**:

- Collaborate with and assist the mandated investigative and protective agencies in their investigations
- Identify existing local child abuse evaluation and treatment centers, including Children's Advocacy Centers, and the organizations with which they partner
- Promote among community partners a designated child protection team staff person as the appropriate point of contact for the hospital and designate an internal liaison who can assist community agencies in handling procedural issues and coordination of services for the victim

Such teams may not always have the advanced, specialized diagnostic capabilities in child maltreatment that more extensive child protection programs will have. In such cases, the children's hospital can connect investigators with a regional, center of excellence-level expert. ([Hospital Example 32](#))

Advanced programs have the capability to allot more time and space, and a heightened level of service to community partnerships. Many children's hospitals find that regular, face-to-face contact with child protective services and law enforcement improves understanding of the medical needs of children who have been abused or neglected, and facilitates the gathering of 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.

Advanced programs:

- Work with the child welfare agency to assign dedicated, “primary” social workers to liaise with the hospital. Request that these primary social workers have advanced training. Consider offering desk space to the primary social workers to facilitate the relationship. Realize that this collaboration is subject to case volume and budget constraints.
- Work with the police department to assign dedicated, “primary” detectives to liaise with the hospital. Request that these primary detectives have advanced training. Consider offering desk space to the primary detectives to facilitate the relationship. Realize that this collaboration is subject to case volume and budget constraints.
- Establish, 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.
- Reach out to and establish relationships with emergency medical services departments that bring children from outlying areas to the children’s hospital in response to suspected child abuse or neglect. The entry point for these children may be at the children’s hospital directly, or may come via referral from general/community hospitals. ([Hospital Example 33](#))
- Coordinate with forensic interviewers, a key component to child sexual abuse cases. Forensic interviewers can be a part of the hospital-based team or contracted by the hospital to do evaluation in an outpatient setting.
- Assume some of the responsibility for maintenance of a healthy and productive multidisciplinary community team

Centers of excellence take a broader leadership role in facilitating community collaboration. In addition to being a strong part of an integrated, multidisciplinary team, such centers are prepared to act as leaders or conveners of teams. These centers may also use their expanded education capabilities to provide more extensive training and consultation to partner agencies such as law enforcement and social services. At this level, the children’s hospital child protection team is likely to be a regional as well as local collaborative partner.

Centers of excellence:

- Serve as a regional medical resource that provides facilitation and coordination for various investigative components from outlying communities. In instances where a particular detective rarely works with the children’s hospital or as part of a multidisciplinary team in addressing cases, the child protection team acts as a “middleman,” creating connections between that officer and central detectives who are “regulars.”
- Create and sign agreements when working within multidisciplinary teams, such as those in Children’s Advocacy Centers ([See Appendix D, Page 60](#))
- Facilitate opportunities for law enforcement agents to get advice from the child protection team on how to handle a case and how to best interact with the medical team
- Offer support to other physicians and health care providers in the community regarding the management of alleged or suspected child maltreatment
- Advocate for community collaboration, legislative reform and systems improvement regarding child protection

- Advocate for child abuse prevention efforts
- Provide leadership and facilitation for regular multidisciplinary meetings of all agencies involved in the identification, treatment and prosecution of child abuse cases: juvenile court, law enforcement agencies, child abuse evaluation and treatment centers, including Children's Advocacy Centers, child welfare agency, district attorney, sexual assault center, judges and other community hospitals ([Hospital Example 34](#))
- Reach out to key community stakeholders through regular multidisciplinary meetings and other means, position the role of the children's hospital and promote a positive public image

31 In the summer of 1999, **Blank Children's Hospital** in Des Moines, IA, decided to create a child protection center based on the Children's Advocacy Center model. The hospital involved community collaborators in the process from the beginning, convening a multidisciplinary planning conference involving law enforcement, county attorneys, the state department of human services, medical and mental health professionals, and victim advocates from a four-county area around Des Moines. Most of the community partners agreed the center was needed, but some law enforcement representatives felt the center might duplicate their services or take away some of their control over investigations. Blank Children's addressed these concerns by creating an environment where law enforcement and child protective services were a critical part of the assessment process occurring at each appointment. The multidisciplinary process allows each professional (and the family) the opportunity to receive immediate information, ask questions, challenge any inconsistencies in the information and formulate a clear, child-focused plan of action. *For more information, contact Chaney Yeast at yeastc2@ihs.org; <http://www.blankchildrens.org>; or download "Confronting Child Abuse and Neglect: Portraits of Child Abuse Teams" at <http://www.childrenshospitals.net>.*

32 Basic and advanced teams often seek the additional expertise found at the center of excellence-level Midwest Children's Resource Center at **Children's Hospitals and Clinics of Minnesota** in St. Paul. For example, when a child in a community 150 miles away was found seriously injured, local investigators suspected abuse and immediately contacted the center. Investigators overnighted X-rays and medical reports, which the center's team reviewed. During local investigators' interviews with the suspected perpetrator of the abuse, they paged hospital child abuse expert Rich Kaplan, M.D., frequently, seeking his input as to whether the mechanism of injury being proposed by the suspect made medical sense. "We were able to have this perpetrator describe with some accuracy how he hurt the child, providing information for team members and safety for the child," says Kaplan. In another case, a team from a distant community consulted with center experts via videoconference. Local police, prosecutors and medical members of the child protection team reviewed the medical evidence with center specialists, seeking their input on a diagnosis. *For more information, contact Rich Kaplan, M.D., at rich.kaplan@childrensmn.org; <http://www.childrensmn.org>; or download "Confronting Child Abuse and Neglect: The Future of Education and Training" at <http://www.childrenshospitals.net>.*

33 The Child Maltreatment Awareness CD-ROM is an educational training resource to increase recognition, reporting and referral behaviors related to child maltreatment among pre-hospital providers. A multidisciplinary team of experts, including emergency medicine and emergency medical services at **Children’s Memorial Hospital** in Chicago collaborated to design the program to reduce injury and mortality from child abuse and neglect. *For more information, contact the Office of Child Advocacy, Children’s Memorial Hospital at 773/388-6770; <http://www.childrensmemorial.org>.*

34 Children’s Advocacy Centers (CAC) play a unique role in the overall community response to child abuse and neglect. The centers bring together a multidisciplinary group of professionals from fields that may include medicine, law enforcement, social services, the courts, mental health and social work, among others, under a single umbrella organization focused on the needs of abused children. The team members work together, conducting joint forensic interviews and making decisions about the investigation, treatment, management and prosecution of child abuse cases. This comprehensive approach helps ensure that no aspect of a particular case (such as the need for housing, mental health counseling or domestic violence intervention) “falls through the cracks” of overall case management. The CAC model also helps prevent further trauma to abused children by avoiding the need for them to participate in multiple interviews. As each CAC is designed to meet the specific needs of a particular community, no two are exactly alike; but they share the core philosophy that child abuse is a multifaceted community problem and no single agency, individual or discipline has the necessary knowledge, skills or resources to serve the needs of all children and their families. In some cases, CACs are housed in and/or headed by children’s hospitals and their child maltreatment teams. In other communities, the children’s hospital partners with one or more CACs to provide medical services, but does not serve as the lead agency. *For more information, visit <http://www.nca-online.org>.*

CHAPTER 8: EDUCATION

Children’s hospitals are setting the standard in providing the specialized training medical professionals need to work in the complex field of child maltreatment. With child abuse likely to be recognized as an official pediatric subspecialty with board certification in fall 2006, it is expected that funding and other support for these educational initiatives will increase.

Education and training opportunities in child abuse and neglect offered by children’s hospitals take multiple forms, ranging from basic classroom lectures to extensive hands-on experiences. Education and training is also targeted at multiple audiences: medical students, residents, students of other health professions, practicing physicians, specialty nurses, other health professionals and other members of the multidisciplinary community team who are not health professionals, but who benefit from an improved understanding of the medical aspects of child maltreatment.

