Trends in Children's Hospital-Based Child Abuse Medical Services: 2012 Survey Findings

Nancy Hanson, BA

Children's Hospital Association (formerly the National Association of Children's Hospitals and Related Institutions) is committed to strengthening the child abuse response from children's hospitals. This commitment is anchored in the belief that children's hospitals—as visible and trusted community advocates for children's health care—are transformational agents in the identification, treatment, and prevention of child abuse and neglect. They are home to more than 80% of the nation's 264 certified child abuse pediatricians.

Children's Hospital Association, an institutional membership organization of 225 hospitals, includes approximately 95% of children's hospitals in the United States. Its members can be grouped into one of four hospital types: (1) children's hospitals within hospitals, (2) freestanding children's hospitals, (3) pediatric programs, and (4) specialty hospitals. These member categories are based on clinical services provided, recognition as a primary teaching site, and governance structure.

The 2012 child abuse trend survey summarized in this article received a response rate of 61% (145 of 237). Nearly all children's hospitals provide services to maltreated children, but the depth and scope of these services vary. The Association conducts a triennial survey of child abuse services to quantify the role of children's hospitals in child maltreatment and serve as a practical benchmarking resource for child protection teams and hospitals. The 2012 survey is the third such collection of data over the last seven years and reflects such information as protection team expenses and revenue, staffing practices, and types of functions and activities.

Hospital-Based Child Protection Teams

The Association developed voluntary guidelines as a self-assessment tool for child protection teams (Children's Hospital Association, 2011). These guidelines offer a three-tiered structure for the development and improvement of child abuse programs while allowing for program flexibility (Table 1). The tiers define *teams* as basic, advanced, or centers of excellence and give recommendations for each level. Ultimately, these suggestions could improve the quality and consistency of medical care to children suspected of being maltreated. In 2012, hospitals were surveyed based on the definitions used in the 2011 guidelines.

Child Abuse Medical Services Survey

The 2012 survey asked teams about a variety of characteristics of their programs, including types of programs, staff, services offered, caseloads, expenses, and resources. The survey was sent to all 225 members of the Association in early 2012. Over half (79 of 145) of survey respondents were physicians, and the majority of those, certified child abuse pediatricians at children's hospitals. The balance of respondents consisted of other types of child protection team members. The 2011 guidelines recommend all acute care children's hospitals respond to child maltreatment at least at the basic level, and 131 of 136 acute care children's hospitals (96%) followed this recommendation. Of all 145 responding hospitals, 27% described their response to child maltreatment as basic, 38% as advanced, and 27% as a center of excellence (Figure 1). Eight percent of respondents offered no services in response to child abuse, meaning they referred all suspected cases of child maltreatment to another health care institution in the community. This percentage fell to 3% if specialty hospitals (generally rehabilitation, burn, and orthopedics hospitals) were excluded.

The guidelines recommend that all child protection teams at the advanced and center of excellence levels should be medically directed, in most cases, by a certified child abuse pediatrician. Overall, such certified pediatricians led 75% (98 of 130) of child protection teams at children's hospitals. They led 90% (35 of 39) of centers of excellence, 85% (46 of 54) of advanced teams, and 46% (17 of 37) of basic programs.

Caseload

The caseload number at children's hospitals is rising. Average caseload increased 9% (from 858 to 934 cases) as reported by the same 68 respondents in both 2008 and 2012 (Figure 2). The increase is 16% for a smaller group of 34 respondents who reported caseload for all three surveys (2005, 2008, and 2012).

