2015

Assessment of Need for Specialized Medical Services for **Child Abuse and Neglect** in New Hampshire

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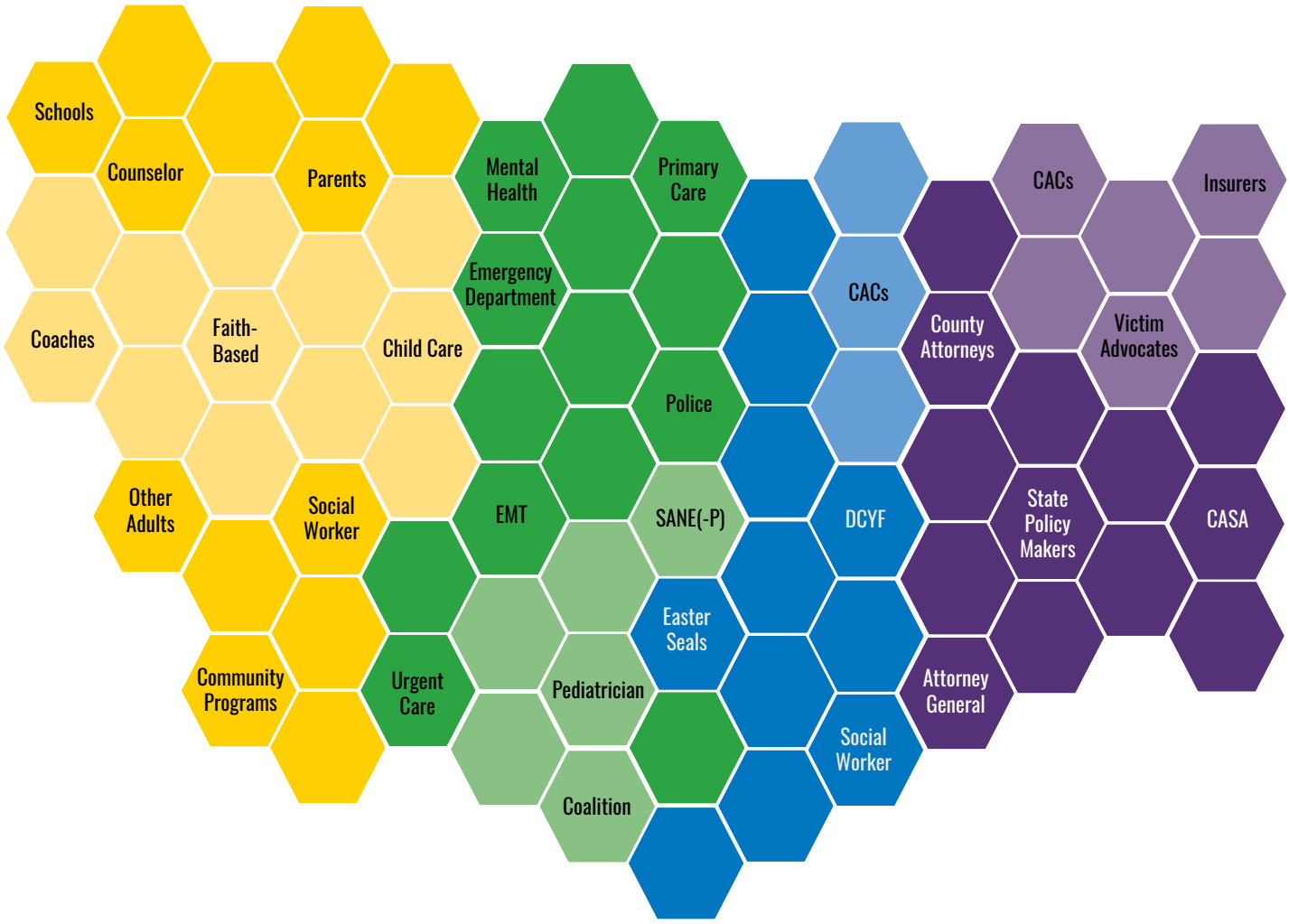
Specialized Medical Care

The Eco-System

Child abuse and neglect can happen anywhere at any time and anyone who suspects that a child has been a victim has a responsibility to report that concern. This may be someone in a school, a coach, a child care provider, a neighbor, or any other person with whom the child comes into contact. In many of these situations, it may not be clear whether a child actually has been mistreated or instead has some other medical condition causing the symptoms in question. This is where specialized medical care can be essential. Child Abuse specialists assist providers such as primary care providers, emergency departments, EMTs, and mental health providers, helping to accurately identify children who have been victimized and separate out those children who have other causes of their problems. In this way, children at risk can be protected and children with other issues are not mistakenly labeled as victims. Child Abuse specialists also provide critical education to everyone who is likely to come in contact with children who may be victims about how to recognize and address abuse and neglect. Further, they assist professionals in other fields such as child protection, law enforcement, and prosecutors to carry out their duties and they provide essential medical opinions in written reports and legal testimony to keep all children safe.



INTRODUCTION

Child abuse and neglect is a major public health concern cutting across social and geographic boundaries: county lines, hospital service areas, incomes and education levels. Yet children and families who have experienced its trauma, may face additional hardship depending on where they live when they seek high-quality evaluation or treatment. According to a report written by members for a special New Hampshire Legislative Commission (Commission) examining this issue in 2014, New Hampshire lacks a comprehensive system of medical professionals who are trained to assess and treat children for potential abuse and neglect. The Commission investigated the factors that impact the capacity and competencies of New Hampshire healthcare providers to assess and care for children under their care. The Commission's report describes a fragmented set of services exacerbated by a lack of stable funding for workforce development, reimbursement of services, and expert testimony. Despite the efforts of generous health and human service providers, treatment is not equitable throughout the state. Children from rural areas are far less likely to be evaluated by an expert. Sadly, the lack of a comprehensive plan to address these issues can result in children returning to abusive homes or conversely being incorrectly diagnosed as abused and/or neglected.

PURPOSE

The overall aim of this three-part assessment is to understand the factors that contribute to the shortage of medical experts available to perform the physical and forensic evaluations of children who have potentially suffered abuse. The chief objectives of this needs assessment were to:

1. Understand the degree to which specialized medical services are needed around the state,
2. Identify service gaps around the state; and,
3. Identify existing and potential funding sources available to pay for services.

APPROACH

In conducting this needs assessment, John Snow, Inc. (JSI) began from the knowledge base contained in the report published by the *Commission to Study Public-Private Partnerships to Fund Medical Care for Abused and Neglected Children* (Appendix A). Upon review of that report and convening an advisory panel comprised of a former legislative commission member as well as representatives of agencies that provided guidance to the Commission, a framework was created for assessing the specific needs in the realm of specialized medical care for abused or neglected children. The framework identified three main foci: the scope of abuse in New Hampshire, the funding necessary for specialized medical care, and the existing capacity for specialized medical care.

METHODOLOGY

To understand the scope of the problem, JSI conducted a three-part assessment including:

1. An environmental scan and search of the literature.
2. An electronic survey of emergency departments to ascertain capacity to respond appropriately to child abuse and neglect.
3. Qualitative research including focus groups and key informant interviews of stakeholders serving abused and neglected children and their families in diverse geographical areas across the state.

Specifically, nineteen key informant interviews were conducted using a standardized script with open ended questions. Two focus groups were held, one with approximately seventeen participant staff members from the state's child protection agency- the Division for Children, Youth, and Families (DCYF)- and one with approximately eleven staff from various state Child Advocacy Centers. Lastly, there were twenty-five responses to an electronic survey of emergency departments (EDs) throughout the state; this represented all New Hampshire EDs where children are evaluated.