Some of the instruction is basic, aimed at “students” who do not intend to specialize in child maltreatment, but who should have a foundation of knowledge about child abuse issues that will help them recognize potential cases of abuse and know when and how to consult the child protection team effectively. These audiences may include general patient care nurses, emergency department physicians, orthopedists and respiratory therapists.

Other instruction is more comprehensive as it aims to train future child abuse and maltreatment specialists, as well as advance the knowledge of current practitioners in the field.

At a **basic program**, the fundamental education and training component involves training of hospital staff so that the child protection team can effectively consult with other hospital professionals. Education for medical students and residents may also be provided, but at this level may be more in the “classroom” rather than hands-on experiences.

In basic programs:

- The child protection team conducts core training in child abuse recognition and referral protocol for medical and other hospital staff, as well as medical students/residents if the hospital has medical student or residency rotations. Ideally there is protected time allotted to permit the team to develop effective curricula for these groups. ([Hospital Example 35](#))
- Child protection team members participate in continuing medical education activities so that the assessment and diagnosis of child abuse is based on the best available medical evidence, best practices and expert opinion. These activities are supported by the hospital.

In **advanced programs**, the children’s hospital team becomes a coordinator, if not the leader, of child maltreatment educational efforts that reach the broader community. Meanwhile, medical students and residents have the opportunity for more hands-on training, such as elective rotations with the child protection team.

In advanced programs:

- Extensive and diverse hospital-based education is provided to residents, students and other trainees. Pediatric residents in particular have increased opportunities for training in child maltreatment issues. ([Hospital Examples 36 and 37](#))
- The child protection team provides community-based training to community-based pediatricians and to child protective services, law enforcement and other nonmedical community stakeholders. ([Hospital Example 38](#))
- The child protection team conducts training to allied health care professionals and community stakeholder groups.

The educational programming at **centers of excellence** is largely distinguished by the opportunities for students and residents to participate in research offered by a child protection team.

In centers of excellence, the child protection team:

- Gives residents, students and fellows (when applicable) the opportunity to participate in research and pursue research funding
- Trains residents, health professionals, students 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. ([Hospital Examples 39 and 40](#))
- May support a fellowship program through its varied activities and structure
- Provides regional and even national training opportunities and peer review through videoconferencing ([Hospital Example 41](#))

35 The Midwest Children’s Resource Center at **Children’s Hospitals and Clinics of Minnesota** in St. Paul provides a one-day orientation to the center and its work as part of all pediatric residents’ primary care experience. All medical students and residents rotating through either of the hospital’s two campuses get a lecture from a faculty member or fellow on child abuse issues every six weeks. Although the hospital is an example of a center of excellence program with extensive educational programming, including a fellowship and a four-week pediatric residency program, its basic educational component is an example of what could be offered by a basic child protection team. *For more information, contact Mark Hudson, M.D., at mark.hudson@childrensmn.org; <http://www.childrensmn.org>.*

36 **Children’s Hospital of The Kings Daughters, Inc.** in Norfolk, VA, has a residency training program in child abuse pediatrics directed by the pediatrician who authored the national residency curriculum guidelines for training in child abuse. Each second year resident rotates through the child abuse program for instruction in medical and physical aspects of child abuse. A one-month elective is available for residents and medical students from Eastern Virginia Medical School and other accredited programs. Pediatric emergency medicine fellows also have a one-month required rotation with the service. Residents, fellows and medical students receive didactic instruction, participate in consultative services on the hospital wards and outpatient clinics and are required to complete pre- and post-surveys on the clinical rotation to improve services. *For more information, contact Suzanne Starling, M.D., at suzanne.starling@chkd.org; <http://www.chkd.org>.*

37 **Doernbecher Children’s Hospital at the Oregon Health Sciences University** in Portland, OR, hosts a monthly resident education series dedicated to different aspects of child maltreatment. The lecture schedule is published annually and all sessions are open to community-based partners. *For more information, contact Joseph Zenel, M.D., at 503/418-5170; <http://www.ohsuhealth.com/dch/>.*

38 “I can say from experience that it’s very successful when the disciplines that are working together train each other,” says Robert Block, M.D., professor and chair of the department of pediatrics at the University of Oklahoma in Tulsa (**Children’s Hospital at St. Francis**) and chair of the American Academy of Pediatrics’ Committee on Child Abuse and Neglect. “It’s equally important for me to understand what the police do when they investigate a report of child maltreatment as it is for them to understand what we do. We help other disciplines become familiar with how we come to a diagnosis.” For example, Block says, an educational presentation to interdisciplinary team partners might include images of the scald pattern on a child who accidentally pulled a pan of hot water over himself, contrasted with images of the burns affecting a child who was intentionally plunged into a pan of hot water, with an explanation of how experts tell the difference between the two. *For more information, contact Robert Block, M.D., at robert-block@ouhsc.edu; <http://www.saintfrancis.com>.*

39 Pennsylvania physicians, working with the Pennsylvania Departments of Public Welfare and Health and the Pennsylvania Chapter of the American Academy of Pediatrics, developed a continuing medical education course for primary care physicians and their staff on recognizing and reporting suspected abuse. This program, known as EPIC SCAN (educating physicians in their communities about suspected child abuse and neglect) pairs a local physician and social workers from county child protection offices to provide education in primary care practices around the state. To date, more than 6,000 professionals have been educated and the program has been expanded for school nurses, paramedics and EMTs. This work, led by Cindy Christian, M.D., co-director, The Center for Child Protection at **The Children’s Hospital of Philadelphia**, is in part possible because of the support given to Christian by the hospital. *For more information, contact Cindy Christian, M.D., at christian@email.chop.edu; <http://www.chop.edu>.*

40 The **Children’s Healthcare of Atlanta** Child Protection Center expands its training programs to health care and community professionals. Twice a year Children’s provides community-based professional trainings. One training is targeted to physicians, nurse practitioners and physician assistants who frequently treat children, but who are not child abuse specialists. Practitioners are taught to identify physical and sexual abuse, understand injuries stemming from head trauma, falls, fractures and burns, and to provide court testimony. The second training is conducted for local law enforcement, child protection services and other agencies involved with child protection investigation and prosecution. The center plans to expand its training program to include in-depth, discipline-specific continuing education modules aimed at physicians, nurse practitioners, nursing technicians and social workers. Each module will focus on the specific skills critical to that professional’s role in the medical evaluation of suspected child abuse cases. Technicians, for example, will be taught how to handle the chain of evidence and how to collect evidence for a rape kit. In addition, the center launched a two-day intensive training course on medical evaluation of child/adolescent sexual abuse. This provides health care professionals with the knowledge and skills to conduct thorough pediatric forensic medical evaluations for suspected sexual abuse. *For more information, contact Laura Eubanks at laura.eubanks@choa.org; <http://www.choa.org>; or download “Confronting Child Abuse and Neglect: The Future of Education and Training” at <http://www.childrenshospitals.net>.*

41 The Midwest Children’s Resource Center at **Children’s Hospitals and Clinics of Minnesota** in St. Paul uses telemedicine extensively in its training and has found it to be an outstanding peer review tool. Participants in any of the center’s trainings or conferences can later access the center’s expertise via teleconference, using the NCAnet videoconferencing system sponsored by the four regional Children’s Advocacy Centers of the National Children’s Alliance. *For more information, contact Carolyn Levitt, M.D., at carolyn.levitt@childrensmn.org; <http://www.childrensmn.org>.*

CHAPTER 9: RESEARCH

After years of being looked at as a sociological problem, child abuse is finally being understood as a medical issue, thanks to the leadership of children’s hospitals and pediatricians. Physicians and other medical professionals in the field are looking to children’s hospitals to set the tone for the future in investigating, treating and preventing cases of child maltreatment. This calls for a strong commitment from children’s hospitals to medically oriented, rigorous, epidemiologically strong research - advanced diagnostic tools, trends, the success rate of interventions and more - into the various factors surrounding child abuse and neglect. Here, children’s hospitals have a dual role: to advance research in their own institutions, and to teach future physicians and pediatric subspecialists the skills necessary to conduct research as they move on in their careers.