Table 1. The Three Levels of Child Protection Teams

Basic

In general, at the **basic** level

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

Advanced

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

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

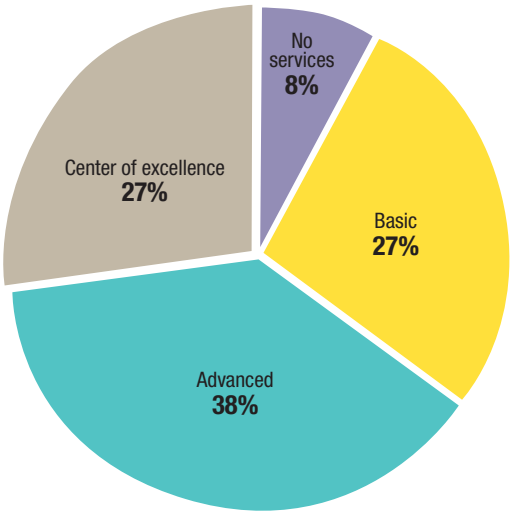
Center of Excellence

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

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

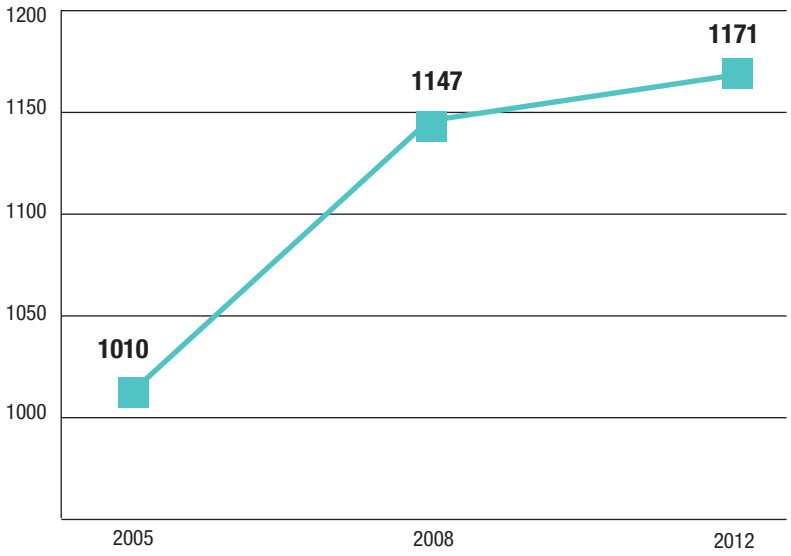
Source: *Defining the Children's Hospital Role in Child Maltreatment, Second Edition* (Children's Hospital Association, 2011), p. 3. All illustrations reprinted with permission.

Figure 1. Child Abuse Program Type (n=145)



Source: *2012 Survey Findings—Children's Hospitals Child Abuse Services* (Children's Hospital Association, 2012), p. 1.

Figure 2. Average Caseload for 2005, 2008, and 2012 (n=34)



Source: *2012 Survey Findings—Children's Hospitals Child Abuse Services* (Children's Hospital Association, 2012), p. 19.

In addition to trend data that show a caseload increase, over two thirds of 2012 survey respondents reported a perception of caseload increase since 2008. They attributed this increase to more referrals from the following: hospital staff (73%), other hospitals and providers (74%), and child protective services, law enforcement, and/or other agencies (68%). This reported increase in child protection team referrals differed from the last 5 years of National Child Abuse and Neglect Data System (NCANDS) information that showed only slight fluctuations in the number and rate of reports to state child protective services agencies (U.S. Department of Health and Human Services, 2012). The perceived increase in referrals could be interpreted as better recognition of the specialized expertise provided by teams and improved coordination with hospital and community partners.

Some respondents believed community awareness and reporting (48%) and the rate of maltreatment (46%) had contributed to more cases, although these were not leading factors in caseload increase. However, the perceived increase in the rate of maltreatment as a factor is contrary to two sources of federal data that showed a decline in substantiated abuse (U.S. Department of Health and Human Services, 2012; Sedlak et al., 2010).

Staffing

Defining the Children's Hospital Role in Child Maltreatment, Second Edition (Children's Hospital Association, 2011) describes the three functions essential to a child protection response: medical leadership, administrative coordination, and social work services. The dedicated *full-time equivalent* (FTE) of medical directors stayed essentially the same at 0.85 in 2008 and 0.84 in 2012 (Table 2). Administrative director FTE and medical social worker FTE each declined: 0.39 FTE and 0.66 FTE respectively. Total FTE on the team remained relatively flat as reported by 61 respondents: 11.49 FTE in 2008 and 11.44 FTE in 2012. There appeared to be no growth and possibly a decline in total FTE of core functions dedicated to child protection teams.

Increases of 0.50 FTE or less were reported for the following positions: nursing/medical assistants, registered nurses, nurse practitioners/physician assistants, forensic interviewers, physicians, and intake coordinators/case managers. There was almost no change in FTE for child abuse fellows and child family advocates. Decreases in FTE were all less than 1.0 for social work therapists, medical social workers, administrative support, coordinators/managers, and psychologists.

