Pediatric Centers of Excellence Advisory Committee Findings and Recommendations

Senate Bill 758
80th Texas Legislature

Submitted by
The Texas Department of State Health Services
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Background

Child abuse is one of the most prevalent and severe dangers faced by children in the U.S. today with 2.04 out of every 100,000 children in the U.S. dying from child abuse in 2006.[1] In Texas, the problem is even greater, with a rate of 3.96 deaths per 100,000 children, the highest rate in the nation.[2] Fatalities disproportionately affect very young children with children younger than one year account for 44.2 percent of fatalities and children younger than age four accounting for 78 percent of fatalities in the U.S. in 2006.[3]

There were 71,344 confirmed victims of child abuse in Texas in 2007.[3] Nearly 80 percent of the perpetrators of confirmed abuse were parents.

Despite the severity of the problem, however, many cases of child abuse are not reported and the exact prevalence of child abuse is unknown.[4] Estimates from national and state surveys have found the lifetime prevalence of child abuse to be anywhere from 25 percent to 50 percent of individuals, depending on the definition of abuse used.[5, 6, 7]

In addition to the suffering experienced by child abuse victims and their families, child abuse has significant costs to society as a whole including health care expenditures, lost work days, and law enforcement and social services expenses.[8] In the short term, children suffering abuse may require hospitalization and medical care for their acute injuries, which tend to be more severe and costly than injuries caused by accidents. In the long term, the experience of child abuse may lead to more chronic physical and mental health problems for its victims, such as permanent disability, post-traumatic stress disorder, addictions, depression, eating disorders, smoking and obesity. Most importantly, abused children that are not identified or treated have a significant risk of becoming an abusive parent.

The Governor, the executive branch, and the Texas Legislature have taken significant steps to reform and improve the practices and policies of child protective services (CPS). At the direction of Governor Rick Perry, the Health and Human Services Commission (HHSC) initiated a statewide review of CPS in 2004 and made recommendations to strengthen investigations and improve services to families and children.

In 2005, the Texas Legislature passed Senate Bill (SB) 6 (Nelson/Hupp) requiring major reforms of child protective services in Texas including the establishment of a "cost effective medical services delivery model" to meet the needs of children served by the Department of Family and Protective Services Department (DFPS) (See Appendix A). SB 6 specified major components of the medical services delivery model including:

- The designation of health care facilities with expertise in the forensic assessment, diagnosis, and treatment of child abuse and neglect as pediatric centers of excellence,[9]
- The establishment of a statewide telemedicine system to allow DFPS investigators and caseworkers to consult with pediatric centers of excellence, and
- The establishment of a medical home, a health passport and a system of monitoring the medical care provided for each child in foster care.

DFPS and HHSC have made significant progress in the implementation of much of the medical services model required by SB 6. In the spring of 2008, HHSC launched the STAR Health Program, a managed medical care program for children in foster care, kinship care, and other forms of DFPS conservatorship. HHSC hired Superior HealthPlan Network to help develop a statewide system of accessible, coordinated and comprehensive healthcare services.

In 2006, DPFS contracted with the University of Texas Health Science Center at Houston (UTHSCH) to create the Forensic Assessment Center Network (FACN) to improve DFPS staff access to medical professionals with expertise in child abuse. In turn, UTHSCH subcontracted with the University of Texas Medical Branch in Galveston, University of Texas Southwestern in Dallas and The University of Texas Health Science Center in San Antonio (UTHSCSA). This network provides medical expertise to DFPS caseworkers when local pediatric abuse and neglect expertise is not available. FACN provides 24-hour support for CPS caseworkers through a statewide toll-free number and a web-based system.

In 2007, the Texas Legislature enacted SB 758 (Nelson/Rose) which modified some of the reforms of Senate Bill 6 and created an Advisory Committee on Pediatric Centers of Excellence relating to abuse and neglect. (See Appendix B)

The Advisory Committee was charged with:

- Developing guidelines for designating regional pediatric centers of excellence (PCOEs),
- Developing recommended procedures and protocols for health care providers when evaluating suspected cases of child abuse and neglect, and
- Recommending methods to finance the centers of excellence and related services.[10]

The Committee has been meeting since January 2008 and has developed this report to begin addressing the above areas of responsibility. Members of the committee are listed in Appendix C. The Department of State Health Services (DSHS) attached an agency cost estimate in Appendix G.

Findings

With the implementation of STAR Health for foster care children and the FACN initiative, it is time to focus on the need for greater capacity in the health care system to prevent, assess, diagnose, and treat child abuse and neglect. While the FACN has made significant strides in addressing the investigative needs of CPS caseworkers, the problem of child maltreatment requires a more comprehensive approach. This approach must address the treatment of the child and family; education of professionals to improve detection and accurate diagnosis; consultation to assist the investigative needs of local law enforcement officials; research regarding the root causes, as well as, improvements in clinical management, and prevention.

Improving the capacity of the health care system to diagnose, treat, and prevent child maltreatment early and accurately by funding regional pediatric centers of excellence will better serve children and their families, promote a more efficient use of limited state resources and begin to contain the growing economic and social costs of child abuse in Texas.

Major issues that have limited the health care system's response to child abuse include:

- the shortage of physicians specialized and experienced in child abuse and neglect,
- low levels of reimbursement for child abuse-related medical services, and
- the resulting under-diagnosis and misdiagnosis of many children.

The limited number of clinicians with the training and expertise on child abuse issues is a major barrier to providing timely and effective child abuse assessment, diagnosis and treatment in Texas. Despite its prevalence, many clinicians receive very little training in child abuse while they are in medical school and in continuing education programs during their career. Most physicians do not regularly examine children who may have been abused or neglected, and many do not have sufficient expertise in how to recognize and handle cases of child abuse and do not feel confident in their ability to do so. [11]

The medical evaluation of a child who may be a victim of child abuse is a complex and time consuming undertaking. There are physicians who specialize in child abuse at some of the children's hospitals and pediatric residency programs in Texas; there is a significant shortage of these specialists in Texas and nationwide. These physicians are busy evaluating and treating the severe cases of child abuse that present as trauma cases or require admission of the child as an inpatient to the hospital because of the severity of the injuries. As a result, there are few specialized physician resources available for comprehensive child abuse evaluations in outpatient settings and in many geographic areas of the state.

Providers dealing with child abuse usually receive reimbursement for only a fraction of the services they provide. Reimbursement in programs like Medicaid is rarely commensurate with the time and skill required to evaluate the complexities of a child abuse case. Furthermore, although medical professionals play an important role in the investigation and prosecution of abuse cases, the time required for depositions, trial preparation and courtroom testimony is not a direct medical service to the patients and usually is not reimbursed.

As a result of the shortage of providers with child abuse expertise, many victims of child abuse may not receive a definitive medical evaluation for child abuse. Studies have shown that as few as one-third of children suffering physical abuse receive the needed medical attention; and furthermore, many children who receive medical attention may not be diagnosed properly.[12] The shortage of specialized physicians also affects the ability to conduct a timely evaluation for child abuse, which is important because bruises fade and injuries heal.

An organized statewide system in Texas for the timely and accurate assessment, diagnosis and treatment of child abuse and neglect will have important benefits.