Should a pediatric subspecialty in child abuse be formally approved, as is widely expected, research will become an even more essential component of child maltreatment programs at children’s hospitals.

It may be difficult for a **basic program** to establish a research agenda on its own as its priorities are focused on the essential elements of referrals, diagnosis, treatment and evaluation of suspected child maltreatment cases. Limitations in staffing and resources will likely preclude any significant research commitment. However, basic programs can undertake relatively simple initiatives that can build a foundation for future research programs, enable teams to evaluate the progress of their interventions, and facilitate the research of larger child protection teams at other institutions.

At a basic program:

- The team’s medical director, social worker(s), nurse(s) and other medical professionals have a fundamental knowledge of the relevant research and literature on child abuse and prevention, including literature classic to the field and new findings ([see Appendix A, Page 47](#)).
- The team has the capacity to perform data collection for cases on which it consults. This is a requirement of state child abuse reporting laws and should be part of the team’s general policies, but the design of any data collection system can be maximized for research purposes. ([Hospital Example 42](#))
- The team participates in multicenter studies headed by other institutions by sharing data.

Advanced programs initiate smaller research studies of their own, in addition to participating in and contributing data to the research of larger centers.

In advanced programs:

- The medical director or other appropriate medical staff keeps the team literature members regularly updated on new developments in child maltreatment literature.
- The team initiates single-center studies, case studies and pilot studies of its own. It may also establish a research infrastructure aimed at enhancing the child protection program's future research capacity. ([Hospital Example 43](#))
- The team seeks out targeted funding designated for research initiatives.

Centers of excellence are distinguished, in part, by the multidisciplinary research components and by the leadership role they take in advancing research on child abuse and neglect.

Centers of excellence:

- Initiate major research initiatives, including multicenter studies, and engage other centers in research
- Train medical students, residents and fellows (each to the degree appropriate to their level of education) in research. Fellows are encouraged to develop and pursue their own research projects.
- Serve as a local and regional resource on the evolving body of research on child maltreatment

42 Simple medical records queries can often provide the necessary data to contribute to projects such as retrospective studies. For example, notes Kathi Makoroff, M.D., who coordinates research at the Mayerson Center for Safe and Healthy Children at **Cincinnati Children's Hospital Medical Center**, "We have initiated and also contribute to multicenter studies that look at the incidence of certain conditions or injuries. Some of these conditions are rare, so it is important to have a large number of centers participating." Even a small program can contribute data to help researchers gather sufficient cases. Because such requests are usually for retrospective studies, they aren't unduly burdensome for small programs. *For more information, contact Kathi Makoroff, M.D., at kathi.makoroff.cchmc.org; <http://www.cincinnatichildrens.org>.*

43 Building on work originally begun by David Chadwick, M.D., **Children's Hospital and Health Center** in San Diego is examining short falls captured in the hospital's extensive trauma database to explore the case-fatality discrepancy in children's inflicted injuries. This research interest extends into the mental health trauma treatment program and collaboration with Children's Child and Adolescent Services Research Center to understand the use of parent-child interaction therapy with Spanish speaking families. *For more information, contact Cynthia Kuelb, M.D., at ckuelbs@chsd.org; <http://www.chsd.org>.*

Section 3:
Administrative Infrastructure
of the Children's Hospital
Child Protection Team

Irrespective of the size and sophistication of a children’s hospital’s child abuse response, building administrative infrastructure helps sustain the hospital’s program. Such investments are necessary to keep a program vibrant and ensure it remains an appropriate part of community response to child maltreatment.

CHAPTER 10: FUNDING AND REIMBURSEMENT

Children who have been maltreated need and deserve a comprehensive medical response — for which children’s hospitals are inadequately reimbursed. But comprehensive care for an abused child stretches beyond immediate clinical needs. Children’s hospitals also provide medical exams, forensic interviews, psychosocial assessments, mental health services and court testimony. These services, too, receive minimal reimbursement.

Because of the low levels of reimbursement from traditional health care sources, children’s hospitals heavily subsidize child abuse treatment and prevention programs. Data collected by NACHRI in a 2002 survey of child abuse programs showed that 92 percent of respondents that provided information on net revenue and total expenses indicated their children’s hospital subsidizes its program (NACHRI, 2002). Overall, no hospital reported a positive bottom line from their child abuse services.

Hospital subsidies, however, can be minimized if children’s hospitals take an aggressive, creative and multifaceted approach to funding. ([Hospital Example 44](#)) 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 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.

Although most child maltreatment programs at children’s hospitals receive some type of hospital subsidization, the majority of revenue (52 percent) to child abuse prevention and treatment programs at children’s hospitals come from public sources. To secure this revenue, some children’s hospitals forged innovative partnerships with public agencies that also have a stake in the prevention and treatment of abuse, and the prosecution of child abusers (NACHRI, 2002).

Some state funding comes in obvious ways; for example, Medicaid reimbursement for medical examinations of children suspected of having been abused. In a number of states, children who are entering or leaving the foster care system must also undergo medical examinations, for which children’s hospital child protection programs can be reimbursed. Unfortunately, these revenue streams are often plagued by chronic underfunding, with reimbursement rates substantially lower than actual costs.

Generally, it’s harder to secure reimbursement from public funds for other services provided by children’s hospitals in the course of child abuse interventions — even though these may be services relied upon by the state, such as forensic interviews and psychosocial assessments. In the 2002 NACHRI survey of child abuse programs offered by or affiliated with children’s hospitals, some 67 percent of respondents indicated that they received no reimbursement at all through Medicaid for psychosocial assessment services. Those hospitals that did receive some reimbursement averaged only 50 percent reimbursement rates (NACHRI, 2002).

To ensure that services can be offered and sustained, a **basic program** should:

- 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
- Assign a cost center(s) specific to the child maltreatment program to facilitate tracking of its expenses
- Assess some of the common noninsurance reimbursement funds that may be available for basic child protection medical services, such as Victims of Crime Act program funds, which 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)
- Partner with other organizations or hospitals to seek out grants and other funding that may be more accessible to cooperative groups than a single organization ([Hospital Example 45](#))

Advanced programs develop additional sources of revenue beyond simple reimbursement and hospital subsidies. These can include:

- Contractual relationships with law enforcement, child protective services, states attorneys general and referral agencies. An advanced program 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. ([Hospital Example 46](#))
- One or more grants of varying sizes from local, state and/or national organizations focused on various aspects of child abuse and neglect
- Targeted funding aimed at specific aspects of a program as the program grows and diversifies. For example, domestic violence programs are a growing part of many evolving child protection programs at children's hospitals; in more than 30 percent of cases, domestic violence goes hand in hand with child abuse (NACHRI, 2004). Centers with such specialized services often seek out focused state or foundation funding. ([Hospital Example 47](#))

A **center of excellence** boasts a diversified funding and reimbursement base. In addition to all of the previously cited sources of income, these programs may also receive support through:

- Multiple research grants that support particular research projects and the time of some of the program's medical staff
- State funding from criminal proceeding fees, or, in the most sophisticated scenario, a stable appropriation from the state ([Hospital Example 48](#))

44 Hospital subsidies don't always take the simple and predictable path of providing a specific amount of dollars toward a program's bottom line. In the case of **The Children's Hospital of Philadelphia**, its support comes in the form of an endowed chair in child abuse prevention. Cindy Christian, M.D., co-director of Safe Place: The Center for Child Protection and Health at Children's Hospital, has held the Children's Hospital of Philadelphia Endowed Chair in Prevention of Child Abuse and Neglect since it was created in 2000. "The hospital has put forth a concerted effort to endow chairs for faculty whose work can not be sustained by clinical revenue alone, yet is important to the health and safety of children," says Christian. The funding of approximately \$75,000 a year supports faculty salary and program development. Although the support comes directly from hospital funds, Christian believes endowed chairs funded by donors could be a promising funding source for child abuse programs. *For more information, contact Cindy Christian, M.D., at christian@email.chop.edu; <http://www.chop.edu>.*