Status of Abuse in New Hampshire

- Environmental scan
- Needs vs. Services
- Lifetime costs of abuse

Status of Funding for Specialized Medical Services

- Reimbursement for services provided
- Cost/ time savings to increase efficiencies
- Funding for current and future capacity

Status of Specialized Medical Care Capacity

- Provider training to build capacity
- System-wide training to ensure appropriate use of medical capacity

ENVIRONMENTAL SCAN

» Definitions

Under New Hampshire statutes, the broad definition of child abuse is comprised of three forms: physical, sexual, and emotional abuse. Emotional abuse will not specifically be discussed for the purposes of this environmental scan, as the scope of this analysis seeks to address specialized medical response to acute physical and sexual abuse, specifically. It is important to note, however, that assessment and care for all types of abuse should incorporate emotional and behavioral health care for adequate long-term, systemic response to care for potential victims. The forms of child abuse considered within the scope of this review are defined below:

- Physical abuse is inclusive of any child who has been "…sexually abused, intentionally physically injured, or physically injured by other than accidental means."[1]
- Sexual abuse is defined as "… the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in or having a child assist any other person to engage in any sexually explicit conduct or any simulation of such conduct for the purpose of producing any visual depiction of such conduct or the rape, molestation, prostitution, or other form of sexual exploitation of children, or incest with children."[1]

New Hampshire also aims to protect children who, while not exposed to physical harm or sexual mistreatment, are not receiving proper care by their parent or guardian. Child neglect is defined as:

- Neglect is defined as "…a child who is without proper parental care or control, subsistence, education as required by law, or other care or control necessary for his or her physical, mental, or emotional health, when it is established that his or her health has suffered or is very likely to suffer serious impairment, and the deprivation is not due primarily to the lack of financial means of the parents, guardian, or custodian, and;
- A child whose parent(s), guardian, or custodian are unable to discharge their responsibilities to and for the child because of incarceration, hospitalization, or other physical or mental incapacity."[1]

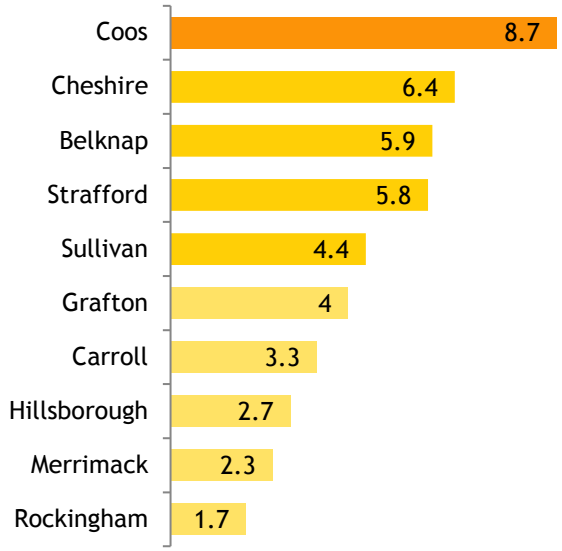
The role of the medical provider is critical to the accurate identification of and subsequent specialized medical care required for victims of child abuse or neglect. The following sections outline the national standards for specialized medical care for potential victims of child abuse or neglect, as well as the current practice environment for specialized medical providers for child abuse or neglect in New Hampshire. The categories of focus in the current environment include: Policy, Socio- cultural, Economic, Workforce and Technological factors influencing the standards of care for this vulnerable population.

» By the Numbers

Key Concepts

- New Hampshire consistently reports a lower percentage of substantiated child maltreatment claims when compared to neighboring New England states.
- The departure of one to two specialized medical providers throughout the state will have a significant impact on the current system and could even lead to a systems collapse.
- There has been a steady growth in nurse providers who are able to provide a limited scope of care to potential victims, specifically SANE-A and SANE-P nurses.
- New Hampshire currently lacks a pipeline for increasing the number of providers in this workforce.

Maltreatment per 1,000 Children in NH



Source: New Hampshire Kids Count 2015 Data Book

2013 Child Maltreatment Rates in New England States[3]						
	Connecticut	Maine	Massachusetts	New Hampshire	Rhode Island	Vermont
Total Children Under 18 Years	785,566	261,276	1,393,946	271,122	213,987	122,701
Child Maltreatment Victims (Founded)	7,287	3,820	20,307	822	3,132	746
Rate	9.3 per 1,000	14.6 per 1,000	14.6 per 1,000	3.0 per 1,000	14.6 per 1,000	6.1 per 1,000

Source: Child Welfare Outcomes Data (2014), Region 1. Retrieved July 2015, from: http://cwoutcomes.acf.hhs.gov/data/tables/mal_overview_victims?state=&region=1.[3]

In 2013, the most recent year for which information is available, there were 11,064 (40.8 per 1,000) children who were the subject of an investigated report alleging child maltreatment in New Hampshire. Of these claims, 7.4% were substantiated, totaling 822 (3.3 per 1,000) child maltreatment victims in New Hampshire.[2] Trend data ranging from 2010-2013 indicate that child fatalities resulting from abuse or neglect has ranged from a low of 0.4 deaths per 100,000 (1 child fatality) reported in 2010 to a high of 1.1 deaths per 100,000 (3 child fatalities) reported in 2013.2 The table *2013 Child Maltreatment Rates in New England States* compares the rate of child maltreatment across states.[3]

Although all health care providers who treat children have baseline skills in maltreatment, access to specialized medical providers in child abuse assessment and care is instrumental to the accurate identification of and subsequent treatment of victims. In terms of specialized medical providers with the training and background to respond to suspected cases, the numbers are lean. Child Abuse Pediatrics recently became a recognized medical specialty and currently there are twenty-four fellowship programs in the nation, that each graduate less than ten specialists per year.[4]

Currently, there is only one accredited medical school in New Hampshire, the Geisel School of Medicine at Dartmouth College, and one Pediatrics Residency Training program – also at Dartmouth-Hitchcock. This program does not offer a fellowship program in Child Abuse Pediatrics at this time. The only hospital in New England that currently offers a fellowship program in Child Abuse Pediatrics is Hasbro Children's Hospital/Brown Alpert Medical School, located in Providence, Rhode Island.[5] Given that there are few providers entering this field on an annual basis, there will likely be a high demand throughout New England for the handful of new child abuse specialists graduating from this program.

Based on the qualitative research conducted during this needs assessment, there are currently three pediatric or family practice doctors and one advanced registered nurse practitioner (ARNP) in New Hampshire with the extensive specialized training and experience to provide services to victims of abuse or neglect. Of these providers, only one is a board certified Child Abuse Pediatrician and this provider is retiring in early 2016. Services are most frequently being provided through Children's Hospital at Dartmouth's Child Advocacy and Protection Program (CHaD CAPP) located at Dartmouth Hitchcock Medical Center (DHMC), and via the Child Abuse Referral and Evaluation (CARE, an affiliate of CHaD CAPP) Program at Exeter Hospital, Elliot Hospital, and Wentworth-Douglass Hospital. There is also child abuse expertise available in a much more limited capacity at Huggins Hospital in Wolfeboro and Southern New Hampshire Medical Center Emergency Department in Nashua. Children in other parts of the state in need of evaluations to assess and treat physical or sexual abuse are often directed to the nearest emergency department, where access to specialized care is not always assured.

Forensic nurses have notably increased in number over the past ten years and have become a vital component of the systemic specialized medical care required for thorough examination of pediatric victims of sexual abuse or assault.[6] Within the field of forensic nursing, there are two categories of Sexual Assault Nurse Examiners (SANEs) who are forensically trained: those with expertise caring for adolescents and adults (SANE-As) and those with additional expertise caring for younger children (SANE- Ps). According to the International Association of Forensic Nurses (IAFN), eleven SANE-A and

Childhood abuse or neglect increases the lifetime likelihood of substance abuse, alcohol abuse, and future abuse, so early identification of instances of abuse or neglect are critical to both short and long term health.

four SANE-P certified nurses currently practice in the state of New Hampshire. The IAFN also reported that two pediatric SANE programs are providing SANE exams in the Emergency Departments, with two more anticipated to be providing services during 2016. These nurses are specialized in sexual abuse or assault, not physical abuse or neglect.

» Political Factors

Key Concepts

- There has been some legislative activity in addressing child abuse and neglect in New Hampshire, primarily focused on multi-sector response protocols.
- States identified as having model response systems had several legislative representatives championing this issue through policy change.

New Hampshire created the Attorney General's Task Force on Child Abuse and Neglect (AGTF) in 1989. The AGTF is comprised of multi-sector professionals and its goals are to "foster the development of the multidisciplinary model for investigating and prosecuting child abuse and neglect cases; offer advanced training to professionals statewide and; support systems reforms through ongoing evaluations of the administrative, judicial and investigative handling of child maltreatment cases in the state."[7] In 2002, Section 169-C:38-a of the New Hampshire Child Protection Act indicated that a standardized protocol for the investigation and assessment of child abuse and neglect cases would be developed.[8] Subsequently, the AGTF published the third edition of a comprehensive protocol to coordinate and facilitate a statewide, multidisciplinary action plan and reporting process in 2008.[9] The protocol outlines the role of each critical member of a multi- disciplinary team, including the broad duties of the medical provider, among their other responsibilities.

According to RSA 169-C, "any medical provider is mandated to report suspected child abuse and neglect to the DCYF. The medical provider who suspects that a child has been abused or neglected must make an oral report immediately (during DCYF available hours) to DCYF Central Intake Office by telephone." New Hampshire, along with 16 other states, additionally requires all persons to report suspected cases of abuse and neglect.[10]

» Sociocultural & Economic Factors

Key Concepts

- Child abuse and neglect have profound adverse short- and long-term effects on its victims.
- Certain populations, including children with disabilities, are especially susceptible to abuse or neglect.
- Instances of child abuse and neglect impact the immediate and peripheral financial costs on society.

Understanding the social and cultural factors that impact the frequency and severity of child abuse is critical to providing adequate specialized medical care.