A statewide system could save the state significant time and money associated with investigation of cases and legal proceedings. CPS and local agencies use significant resources investigating whether or not abuse has occurred and collecting evidence for prosecution. Medical information collected early in the process and interpreted by a qualified child abuse physician can save time and effort in legal proceedings by presenting a clear picture of how abuse occurred, if it did occur, or by ruling out abuse early on if there was no abuse.

Early diagnosis is important to preventing the short-term and long-term harm an abused child will suffer with continued abuse. By detecting the abuse early, a child may be protected more quickly and separated from the abuser and placed in a healing environment if necessary.

In addition to early diagnosis in cases of abuse, accurate diagnosis is also crucial. Investigations of abuse referrals when abuse has not occurred can lead to significant trauma for children and families, especially when children are removed from the home and become involved with law enforcement, CPS and the court system. Medically-oriented child abuse teams have been shown to assist in accurately determining if a child's injuries are due to abuse, which could prevent the unnecessary use of resources required for an investigation and the potential for an out-of-home placement for a child who has not, in fact, suffered abuse.[13]

A recent study conducted in San Antonio found that 20% of children referred to CPS for suspected physical abuse who were initially examined (and in many cases referred) by physicians not specializing in child abuse were found to have accidental injuries or conditions simulating abuse when assessed by child abuse pediatricians. [14] In addition, this study found that more than 40% of the physicians conducting the initial examination did not document their opinion regarding the likelihood of abuse; this can be confusing to CPS when the physician is the referral source, or may lead to erroneous interpretation of the medical records when CPS is unable to access medical expertise.

Program Development Recommendations

The Committee endorses the creation of Texas MEDCARES (Texas Medical Child Abuse Resources and Education System), a regional system of medical child abuse programs to improve the assessment, diagnosis and treatment of child abuse and neglect, to be developed into a statewide service system over the next 10 years.

The Committee recommends establishing 3 MEDCARES program levels:

- **level 1 (center of excellence),**
- **level 2 (advanced program),**
- **level 3 (basic program).**

Table 1 summarizes the 3 program levels. More detailed guidelines for the designation of programs are in Appendix D.

Table 1
Levels for MEDCARES Child Abuse Programs

	3-Basic	2-Advanced	1-COE
Staff	1 trained physician and an individual responsible for social work. Either may be team administrative coordinator.	At least 1 FTE physician, 1 dedicated social worker, 1 coordinator. Other staff as needed.	At least 2 FTE board eligible/certified child abuse pediatricians as part of full multi-disciplinary team.
Services	May not be 24/7 but available for all serious cases. Comprehensive medical evaluation, case consultations, psychosocial assessments, photo documentation, mental health referrals, may refer to Child Advocacy Centers (CACs) for sexual abuse.	Increased availability of services and response time. Team consults on inpatient and outpatient cases.	Increased size, volume and support from medical subspecialties, mental health care and counseling.
Prevention	Participates in community efforts. Serves as public spokesperson.	Serve on relevant community boards.	Regional leadership on prevention; hosts conferences and task force meetings.
Collaboration and Advocacy	Works with investigation and protection agencies and CACs.	CPS assigns social worker to the hospital; relationships with EMS multidisciplinary community team.	Regional resource for outlying communities; outreach to community stakeholders.
Education	Conducts core training and referral protocols for hospital staff and medical students/residents; participates in Continuing Medical Education (CME).	Training for residents, medical students, community pediatricians, CPS, law enforcement and others.	Advanced training for pediatricians interested in becoming child abuse specialists; may support a fellowship or regional/ national training opportunities.
Research	Collects data on cases.	Regular updates on new developments.	Recognized authority for child maltreatment research.

Risk Management	Review and update protocols regularly. Consults with hospital legal counsel. Meets Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards on abuse identification, staff education.	Medical oversight of cases evaluated by nurses, Sexual Abuse Nurse Examiners (SANEs)	Organizes regional peer review meetings. Conducts grand rounds.

The structure of each program requires a multi-disciplinary team involving physicians, nurses, social workers and other professionals.

The core functions of a MEDCARES program include:

- providing comprehensive medical evaluations, psychosocial assessments and photo documentation of suspected victims of child abuse;
- serving as a medical referral resource for the medical community and other stakeholders;
- providing training to medical students, residents, community physicians, nurses, social workers, counselors and other professionals;
- providing case consultation and training to law enforcement officials;
- providing case consultation and training to CPS caseworkers;
- supporting research to develop evidence based practice guidelines; and
- working with other community and regional resources on prevention and treatment services for children and their families.

The state should focus on the development of a limited number of level 1 and 2 programs in 2010-2013.

The first step in better meeting the needs of children across the state is increasing the number of pediatricians with specialized experience in child abuse and enhancing the capacity of existing programs in Texas to serve more children. This requires recruiting, hiring and training additional pediatric specialists as well as other professionals required for these multi-disciplinary programs.

Because of the national shortage of qualified providers, Texas needs to develop its own capacity with expanded training opportunities and fellowship programs.[15] Currently, the University of Texas Health Science Center at San Antonio (UTHSCSA) hosts the only recognized fellowship program in child abuse and neglect in Texas.[16] These increased training and educational opportunities should be organized around pediatric residency programs and linked to the children's hospitals in the state that currently have child abuse specialists.

Following the development of level 1 and 2 programs, which would increase the number of specialists available as well as training and consultation capacity, the state should focus on the development of level 3 programs linked to level 1 and level 2 programs.

There are significant programs in place that need to be sustained and linked to the development of MEDCARES.

There are existing initiatives in Texas that relate to this effort to develop a statewide system of medical child abuse programs. These include:

- The Forensic Assessment Center Network (FACN),
- Children's Advocacy Centers (CACs),
- Child Fatality Review Teams (CFRTs), and
- Child abuse teams based in children's hospitals around the state.

The development and designation of medical child abuse programs is not intended to replace or substantially alter the functions of these existing programs. However, there should be strong working relationships among these programs.

FACN would continue to contract for consultation services and training for Child Protective Services (CPS) caseworkers and investigators. FACN was designed by DFPS to provide a network of resources that would allow CPS better access to medical professionals with expertise in child abuse and neglect and to "fill in the gaps" for cases where local expertise in these areas was not available. FACN was not designed to be a direct medical care services initiative or to provide consultation to other agencies involved in child abuse.

Children's Advocacy Centers (CACs) facilitate multidisciplinary collaboration and provide support and services to CPS, law enforcement and the alleged victim as the case is being investigated.[17] CACs also link victims to mental health services, crime victims' compensation assistance, social services agencies and medical services.[18] Although some CACs in Texas provide medical exams in-house, most refer children to a hospital or doctor off-site to receive medical exams and to evaluate other related health concerns.[19]

The 61 CACs in Texas have service areas reaching 92 percent of the child population in the state and focus most of their efforts on child sexual abuse.[20, 21] Although nearly 40,000 Texas children are served by CACs annually, almost half of the children confirmed by CPS of having suffered abuse did not receive services from a CAC in FY 2007.[22, 3]

The development and designation of medical child abuse programs would create additional medical resources that could be used by CACs.

Child Fatality Review Teams (CFRTs) are another element of the child abuse infrastructure in Texas. The 31 active teams throughout the state review child deaths in their areas with the goal of reducing the amount of preventable child fatalities, which includes those related to child abuse as well as natural deaths and deaths from unintentional injuries.[23] While many CFRTs are located in communities where there are also CACs, some communities only have one or the other and CFRTs often consist of the most experienced child abuse providers in the community.[24]

The surveillance and study of child deaths is an important public health research activity that can lead to more effective community prevention and early intervention activities. Medical child abuse program staff would participate on local CFRTs.