45 In December 2003, the South Carolina Children's Hospital Collaborative received a \$1.1 million grant from The Duke Endowment. The collaborative is a nonprofit organization comprised of the four children's hospitals in South Carolina — **The Children's Hospital Medical University of South Carolina**, Charleston; **Palmetto Health Children's Hospital**, Columbia; **Children's Hospital - Greenville Hospital System**, Greenville; and **McLeod Children's Hospital**, Florence. Funds from the grant are being used to establish the South Carolina Children's Advocacy Medical Response System — a statewide medical response network for the assessment and treatment of child abuse. Olga Rosa, M.D., an experienced forensic pediatrician, was recruited from Florida to lead the effort. Together, Rosa and the collaborative are working to improve reimbursement for forensic medical services, improve the quality of care provided to children, address child abuse legislative needs, and increase the number of medical providers with training in child abuse assessment. *For more information, contact Rosa Olga, M.D., at orosa@gw.mp.sc.edu or Maggie Michael at michaelm@musc.edu; <http://www.scchildrenshospitals.org>.*

46 **Alfred I. duPont Hospital for Children** in Wilmington, DE, pieced together a number of state sources to support the Children's Advocacy Center it sponsors, including a line item in the state's Department of Services for Children, Youth, and Families. "There are Justice dollars out there that can be tapped," says Edward Woomer, L.C.S.W., director of patient and family services at the hospital. "We've worked for years with our partners on the prosecution side – the attorney general, child protective services, the police – so they understand that successful prosecutions are the result of collaborative efforts from all agencies." When the center was created 15 years ago, it launched with \$50,000 in grant funding from the state's Juvenile Justice Act, support which continues to this day. The program also receives support from the state's violent crime compensation fund. "The attorney general wanted all the children who went through the system to have mental health evaluations, but insurance wouldn't pay," says Woomer. "So she legislated some of the money from the violent crime fund go to services for screening, treatment and forensic interviewing." Other state support includes approximately \$41,000 per year to subsidize the salary of a social worker who provides emergency management of child abuse cases brought into the emergency room. *For more information, contact Edward Woomer at ewoomer@nemours.org; <http://www.nemours.org>.*

47 A domestic violence screening initiative at the Children’s Advocacy Center of the **Morgan Stanley Children’s Hospital of NewYork-Presbyterian** in New York City secured initial state funding of \$50,000 for the program’s first year in 2000, followed by a three-year grant of \$150,000. Support for a similar screening program at the **Children’s Hospital of Michigan** in Detroit came from the Blue Cross and Blue Shield Association. **The Children’s Mercy Hospital** in Kansas City, MO, launched the “It’s Time to Ask” screening initiative with a three-year, \$400,000 grant from the federal Health Resources and Services Administration. *For more information, contact Jocelyn Brown, M.D., at 212/305-2393; <http://www.childreasnyp.org>; or download “Confronting Child Abuse and Neglect: Understanding the Link Between Domestic Violence and Child Abuse” at <http://www.childrenshospitals.net>.*

48 One of the most extensive systems of state reimbursement for child abuse and neglect services at a children’s hospital can be found in New Jersey. There, four hospital-affiliated programs make up the New Jersey Regional Child Abuse Diagnostic and Treatment Centers (RDTC), a statewide network that offers a multidisciplinary approach to the investigation, medical and mental health evaluation and treatment of suspected child abuse. Each RDTC serves a distinct geographic area of New Jersey. All children in the state requiring medical examination for suspected abuse can be evaluated at an RDTC. The RDTC network receives an annual state appropriation of roughly \$2 million (an average of \$500,000 per site) to cover core staff, overhead and equipment. Each RDTC augments the appropriation with a fee-for-service contract with the state Department of Youth and Family Services (DYFS). The DYFS contract covers payment for the physician fees associated with the medical evaluation of suspected child abuse (radiology studies, lab tests, etc., are billed separately), provision of psychological evaluation and treatment services and expert testimony. Each RDTC contracts with DYFS individually; annual contracts range from \$250,000 to \$500,000 per year. “It didn’t happen overnight,” says Martin A. Finkel, D.O., director of the New Jersey 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**, one of the four sites, and architect of the legislative initiative. “It took 10 years of pushing and pushing to get legislation passed in 1998 that created the RDTCs. We approached it with the goal of making ourselves part of the fabric of how child protective services does business in the state. I explain it like this: you wouldn’t tolerate a fire department that only put out fires every other Wednesday and Friday, so why would you tolerate that in child protection? RDTC’s are an important vehicle to assure 24-hour availability of these critically important services.” *For more information, contact Martin A. Finkel, D.O., at finkelma@umdnj.edu; http://som.umdnj.edu/ctr_excellence/NJCARESInstitute.htm.*

CHAPTER 11: 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. By committing to a strong child protection program, a children's hospital improves its capability to manage such risk.

On the other side of the coin, 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 program's policy 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.

A **basic program:**

- Utilizes the expertise of its medical director to guide and set standards for the hospital's participation in its state's mandatory child abuse reporting program. 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.
- Develops an organized plan for demonstrating compliance with JCAHO standards requiring that hospitals have criteria for identifying abuse and that staff be educated in abuse issues
- Educates the hospital's legal counsel on services and policies, and seeks legal input on a general basis and in the event a problem arises

An **advanced program:**

- 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.
- Develops a specific plan for addressing instances in which accusations of abuse or inappropriate behavior are leveled at staff ([Hospital Examples 49 and 50](#))

A **center of excellence:**

- 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 a suspected case of child abuse
- 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 appropriate ways of managing these situations

49 In 2005, a patient at one children's hospital was critically injured when the sibling of another patient slipped into her room, unnoticed by staff, and allegedly dropped the child to the floor (the hospital has asked not to be identified). After this incident, the hospital significantly revised and supplemented its existing security policies. Siblings are no longer allowed to sleep overnight in a patient's room (with the exception of infant siblings under 6 months of age who are exclusively breastfed), and children younger than 14 years must be accompanied and supervised by an adult at all times. An unsupervised child will be returned to the parent or guardian. If the child is found unsupervised a second time, the parent or guardian will be asked to remove the child from the hospital. In addition, all three hospital inpatient units, the PICU and the NICU are closed units that use card readers to restrict access. Visitors must be identified through a video intercom system to enter or leave the unit and are not permitted entrance without a visitor badge.

50 One children's hospital found itself in the position of developing policies to deal with accusations of abuse by staff only after a specific accusation had been made (the hospital has asked not to be identified). The accused staff member was given a paid leave of absence until the hospital's internal inquiry found no credible evidence of abuse. At that point, the staff member was allowed to return to work, but was employed in areas of the hospital in which he would not come in contact with the patient involved in the complaint, and he was relieved of all patient care responsibilities until he was cleared of all charges by the legal system. In addition, until the time the complaint was resolved, any contact between hospital staff and the involved patient required a witness. The family was asked to voluntarily agree to 24-hour videotaping of the patient's room. The family agreed and a monitor was on all the time at the nurses' station. In addition, copies of all videotapes were sent to the risk management department at the hospital in the event additional charges were leveled. These procedures are now official policy at the hospital.

Conclusion

Weaving together a seamless, timely and effective system of maltreatment response that provides quality medical care and emotional healing to children, as well as appropriate justice to offending adults, is a challenge for every community. Attracting and retaining qualified clinicians in the child abuse field is no small task. Poor reimbursement rates and outside funding challenges can make the idea of developing or expanding hospital-based child protective services seem daunting. But the mission of all children's hospitals must extend to our nation's most vulnerable children.

“Defining the Children’s Hospital Role in Child Maltreatment” provides practical and most importantly, achievable guidelines on building sustainable child abuse programs. NACHRI hopes that this document will inspire children’s hospital leaders to assess comprehensively how maltreated children are cared for in their institutions, as well in their communities. Whether a hospital is working to establish a basic child abuse program or to expand an existing program, these guidelines offer a framework.

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 help develop a better coordinated health response to one of the nation’s most complex and confounding medical issues.