Table 2. Change in FTE in 2008 and 2012

Core functions	**FTE 2008**	**FTE 2012**	**Change in FTE**
Medical director (n=50)	.85	.84	(.01)
Administrative director (n=22)	1.19	.80	(.39)
Social worker – medical (n=29)	2.30	1.64	(.66)
Additional functions	**FTE 2008**	**FTE 2012**	**Change in FTE**
Nursing/medical assistant (n=13)	.91	1.41	+.50
Registered nurse (n=17)	2.03	2.47	+.44
Nurse practitioner/physician assistant (n=29)	1.37	1.70	+.33
Physician (n=37)	1.30	1.51	+.21
Forensic interviewer (n=14)	2.72	2.92	+.20
Intake coordinator/case manager (n=12)	1.59	1.70	+.11
Child/family advocate (n=12)	1.23	1.18	(.05)
Fellow (n=11)	1.45	1.39	(.06)
Psychologist (n=14)	1.48	1.35	(.13)
Coordinator/manager (n=18)	1.61	1.48	(.13)
Administrative support (n=43)	1.97	1.83	(.14)
Social work therapist (n=12)	4.79	3.95	(.84)

Source: *2012 Survey Findings—Children's Hospitals Child Abuse Services* (Children's Hospital Association, 2012), p. 19.

Expenses and Revenue

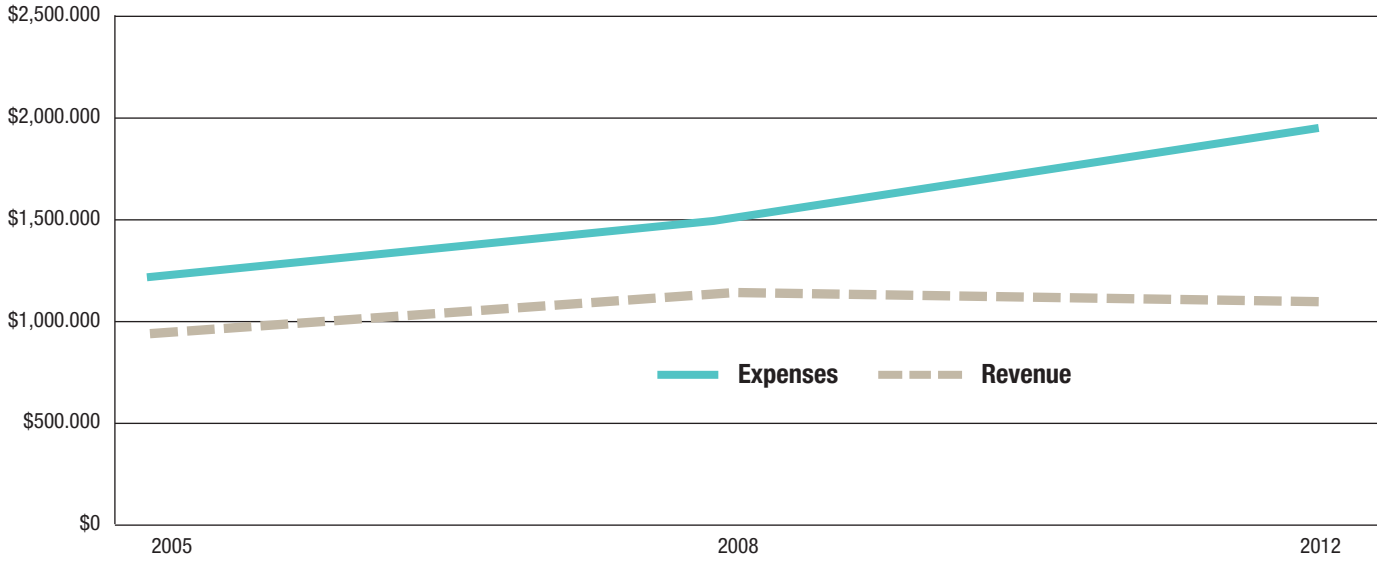
Consistent with the national rise in health care costs, direct operating expenses increased 10% since 2008 to an average $1,384,519, according to 36 respondents. At the same time, revenue shrunk 10% since 2008 to an average of $1,089,457, according to 25 respondents (Figure 3).

A group of 17 respondents reported expenses and revenue for all three surveys in 2005, 2008, and 2012. Their figures show a 60% increase in expenses and a 17% increase in revenue. With expenses going up and revenue not keeping pace, the difference will continue to widen.