The child abuse teams based in children's hospitals are concentrated in the largest cities in Texas and reflect the diversity of their communities with varying levels of staffing and services. Although each hospital-based child abuse team is unique, in all cases there is at least one pediatrician specializing in child abuse that leads the team and is supported by a variety of professionals including SANEs, nurse practitioners, social workers and others. The teams handle both sexual and physical abuse cases and some teams serve significant numbers of cases of neglect. For the most part, the hospital-based child abuse teams in Texas focus their work on the evaluation of cases of abuse, but some hospital-based child abuse teams also dedicate considerable resources to prevention, research and treatment and rehabilitation services for abuse victims.

Hospital-based child abuse teams in Texas hospitals do not receive state funding to provide the comprehensive services proposed in this report; hospitals provide the major financial support for the child abuse team. Very limited reimbursement is available from private insurance providers, Medicaid, law enforcement, the local prosecutor's office, research funding, donations and other grants. Funding is available for physician team member consultation to CPS at some sites through FACN.

The Committee recommends that the Texas Legislature give responsibility for the development and oversight of the medical child abuse programs to DSHS.

The Committee recommends continuation of the Advisory Committee created by SB 758 to provide input and guidance to the DSHS program office, to ensure coordination with FACN administered by DFPS, to allow consideration of regional differences and needs in system development and to provide clinical expertise in the development of any recommended guidelines, protocols and practice resources.

The Committee believes that child abuse is a public health problem and that public health and health care system resources must be brought to bear on the problem along with the resources of social services and legal systems.

DSHS has extensive experience and expertise in child health care issues and programs as the federal Title V maternal and child health grantee. DSHS operates direct care programs for children as well as population based prevention activities that provide information to the public and the medical community related to healthy development and child abuse. For example, DSHS provides information to health care providers on immunizations, newborn screening, postpartum depression and shaken baby syndrome as well safe sleep for babies.

DSHS operates the state's public health surveillance systems, including providing support to the state child fatality review committee. This committee is a multidisciplinary group whose mission is to reduce the number of preventable child deaths by understanding of the causes and incidence of child deaths in Texas, identifying procedures within state agencies to reduce the number of preventable child deaths; and making recommendations for changes in law, policy, and practice to reduce the number of preventable child deaths.

Finally, DSHS has the responsibility for the development of the state trauma system, including the designation of trauma facilities, the development of trauma designation guidelines, training of health professionals and the administration of the trauma grants and funds.

The Committee believes that this experience in child health, public health, and health systems development makes DSHS the appropriate lead state agency for MEDCARES.

New responsibilities of DSHS related to MEDCARES will include:

- Establishing minimum standards and requirements to receive state funding,
- Making and monitoring start up and enhancement grants to develop programs,
- Convening regular meetings of the Advisory Committee,
- Supporting the development and dissemination of best practices including quality assurance processes,
- Promulgating guidelines and clinical practice resources on child maltreatment to hospitals, emergency departments and medical professionals, and
- Making periodic reports on progress to the Texas Legislature, the Governor, the Texas medical community and other interested stakeholders.

As required by SB 758, the Committee's recommendations for procedures and protocols for the evaluation and management of suspected child abuse and neglect in hospitals and emergency departments are included as Appendix E.

Financing Recommendations

The Committee recommends that the state support eight level 1 and level 2 programs in the 2010-2011 biennium.

The Committee believes that the following local programs should be able to achieve level 1 or level 2 designations by the second year of the next biennium:

- Austin (Dell Children's Medical Center of Central Texas)
- Corpus Christi (Driscoll Children's Hospital)
- Dallas (Children's Medical Center of Dallas)
- Fort Worth (Cook Children's Health Care System)
- Galveston (UT Medical Branch)
- Houston (Texas Children's Hospital)
- Houston (UT Health Sciences Center Houston/Children's Memorial Hermann Hospital)
- San Antonio (CHRISTUS Santa Rosa Children's Hospital)

State funding for these programs will build on, and enhance the infrastructure of existing hospital based programs.

The Committee recommends that start-up funding should be made available in the 2010-2011 biennium to fast-track the development of programs in Lubbock, El Paso, Temple and Amarillo.

The Committee believes that there are high services needs in these regions and they should receive state funding with the goal of achieving level 1 or level 2 designations in the 2012-2013 biennium. Programs in these areas are less developed than the eight local programs underway in Austin, Corpus Christi, Dallas, Fort Worth, Galveston, Houston and San Antonio, but state start-up funding and technical assistance from more advanced programs will help to build a statewide system more quickly.

The Committee believes that it will cost about $1.5 million per year to operate a level 1 medical child abuse program and that the state should fund 65 percent of the cost of a designated program (level 1 or level 2). (See Appendix F)

The Committee recommends that the Texas Legislature appropriate sufficient new funding per year for DSHS to administer the program.

Implementing a new program will require sufficient staff resources and other support to undertake the duties for DSHS outlined above.

The Committee recommends that HHSC and DSHS develop a methodology to use Medicaid federal funds to help fund the program to the extent possible, consistent with keeping administrative costs low for grantees. This activity should occur during the first two years of program operation.

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[9] Texas Family Code, ch. 266, sec. 266.003. Medical Services for Child Abuse and Neglect Victims.

[10] Texas Senate Bill 758, 80th Legislature, regular session (2007).

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[12] Jean I. Layzer and Barbara D. Goodson, Child Abuse and Neglect Treatment Demonstrations, *Children and Youth Services,* 1992, 14, pp. 67-77.

[13] Gregory H. Wallace, Kathi L. Makoroff, Heidi A. Malott and Robert A. Shapiro, "Hospital-based multidisciplinary teams can prevent unnecessary child abuse reports and out-of-home placements," *Child Abuse & Neglect,* Vol. 31, Issue 6, June 2007, pp. 623-629.

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[17] Interview with Selena Muñoz, Director of Program Services, Children's Advocacy Centers of Texas, Inc., Austin, Texas, October 18, 2007.

[18] Children's Advocacy Centers of Texas, Inc., 2006 Annual Report for the period September 1, 2005 through August 31, 2006, Austin, TX.

[19] Children's Advocacy Centers of Texas, Inc., 2007-2008 Directory, Austin, TX.

[20] Interview with Selena Muñoz, Director of Program Services, Children's Advocacy Centers of Texas, Inc., Austin, Texas, October 18, 2007.

[21]. Interview with Selena Muñoz, Director of Program Services, Children's Advocacy Centers of Texas, Inc., Austin, Texas, October 18, 2007

[22.] Children's Advocacy Centers of Texas, Inc., 2006 Annual Report for the period September 1, 2005 through August 31, 2006, Austin, TX.

[23] Texas Department of State Health Services, Texas Child Fatality Review Team Annual Report 2006, Online: Available: http://www.dshs.state.tx.us/mch/pdf/TEXASC~1.pdf.Accessed May 2, 2008

[24] Telephone interview with Dr. James Lukefahr, Center for Miracles – Christus Santa Rosa Children's Hospital, San Antonio, TX, April 29, 2008.