“Defining the Children’s Hospital Role in Child Maltreatment” should inspire all pediatric leaders and allied organizations to begin a conversation on how to provide the highest quality care possible to maltreated children. Together, the community of children’s hospitals can make a difference.

Tell NACHRI how you’ve used “Defining the Children’s Hospital Role in Child Maltreatment.” Did your institution use the guidelines to create a new policy, to advocate for a new staff person or educate your board? NACHRI wants to hear about it. E-mail Sharon Ladin, director, advocacy programs, NACHRI, at sladin@nachri.org.

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Appendixes

Appendix A: Child Abuse Resources, Meetings and Training

Books and Manuals

The American Academy of Pediatrics. *The visual diagnosis of child physical abuse*. (2nd ed.). (1995). Thousand Oaks, CA: AAP.

Chandler, N. (2000). *Best Practices For Establishing A Children's Advocacy Center Program, Third Edition*. Washington, DC: National Children's Alliance.

Finkel, M.A., & Giardino, A.P. (Eds.). (2001). *Medical evaluation of child sexual abuse*. (2nd ed.). Thousand Oaks, CA: Sage Publications, Inc.

Girardin, B.W., Faugno, D.K., Spencer, M.J., & Giardino, A.P. (Eds.). (2003). *Sexual assault: Victimization across the life span: A color atlas*. St. Louis, MO: GW Medical Publishing, Inc.

Giardino, A.P., Datner, E.M., & Asher, J.B. (Eds.) (2003). *Sexual assault: Victimization across the life span. A clinical guide*. St. Louis, MO: GW Medical Publishing, Inc.

Lazoritz, S., & Palusci, V. (2002). *Shaken baby syndrome: A multidisciplinary approach*. Binghamton, NY: The Haworth Maltreatment & Trauma Press.

Peterson, M.S., & Durfee, M. (2003). *Child abuse and neglect: Guidelines for identification, assessment, and case management*. Volcano, CA: Volcano Press.

Reece, R.M. (Ed.). (2005). *Child abuse: treatment of common ground for mental health, medical and legal practitioners*. Baltimore, MD: The Johns Hopkins University Press.

Reece, R.M., & Ludwig S. (Eds.) (2001). *Child abuse: Medical diagnosis and management* (2nd ed.). Philadelphia: Lippincott, Williams and Wilkins.

Reece, R.M., & Nicholson, C.E. (Eds.) (2003). *Inflicted childhood neurotrauma*. Elk Grove, IL: The American Academy of Pediatrics.

Wolf, M., Chandler, N., and Pape, J.(Eds.). (2004). *Putting Standards into Practice: A Guide to Implementing NCA Standards for Children's Advocacy Centers, Second Edition*. Washington, DC: National Children's Alliance.

Journals

Child Abuse and Neglect: The International Journal (monthly); <http://www.ispcan.org> (as of November 2005) A global, multidisciplinary forum on all aspects of child abuse and neglect including sexual abuse, with special emphasis on prevention and treatment

Child Maltreatment (quarterly); <http://cmx.sagepub.com> (as of November 2005)
Original research information and technical innovations on child abuse and neglect

The Quarterly Update (quarterly); <http://www.quarterlyupdate.org> (as of November 2005)
Reviews of recent peer-reviewed articles on the diagnosis, prevention and treatment of child abuse and neglect

American Academy of Pediatrics Policy Statements

Statements can be found at <http://www.aap.org> as of November 2005

“Assessment of Maltreatment of Children with Disabilities”

Pediatrics, Vol. 108, No. 2, August 2001 (Joint with Committee on Children with Disabilities)

“Distinguishing Sudden Infant Death Syndrome from Child Abuse Fatalities”

Pediatrics, Vol. 107, No. 2, February 2001

“Distinguishing Sudden Infant Death Syndrome from Child Abuse Fatalities” Addendum

Pediatrics, Vol. 108, No. 3, September 2001

“Forgoing Life-Sustaining Medical Treatment in Abused Children”

Pediatrics, Vol. 106, No. 5, November 2000 (Joint with Committee on Bioethics)

“Guidelines for the Evaluation of Sexual Abuse of Children: Subject Review”

Pediatrics, Vol. 103, No. 1, January 1999

“Investigation and Review of Unexpected Infant and Child Deaths”

Pediatrics, Vol. 104, No. 5, November 1999 (Joint with Committee on Community Health Services)

“Medical Necessity for the Hospitalization of the Abused and Neglected Child”

Pediatrics, Vol. 101, No. 4, April 1998 (Joint with Committee on Hospital Care)

“Oral and Dental Aspects of Child Maltreatment”

Pediatrics, Vol. 104, No. 2, August 1999 (Joint with American Academy of Pediatric Dentistry)

“Public Disclosure of Private Information About Victims of Abuse”

Pediatrics, Vol. 87, No. 2, February 1991

“The Psychological Maltreatment of Children: Technical Report”

Pediatrics, Vol. 109, No. 4, e68, April 2002

“The Role of the Pediatrician in Recognizing and Intervening on Behalf of Abused Women”

Pediatrics, Vol. 101, No. 6, June 1998

“Shaken Baby Syndrome Rotational Cranial Injuries: Technical Report”

Pediatrics, Vol. 108, No. 1, July 2001

“When Inflicted Skin Injuries Constitutes Child Abuse”

Pediatrics, Vol. 110, No. 3, September 2002

NACHRI Child Abuse Profile Series Children’s Hospitals on the Frontlines

The NACHRI Board of Trustees has made child abuse and neglect prevention and treatment a priority area. To address children’s hospital needs in this area, NACHRI launched a series of hospital-based child abuse prevention and treatment program profiles. To access the studies, visit <http://www.childrenshospitals.net> and select “Child Advocacy.”

The Future of Education and Training — Learn how children’s hospitals offer models of child maltreatment education for medical students, residents and clinicians.

Portraits of Child Abuse Teams — This profile features four children’s hospitals that have built child abuse programs designed to address unique community needs. It explores issues of initial startup, long-term growth and sustainability, funding sources, alliance building and turf issues, challenges faced and lessons learned.

Understanding the Link Between Child Abuse and Domestic Violence — In more than 30 percent of cases, domestic violence goes hand in hand with child abuse. Even when children are not physically harmed, they see far more than parents imagine. Learn how children’s hospitals are integrating domestic violence services into existing child abuse treatment and prevention programs.

Mandated Medical Expert Review for All Chicago Children — Learn how a consortium of Illinois hospitals created the Multidisciplinary Pediatric Education and Evaluation Consortium, about the program’s mission, how they secured funding and what they learned.

A Simple Model, A Vital Purpose: Preventing Shaken Baby Syndrome — Learn how children’s hospitals in Pennsylvania, Minnesota, Michigan, Utah, Ohio and Arizona used the Upstate New York Shaken Baby Syndrome Education Program to successfully prevent and reduce shaken baby syndrome cases. Find out how each hospital adapted the program, key challenges faced and lessons learned.

Using Multidisciplinary Expertise to Detect Child Abuse — One of the most successful comprehensive child abuse evaluation programs is the Spurwink Child Abuse Program, affiliated with the **Barbara Bush Children’s Hospital at Maine Medical Center** in Portland. Learn about the program’s multidisciplinary team format and its “one size doesn’t fit all” mantra. Information on funding, the evaluation process, medical evaluations and evaluation data included.

Legislative Advocacy Creates Fiscal Solvency for Regionalized Child Abuse Services: The New Jersey Approach — Learn how legislation to create and fund the New Jersey Regional Child Abuse Diagnostic and Treatment Centers (RDCs) – a statewide network of four hospital-affiliated programs that provide a multidisciplinary approach to the investigation, medical evaluation and treatment of suspected child abuse – became successful. The New Jersey RDC network is one of the few in the United States that receives a stable, annual appropriation from a state government.