Between 1992 and 1995, Kaiser Permanente and other research partners began the Adverse Childhood Experiences (ACE) Study, in which they surveyed Health Maintenance Organizations (HMO) enrollees in the San Diego area about "childhood abuse and exposure to household dysfunction as they grew up" when they presented for health maintenance evaluations at a local community health center.[11] The study's logistic regression found that patients who had four or more categories of adverse childhood experiences were four to twelve times more likely to have increased health risks for alcoholism, drug abuse, depression, and suicide rate than patients who had not experienced any type of adverse childhood experiences. Similarly, smoking, heart disease, and sexually transmitted infections were found to be two to

four times more likely in this population.

nationally, rates of past abuse among people in prison are **twice** those of the general population

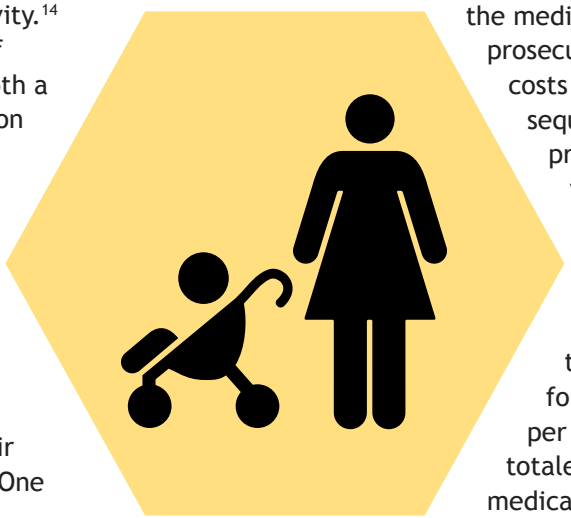
Other studies have supported the findings of the ACE studies, specifically with regards to drug abuse being a major contributing factor to the cycle of child abuse and neglect. Studies have also shown that exposure to parental alcohol abuse is highly associated with adverse childhood experiences, such as child abuse or neglect.[12] Furthermore, a long term effect of child abuse and neglect is the susceptibility to drug abuse. One study found that among individuals in treatment for drug abuse, as many as two-thirds of treatment recipients reported being abused or neglected as children.[13] This is a vicious cycle in which addiction can be both a cause and result of child abuse and neglect. Not only is this impacting the long-term health and well-being of the victim, but it is also adding an economic burden to society. An analysis conducted by PolEcon Research and New Futures found that in New Hampshire alone, alcohol and drug misuse cost New Hampshire more than $1.84 billion annually in lost productivity and earnings and increased expenditures for healthcare, and public safety. More discussion on the overall economic impact of child abuse and neglect will follow.

Child abuse and neglect has an impact not only on the victim's health acutely, but also on their chronic social health and well-being. Victims of child abuse and neglect are more prevalent in the criminal justice system. Studies have shown that 14% of all men in prison and 36% of women in prison in the US were abused as children, about twice the frequency seen in the general population.[15] Additionally, children who experience child abuse and neglect are about nine times more likely to become involved in criminal activity.[14] These data suggest that instances of child abuse and neglect can have both a short- and long-term consequences on the life of victims.

Another vulnerable population that is at greater risk for abuse or neglect is children with disabilities. It is well known that compared to children without disability, children who have one or more disabilities suffer child abuse at a higher rate and their abuse more often goes unreported. One study found that of 40,430 alleged abuse victims, 11% were categorized as children with minor disabilities, and 1.2% as children with severe disabilities. More of the children with disabilities were found to be victims of sexual abuse as opposed to physical abuse when compared proportionally to typically developing peers. Additionally, children with disabilities were more likely to experience physical abuse from a parent or parent-figure in comparison to their typically developing peers.[15] This is often an indirect function of society's response to, and added parental stresses of, being a caregiver to a child with a disability as opposed to the disability itself being the cause of abuse or injury. For example, adults may decide against making any formal reports of abuse they may witness because of the child's disability status, making the abuse of those with disabilities easier for the abuser.[16] Research has also shown that the abusers are usually parents or other close caregivers who maintain secrecy and do not report out of fear of legal and other ramifications. In 2012, it was reported that among the 901 unique victims of child abuse in New Hampshire, there were 411 diagnoses (46%) of disability.[17]

One particularly common barrier to identifying incidents of child abuse or neglect among children with disabilities is limited or atypical communication skills. Additionally, physical injuries may be incorrectly attributed to the disability (e.g. vision impairment, physical limitations, etc.) when in fact injuries are a result of maltreatment. According to research done regarding barriers for providing quality child abuse and neglect assessment and care, limitations identified by health care professionals include lack of resources, lack of knowledge regarding disabilities, systems conflicts, and rural issues, such as limited numbers of providers and lack of transportation.[18]

Incidents of child abuse and neglect have an economic cost on society, not only through the required services from the initial investigation through the medical evaluation and potential prosecution processes, but also through costs of both the short- and long-term sequelae described above, as well as productivity losses throughout the victim's life. A comprehensive study conducted by X. Fang et al. in 2012 found that the average lifetime cost per victim of nonfatal child maltreatment totaled $210,012. The study also found that the average lifetime cost per case of fatal child maltreatment totaled $1,272,900 when considering medical costs and productivity losses.[20]



Using these numbers, we can estimate that the costs of the 822 victims of child maltreatment in 2013 will be approximately $172,629,864 over the course of their collective lifetimes.

In another recent study (2012), the annual costs of child maltreatment were calculated using direct and indirect categories that are known to reflect the short and long- term needs of child abuse and neglect victims. The total direct and indirect cost of child maltreatment in the United States calculated by this study is $80,260,411,087.20 The breakdown of direct and indirect costs is as follows:

Direct Costs:

Acute Medical Treatment/ Hospitalization	$2,907,592,094
Mental Health Care System	$1,153,978,175
Child Welfare System Services	$29,237,770,193
Law Enforcement	$34,279,048
Total Direct:	**$33,333,619,509.64**

Indirect costs:

Special Education	$826,174,734
Early Intervention	$247,804,537
Emergency/Transitional Housing	$1,606,866,538
Juvenile Delinquency	$3,416,149,283
Chronic Mental Health and Health Care	$270,864,199
Adult Criminal Justice System	$32,724,767,699
Lost Worker Productivity	$7,834,164,589
Total Indirect	**$46,926,791,578**

This is a tremendous societal cost that could be reduced by a timely and comprehensive response to instances of suspected child abuse and neglect to ensure early detection, assessment, and proper intervention.

» Workforce Factors

Key Concepts

- New Hampshire has only three pediatric or family practice doctors and one advanced registered nurse practitioner (APRN) with the required specialized training and experience to provide services to victims of abuse or neglect.
- 15 total Sexual Assault Nurse Examiners (SANE-A & SANE –P) are currently practicing in the state.
- New Hampshire currently lacks a pipeline for increasing the number of providers in this workforce.
- There is a lack of formal training opportunities for increasing knowledge and capacity among general practitioners and emergency room doctors to ensure adequate medical response to potential instances of child abuse or neglect.

In New Hampshire there is a very limited pool of medical providers with comprehensive specialized medical skills to evaluate, treat, consult on, or provide legal testimony on cases of child abuse and neglect. As stated previously in the By the Numbers section of this report, there are currently a very limited number of physicians and nurses available in the state who are trained to do appropriate specialized medical exams. Furthermore, the current workforce is bound to only a few areas of the state and will continue to dwindle with scheduled retirements in 2016. As noted above, one APRN is currently based at CHaD CAPP and is experienced in this field, but both workload capacity and restricted mobility throughout the state limits the geographical spread of this position's services.

An additional issue is that conducting specialized examinations of children who may have been abused or neglected is often a supplemental activity added to the current responsibilities of pediatric and family practice clinicians engaged in other day-to-day care. Therefore, they are frequently overburdened with current caseloads, not able to schedule the longer appointment times needed for abuse or neglect cases, and may not have the available time to keep up with necessary extra training and peer-review to maintain the highest standards of care for child abuse or neglect. Further, with no specialized child abuse or neglect fellowship at the only accredited medical school in the state, and little to no economic incentive for New Hampshire providers to obtain certification in this field, the capable workforce is limited and state systems are not well positioned to stimulate provider growth in this specialty. Pediatric Sexual Assault Nurse Examiners (SANE- Ps) are trained

Families with potentially abused or neglected children are very often experiencing larger crises as well such as substance use, alcohol use, or housing instability, and need further services.

and able to provide care for pediatric sexual assault cases, but not other forms of potential abuse or neglect.

Another workforce barrier is difficulty meeting the training requirements for nurses working toward the goal of being designated as a SANE-P. This certification allows the nurse examiner to conduct exams and gather evidence for younger children. For example, there are many nurses that are interested in obtaining SANE-P certification, but they are not able to get the required supervised clinical peer review hours. This assessment identified two reasons for the shortage of trained SANE-P professionals. First is a dearth of qualified medical personnel with available time to supervise the required clinical hours for those new to the field. Second, with the exception of the hospitals in Manchester, Nashua, or Lebanon, there is not a high enough pediatric maltreatment caseload in one location. Travel to other towns or surrounding states for these hours is possible, but doing so requires the support or buy-in of the nurse's home institution. Similarly, SANE-P nurses are specially trained to respond to instances of child sexual abuse, thereby extending capacity in these cases, but not in cases of identified or suspected physical abuse or neglect.