Appendix A: SB 6 – Medical Services Summary 79th Texas Legislature

Sec. 266.003. MEDICAL SERVICES FOR CHILD ABUSE AND NEGLECT VICTIMS.

(a) The commission shall collaborate with health care and child welfare professionals to design a comprehensive, cost-effective medical services delivery model, either directly or by contract, to meet the needs of children served by the department.

The medical services delivery model must include:

(1) the designation of health care facilities with expertise in the forensic assessment, diagnosis, and treatment of child abuse and neglect as **pediatric centers of excellence;**

(2) **a statewide telemedicine system** to link department investigators and caseworkers with pediatric centers of excellence or other medical experts for consultation;

(3) identification of **a medical home for each foster child** on entering foster care at which the child will receive an initial comprehensive assessment as well as preventive treatments, acute medical services, and therapeutic and rehabilitative care to meet the child's ongoing physical and mental health needs throughout the duration of the child's stay in foster care;

(4) the development and implementation of **health passports** as described in Section 266.006;

(5) establishment and use of **a management information system that allows monitoring of medical care** that is provided to all children in foster care;

(6) the use of medical advisory committees and medical review teams, as appropriate, to establish **treatment guidelines and criteria** by which individual cases of medical care provided to children in foster care will be identified for further, in-depth review;

(7) development of the training program described by Section 266.004(h);

(8) provision for the summary of medical care described by Section 266.007; and

(9) provision for the participation of the person authorized to consent to medical care for a child in foster care in each appointment of the child with the provider of medical care.

(b) The commission shall collaborate with health and human services agencies, community partners, the health care community, and federal health and social services programs to maximize services and benefits available under this section.

(c) The executive commissioner shall adopt rules necessary to implement this chapter.

Appendix B: SB 758 – Establishment of PCOE Committee 80th Texas Legislature

SECTION 21. Chapter 266, Family Code, as added by Chapter 268, Acts of the 79th Legislature, Regular Session, 2005, is amended by adding Section 266.0031 to read as follows:

Sec. 266.0031. COMMITTEE ON PEDIATRIC CENTERS OF EXCELLENCE RELATING TO ABUSE AND NEGLECT. (a) The committee on pediatric centers of excellence relating to abuse and neglect is composed of 10 members appointed by the executive commissioner. The members must include:

(1) a representative of the attorney general's office;

(2) a representative of the Department of State Health Services;

(3) a representative of the Department of Family and Protective Services;

(4) a representative of the Health and Human Services Commission;

(5) a representative of a child advocacy center;

(6) three pediatricians who specialize in treating victims of child abuse;

(7) a representative from a children's hospital; and

(8) a representative of a medical school, as defined by Section 61.501, Education Code, with expertise in forensic consultation.

(b) The executive commissioner shall designate a member representing the Department of State Health Services as the presiding officer of the committee.

(c) If there is a medical director for the department, the executive commissioner shall appoint the medical director to be the department's representative on the committee.

(d) The committee shall:

(1) develop guidelines for designating regional pediatric centers of excellence that:

(A) provide medical expertise to children who are suspected victims of abuse and neglect; and

(B) assist the department in evaluating and interpreting the medical findings for children who are suspected victims of abuse and neglect;

(2) develop recommended procedures and protocols for physicians, nurses, hospitals, and other health care providers to follow in evaluating suspected cases of child abuse and neglect; and

(3) recommend methods to finance the centers of excellence and services described by this section.

(e) The committee shall report its findings and recommendations to the department and the legislature not later than December 1, 2008.

(f) This section expires January 1, 2010.

Appendix C: Pediatric Centers of Excellence Committee Members

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Appendix D: Designation Guidelines for Child Abuse Programs

Develop guidelines for designating the components of a pediatric center of excellence, an advanced child abuse program, and a basic child abuse program.

Background/overview of work to date:

General comments

The Pediatric Centers of Excellence Committee has reviewed and discussed 5 primary sources of information: NACHRI's Defining the Children's Hospital Role in Child Maltreatment; the American Academy of Pediatrics Committee on Child Abuse clinical report "Evaluation of Suspected Child Physical Abuse;" the American Academy of Pediatrics Committee on Child Abuse Health CAREs Centers of Excellence model for child abuse; the needs assessment summary conducted by DFPS in March 2006; and the results of the on-line survey conducted February 2008. Committee members agree that the NACHRI definitions/designated components for pediatric centers of excellence (COE), advanced child abuse programs and basic child abuse programs provide a logical and appropriate framework for achieving the first goal/directive of the committee. All of the documents reviewed have significant overlap and potential for synergy. The Texas-specific information allows the committee to fine-tune the NACHRI model according to the resources available in Texas.

Specific comments

1. **NACHRI model.** This document provides extensive and specific guidance for designating basic, advanced, and COE in 9 areas:
    1. Staff
    2. Services
    3. Policies
    4. Prevention and Advocacy
    5. Community Collaboration
    6. Education
    7. Research
    8. Funding
    9. Risk Management

    Since "Policies" addresses the second directive of the committee and "Funding" addresses the third directive, these categories will not be incorporated in this draft (at least initially). Considering the remaining components, the AAP Health CARES center of excellence model incorporates most of these components as well, but into broader categories:
    1. Service: promote evidence-based best practices by primary and secondary health care providers. Includes Education, Services, Risk Management.
    2. Workforce: addresses the need for sufficient numbers of trained pediatricians. Incorporates Education.
    3. Research: the development and testing of evidence-based health care approaches. Includes Prevention and Research.

4. Prevention: enhancing health care providers' role to reduce future health harms. Incorporates Service, Education, Prevention and Advocacy.

It is interesting to note that the Health CAREs model does not incorporate community collaboration or multi-disciplinary coordination. Based on the survey and needs assessment, these components are deemed essential for the Texas model.

2. NACHRI principles.

1. Child maltreatment is primarily a public health problem, not a prosecutorial problem.
2. Each level program must meet and maintain the previous level guideline.
3. Before establishing or expanding a program, a comprehensive community needs assessment should be conducted, incorporating information from law enforcement, CPS, mental health, domestic violence service providers, and Children's Advocacy Centers (CACs).
4. Physicians, at all levels, must be experienced and trained in child abuse and neglect, and up-to-date in best practices for patient care, examination, diagnostic skills, and management skills. In addition, all physicians should be comfortable with public appearances and active in educational and training activities. A curriculum or criteria for maintaining competency will be developed by the PCOE.
5. All level programs should either conduct scholarly research or have protocols whereby physicians and other professionals maintain up-to-date knowledge in child abuse research.

3. Needs assessment report by DFPS.

1. Accessibility. The best resources are Children's Hospitals and medical schools, in part due to the need for 24/7 availability. There is some variability in accessibility, due to constraints of funding, expertise, space. For example, when court testimony is required, the physician cannot generate patient revenue and can lose up to $5000 a day, so his/her involvement may be limited by the practice or the institution; hospitals vary in their support of physicians, particularly when they are needed for testimony.
2. Expertise. There is considerable need for knowledgeable and experienced physicians. There are vast areas in Texas that have no such resource. There is also a need for pediatric radiologist to be available to review films.
3. Infrastructure. A CPS liaison for the hospital is an identified need. Most programs locate the liaison on-site. In addition, face-to-face case consultations between physician and investigator appear to be more effective than telephone and email correspondence. Hospitals indicated a willingness to provide cross-training for CPS and to help with training for photo-documentation. Photo-documentation appears to be an important component, and permits the few physicians to maximize their efficiency by balancing the patients they need to see in person with the less-emergent cases that may be adequately assessed by photo- and case review.