Profile in Prevention: Achieving Real Concrete Improvement in the Lives of Children and Families — **Arnold Palmer Hospital for Children and Women** in Orlando, FL, developed Healthy Families Orange, a community-based home visiting program offered to families with newborns. The program, which runs in the four ZIP codes of Orange County that have the highest incidence of child abuse, has reduced participants’ involvement in incidents of child abuse or neglect. Learn how program funding is secured, how it’s managed in a complex health care system and its impact on the community.

Meetings and Training

American Academy of Pediatrics National Conference and Exhibition; annually in fall; <http://www.aap.org> (as of November 2005)

American Professional Society on the Abuse of Children Colloquium Trainings and Institutes; <http://www.apsac.org> (as of November 2005)

Midwest Regional Children's Advocacy Center Basic and Advance Training Academies; multiple sessions annually; <http://www.childremsmn.org/MRCAC/index.asp> (as of November 2005)

National Children's Alliance Leadership Conference; annually in summer; <http://www.nca-online.org> (as of November 2005)

National Symposium on Child Abuse; annually in March; <http://www.nationalcac.org> (as of November 2005)

North American Conference on Shaken Baby Syndrome; biannually; <http://www.dontshake.com> (as of November 2005)

San Diego Conference on Child and Family Maltreatment; annually in January; http://www.chadwickcenter.com/san_diego_conference.htm (as of November 2005)

The Ray Helfer Society Annual Meeting; annually in fall; <http://www.helfersociety.org> (as of November 2005)

NACHRI Child Abuse Surveys

National Association of Children's Hospitals and Related Institutions (NACHRI). (2002). Child Abuse Program Survey Findings. Available on <http://www.childrenshospitals.net> (as of November 2005)

National Association of Children's Hospitals and Related Institutions (NACHRI). (2006). Defining the Children's Hospitals Role in Child Maltreat: 2005 Survey Findings. Available on <http://www.childrenshospitals.net> (as of February 2006)

Appendix B: Lobbying Practice Activities Questions and Answers for Nonprofits

1. May a children’s hospital entity engage in lobbying activity without jeopardizing its non-profit status?

Yes. A non-profit may lobby, as long as the lobbying does not comprise a substantial part of the organization’s total activity.

2. How much is a “substantial part” of an organization’s activities?

The IRS offers organizations two choices. If the organization is going to spend minimal amounts of time and money on its lobbying activities and the lobbying is not going to be a high-visibility effort, it may choose to rely on the IRS’s “Substantial Part” test. This is a subjective test in which the IRS evaluates the amount and nature of the organization’s lobbying activity. Since the IRS has not issued specific regulations defining the parameters of the Substantial Part test, it is not an absolutely reliable means of determining the threshold for permissible lobbying.

Alternatively, an organization may spend approximately 20% of its total annual “exempt purposes” expenditures on lobbying without jeopardizing its tax status, by electing to use the “Expenditure Test.” Of this amount, no more than 25% may be used in grassroots lobbying. To elect the Expenditure Test, the organization must file Form 5768 with the IRS. IRS regulations provide a detailed formula for calculating the exact amount, under this test, that an organization may spend without incurring penalties.

3. How does the IRS define lobbying?

Under the Expenditure Test regulations, lobbying is activity directed toward influencing legislation, and includes both direct and grassroots lobbying. Legislation includes any act, bill, resolution, or similar item (such as an executive appointment subject to confirmation) requiring a vote by Congress, a state legislature, or local governing body or by the public, such as a referendum, constitutional amendment, initiative, or ballot measure.

4. What is meant by grassroots lobbying?

Lobbying is divided into two categories, direct and grassroots. Direct lobbying involves direct communications with members or staff of a legislative body (Congress, a state legislature, or local council) or a government employee who participates in the legislative process. The communication must:

- refer to specific legislation, and
- reflect a view on the legislation.

Grassroots lobbying involves communicating with the general public, directly or through an organization’s members, to encourage public action with respect to specific legislation:

A communication is grassroots lobbying if it:

- refers to specific legislation;
- reflects a view on the legislation; and
- contains a “call to action,” such as:
 - encouraging recipients to contact legislators;
 - providing a legislator’s name, address, and phone number;
 - providing a petition or tear-off postcard to send a legislator; or
 - identifying a legislator as being opposed to a particular view, undecided, the recipient’s legislator, or a member of the committee or subcommittee that will consider the legislation. Identifying the sponsor of legislation is not a call to action.

Moreover, a paid mass media communication (including television, radio, newspaper, and magazine advertisements) may be deemed grassroots lobbying, if the ad:

- appears within two weeks of a vote on some highly publicized legislation; and
- reflects a view and either refers to the specific legislation or encourages the public to contact legislators on the general subject of the legislation.

5. What costs are included as lobbying expenditures?

Under the Expenditure Test regulations, all costs associated with putting out lobbying communications are considered lobbying expenditures. These include costs for research, drafting, staff and overhead, mailing, copying and distribution.

6. If hospital employees choose to lobby on their own time, does that activity count against the hospital's limits?

Not necessarily. As long as they are not reimbursed, officers, members and volunteers of an organization may lobby at their own expense. Their costs associated with these activities are not considered lobbying expenditures of the organization. If, however, the hospital recruits the volunteers and urges them to take some action, such as circulating petitions to send to legislators in support of legislation, the related costs and any training expenses incurred by the organization are grassroots lobbying expenses.

7. May a non-profit children's hospital comment on regulations?

Yes. Working with administrators and enforcement authorities, once legislation is passed, is not considered lobbying, under the Expenditure Test regulations. Thus, an organization may vigorously assert its interests during the regulatory process without incurring penalties or jeopardizing its non-profit status.

8. May a children's hospital engage in public debate on issues of importance to it, without conducting "lobbying activity," as defined by the IRS?

Yes. There are a variety of ways that a nonprofit can participate in public policy debate. A children's hospital may distribute nonpartisan analysis and studies on legislative issues to the general public, including legislators. The analysis may state the hospital's view, but may not be one-sided in its overall presentation of the issues and competing points of view. It may identify key legislative players, but may not provide addresses or phone numbers or encourage recipients to contact the legislators.

Similarly, an organization may disseminate examinations of broad social problems. Thus, for example, a children's hospital may communicate with legislators or the public on the problem of uninsured children and its impact on hospitals' ability to provide quality health care to seriously ill children, as long as those communications do not refer to specific legislative proposals or directly encourage recipients to take action with respect to legislation.

A children's hospital may provide testimony or technical advice that is directly responsive to a written request from a legislative committee or body (not just an individual member), as long as that advice is available to all members of the body.

A children's hospital may also provide issues briefings and training in lobbying techniques, provided the instruction does not focus on a future lobbying campaign regarding specific legislation.

There is, in addition, a limited exception known as “self defense” lobbying. This is direct (not grassroots) lobbying on legislation that has a potential effect on the existence of the organization, its powers and duties, tax-exempt status, or deductibility of contributions, and it is not subject to the normal limits on lobbying activities. Thus, if legislation were proposed to eliminate the non-profit status of hospitals, a children’s hospital could lobby government officials without limit to oppose that plan. However, if the legislation merely reduced Medicaid funding, that would not be considered a direct enough threat to invoke this exception.

None of these activities -- nonpartisan analysis, examinations of broad social problems, technical advice, training, or self-defense lobbying -- counts as lobbying activity under the Expenditure Test regulations.

9. Does an organization have to register with the federal government if it engages in lobbying activities?

An organization that chooses the Expenditure Test must file Form 5768 with the IRS. An organization need not register or report activities under the Lobbying Disclosure Act (LDA) unless it:

- spends more than \$24,500 on lobbying the federal government (as broadly defined in the LDA), and
- has at least one employee who spends at least 20% of his or her time on lobbying and has made at least two direct lobbying contacts with a Member or staff of Congress or a high-ranking executive branch official.

Under the Byrd Amendment and OMB regulations, organizations that receive federal contracts, grants, loans, or cooperative agreements must certify that appropriated funds were not used for lobbying and must report payments with non-appropriated funds to lobby for a particular contract, grant, loan or cooperative agreement.