The state of New Hampshire is heavily reliant on Child Advocacy Centers (CACs) to facilitate the multi-disciplinary response necessary in cases of suspected criminal-level child abuse or neglect where victims are able to participate in an interview. As such, it is imperative that the CACs maintain the accreditation standards as required by the National Children's Alliance. There are several stipulations in the National Children's Alliance Standards for Accredited Members (Standards) specifically regarding the training and experience of their consulting medical providers. In particular, the Standards stipulate that CACs have a defined relationship with a specialized medical provider, that all CAC clients are routinely offered specialized medical evaluation and treatment services (regardless of the family's ability to pay), and that those medical services are coordinated with a multidisciplinary team. The Standards specifically stipulate that "medical evaluations should be provided by health care providers with pediatric experience and child abuse expertise."[21] Furthermore, the Standards require that medical providers meet at least one of the following training criteria:

- Child Abuse Pediatrics Sub-board eligibility
- Child Abuse Fellowship training or child abuse Certificate of Added Qualification
- Documentation of satisfactory completion of competency-based training in the performance of child abuse evaluations
- Documentation of 16 hours of formal medical training in child sexual abuse evaluation

In addition, the Standards require the following continuous quality improvement activities:

- Ongoing education in the field of child sexual abuse consisting of a minimum of three hours per every two years of CEU/ CME credits
- Photographic documentation of examination is recommended. Photo documentation enables peer review, continuous quality improvement, and consultation

Other recommendations from the Standards include the ongoing peer review of all medical evaluations and, for providers who do not have certification or experience with potential victims of child abuse or neglect, as is often the case in emergency departments, a defined system providing for consultation with a medical provider experienced in child abuse evaluations. These requirements are somewhat concerning for New Hampshire, as the lack of medical providers who meet the National Children's Alliance standards put the

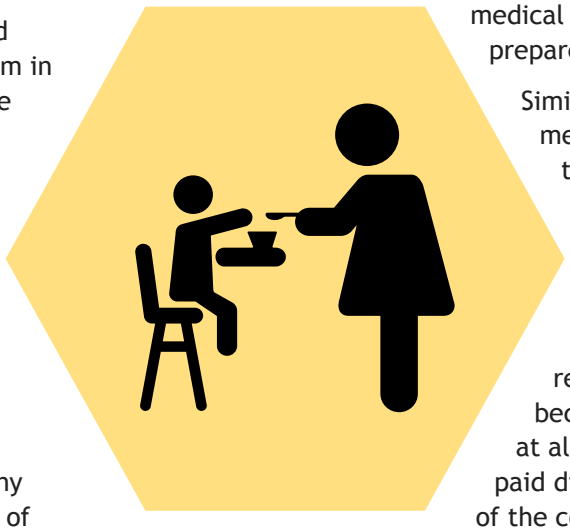
accreditation status of several of the state's CACs in jeopardy.

Appropriate care responses are also required by both child abuse specialty providers and the child's pediatrician or family physician. For example, many children initially evaluated at a CAC who are thought not to have acute injuries or who do not decisively disclose abuse after the initial interview are often referred back to their pediatrician or family provider for follow up medical care. This current system suggests the need for system-wide training and education for those providers who do not specialize in child abuse in order to respond appropriately to instances of abuse. Currently in New Hampshire, there is no formal, statewide protocol for coordinating care between child abuse pediatricians and children's primary care providers.

Limited compensation for specialized medical services is a common problem in child abuse or neglect cases. In acute sexual assault cases, the Victim's Compensation fund is automatically billed by the hospital where the medical evaluation is done. However for all other types of cases, the compensation is far murkier. According to the New Hampshire Task Force protocols, insurance information should be obtained by appropriate medical personnel, and the insurance company should be billed directly for the cost of the examination if the family has health insurance. In these cases, the family is responsible for co-payment and deductibles. If the victim's family does not have health insurance, or if the family cannot afford the associated charges, the New Hampshire Victims' Compensation Program out of the Attorney General's Office can supply funds to reimburse medical providers on behalf of child abuse or neglect victims to cover burdensome costs.[22] This requires the uninsured family to pay the medical provider up front, if possible, and then complete paperwork and wait for any potential reimbursement to come later. It is unclear whether New Hampshire providers are receiving reimbursement for medical evaluations and lab tests attributed to cases of acute child sexual assault.

One model state, Missouri, has a statewide network comprised of hospital clinics, emergency departments, and private practices organized to accept referrals and provide standardized referrals, and examinations and ensure that the victim and their family are never billed. Participants in the network are required to participate in initial training and eight hours of annual continuing education. Participants must also collect data and conduct the evaluations in a standardized format. In return, the coordinating state agencies that administer the program guarantee uniform reimbursement rates plus payment of lab fees.[23]

New Hampshire's lack of stable funding for the initial medical evaluation and subsequent follow-up contributes to workforce scarcity and results in difficulty with training of and ongoing peer-review among the existing workforce. State protocols call for the CACs to coordinate care for children evaluated at their location for possible abuse or neglect, but the state provides no corresponding funding to meet this requirement. In addition, the CACs cannot provide compensation to a busy medical provider to spend the time to prepare for attended legal proceedings.



Similarly, state expectations that medical providers need to give court testimony to found cases of abuse or neglect are difficult to meet. Barriers to the involvement of medical providers in the court system include a lack of adequate funding for their time and a reluctance of many providers to become involved in legal proceedings at all. The current rate of compensation paid directly by the state is not reflective of the cost of the commitment to testify, including time, travel, and expertise. In many cases, time, travel and expertise is not paid for at all for testimonies.

» Technological Factors

Key Concepts

- There is a lack of uniformity in the responsible entity and use of technology for documenting evidence in potential cases of child abuse or neglect.
- Telemedicine technologies are not currently utilized in New Hampshire for consulting in cases of potential cases of abuse or neglect.
- There are states with best-practice uses of tele-health to ensure children seen in remote areas (e.g. rural) benefit from the expertise of specialized medical providers who are not able to travel to their location in a timely manner.

The availability of and access to technology that facilitates timely and accurate identification of potential

victims of child abuse or neglect are critical to supporting the workforce. The American Academy of Pediatrics (AAP) provides recommendations on the appropriate evaluation of potential victims of abuse or neglect, including strongly urging the complete documentation of visible injuries using body diagrams and photographs (or other imaging techniques). Sufficient documentation facilitates peer review as well as court testimony, when required. Adequate photo documentation will also reduce the likelihood of a repeat examination of the child.[23] Additionally , according to the AAP, diagnostic impressions should address whether the explanation adequately correlates with the severity, age, pattern, and distribution of the injury or injuries and the likelihood of non-accidental causes for the injury.[24]

In the state of New Hampshire, x-rays and photographs ordered to identify and document injuries consistent with potential abuse can be reimbursed under state Title XII Section 169-C:33 Photographs and X-Rays through the Department of Public Safety and Welfare. Investigators from law enforcement or Child Protective Services can be specially trained to take forensic photographs (not including those depicting sensitive areas of the child's body).

Medical providers in New Hampshire should have clear protocols on who is responsible for documenting such injuries depending on who is involved in the case, especially given that medical personnel or departments can obtain reimbursement for the reasonable cost of photographs or x-rays taken for the purpose of identifying potential victims of abuse or neglect.[25]

Federal funds are limited in availability to enhance and sustain technological infrastructure for specialized medical care of child abuse and neglect victims. Such funds are typically made available through grant application processes, such as Child Abuse Multidisciplinary Intervention (CAMI) Fund, Child Abuse Prevention and Treatment Act (CAPTA) State Grants, among others. At this time, none of these funds are going to New Hampshire medical providers to subsidize their activities.

Technological advancements in the field of medicine and primary care are creating new opportunities with regards to medical evaluations of potential child victims of abuse or neglect. One way in which technology can be used in such evaluations is through consultations with pediatric child abuse experts via telemedicine. As stated previously, cases of abuse or neglect occur at any time. In emergencies or after hours circumstances, it may be difficult to have an immediate response from child abuse and neglect pediatric specialist, especially if the potential victim is from a rural or remote area in the state. Studies have shown that more than two-thirds of abuse or neglect cases present in "off-hours", between 5pm and 9am.[26] In other states, telemedicine has proved to be a very useful method in supporting child abuse assessments in rural areas in the absence of local child abuse experts.

The potential for using experts located remotely who are qualified to medically assess abuse cases further supports the use of telemedicine. While the use of telemedicine to conduct evaluations is relatively new in the field of child abuse and neglect acute care, studies have shown that the use of telemedicine consultations during the evaluation of potential victims of abuse or neglect can improve examination and evidence collection effectiveness.[27]

Specifically, the state of Florida has been one of the early adopters to the use of telemedicine and has shown promising results with regards to an increase in reports of suspected abuse or neglect from rural or remote areas that previously did not have real time access to child abuse experts.