There is also a need for quality assurance among and between the medical providers. Scheduled peer review of cases is commonly used. Risk management should include the provision of expert medical oversight for all SANEs. There is currently no funding stream for the latter except in cases where the medical director is affiliated with the program and therefore supported by the hospital. There are far more SANEs and SANE programs than expert physicians who could provide appropriate medical oversight. Sending images via encryption is one method that some centers utilize to provide this oversight expeditiously for remote programs.

4. Training. The need to train front-line health care professionals on recognizing suspected abuse and neglect and how/when to refer to a specialist is a high priority.

4. **AAP Evaluation of suspected child physical abuse.** This document outlines a general clinical approach for suspected physical abuse, but also outlines services and equipment needed to adequately assess abuse. Photo-documentation of visible injuries, accessibility to accurate and timely medical assessments (24/7), accessibility to key diagnostic tests such as radiographs, CT, MRI and serologic tests necessary to address coagulopathies, intra-abdominal injuries and bone disorders, and accessibility to key subspecialists, especially in radiology, surgery and mental health are recommended.

COMPONENTS OF BASIC, ADVANCED AND CENTER OF EXCELLENCE

General comments

This section will describe each program level with respect to staff, services, community/MDT collaboration, risk management, education, prevention, and research. The NACHRI model will provide the framework and Texas-specific data will modify the details.

BASIC

The physician providing services at the basic level must be experienced and trained in all types of child abuse and neglect, with demonstrated competency in patient care, examination approach, diagnostic skills, judicious use of diagnostic testing, management skills, documentation, and accessibility to investigators and other medical providers that need case consultation and medical expertise. The physician must participate in peer review to maintain a current level of knowledge, and provide training to medical and non-medical professionals. Prior to receiving designation as a basic center, the physician is responsible for facilitating/conducting a needs assessment of the community, which summarizes the extent and nature of local support and resources for the establishment of a child abuse assessment center.

1. **STAFF**. Staff consists of one physician and individual(s) responsible for social work assessment and administration/coordination. The physician can also assume the administrative responsibilities. The physician must demonstrate the following:
    - 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.
- 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. Provides for appropriate photo-documentation of injuries.
- Provides leadership for the hospital/CAC 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.

The following are the requirements of a team coordinator of a basic program:

- The role of team coordinator should be addressed specifically in the hospital or children's advocacy center job description of the position assigned this role. Through this paid position, the hospital or CAC visibly demonstrates its commitment to child abuse services.
- The hospital/CAC 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/CACs 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/CAC support, in periodic professional educational efforts to increase his/her 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. He/she is also responsible for collaboration and cooperation with other basic, advanced and centers of excellence in the network.

The team of a basic program works collaboratively to:

- Ensure core data and tracking functions are performed and reported in a timely manner, and develop a quality assurance structure for case tracking.
- Develop and integrate the community child abuse team (often the CAC) 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/CAC policies regarding privacy and confidentiality.
- Serves as a point person for referrals from community agencies and community hospitals.

- Supports collection and documentation of patient history and examination findings by various providers to achieve an accurate diagnosis. This includes photo-documentation and documenting all explanations offered to any hospital personnel by caregivers for injuries being observed and treated by the team.
    - Documentation is kept in a well-organized, accurate system that can easily be accessed for case management and investigations.
- Provides basic information to community agencies about the medical evaluation of child abuse
- Participates in peer review organized by advanced and/or PCOEs.
    - Establish, in accordance with the second directive of this committee, protocols and procedures for: child abuse reporting, medical evaluation of various types of suspected child maltreatment, appropriate timing, location, and provider of medical assessments, procedures for maximizing reimbursement, ensuring child safety when child abuse is detected in a medical setting, internal and external referral procedures, confidentiality, and the process by which medical information can be appropriately shared with members of the community-based team.

2. **SERVICES**. 24/7 availability may not be possible with the Basic program; but the physician should be available to see or consult on all serious child abuse cases requiring medical care, and most non-emergent cases of suspected physical abuse, sexual abuse, and neglect that require medical expertise. The physician must have experience with acute and non-acute sexual abuse examinations or knowledge about the appropriate referral sources through the CAC or medical facilities. The physician should also coordinate medical and psychosocial assessments, and provide appropriate mental health screens and referrals. The services of a basic program include:
    - A comprehensive medical evaluation, based on specific criteria, protocols and procedures developed by skilled medical providers.
    - Case consultations and evaluations conducted 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 obtaining 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/CAC has experts available to refer for timely sexual abuse examinations with a local or regional Children's Advocacy Center or Sexual Assault Nurse Examiner program. Similarly, if a child physical abuse case requires photo-documentation that is not available through the child protection team, the hospital/CAC has experts available (Forensic Nurse Examiners, specially trained CPS or law enforcement investigators) to refer for timely physical abuse examinations.
        - Some accessibility to a pediatric radiologist; images can be sent electronically or by mail.
        - Psychosocial assessments and mental health referrals are provided.

3. **COMMUNITY AND MULTI-DISCIPLINARY COLLABORATION**. Basic team functions:
    - 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.

4. **RISK MANAGEMENT**.
    - Provides a system for review and updating of all protocols on a scheduled basis
    - 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.
    - Devises a system for medical oversight and review of children evaluated by other medical providers or nurses (SANEs) that ensures appropriate review of cases, with medical evidence of abuse.

5. **EDUCATION**. There are several levels of educational targets: within one's hospital, with other medical facilities and providers, regional investigative agencies, community advocacy agencies, community, medical students, pediatric residents, and fellows. Each successive level requires more extensive involvement of the child abuse team. The Basic child protection team incorporates the following:
    - 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.
    - 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.

6. **RESEARCH**
    - The team's medical director has a fundamental knowledge of the relevant research and literature on child abuse and prevention, including literature classic to the field and new findings.
    - The team collects key data for cases on which it consults and is provided with the staff support needed to do so.

7. **PREVENTION**. Prevention is a way to maintain community outreach, involvement, and support. Basic programs should:

- Participate in child abuse prevention efforts and contribute to community advocacy initiatives focused on child maltreatment (such as Child Abuse Prevention Month activities).
- Ensure that the child maltreatment team's medical director and/or staff has training or guidance in serving as a public spokesperson, and make 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.
- Promote child abuse prevention within the hospital, including utilization of the state-mandated DSHS shaken baby intervention materials.

ADVANCED

In addition to each component outlined under "Basic," the Advanced Child Abuse Team must incorporate the following:

1. **STAFF**. Staff consists of at least one FTE pediatrician, at least one dedicated social worker or case manager, and one person responsible for administration/coordination. Many Advanced programs will require additional staff to meet the required components. Medical staff should:
   - Ensure appropriate clinical coverage for child maltreatment cases based on community needs and staffing ratios at the hospital/CAC.
   - Serve as the medical leader for peer review and educational programs coordinated by the child protection team.
   - Provide mentoring for other physicians as they learn to manage or consult on child abuse and maltreatment cases.
   - Encourage quality assurance efforts that examine team functions.
   - Enable collaborative team meetings.
   - Direct the improvement of medical services to abused and neglected children in the children's hospital/CAC by employing appropriate protocols and procedures.
   - Help secure ongoing administrative support and funding.