10. What is the penalty for excessive lobbying?

The IRS imposes an excise tax on excessive lobbying expenditures, or excessive grassroots lobbying, equal to 25 percent of the amount of the excess (under the Expenditure Test regulations) or 5 percent of the amount of the expenditures (under the Substantial Part Test). If the IRS finds that an organization has exceeded the allowable lobbying expenditures by an average of 150 percent over a four-year period, it may revoke tax-exempt status (though excessive lobbying over any period, as short as one or two years, may lead to revocation).

11. May officials and employees of children’s hospitals get involved in political campaigns?

Yes. As long as they are using their own time and resources, individual officials and employees may participate in campaigns or party activities, e.g., by making campaign contributions, raising funds, and volunteering their time.

Updated 10/05

For more information on lobbying rules for nonprofit hospitals and a complete set of guidelines, visit <http://www.childrenshospitals.net>; or contact Sharon Ladin, director, Advocacy Programs, NACHRI, sladin@nachri.org.

Appendix C: Sample Child Advocacy and Protection Program Report

Rainbow Babies and Children's Hospital Child Advocacy and Protection Program 2004 Report of Activities

The Child Protection Program at Rainbow Babies and Children's Hospital serves not only the hospital, but also the community through:

- Consultation to University Hospitals physicians on cases of suspected child maltreatment both inpatient and outpatient, as well as to community physicians
- Forensic sex abuse evaluations at the request of child protection agencies, law enforcement, and referring physicians
- Education of medical students, residents, faculty, and health care and social service professionals through lectures, seminars, case conferences
- Consultation to community agencies and law enforcement
- Participation in community activities related child maltreatment such as the Cuyahoga County Child Death Review Committee
- Testimony in criminal cases, as well as child custody cases, in which members of the Child Protection Team and RB&C have involvement
- Electives offered to RB&C residents and CWRU medical students

This year the program was distinguished by designating Rainbow a "No Hitting Zone", an initiative that included in-services for over 300 staff of all disciplines and on-going orientation talks for new RN's. This innovative initiative was presented at the 2005 NACHRI Advocacy Conference in New Orleans.

Invaluable support is provided by the social work staff at Rainbow and MacDonald Women's Hospitals, who provide the direct social service contact with our patients.

Child Protection Team
Lolita M. McDavid, MD
Darlynn Constant, LISW
Lauren McAliley, MSN

SUBSTANCE ABUSE

74 maternal + toxicology screens during pregnancy

38 marijuana 2 alcohol
28 cocaine 2 opiates
2 amphetamines 2 PCP

32 substance abuse history but no + toxicology

20 cocaine
12 marijuana

31 maternal + toxicology screens at delivery

17 marijuana
14 cocaine

12 infants with + toxicology screens at delivery

9 cocaine
3 marijuana

4 misc.:

16 y/o intubated for alcohol intoxication
4 y/o with crack ingestion
15 y/o with PCP ingestion
13 y/o suicidal who feels unsafe due to mother's drug use

SEXUAL ABUSE (does not include Care Clinic)

149 disclosure history
16 age difference between mother and father of infant meets reporting criteria
13 medical indicators
7 sexual abuse witnessed by someone
2 behavioral indicators

Reports of sexual abuse by age

22 reports	3 years old	9 reports	17 years old
17 reports	4 years old	8 reports	8 years old
16 reports	13 years old	8 reports	10 years old
14 reports	15 years old	7 reports	11 years old
12 reports	12 years old	6 reports	9 years old
12 reports	14 years old	6 reports	16 years old
12 reports	2 years old	1 report	1 years old
12 reports	5 years old	1 report	11 month old
12 reports	7 years old	1 report	7 month old
11 reports	6 years old		

CHILD AT RISK

- 47 depressed parent or other psychiatric concerns
- 28 child injured or at risk due to domestic violence
- 22 siblings removed due to abuse, neglect, or inability to provide care
- 14 inadequate resources
 - 5 risk factor unknown
 - 5 teen parent without adequate plan
- 3 unaware of pregnancy; no prenatal care
- 2 children involved in altercation between adults at day care
- 2 home delivery with no prenatal care
- 2 parent unable to provide for child's complex medical needs (1 unwilling, 1 cognitively impaired)
- 2 unable to locate mother of child for discharge
- 2 teen parent with multiple run-away episodes
- 2 housing concerns
- 2 guardianship concerns
- 1 caretaker of special needs child "terrorizing" household
- 1 history of sibling fatality
- 1 teen mother in DCFS custody
- 1 pregnant 18 y/o with Pinesol ingestion
- 1 pregnant mother ingested rat poison
- 1 parent refusing to visit and lack of interest in child's care
- 1 mother intoxicated in patient's room
- 1 mother on DCFS "alert list"
- 1 12 y/o allowed to drive; in MVA
- 1 chaotic household
- 1 teen parent on parole
- 1 parental aggression and depression
- 1 child afraid to go home – bullied by siblings
- 1 house fire – sibling died
- 1 15 y/o suicidal patient whose parents refused to come to hospital
- 1 hypothermia – child locked out of home due to family conflict
- 1 gang involvement, runaway
- 1 abandonment

NEGLECT

- 50 inadequate supervision resulting in injury
 - 31 miscellaneous injuries
 - 11 burns
 - 8 ingestions
- 54 medical neglect
 - 7 failure to thrive
 - 7 failure to meet basic needs
- 4 MVA, child unrestrained
- 2 educational neglect

Reports for inadequate care or supervision include:

epidural hematoma – fall from kitchen table
epidural hematoma – fall through open register
hypothermia
loss of fingers – firecracker injury
diet coke in 9 m/o's bottle
multiple fractures – 3 y/o fall from window
skull fracture – fall from window
3 y/o fell from window
2 children unattended in hot car (8, 1)
5 y/o found wandering in street with no shirts and shoes
3 y/o with new burns and old burn scars
near-drowning
14 y/o injected by mother with animal tranquilizer
1 year old fell from crib – handrails are left down
5 y/o fell off motorcycle
3 m/o found abandoned in a car seat
chipped teeth – unsupervised toddler fell from table
child run over by car
3y/o left alone at hospital all day, in care of sibling (child patient)
femur fracture – fall down stairs
2 gun shot wounds
runaway 13 y/o put out of house by mother
2 Tylenol ingestions
13 m/o with marijuana ingestion

PHYSICAL MALTREATMENT

66 bruises, scars, lacerations, or severe beatings
33 fractures (6 skull, 5 femur, 4 rib, 4 humerus, 4 spiral, 3 tibia,
2 fingers, 2 radial, 1 tibia, 1 clavicle, 1 dislocated elbow)
11 closed head injuries
5 burns (3 buttocks, 1 arm, 1 hand)
2 choking victims
2 bite marks
1 jump from second story window to avoid beating
1 stab wound
1 stroller of 3 m/o intentionally tipped over during argument

Reports of physical maltreatment by age:

30 reports	0-11 months	4 reports	4 years old
12 reports	1 years old	4 reports	5 years old
12 reports	2 years old	4 reports	6 years old
8 reports	15 years old	4 reports	12 years old
6 reports	10 years old	3 reports	9 years old
6 reports	17 years old	3 reports	14 years old
6 reports	3 years old	3 reports	16 years old
5 reports	7 years old	1 report	8 years old
5 reports	11 years old	1 report	unknown

REPORTS FOR CHILD FATALITIES

14 y/o male victim of gunshot wound
12 y/o female hanging victim
9 y/o found convulsing; suddenly stopped breathing
6 y/o brought to ED in full arrest; hx of medical problems
9 m/o brought to ED in full arrest
5 m/o found unresponsive in car seat
5 m/o found unresponsive in crib
5 m/o sleeping with mom; found unresponsive
4 m/o found unresponsive – wrapped in playpen blanket
4 m/o (?) found unresponsive
3 m/o found unresponsive in shelter crib
3 m/o found unresponsive
3 m/o found unresponsive
2 m/o found unresponsive in crib
1 m/o found unresponsive
Neonatal death of twins @17 weeks; mother + toxicology for marijuana

CARE CLINIC

96 exams: (2 R3 – inpatient unit, 1 Pediatric Practice, 1 ED, 92 Care Clinic)

Appendix D: Sample Contracts and Service Agreements

Sample Medical Examinations Service Agreement (Provided by the National Children's Alliance)

This Service Agreement, made and entered this ____ day of (insert month and year), by and between _____ CHILDRENS ADVOCACY CENTER, INC., Address, herein after referred to as the FIRST PARTY and _____, herein after referred to as the SECOND PARTY.