EMERGENCY DEPARTMENT SURVEY

Key Concepts

- Most Emergency Departments do not have access to needed expertise and resources, and access has declined since 2008.
- Nearly half of Emergency Departments do not have maltreatment protocols in place.

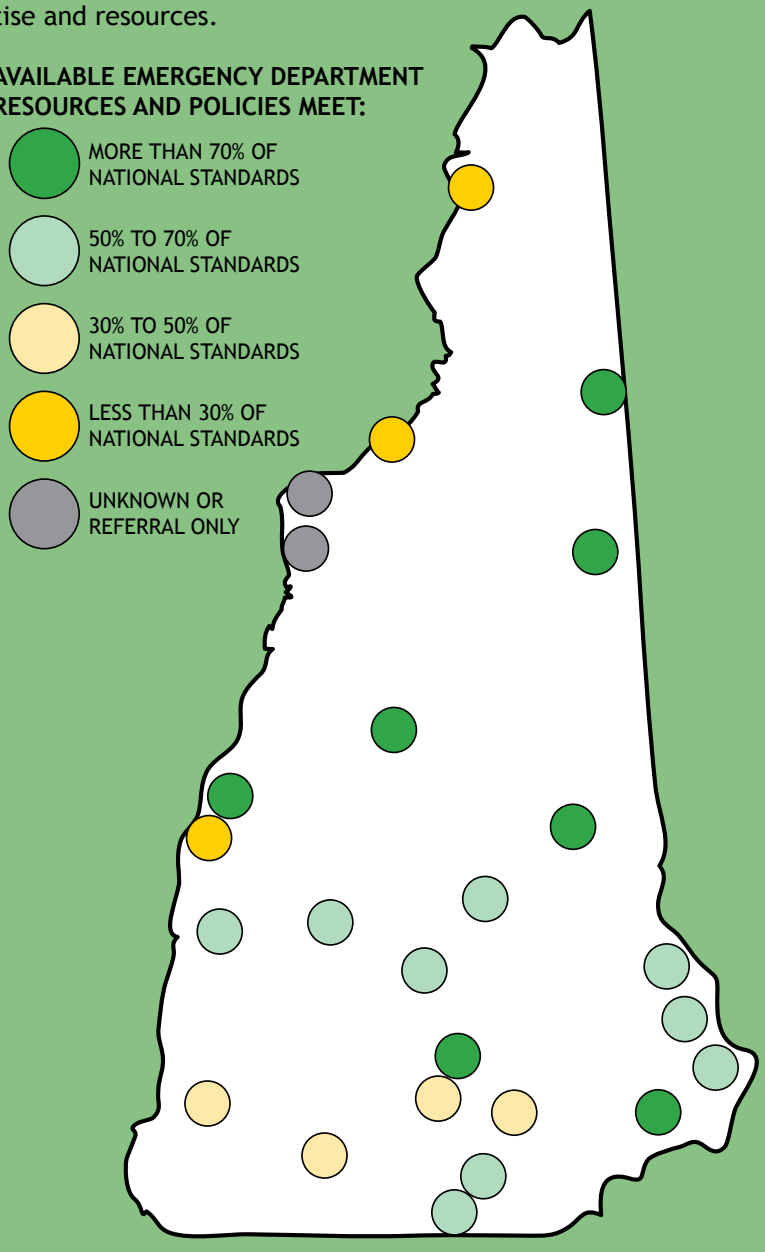
During the summer of 2015, a survey was distributed to the twenty-five active emergency departments (EDs) that serve children in the state. The survey was designed to assess whether or not EDs are adequately resourced to address cases of child abuse and neglect. All twenty-five (N=25) EDs responded to the survey, with two leaving the entire survey blank and stating they refer all cases to CHaD CAPP. Comparisons were made to a similar survey that was distributed in the spring of 2008, to which seventeen EDs responded. Not all questions from the 2015 survey could be compared to the 2008 survey, as some questions were changed or not included in the prior version. The full 2015 survey can be found in Appendix B.

In 2015, 95.7% (n=23) of the state's EDs reported that the frequency of potential cases of child abuse or neglect seen was less than once per week and one emergency department reported seeing potential cases of child abuse/neglect one to three times per week. In 2008, 88.2% (n=15) reported the frequency of potential cases of child abuse or neglect was less than once per week. It is worth noting that these numbers likely do not reflect the full number of children who do present with signs of abuse or neglect, just those that are identified within the emergency departments. When asked if a medical provider with child abuse/neglect expertise is available to come to the hospital's emergency department to consult on cases, 47.8% of hospitals in 2015 reported there were no specialized medical providers available to consult on cases, whereas 36.8% of respondents reported no availability of specialized medical providers

ALIGNMENT WITH NATIONAL EMERGENCY DEPARTMENT STANDARDS

Using the survey conducted, ED's reported policies and resources were measured for overall preparedness to respond to instances of child abuse or neglect using the standards set by the American Academy of Pediatrics guidelines for Care of Adolescent Sexual Assault Victims/Evaluation of Suspected Child Physical Abuse and the North Carolina State Guidance for Emergency Departments. Total possible value, representing full alignment with guidance, is 100%.

It is important to note that the goal may not be for all EDs to reach 100%, but rather to measure variation in resources and policies across EDs. It is clear from these results that children may get different care depending on where they are seen, and that emergency departments are not well equipped to assess and treat abused or neglected children without expanded access to expertise and resources.



FULL METHODOLOGY IS OUTLINED IN APPENDIX C.

in 2008.

When queried on the specialized medical provider(s) that act as the primary resource for case expertise, five providers were identified throughout the entire state, two of whom were identified as covering seven of the eleven emergency departments who reported having access to a primary resource for case expertise. It is worth noting that only three of the five listed specialized medical providers have been recognized as being qualified specialists in Child Abuse and Neglect patient care in other aspects this needs assessment, suggesting that the other two providers are not actively providing care or are not integrated into the state system. Further, 52% (n=12) reported that their emergency departments do not have a medical provider available 24/7 with expertise in the collection of forensic evidence in cases of sexual assault of an adolescent and 70% (n=16) do not have such a resource for cases of sexual assault of a pre-adolescent child.

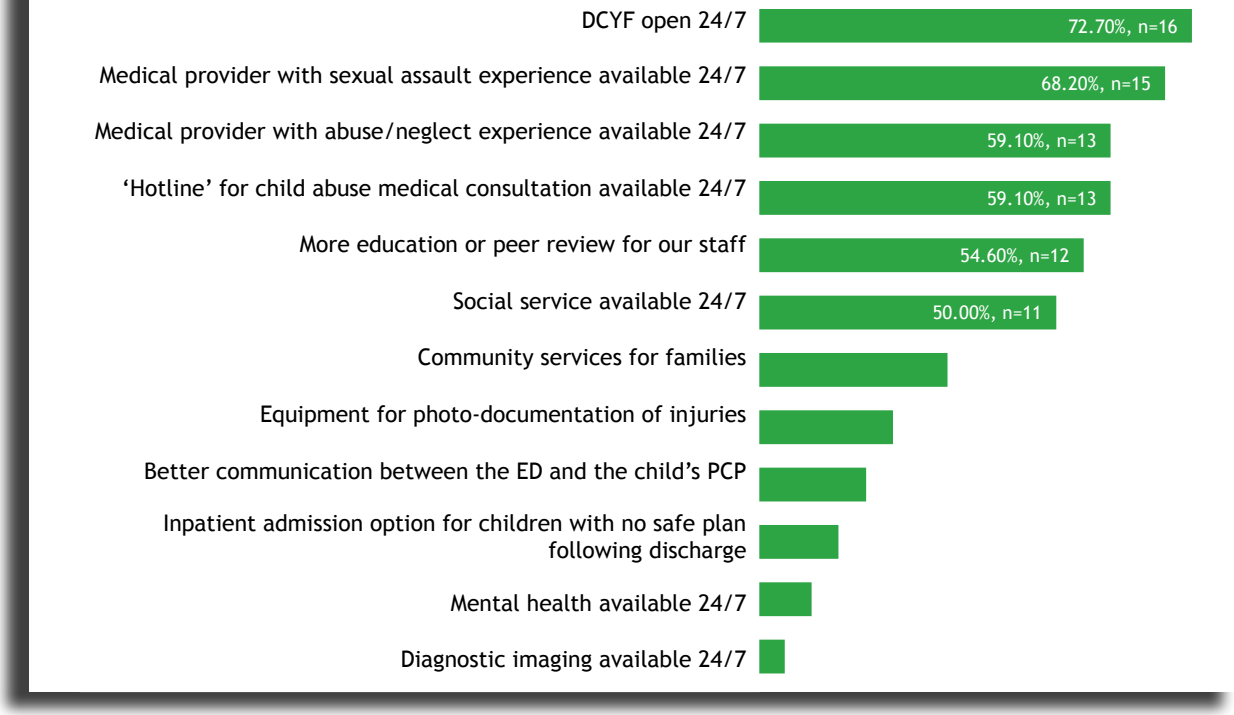
Similarly, 78.3% reported either not having access or only having access via phone consultation to a medical provider with child abuse and neglect expertise. Survey responses show all EDs routinely referring patients back to their primary care providers for follow-up if abuse is suspected, though the capacity for primary care providers to conduct adequate follow-up was not a subject addressed in this survey and as mentioned is an unknown factor in assuring adequate care for these children.