   The team coordinator and other team members are expected to:
   - Work with the team director and hospital fundraising staff to secure ongoing administrative support and funding.
   - Organize, facilitate, or participate in multidisciplinary child protection team meetings within the hospital and/or community-based/CAC team meetings.
   - Organize, facilitate, or participate in internal and/or cross-institutional peer review systems (child fatality review teams, MDT case staffings, etc).
   - Identify gaps within the community child abuse response system and pursue opportunities for improved team operation with the medical director, the hospital administration and/or the leadership of the community-based team.

2. **SERVICES**. The primary differences between services provided by the Basic program and those provided by the Advanced program are the accessibility/availability of the child abuse team, the more diverse clinical settings (inpatient and outpatient) and the response time. In addition, Advanced programs have sufficient staff to serve a larger population than the Basic program. The following are the responsibilities of the Advanced Program:

- Establishing a policy for timely notification of suspected cases of child maltreatment to the hospital's child abuse response team.
- The child protection team is consulted for inpatient and outpatient suspected victims of child maltreatment and oversees the medical evaluations.

3. **COMMUNITY AND MULTIDISCIPLINARY COLLABORATION**
   - Work with CPS to assign dedicated, "primary" social workers to liaise with the hospital. Request that these primary social workers have advanced training.
   - Establish, as appropriate, regular meetings to review cases with medical providers and multidisciplinary team members; provide resource and contact information for individuals and hospitals needing child abuse assessments and expertise.
   - 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.
   - Coordinate with forensic interviewers, a key component to child sexual abuse cases.
   - Assume some of the responsibility for maintenance of a healthy and productive multidisciplinary community team.

4. **RISK MANAGEMENT**. Advanced programs are expected to devise and provide a system for medical oversight and review of cases evaluated by other medical providers or nurses (SANEs), especially those cases determined to have medical evidence of abuse. The results and importance of these activities should be shared with multidisciplinary partners to promote appropriate referrals for medical expertise.

5. **EDUCATION**. Advanced programs are expected to provide:
   - Extensive and diverse hospital-based education to residents, students and other trainees.
   - Community-based training to community-based pediatricians and to child protective services, law enforcement, CAC staff, and other nonmedical community stakeholders.

6. **RESEARCH.** The primary difference in research activities between the Basic and Advanced program is the consistency and frequency with which knowledge is updated and provided to the team. In addition, such updates can be collaboratively exchanged with Basic programs and PCOE. The medical director or other appropriate medical staff keeps the team members regularly updated on new developments in child maltreatment literature. This can be accomplished through a child abuse listserve or The Quarterly publication.

7. **PREVENTION**. The Advanced child abuse team engages in the prevention activities outlined under "Basic" and plays an active role on committees as follows:

- 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.

CENTERS OF EXCELLENCE

In addition to the components required of "Basic" and "Advanced" Child Abuse Teams, the Centers of Excellence are expected to provide the following:

1. **STAFF**. Staff consists of at least two FTE board eligible/certified Child Abuse pediatricians, at least one FTE individual(s) responsible for social work assessment and at least one administrator/coordinator. In addition to the requirements listed under Basic and Advanced programs above, the Child Abuse pediatrician:
   - 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.
   - Provides medical leadership for related community programs, such as Children's Advocacy Centers, domestic violence prevention and intervention programs, child abuse prevention programs, and advocacy programs.
   - Serves as a source and facilitator of peer review locally and regionally and mentors colleagues, including physicians at Basic and Advanced programs.
   - Leads research efforts focused on child abuse and neglect and is knowledgeable about the steps needed to protect patients when conducting such research.

   The team coordinator and other team members are responsible for:
   - Coordinating and supporting the child protection team's community advocacy and prevention efforts.
   - Facilitating the team's research program and educational offerings, including the logistical and administrative coordination of fellowships, internships and residency rotations.

2. **SERVICES**. The PCOEs differ from the Advanced programs primarily in team size and constitution, volume of patients, and degree of medical expertise and support from medical subspecialties. PCOEs provide the following:
   - 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.
   - 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.

3. **COMMUNITY AND MULTIDISCIPLINARY COLLABORATION.** The PCOE will:
    - Serve as a regional medical resource that provides facilitation and coordination for various investigative components from outlying communities.
    - Create and sign agreements when working within multidisciplinary teams, such as those in Children's Advocacy Centers.
    - 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, CPS, district attorney, sexual assault center, judges and other community hospitals.
    - 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.

4. **RISK MANAGEMENT**. The PCOE is responsible for facilitating and organizing regional peer review meetings to review and discuss cases. In addition, members of the PCOE team:
    - Train 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.
    - Use 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.
    - Provide updates in the child maltreatment literature, opportunities for training in child maltreatment, and other educational venues for the Advanced and Basic programs in their region.

5. **EDUCATION**. The PCOEs are responsible for developing advanced training for pediatricians interested in becoming child abuse specialists. In addition, COEs:
    - Train residents, health professionals, students and/or allied professionals in advanced multidisciplinary topics related to child maltreatment.
    - May support a fellowship program through its varied activities and structure.
    - Provides regional and even national training opportunities.

6. **RESEARCH**. The COE differs from other levels in that it is a recognized authority for current child maltreatment research and conducts research and analysis of gathered data. As such, the COE serves as a local and regional resource on the evolving body of research on child maltreatment.

7. **PREVENTION.** The COE provides regional leadership in this area in the following ways:
    - 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.
    - Hosts and/or provides facilities, in conjunction with the hospital, for prevention conferences, child abuse task force meetings and other events surrounding child maltreatment.
    - Ensures prevention is a key component of medical education programs, fellowships and other training initiatives such as continuing education.

Appendix E: Practice Guidelines for Child Abuse Programs

CLINICAL PRACTICE RESOURCE
FOR HOSPITALS AND EMERGENCY DEPARTMENTS:

Evaluation and Management of Suspected Child Abuse or Neglect

IDENTIFY THE CHILD WHO MAY BE A VICTIM OF ABUSE OR NEGLECT.

A. Injuries (bruises, burns, fractures) that should be carefully considered for evaluation for *PHYSICAL ABUSE*:

1. Age 0-6 months: *Any injury.*
2. Age 6 months or older:
   a. Bruises, lacerations, or burns to protected, fleshy, or flexor surfaces—*for example*, inner thighs, abdomen, neck, face (other than frontal prominence), pinna, genitalia.
   b. Bruises, lacerations, or burns showing an object pattern—*for example*, belt loop, cigarette burn, curling iron.
   c. Suspicious oral injuries, *especially* frenulum and palate lacerations
   d. Third-degree burns or large second-degree burns, *especially* scald burns.
   e. Fractures, *especially* metaphyseal fractures, complex or wide skull fractures, rib fractures, spiral fractures of humerus or femur, scapula fractures.
   f. Significant head injury, *especially* subdural hematoma, retinal hemorrhage, subgaleal hematoma, avulsed hair, complex or wide skull fracture. Head injury should be considered whenever a child presents with vomiting or altered consciousness, or bloody spinal fluid is found on lumbar puncture, but an infectious process cannot be readily diagnosed.
   g. Intraabdominal injury without another reasonable explanation (e.g. severe car accident), *especially* rupture or hematoma of internal organ.
3. Age 0-10 years: Positive urine or blood screen for alcohol or drugs of abuse.