Hospital Support of Direct Expenses

Prior surveys demonstrated that child protection teams are not financially self-sustaining: They do not bring in enough money to cover their costs

Figure 3. Expenses and Revenue in 2005, 2008, and 2012 (n=17)



Source: Unpublished 2012 Children's Hospital Association survey data.

and the hospital absorbs the shortfall. The 2012 survey used a new approach to quantify this gap. It asked respondents how much of the direct expenses the hospital covered for fiscal year 2011 and found that the hospital covered 47% of an average of $1,113,703 in direct expenses (i.e., $523,440 of direct expenses) for 59 respondents. For indirect expenses, the hospital covered over half (58%) of an average of $211,088 in indirect expenses (i.e., $122,431 of indirect expenses) for the same 59 respondents. There was variability among the 59 hospitals for reporting how much the hospital covered; nine hospitals reported that the hospital fully covered their expenses and five hospitals reported that the hospital covered none of their expenses. Figure 4 shows the distribution by hospital for these numbers.

Other Sources of Support for Expenses

The survey asked whether other organizations covered any child protection team expenses in addition to the hospital. Another organization covered some of the direct or indirect expenses for 62% of respondents (73 of 118). Of the 70 respondents who provided more detail, more than 20% reported various contracts, grants, and university support. Almost 15% cited a children's advocacy center as covering some portion of expenses.

Revenue

Child protection teams reported average revenue of $722,174 in 2012 (n=55) (Table 3). The majority of respondents (84%) depended on three or more sources of revenue. Medicaid, private payer, and reimbursement for services (including contracted services) provided to local, county, or state agencies or university/school were the most frequently cited revenue sources (n=104).

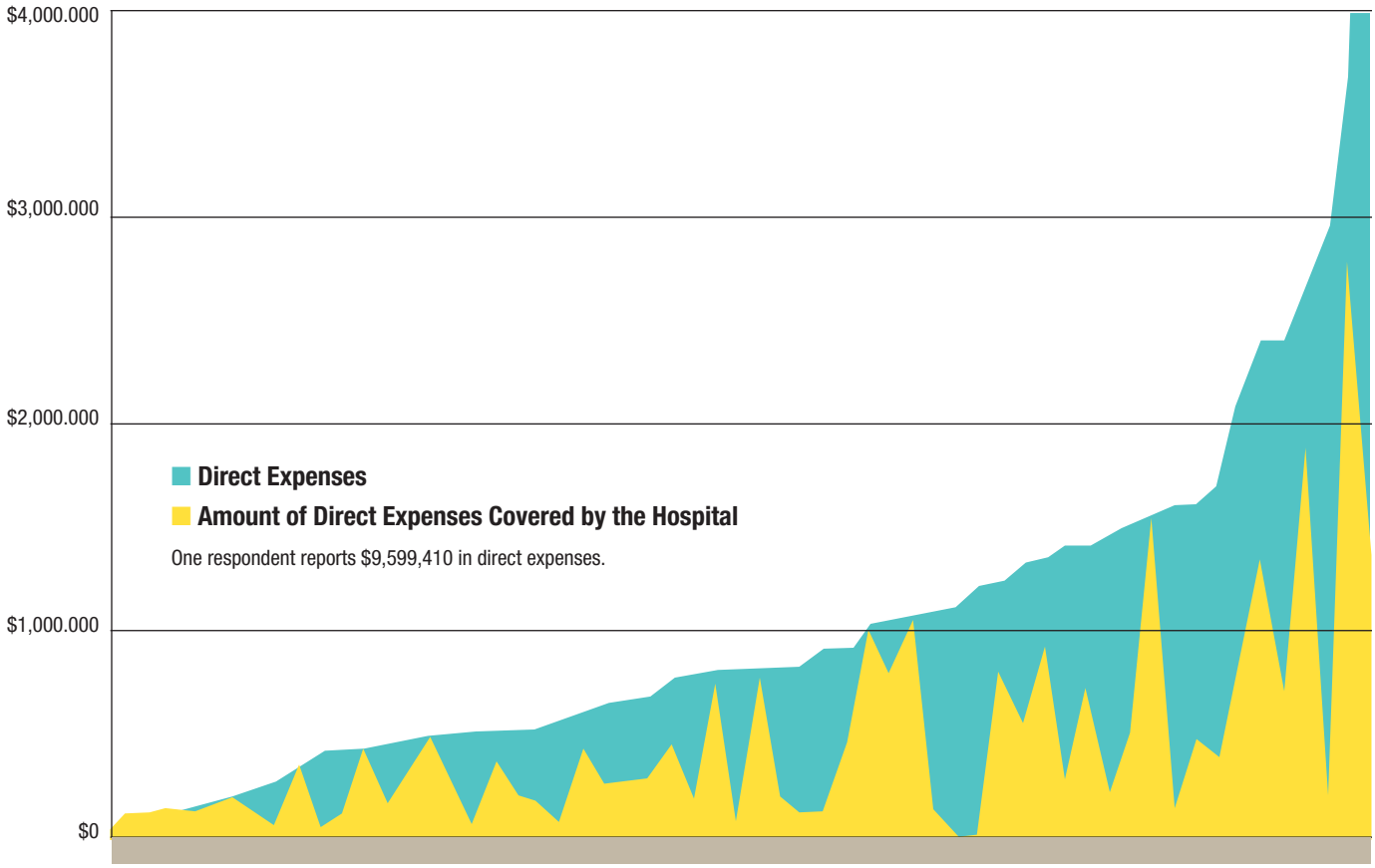
Respondents indicated the one revenue source that provided the most money to their team. Almost half revealed that either Medicaid or reimbursement for services (provided to local, county, or state agencies or university/school) was their single largest source of revenue. On average, Medicaid accounted for 30% of team revenue (n=50).