Other deficits that were identified through the 2015 survey were a general lack of uniformity in New Hampshire emergency department protocols. Specifically, 47.8% of respondents reported that their facility does not have a protocol or guideline in place for the maltreatment assessment of children who present with injuries. Two EDs reported that they do not always contact the police department in cases of suspected sexual or serious physical abuse because they do not consider this to be the ED staff's responsibility, which is not in alignment with New Hampshire statute RSA 169-C:29-30. This statute states that in the event of suspected serious child abuse or neglect, a report should immediately be made.

The 2015 survey also provided the opportunity for emergency departments to indicate the resources that are needed to better care for children with suspected abuse or neglect. The highest response among emergency departments was for the DCYF to be accessible twenty-four hours a day, seven days a week (72.7%, n=16), followed by 24/7 access to medical providers with sexual assault (68.2%, n=15) and abuse/neglect (59.1%, n=13) experience, as well as medical consultation via 'hotline' (59.1%, n=13). The full response list is included in the graph below.

The responses indicate a need for more access to personnel with the necessary skills to ensure the patient and their families are receiving the best possible services. Interest in peer review and cross-sector collaboration is also evident.

OVER HALF OF EDs SURVEYED INDICATE A NEED FOR 24 HOUR ACCESS TO MEDICAL EXPERTISE AND OTHER SERVICES



QUALITATIVE RESEARCH

Key Concepts

- The necessary funding for specialized medical care requires reimbursement for immediate medical services, as well as non-medical activities with multi-sector agencies in the event of criminal proceedings.
- Building specialized medical care capacity & competencies will require formal leadership and structure, as well as expanding capacity and competencies among providers through systems-wide trainings.

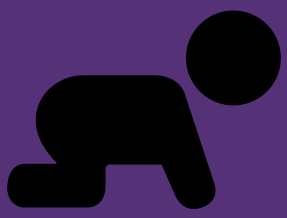
In the summer of 2015, nineteen key informant interviews were conducted using a standardized script with open ended questions that focused on the experience of interviewees in accessing specialized medical care for children who may have been abused or neglected. Two focus groups were conducted using a modified version of the key informant interview script: one with approximately seventeen participant staff members from the Division for Children, Youth, and Families (DCYF) and one with approximately eleven staff from various state Child Advocacy Centers (CACs).

Payment for the services needed to provide appropriate medical response and care to abused and neglected children is a patchwork of complex but generally inadequate funding. Qualitative research with providers throughout the state indicates that between 75% and 90% of the time spent providing necessary services are not reimbursed under current models. The initial exam is typically covered by insurance, but the time spent conferring with colleagues, social workers, mental health professionals, DCYF, CACs, police, attorneys and others is not reimbursed. Further, the care coordination that is essential to appropriate response to cases of potential abuse and neglect is generally not reimbursable. Without this care coordination vulnerable children are quick to slip through the cracks. Medicaid provides some care coordination services by telephone without additional expense to medical providers, but these were widely reported to not be robust enough to meet the needs of families or children in crisis. It was emphasized in key informant interviews that those providers who do this work do so because it is important, not because it pays well, so they understand there will be some lower reimbursement. Key informants also stressed repeatedly

providers estimate **65-90%** of services are not reimbursed in current models

that it is not reasonable to expect children will receive high quality assessment and care based on kindness and good intentions alone. It is essential that adequate resources be available to respond to potentially abused or neglected children, regardless of where or when they are seen. This must include a combination of stable funding, adequate reimbursement, and a strong network of response.

In the event that a case moves toward criminal charges, specialized medical providers are often consulted in that process, as well as called to testify as either a fact or expert witness in a criminal proceeding. The distinction between the two types of witnesses is that a fact witness reports on the results of any medical examination and treatment but is not legally allowed to provide opinions (such as interpretation of the meaning of findings), while an expert witness is allowed to do so. According to providers interviewed, the time involved in court appearance can range from a few minutes to answer questions from a county attorney to an entire day waiting in court for the case to come up in front of the judge or jury. Reimbursement for the services of a fact witness is virtually non-existent, ranging from none to a reported maximum received of $24. The loss of time in the office for those providers operating in private practice or other fee-for-service models is substantial, leading to a sizable loss of income and requiring that previously scheduled patients, office personnel and covering partners be inconvenienced. Similarly, the time spent doing case reviews, as is necessary for all providers in this field, is unreimbursed and results either in less time available to see patients (with associated impact on income) or a reduction in personal time. Ongoing uncertainty and enrollment lapses in Medicaid further contribute to reimbursement concerns for services provided to potentially abused or neglected children. Providers report that the vast majority of patients who are seen with suspicion of abuse or neglect are Medicaid recipients. Medicaid in New Hampshire, expanded or otherwise, drives concerns regarding fair compensation



According to local specialty medical providers, infants are more susceptible and possibly more prone to physical abuse, and there are the fewest services to respond to the unique needs of those children.

that sufficiently enables providers to adequately respond to the complex needs of abused and neglected children, as Medicaid offers far lower reimbursement than other payers. Another challenge related to overrepresented Medicaid population in these cases is the turnover in Medicaid coverage. Those interviewed noted that patients often believe they have Medicaid coverage but, in fact, they are no longer covered due to lapses in enrollment, because of failure to update paperwork or confirm ongoing eligibility. Working with families to reauthorize Medicaid coverage while that family is in crisis presents a unique challenge—further taxing the time and resources of providers as well as the family. In the event that Medicaid coverage has lapsed and cannot be reinstated, even more of these services can go unreimbursed.[28]

Medicaid programs noted that they can work with families to reinstate this coverage, but this still leaves the identification and coordination to be done by medical staff. Medicaid programs also noted that they do risk assessments upon enrollment, and a care coordinator will follow up with the family if there is risk identified. Interviewed Medicaid staff stated that appropriate services are covered, though there may be a question of appropriate billing, and they do not foresee a great deal of change in reimbursement of these services in the near future. There was also indication that training could be provided around appropriate billing.

If an abused or neglected child's family does not have health insurance, or if the family cannot afford the associated charges, the New Hampshire Victims' Compensation Program is supposed to be able to supply funds to reimburse medical providers on behalf of child abuse or neglect victims to cover burdensome costs.[23] This can require the uninsured family to pay up front and then complete paperwork and wait for any potential reimbursement to come later. This is contrary to many states where policy states that victim's families are not to be billed for assessment.

Child Advocacy Centers (CACs) also play a key role in responding to many cases of potential abuse or neglect and, by statute, must be involved in potential criminal cases of this nature. Unfortunately, the CAC network as a whole, reports needing to raise nearly half of their funding on their own.

BUILDING SPECIALIZED MEDICAL CARE CAPACITY & COMPETENCIES

» Leadership and Structure

Through the qualitative research completed during the preparation of this report, a picture emerged of a lack of formal, concrete structure and leadership in providing specialized medical care to potential victims of child abuse or neglect. While there are many providing services and responding to needs, there is a lack of cohesion across those services. There is currently no central entity designed to address the complex medical needs of children who may have been abused or neglected. This includes identifying promising practices in assessment and treatment, crafting and advocating for policy reform, or shaping the overall vision for the response and care of potentially abused or neglected children in New Hampshire. As a result of this lack of leadership, research completed during the preparation of this report has shown that there is very little standardization across the state. Children that present with signs of potential abuse or neglect may receive a different response or follow a different path depending on where they live, where they are seen, and even what time of day it is.

» Expanding Capacity and Competencies among Providers

Consider the child with a newly discovered heart murmur: it is likely that child can be evaluated in a primary care office but sometimes there is a need for the advanced skills of a pediatric cardiologist. The same is true in cases of possible maltreatment. Specialized medical care must be available in instances of suspected child abuse or neglect, specifically care that is high quality, organized, comprehensive and integrated with the other services. To begin to address this need, an expansion of the number

of medical providers with relevant skills is critically needed across the state at all levels.

Qualitative research participants confirmed much of what was reported in previous sections of this report: there are very few of providers who are trained to do appropriate and thorough assessments of children who may have been abused or neglected. Several also mentioned that one position for a specialized medical provider has been vacant since early 2014, with very few applicants – a problem that is being experienced across the nation. Virtually no staffing pipeline currently exists to fill positions being left empty by attrition. The vast majority of non-provider participants (e.g. DCYF, CACs, law enforcement) in interviews and focus groups identified one of two providers as their primary medical contact for suspected cases of child abuse or neglect.