B. Findings that should be carefully evaluated for *SEXUAL ABUSE*:

1. Any injury to the genitalia (*especially* to the hymen or vestibule in girls) or anus.
2. Any history or statement or witnessed incident consistent with sexual abuse.
   In addition, for children ≤13 y.o., mentally impaired children, and those 14-17 y.o. whose partner is 3 or more years older:
3. Identification of an STD: Chlamydia, gonorrhea, HSV, HPV, HIV, HBV, HCV, Trichomonas, syphilis.
4. Positive pregnancy test.
   - ***Note:*** *State law states that medical personnel must report as abused any unmarried minor under age 17 (i.e., before the 17th birthday) who has had sexual contact UNLESS they are at least 14 years old, and you document an AFFIRMATIVE DEFENSE. An Affirmative Defense exists if the minor is at least 14 years old, all partners are within 3 years of their age and of the opposite sex, and there was no force, duress, or threat.*

C. Findings that should be carefully evaluated for *NEGLECT*:

1. Growth parameters below expected for age.
2. Lack of medical care for a significant health problem—*for example*, no medications for asthma, diabetes; no care of severe dental caries.
3. Lack of normal bonding with parent/guardian.
4. Disregard of one or more basic child care needs—*for example*, child found in street, failure to place child in auto safety seat or belt.
   - Note: A child may have findings suggesting more than one form of abuse or neglect.

CONSIDER THE EXPLANATION GIVEN BY THE PARENT/GUARDIAN OR CHILD.

A. Possible *PHYSICAL ABUSE*.

1. Does the parent/guardian or child give a *logical explanation* that is consistent with the age, pattern, and severity of the injury?
   a. Consider developmental level of child. Is the child capable of the alleged action? *For example*—a 6-month-old cannot unbuckle a car seat.
   b. Consider biomechanics of injury. *For example*--a fall from less than 4 feet rarely causes a fracture and almost never causes intracranial hemorrhage; a child who cannot crawl or walk cannot self-inflict a bruise, fracture, burn, or laceration.

B. Possible *SEXUAL ABUSE*.

1. Does the parent/guardian or child give a *logical explanation* that is consistent with the examination findings? *For example*--in a child with venereal warts, is there documentation of maternal HPV infection during pregnancy or delivery?

C. Possible *CHILD NEGLECT*.

1. Does the parent/guardian give a *reasonable explanation* that is consistent with the pattern and severity of the findings suggesting neglect (and can he/she provide documentation)? *For example*—has a child who is small for age been worked up for medical or familial causes of short stature/failure to thrive?

WORKUP AND INITIAL MEDICAL MANAGEMENT.

A. In ALL cases of suspected abuse or neglect.

1. **Report case to Texas Department of Family and Protective Services (Children's Protective Services) via telephone for emergent cases, statewide number: 1-800-252-5400 (*e.g. child's caregiver refuses medical care and threatens to leave AMA*); or on-line for non-emergent cases (*e.g. child is in a safe home environment)*: www.txabusehotline.org.**
   Have ready at hand as much of the following as possible:
   - the facts of the case,
   - the child's and parents' home address, phone numbers, dates of birth
   - siblings' names, ages, and whereabouts

2. In cases of clear criminal activity or where CPS does not have authority to investigate, notify the law enforcement agency *with jurisdiction in the location where the abuse probably occurred.*
3. Contact Hospital Security and/or local police department if there is imminent risk of violence or other criminal activity on hospital premises, or if there is a risk that the parent may attempt to leave the hospital with the child.
4. Consult hospital social worker.
   - ***NOTE:*** *Social workers may assist in reporting cases of suspected abuse to CPS or law enforcement, but the clinician who recognizes the suspected abuse has the ultimate legal responsibility to make certain the report is made.*
5. Attempt to obtain parent/guardian consent for treatment, procedures, and photographs. *However, consent is not necessary if it is refused. The Texas Family Code (§32.005, rev. 7/17/2000) permits a physician to examine a child under age 16 when abuse or neglect is suspected, if necessary without the consent of the parent, guardian, or child. "Examination" may include X-rays, blood tests, and photographs.*
6. Clearly document a complete History and Physical Examination that includes (if applicable) the child's statement about the cause of injury.
7. Photograph visible injuries, *and* carefully diagram all positive examination findings.
8. *Do not discharge child if a potential perpetrator may have access to him/her* until CPS has made a disposition. Consider admission to the hospital if necessary.
9. Arrange or recommend to parent/guardian or CPS that any siblings or other children in the household be examined as soon as possible.
10. Inquire whether any adult in the household is a victim of domestic violence, and refer for services if necessary.

B. Suspected *PHYSICAL ABUSE.*

1. Age 0-2 years: complete skeletal survey in all cases (*not* long bone series or "babygram").
2. Age 2-5 years: skeletal survey should be considered (*not* long bone series or "babygram").
3. Nuclear medicine bone scan (or repeat skeletal survey in 2 weeks) if index of suspicion for skeletal injury remains high despite negative initial skeletal survey (*for example*-- in cases of Shaken Baby Syndrome).
4. CT scan of head if suspected acute intracranial injury; MRI scan of head instead of a CT if subacute (older than 5 to 7 days) or chronic intracranial injury.
5. CT scan of abdomen if suspected serious blunt thoracoabdominal trauma.
6. For detailed imaging standards and protocols, consult the listed reference from the American Academy of Pediatrics Section on Radiology.
7. CBC, platelet count, prothrombin time (PT) and partial thromboplastin time (aPTT) if large bruises are present. Consider factor assays if PT or aPTT are prolonged or if there is a known family history of bleeding. Consider consultation with a pediatric hematologist for cases involving extensive bleeding/bruising and no other sign of abuse (such as fractures).
8. Serum liver transferase (AST/ALT), amylase, lipase levels and *bag / clean catch* urinalysis if abdominal trauma is suspected or present.

9. Ophthalmology consult for thorough fundoscopy in cases of:
   - Suspected intracranial injury.
   - Suspected Shaken Baby Syndrome (metaphyseal fractures, subdural/subarachnoid hemorrhage, and/or posterior rib fractures).
   - Spiral fracture, metaphyseal fracture, or other injury in child under age 2 suggestive of shaking or twisting injury.
   - Fracture in infant under age 6 months.