WHEREAS the FIRST PARTY desires to purchase services from the SECOND PARTY in the capacity of medical examinations provided to children served at the __CAC.

THEREFORE, in consideration of the mutual covenants and conditions contained herein, it is hereby mutually understood and agreed by and between the parties as follows:

1. The effective date of this agreement shall be as of _____.
2. The work performed by the SECOND PARTY shall consist of providing *comprehensive sexual abuse examinations for children referred to the (name) CAC for this purpose.*
3. The FIRST PARTY shall pay the SECOND PARTY in accordance with accounts payable policies the sum of _____ Dollars (\$_____) per examination over the term of the agreement.
4. The SECOND PARTY should submit/sign an invoice by the 15th and 31st of each month to the FIRST PARTY.
5. Payment to the SECOND PARTY will be made on a bimonthly basis (15th and 30th or 31st) by the FIRST PARTY for examinations for which it has received reimbursement.
6. This Agreement shall be ongoing until such time as either party notifies the other in writing of intent to discontinue service. Notification must be made 30 days prior to intent to terminate.
7. An executed copy of the Agreement will be returned to the SECOND PARTY.

Executive Director

Service Provider

Date

**Sample Agreement with University System for Provision of Medical Services
(Provided by the National Children’s Alliance)**

This Agreement is entered into this 1st day of January 20__ (the “Execution Date”), by and between the Board of Regents of the University of (State), on behalf of the College of Medicine - (city), hereinafter referred to as the “COLLEGE”, and the _____ Children’s Advocacy Center, hereinafter referred to as “CAC”. This Agreement will set forth the terms pursuant to which CAC will reimburse losses incurred by College in providing medical services and supplies necessary for child abuse exams for children referred to CAC.

RECITALS

WHEREAS, COLLEGE has previously participated in the public service program administered by CAC (the “CAC Program”). The CAC Program is of mutual interest and benefit to COLLEGE and CAC, will further the instructional and public service objectives of COLLEGE in a manner consistent with its status as a nonprofit, state, educational institution, and may derive benefits for both CAC and COLLEGE through the advancement of knowledge and through the advancement of public service. COLLEGE may desire to continue to participate in the CAC Program because of the many tangible and intangible benefits that accrue to COLLEGE as a result of that participation, including COLLEGE program development, research opportunities, national and international publicity and recognition, and physician training in unique disciplines not practiced elsewhere. However, the parties acknowledge that such participation engenders some risk that COLLEGE will not be fully compensated for all of the services and supplies COLLEGE might chose to provide while participating in the CAC Program, and CAC desires to assist COLLEGE by ameliorating any such funding deficit to the extent that CAC has funds available for that purpose.

NOW, THEREFORE, in consideration of the promises and mutual covenants herein contained, the parties agree to the following:

1. COLLEGE Participation in the CAC Program. If COLLEGE chooses to participate in the CAC Program, COLLEGE will provide medical evaluations of children referred for alleged child abuse, including all necessary medical supplies, and including, but not limited to, the following services:
 - a. Medical history
 - b. Physical exam
 - c. Appropriate lab tests and x-rays
 - d. Any other services necessary to accomplish the medical evaluation
 - e. Appearing as a witness and as an expert witness in litigation
 - f. Training and educational services
 - g. Research and publication activities
 - h. Case consultations
 - i. Participation in interagency multidisciplinary team reviews

2. COLLEGE Personnel. If COLLEGE chooses to participate in the CAC Program, COLLEGE will provide and supervise (except as indicated) the following personnel to facilitate the performance of the medical evaluations:
 - a. Licensed Practical Nurse
 - b. Pediatric Nurse Practitioner
 - c. Medical Director
 - d. 2 Physicians
3. Term. Following the Execution Date, this Agreement shall be continued for consecutive annual terms of January 1 through December 31, unless otherwise terminated; provided, however, that the amount of the Cap (defined below) shall be renegotiated each year. The College of Medicine – (city), Department of Pediatrics will be responsible for fiscal and administrative review of this Agreement no later than June 30th of each year. Either party may terminate this Agreement, with or without cause, with 90 days written notice. This Agreement can be modified at anytime by written agreement of the parties hereto.
4. Reimbursement for Services and Supplies. On or before the 30th day of each month following the Execution Date, the COLLEGE shall provide CAC with an itemized accounting for services and supplies provided to the CAC Program during the previous month and all revenues related to the CAC Program collected during such previous month. Revenues related to the CAC Program shall include patient fees, honorariums, witness fees, gifts, grants and other consideration having monetary value and related to the participation of COLLEGE in the CAC Program. CAC shall pay to the COLLEGE an amount based on the net deficit, if any reflected in such accounting, on a cumulative basis for the contract year, and shall make payment to the COLLEGE within 10 days after the accounting is received. Failure of COLLEGE to provide such accounting to CAC by the 30th day of each month does not constitute waiver of CAC's financial responsibilities contemplated hereunder when such accounting is made.
5. Obligation to Provide Funds Limited. The obligation of CAC to provide funds to COLLEGE pursuant to this Agreement shall be limited to \$_____ (the "Cap"). Thus, CAC shall not be obligated to fund COLLEGE for any deficit incurred by COLLEGE in excess of \$_____ during the term of this Agreement, unless the parties agree otherwise in writing. Nothing in this Agreement shall obligate COLLEGE to assume obligations or provide services at no cost as a result of participating in the CAC Program.
6. Status of Personnel. It is agreed that the personnel provided pursuant to Paragraph 2 above are employees and agents of the COLLEGE and that such personnel are not employees of CAC.
7. Liability. Each party shall be responsible for its own intentional and negligent acts and omissions. The COLLEGE's liability is governed by the (State) Governmental Tort Claims Act.

8. Insurance. The COLLEGE certifies that its physicians are covered by appropriate malpractice insurance. The COLLEGE is self-insured according to the (State) Governmental Tort Claims Act.

9. Amendment. This Agreement may be amended at any time upon the written agreement of both parties.

10. Governing Law. This Agreement shall be construed pursuant to the laws of the State of (State).

11. Captions. The Paragraph captions included in this Agreement are for convenience only and are not intended as part of the Agreement.

12. Equal Opportunity. As applicable, the provisions of Executive Order 11246, as amended by EO 11375 and EO 11141 and as supplemented in Department of Labor regulations (41 CFR Part 60, et seq.) are incorporated into this Agreement and must be included in any subcontracts awarded involving this Agreement. The parties represent that all services are provided without discrimination on the basis of race, color, religion, national origin, disability, sex or veteran's status; they do not maintain nor provide for their employees any segregated facilities, nor will the parties permit their employees to perform their services at any location where segregated facilities are maintained. In addition, the parties agree to comply with Section 504 of the Rehabilitation Act and the Vietnam Era Veteran's Assistance Act of 1974, 38 USC §4212.

13. Payment. Payment to the COLLEGE shall be made to: The Univeristy of (State) Health Sciences Center. The Payment should be mailed to:
 University of (State)-(city)
 Department of Pediatrics
 Insert address

 Name
 Title
 UNIVERSITY DEPARTMENT

Date: _____

 Name
 Executive Director
 Children's Advocacy Center

Date: _____

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ABOUT NACHRI

The National Association of Children's Hospitals and Related Institutions is a not-for-profit membership association of more than 190 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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NACHRI, January 2006

**The following organizations have endorsed
*Defining the Children's Hospital Role in Child Maltreatment:***

American Academy
of Pediatrics



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