Many stated that they only know how to contact the provider in the event of potential cases of child abuse or neglect through informal work dynamics and relationships. Most respondents stated that they reach a specialized provider by calling them on their cell phone and would not know how or where to reach out further in the event that they were not able to reach that provider. This suggests that a systematic protocol to formally request the services of a specialized medical professional in cases of potential child abuse or neglect does not currently exist.

The availability of SANE or SANE-Ps was identified as being valuable in the hospitals where those staff existed, but it was noted that their expertise is limited to sexual assault and only SANE-Ps have expertise with children. The New Hampshire Coalition of Domestic and Sexual violence is expanding availability of SANE-Ps throughout the state, as noted earlier, however issues of peer review and proctored case review may persist. SANE-Ps as well as other providers who do not see a critical mass of child abuse cases require time for peer review of cases. Participants noted that if any clinician does not see more than one hundred cases annually, all of their child maltreatment cases should be peer reviewed. There are only two providers in the state who meet that standard of 100 cases. In light of this, there is consensus that a more robust peer review structure is necessary. CHaD CAPP has been hosting online conference-style peer reviews for several years and recently has been actively encouraging more participation from clinicians across the state. The adoption of this peer review model is hindered by a number of issues:

- Potential participants in peer review reported not being aware of or having adequate information about the availability of peer review, such as the online review done by CHaD CAPP. There are also professionals who are not aware that they need peer review.
- There is a lack of buy-in from employers who may not allow for the needed time away from patient care to participate in peer review.
- Proctored case review requires the support of both the home institution and the institution employing the proctor or reviewer. No consistent formal agreements exist to facilitate this, so requests for review are done on a case-by-case basis, making it very challenging to complete in a timely manner.

It was widely noted in interviews that providers and hospitals generally have a protocol in place for suspected child sexual abuse cases, but are far less comfortable identifying and responding to potential physical abuse and neglect. Many participants identified a dearth of knowledge related to the decision of treatment versus

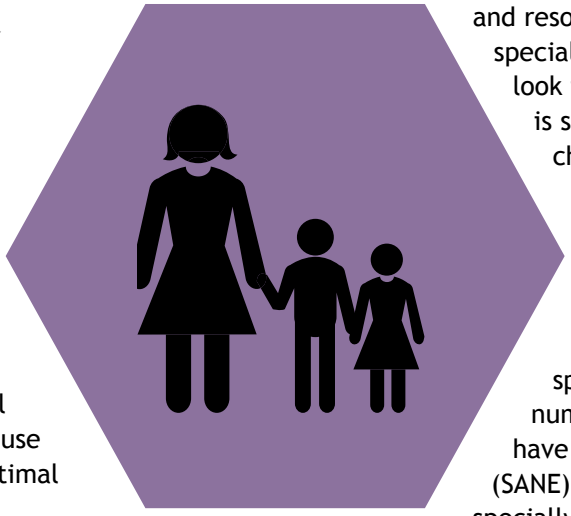
According to those interviewed, communication gaps are pervasive across the whole sector, leading to lapses in timely assessment and care. The following concerning anecdotes were repeated by several participants:

- An organization refers a family to a provider for assessment and treatment, but the family does not show up, and the provider receiving the referral does not let the referring agency know.
- An organization refers a child for immediate assessment, but the organization receiving the referral schedules as an assessment visit for a later time.
- A family is in crisis and in taking steps to address the other needs of the family, a child who has signs of potential abuse or neglect does not receive an appropriate, expert, timely assessment.
- An organization will call for specialized medical review only after they have done their initial interview, sometimes losing up to a week.

referral for patients presenting with signs of abuse or neglect. For example, children who may have been abused or neglected but are perceived not to have acute injuries or who disclose after the fact, either at the emergency department or to another medical or social service provider, may be referred back to their pediatrician or primary care provider for follow up medical care as opposed to an immediate evaluation by a specialized medical provider. Given the very limited number of specialized medical providers in New Hampshire, many see the need to create a standardized way to know which specialized providers are available and when, as well as a formal and systematic way to contact them. More broadly, participants suggest there is an overwhelming need for an increase in resources, training, and education for non-specialized providers and healthcare staff in order to respond appropriately to instances of possible abuse or neglect within an established system.

» System-wide training for appropriate use of medical capacity

A coordinated, comprehensive response to the needs of children who may have been abused or neglected requires a strong network of agencies across communities that are each clear on the stakes as well as their specific roles and responsibilities. Further, accessing an expert medical evaluation for cases of suspected abuse or neglect is critical to achieving optimal outcomes for these children.



Furthermore, formative research through this needs assessment identified that many medical providers hesitate to appropriately report instances of potential child abuse or neglect out of fear of having to testify. Participants across all sectors noted concerns about testifying or a desire not to testify as a barrier to appropriate identification and care of child abuse and neglect. Training is needed around what testimony entails, how to participate without undue duress, and how to receive reimbursement for the time spent preparing for, traveling to, and participating in court. Providers' time needs to be adequately reimbursed to enable them to provide sufficient care and the necessary follow-up that is essential to the both the health and safety of the child and the prosecution of substantiated cases of child abuse and neglect.

Virtually all stakeholders participating in this needs assessment stated that there was a need for training across the board. Specific points brought up include:

- Confusion throughout most sectors about what relevant privacy or HIPAA statutes apply in cases of potentially abused or neglected children, and in accessing specialized medical care. This limits the sharing of essential medical information between treating professionals.
- General hesitation among all people to report, discuss, and address child abuse and neglect, according to participants. Many noted that it is important that we break down these barriers in order to protect children and support families. Further, there is a lack of understanding about what is 'normal' among children and families.

A number of issues were raised as training and resource needs for medical staff and providers who are not specialists in child abuse or neglect. According to qualitative participants training, education, and resources are needed for non-specialized providers to know what to look for, what to do if abuse or neglect is suspected, and what happens once a child is referred.

Participants noted that across the board there is a need to know who to call in instances of suspected child abuse or neglect, both for consultation and specialized treatment. A limited number of emergency departments have Sexual Assault Nurse Examiners (SANE) or Pediatric SANEs that are specially trained to respond to sexual assault, but most sites are inadequately prepared to respond to physical abuse or neglect cases. This is made more concerning by the fact that some qualitative research participants said that in the event that they were not able to reach a specialized medical provider in a case where abuse or neglect is suspected, the child would be directed to the emergency department or urgent care. The Advisory Panel for this assessment noted that most emergency departments are simply not the place for children who may have been abused or neglected to be sent, as emergency departments lack appropriate, quiet places to assess the child and frequently run on a very lean staff that preclude someone from being able to dedicate the necessary one on one time with the child.

Some children have been abused or neglected but are

Emergency Departments and pediatricians are often the first line of response to abused or neglected children, but many do not have access to an appropriate specialized provider.

perceived not to have acute injuries or disclose non-acute events, either in emergency departments or in social service settings. They are often referred back to their pediatrician or primary care provider for follow-up medical care. Non-specialized providers, such as primary care providers or pediatricians, as well as social service and school staff, also express broad concern about reporting potential abuse or neglect and losing the trust of the family. Focus groups noted shifts in reporting behavior where schools and others are more likely to report suspected abuse or neglect anonymously. These organizations report concerns about needing to maintain relationships with those families who may have other children in the school or daycare, for example. Lost trust can also occur when cases are misidentified. The Advisory Panel noted that misidentification is a concern, as non-specialty providers sometimes report signs of sexual abuse that are in fact perfectly normal and not signs of abuse, but often equivocate in instances of suspected physical abuse because an injury could be from something other than abuse. The importance of non-specialized providers and other reporters having resources that support access to proper assessment, care, and follow-up in instances such as these was noted as a top priority.

In cases that could result in criminal charges, participants suggest that non-specialized medical providers sometimes do not report or refer appropriately out of fear of having to testify in court. Some specific reasons given for this sentiment were being made to appear unreliable or incompetent by cross examination, and generally not knowing what to expect. Training is needed around all aspects of how to work with the court systems as a medical provider or reporter of suspected abuse or neglect.

» What has worked in the past?