Table 3. Sources of Revenue That Provide the Most Money to Teams (n=94)

Greatest sources of revenue	Number of respondents
Medicaid	28
Reimbursement for services	16
Hospital foundation	14
Victims of crime compensation	10
State budget line item	9
Other	17

Source: *2012 Survey Findings—Children's Hospitals Child Abuse Services* (Children's Hospital Association, 2012), p. 11.

Figure 4. Distribution of Direct Expenses and How Much the Hospital Covers (n=59)



Source: *2012 Survey Findings—Children's Hospitals Child Abuse Services* (Children's Hospital Association, 2012), p. 9.

Change in Revenue Sources

For both 2008 and 2012, 47 respondents provided revenue source data. The average number of revenue sources accessed by teams remains fairly constant: a total of 6.23 sources in 2008 and 6.09 sources in 2012. However, a possible shift in sources used was suggested by an increase in respondents who include Medicaid, reimbursement for services, and private payer as part of their funding portfolio. At the same time, fewer of the 47 respondents received revenue from SCHIP, TRICARE, state attorneys general, the hospital foundation, and the U.S. Department of Justice. There was less or little change for funds from the National Children's Alliance, other foundations, state budget line items, individual donations, victims of crime compensation, and court fees and fines.

Reimbursement for Services

Inadequate reimbursement is a persistent challenge for child protection teams and hospitals. Respondents most frequently reported that the following routine activities of child protection teams are not reimbursed: phone consults, written expert opinions, and psychosocial assessments.

Education and Training

Despite the grim financial picture, more child protection teams are educating other health care professionals and community partners than were in 2008. The largest increases are in education for child-care/daycare providers (19% more teams), psychologists (16% more teams), pediatric fellows (14% more teams), pediatric/family practices (12% more teams), child protective services (11% more teams), and prosecution (10% more teams). Other types of professionals for whom training was provided by the hospital's child protection team increased between 3% and 10%, including law enforcement, social workers, medical students, and residents.

The data show that from 2008 to 2012, there was an incremental increase in whether training was funded (the survey doesn't differ-

entiate between partial or full funding) for the majority of the training types; from 2008 to 2012, however, there was greater change in the number of respondents who indicated that training was unfunded. For example, more respondents who provided training to prosecution, law enforcement, pediatric/family practices, and psychologists noted that training was more often unfunded in 2012 than in 2008.

Children's Advocacy Centers

In 2012, a quarter of respondents (33 of 131) reported that their hospitals house a children's advocacy center (CAC). Medical services were provided to one or more independent CACs by 62% of respondents (80 of 130). Thirty-eight respondents neither housed nor provided services to a CAC.

Prevention

Recognizing that child abuse prevention activities are not the exclusive purview of the hospital's child protection team, the survey sought to understand whether others in the hospital engaged in prevention activities. A six-point Likert scale measured the frequency of prevention activities for both the team and others in the hospital: *never, rarely, sometimes, very often, always,* and *don't know.*

For most prevention activities listed, the team reported *very often* or *always* engaging in the activity more frequently than others in the hospital (Table 4). The child protection team consistently *very often* or *always* conducted screening for interpersonal violence, caregiver substance abuse, and maternal mental health about 30% more often than did others in the hospital. The team also conducted shaken baby/abusive head trauma education, general community awareness of maltreatment, and sexual abuse prevention education more frequently than others in the hospital.