C. Suspected *SEXUAL ABUSE.*

1. Complete physical examination.
2. Age 0-2 years: skeletal survey in cases with visible acute injuries.
3. Age 2-5 years: skeletal survey should be considered if visible acute injuries.
4. *For all cases:* Careful inspection of external genitalia and anus for evidence of trauma, in exam setting with adequate lighting, positioning, and magnification.
   - Position child in frog-leg supine position; adolescent male in sitting or supine position for genitalia and decubitus or supine knee-chest position for anus exam; adolescent female supine in stirrups.
   - In girls, use labial traction technique to visualize vestibule and hymen. Also inspect labia majora, perineum, inner thighs, lower abdomen.
   - In prepubertal girls, position in the prone knee-chest position to confirm suspected abnormal hymenal or vestibular findings. (Abnormal findings in adolescent girls can be confirmed using a cotton swab or balloon catheter.)
   - In boys, careful inspection of penis, scrotum, perineum, inner thighs, lower abdomen.
   - In both sexes, careful inspection of anus and perianal area for evidence of trauma. Use gentle gluteal separation to inspect anal rugae and outer canal.
5. *For non-acute sexual abuse allegations:*
   - Children may be referred to a local sexual abuse examination center (e.g. Children's Advocacy Center) for examination on the next available business day *if* the child is in a safe home environment and parent/guardian agrees to the referral.
   - Testing for sexually transmissible disease should be performed if one or more of the following are true: If the history suggests the child had genital, anal, or oral contact with the perpetrator's genitalia; if there is evidence of genital, anal, or oral trauma; or if genital or anal discharge is present:
     a. Cultures (*not DNA probes or other screening tests*) of: throat, vagina (in prepubertal or young teen girls), cervix (in postpubertal girls), male urethra, and/or anus for gonorrhea;
     b. Cultures (*not DNA probes or other screening tests*) of: vagina (in prepubertal or young teen girls), cervix (in postpubertal girls), male urethra, and/or anus for chlamydia.
        - ***Note***: Minitip synthetic-fiber swabs can be used in young children to minimize discomfort.
        - ***Note***: For evidentiary purposes, nonculture tests for gonorrhea and *Chlamydia* (such as the GenProbe) cannot be used for child sexual assault victims. If a child has a positive result on a nonculture test (e.g.

at a facility where culture is not available), the child should be sent to a center having the capability to obtain true cultures prior to initiating antimicrobial therapy.

c. Blood should be drawn for syphilis and HIV testing. Consider also testing for HBV and HCV.
d. Wet prep (for trichomonas, sperm, clue cells, yeast, or leukorrhea) if a discharge is present.
e. Culture for HSV if vesicles/ulcers are present.
f. In postpubertal females, if speculum exam is done, consider obtaining Pap smear.

6. For acute sexual assault (penetrating genital injury and/or contact with perpetrator's genitalia within the past 48 to 72 hours):
   - A forensic evidence collection kit should be utilized after contacting relevant law enforcement agency for authorization.
   - Tests for chlamydia and gonorrhea should generally *not* be obtained in the acute setting unless there is an additional clinical indication (e.g. a discharge) or if the abuse has been ongoing over time. Blood tests for HIV and syphilis (+/- HBV and/or HCV) may be obtained in order to establish a negative baseline.
   - Send urine for routine drug testing ("UDS") ***plus*** "GHB and Rohypnol" if the victim claims to have been drugged.
   - Prophylactic antibiotic therapy against gonorrhea, chlamydia, and trichomonas should be administered: Refer to www.cdc.gov/mmwr for the latest guidelines from the Centers for Disease Control and Prevention.
   - Prophylactic antiretroviral therapy (nPEP) may be offered in high-risk cases: Refer to www.cdc.gov/mmwr for the latest guidelines from the Centers for Disease Control and Prevention. Patients prescribed nPEP must agree to medical follow-up within 5 days to assess compliance and tolerability of the medication regimen.
   - Administer hepatitis B vaccination to protect against HBV in previously unvaccinated patients.
   - *If a UPT at the time of examination is negative,* emergency contraception should be offered to all pubertal or postpubertal female victims. The best-tolerated regimen is the progestin-only pill **Plan B one pill by mouth q12 hours X ii**. *It is very important that the two doses be taken exactly 12 hours apart*; therefore, it is helpful to discuss with the patient the exact times that she plans to take the medication. It is desirous that this regimen be initiated within 72 hours of sexual assault, but it is likely to be effective out to 96 hours.
   - Consult Gynecology or Surgery in cases of severe anogenital injury.
7. Arrange medical follow-up according to the following schedule:
   - 2-3 weeks following an acute assault for re-examination of injuries (to document healing) and re-evaluation for STD and/or pregnancy if indicated;
   - In 6, 12, and 24 weeks for testing for HIV and syphilis.
8. Refer for psychological counseling. Crisis counseling for child and family is often necessary.

D. Suspected *CHILD NEGLECT.*

1. Complete physical examination, including inspection of genitalia and search for dysmorphic features.
2. Developmental assessment.
3. Age 0-2 years: skeletal survey in all cases with suspicious visible acute injuries.
4. Age 2-5 years: skeletal survey should be considered if suspicious visible acute injuries.
5. Nuclear medicine bone scan (or repeat skeletal survey in 5-7 days) if index of suspicion for skeletal injury remains high despite negative initial skeletal survey.
6. MRI scan of head if there is a suspicion for subacute or chronic intracranial injury.
7. Consider laboratory evaluation (e.g. child is Failure to Thrive): CBC, electrolytes, glucose, urinalysis, urine culture, ESR, total protein, albumin. Other labs as clinically indicated (e.g., lead level).
8. Nutrition consult/assessment with caloric quantification.
9. Other consults (Developmental Pediatrics, Genetics, etc.) as clinically indicated.
10. Document child's caloric intake, weight gain, and response to hospital staff.
11. Document level of parental involvement and any concerns regarding inappropriate parental behaviors, attachment, statements, or level of knowledge regarding the child, his/her care, or his/her condition.

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Appendix F: Sample Budget – Development of One Pediatric Center of Excellence

CHILD ABUSE ASSESSMENT CENTER OF EXCELLENCE

LABOR RELATED EXPENSES

Administration/Management

1.0 Manager	$75,000
1.0 Community Liaison	$60,000
1.0 Administrative Asst	$25,000

Abuse Assessment Center

2.0 Nurse Practitioner	$170,000
1.0 Medical Assistant	$23,000
2.0 Social Worker	$100,000
2.5 Physician	$540,000

Benefits

FICA/Tax/Etc. (assumes 20% of Salaries)	$198,600

Salaries/Benefits Sub-Total $1,191,600

Contracted Services

Psychologists*	$50,000

Contracted Services Sub-Total $50,000

NON-LABOR EXPENSES

Supplies

Medical Supplies	$25,000
Office Supplies	$3,000
Other Minor Equip	$2,000
Food	$1,500
Other Non Med Supply	$500

Purchase Services/Other

Purchased SVC**	$32,000
Advertising	$30,000
Leases	$90,000
Sponsorships	$8,000
Travel/Education	$25,000

Supplies Sub-Total $217,000

CENTER OF EXCELLENCE TOTAL $1,458,600

Notes:

* This model contracts for psycho/social counseling in lieu of a full employment model.

**Purchased Services includes things such as parking, educational pamphlets, giveaways, etc.

Appendix G: Sample Budget

Department of State Health Services

LABOR RELATED EXPENSES	
Administration/Management	
2.0 Program Spec. IV	$ 154,889
1.0 Program Spec. III	$ 72,811
0.05 Administrative Asst	$ 2,291
Benefits	
Retirement/OASI/Ins.	$ 65,707
Salaries/Benefits Sub-Total	**$ 295,698**

NON-LABOR EXPENSES	
Other Operating Expenses	$ 5,135
Capitalized Other Operating	$ 22,490
Capitalized IT Equipment	$ 4,262
Indirect Costs	$ 85,711
Non-Labor Sub-Total	**$ 117,598**

DEPARTMENT OF STATE HEALTH SERVICES TOTAL $ 413,296

Amounts represent cost estimate for first two years