Others in the hospital *very often* or *always* conducted crisis support for families in the hospital and safe sleep education more frequently than child protection team members. Both groups engaged equally in parenting education and home visiting. For many of these activities, respondents indicated between 10% and 20% of the time they *don't know* whether others in the hospital are conducting the activity, perhaps signaling a lack of communication or decentralization of prevention activities across the organization.

Table 4. Prevention Activities *Very Often or Always* Conducted by the Child Protection Team and Others in the Hospital (n=116)

Prevention activity	Child protection team	Others in hospital	Difference
Screening for IPV	88%	58%	30%
Screening for caregiver substance abuse	80%	52%	28%
Screening for maternal mental health	76%	46%	30%
Crisis support for families in the hospital	72%	80%	(8%)
Shaken baby/AHT education	68%	46%	22%
Parenting education	60%	60%	0%
General community awareness of maltreatment	59%	17%	42%
Sexual abuse prevention education	55%	17%	38%
Safe sleep education	52%	58%	(6%)
Lobbying for legislation that supports prevention	25%	11%	14%
Evaluation of, or research on, prevention activities	20%	14%	6%
Home visiting	6%	6%	0%

Source: *2012 Survey Findings—Children's Hospitals Child Abuse Services* (Children's Hospital Association, 2012), p. 15.

Evaluation and Research

A five-point Likert scale was used to explore how the child protection team tracks its work: *never, rarely, sometimes, very often*, and *always*. More than half of the time, child protection teams either *always* or *very often* collected the number of consults they made, reports made to child protective services, previous referrals, number of teaching sessions, and case resolution. Fewer *always* or *very often* tracked the services received by families and the time from referral to the completion of services. Over half (58%) of respondents indicated the child protection team conducts original research for the purposes of publication or presentation. Of those, about a third (22 of 64) were externally funded.

Summary

Overall, the Children's Hospital Association 2012 survey of hospital-based child abuse services found that children's hospital-based child protection teams are growing in the number of cases they see. While expenses are rising, revenue is not. Respondents still rely on an assortment of revenue sources; however, it appears that teams are increasingly counting Medicaid, private payers, and reimbursement for services (including contracted) among their revenue sources. In many cases, expenses are largely absorbed by the hospital. Growing numbers of child protection teams now deliver education and training to other health professionals and community partners. Child protection teams also conduct a variety of prevention activities, typically more frequently than others in the hospital. The full findings report is available at **http://www.childrenshospitals.net/2012childabusesurvey**. Complimentary hard copies of the report and customized benchmarking data are available upon request. The next triennial survey is scheduled to be collected in 2015.

References

Children's Hospital Association (formerly known as National Association of Children's Hospitals and Related Institutions). (2011). *Defining the Children's Hospital Role in Child Maltreatment, Second Edition.* Retrieved from: **http://www.wrcactoolkit.org/upload/Children's%20Hospitals'%20role%20in%20child%20maltreatment.pdf**

Children's Hospital Association. (2012). *2012 Survey Findings—Children's Hospitals Child Abuse Services.* Retrieved from: **http://www.childrenshospitals.net/AM/Template.cfm?Section=Child_Abuse_and_Neglect&Template=/CM/ContentDisplay.cfm&ContentID=64502**

Sedlak, A. J., Mettenburg, J., Basena, M., Petta, I., McPherson, K., Greene, A., and Li, S. (2010). *Fourth National Incidence Study of Child Abuse and Neglect (NIS–4): Report to Congress, Executive Summary.* Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families.

U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2012). *Child Maltreatment 2011.* Available from: **http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment**

About the Author

Nancy Hanson, BA, is Associate Director of Child Health Advocacy at the Children's Hospital Association. Since 2007 she has been supporting member hospital efforts to promote the optimal, healthy development of children, especially in the areas of child maltreatment, injury prevention, and childhood obesity. She was the project director of the 2012 Children's Hospitals Child Abuse Services Survey and led the development of the second edition of *Defining the Children's Hospital Role in Child Maltreatment.* Contact: **nancy.hanson@childrenshospitals.org**