In this qualitative research, participants identified several things that have been done in the past or in communities that they believe had a positive impact, and could be scaled statewide:

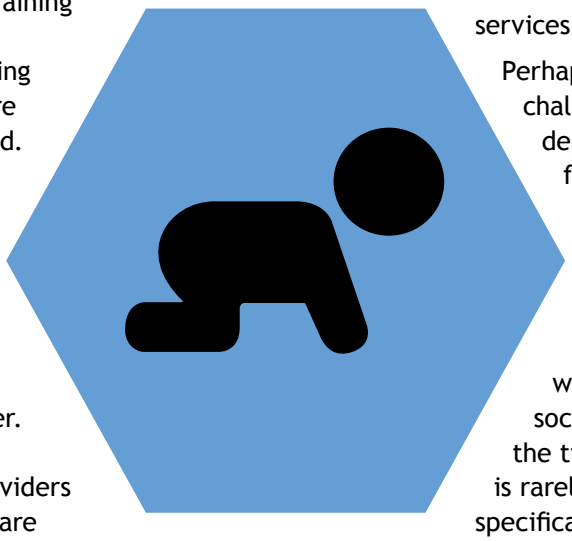
- One of the Child Advocacy Centers (CACs) has begun sending letters to primary care providers (PCPs), as part of their case management, alerting the PCP to the fact that their patient has been seen at the CAC and inviting further conversation or collaboration around that child. PCPs have responded very positively to this, and it has opened the door to more collaboration and trust between the CAC and PCPs.
- Several interviewees mentioned that in the past there had been some training done by the AGTF around the Child Abuse Protocol and generally what to expect in court. Complementary trainings have been done by doctors for other medical professionals who may have to testify or give a statement to provide them with appropriate language and explain the process from a medical standpoint.
- In the past, a nurse was embedded in each DCYF office to help with medical case management. Also, the principal child abuse medical specialty program in the southeastern part of the state and the Rockingham County CAC had a case management staff. Both of these case management positions allowed organization staff to dedicate their efforts to their area of expertise while having an appropriate party available to respond to secondary and tertiary needs. The loss of these positions has had a significant adverse effect on the care children and their families receive.
- Many participants see great value in victim and or family advocates, as they were someone the family could turn to during the process in the event that cases of abuse or neglect went to criminal proceedings. Unfortunately, there are far fewer of these than in the past because of tight budgets and positions going unfilled.

KEY FINDINGS

- A number of themes emerged from this assessment, some pertaining to specialized medical care directly, while others will require a multi-sector response to improvements in the overall response system to instances of child abuse and neglect. Recommendations in the following section seek to address access to specialized medical care specifically, while also addressing the roles of medical care in the larger multi-disciplinary picture.

» Training is needed across all stakeholders in the area of child abuse and neglect

There is a need for comprehensive training among all medical professionals to assure that best practices in addressing suspected child abuse and neglect are known, understood, and implemented. Key components include institutional protocols and policies to implement to ensure standardized care; that personnel respond sensitively so as to not traumatize the child further; and that guidelines clearly establish when to call for a specialized medical provider. Training must also cover why the involvement of specialty medical providers is essential in ensuring that children are accurately assessed. Experience shows that when children are examined by medical providers with specialized training and expertise in child maltreatment, the accuracy of the diagnosis is significantly better. Accurate diagnosis limits trauma to both children who have experienced abuse neglect as well as for those who might otherwise be inaccurately identified as such.



» Emergency Departments need training, protocols, and access to specialized providers in order to adequately respond to presenting cases of abuse or neglect

Emergency Departments are poorly equipped to meet the needs of abused children and their families, as they reported frequently not having the specialized staff, training, or protocols to do so. Emergency Department survey responses were analyzed, attributing a point value to each response that aligns with American Academy of Pediatrics standards for response to a potential case of child maltreatment, and no points to those answers that did not align with the standards. The full Methodology can be found in Appendix C. Two emergency departments left all answers blank and stated that they refer elsewhere and another six emergency department received less than 50% of available points toward meeting the Standards. Resources are scarce and the demands on emergency departments are many, so it should not come as a surprise that many cannot adequately respond to needs as complex as those of abused or neglected children. As noted in the survey results, nearly half of emergency departments do not have a protocol in place for maltreatment assessment, and more than half do not have a medical provider with expertise in the collection of forensic evidence available twenty-four hours a day, seven days a week in cases of sexual assault of an adolescent or pre-adolescent. The majority of emergency departments reported needing twenty-four hour access to services such as social services or specialized medical services.

Perhaps most importantly, it is challenging for general emergency departments without dedicated facilities and staff to be "child-centered", or to operate in way that is sensitive to the needs of the child. The emergency department cannot act as the medical home for that child, and while they may have access to a social worker or care coordinator at the time of the child's visit, that person is rarely trained to work with children specifically and at some point the child needs to have access to those resources in the community. Further there are often more complex issues that require long-term attention comprehensive care coordination, which is best accessed through the medical home.

» There is a need for a cohesive structure to ensure that children are receiving consistent and appropriate care

Throughout the course of this needs assessment, no agreed upon structure was identified to ensure that children are receiving consistent and appropriate care. Research showed that Emergency Departments, which often serve as a first point of contact for victims with the system of care, provide referrals to a number of different sources, ranging from the police and DCYF to telephoning specialized medical providers through their personal contact information. Because New Hampshire currently lacks an identifiable leadership body in this field, there is no uniformity in expectations, policy, and guidelines for caring for potential victims of maltreatment across the state. While organizational policies that exist motivate individual action, there is no collective consensus through

	2012		2011		2010		2009	
	Investigated (per 1,000)	Confirmed Maltreatment (per 1,000)	Investigated (per 1,000)	Confirmed Maltreatment (per 1,000)	Investigated (per 1,000)	Confirmed Maltreatment (per 1,000)	Investigated (per 1,000)	Confirmed Maltreatment (per 1,000)
New Hampshire	42	3	39	3	35	3	33	4
	7%		8%		9%		12%	
Vermont	NA	NA	29	5	32	5	28	5
	-		17%		16%		18%	
Maine	42	14	35	12	32	12	34	14
	33%		34%		38%		41%	
Rhode Island	39	15	37	14	38	15	34	12
	38%		38%		39%		35%	
Mass.	44	14	44	14	46	17	49	24
	32%		32%		37%		49%	
Conn.	38	10	45	12	40	12	37	11
	26%		27%		30%		30%	

Source: Kids Count Data Center. (2015). Retrieved July 2015, from: http://www.datacenter.kidscount.org/data/tables/6221-children-who-are-confirmed-by-child-protective-services-as-victims-of-maltreatment?loc=1&loct=2#detailed/2/8,21,23,31,41,47/false/868,867,133,38,35/any/12943,12942

a formalized system, nor is there officially recognized leadership in appropriately assuring the holistic care and safety of children through the state.

Leadership is needed to guide both state and institutional policy. It is also needed to lead efforts in structuring a system that ensures access to appropriate specialized medical care for non-specialty providers, as well others who need expert opinion and assessment of potential maltreatment. As noted in the qualitative research, continuing to rely on the goodwill of a small number of providers willing to provide these largely unreimbursed services is not sustainable. Stronger leadership could bring together a core group that can share responsibility and knowledge.

» Improved communication, coordination, and collaboration are needed for the health and safety of children

This assessment has identified that there is a dearth of institutional knowledge, collaboration, and communication regarding the coordinated care for victims of physical abuse or neglect. As stated previously, there are few statewide guidelines for directing assessment, referrals, and follow-up from the Emergency Department and elsewhere, the case reviews held by CHaD CAPP have low attendance, and there appears to be little to no incentive for collective learning among primary care providers. Improved communication, coordination, and collaboration between the multiple sectors that are involved in suspected cases of abuse or neglect could play a vital role in addressing and mitigating the potential for further harm.

Multi-sectorial or multi-disciplinary response has long been the aim of the state, as indicated in existing statute. Further, it has been shown to work well in other states, such as Missouri. Unfortunately, the resources necessary to facilitate robust communication, coordination, and collaboration that would allow providers and other stakeholders to fully realize the benefits of multi-disciplinary response remains lacking in New Hampshire.

» Existing data suggests that New Hampshire is not identifying or categorizing children as victims of maltreatment in a way that is consistent with other states.

The data presented in the table above is excerpted from the 2015 Kids Count data[31]. As shown, New Hampshire's reported rate of confirmed maltreatment as a percent of children who are subjected to an investigation is substantially lower than that of surrounding states. However, according to this information, the rate of investigated cases is similar to other New England state. Thus, variance in the rate of reporting suspected cases of maltreatment is not likely to be the reason for the lower rate of confirmed cases.

The median ratio of confirmed cases per investigated cases among the other five New England states in the four years examined is 33%, while New Hampshire's highest rate of confirmation was 12% in 2009. Data and anecdotal references have suggested that New Hampshire reporting

metrics are not all encompassing for reporting the full breadth of maltreatment incidences, allowing for the possibility of under-reported instances of child abuse or neglect. This issue needs to be examined further to be sure that maltreated children are being appropriately identified and served.

There are a number of known gaps in the reported maltreatment data in New Hampshire, one of which is that DCYF data do not include those instances where abusers are from outside the child's home and police records do not provide age-specific data on victims. Child Advocacy Centers also do not consistently record data on children evaluated or referred for specialized medical exams as compared with referrals for primary care. A clearer understanding of how many children need this specialized care is key to developing and sustaining a culture of response to their needs.

In the period from 2009 to 2012, among the five other New England states, the median rate of investigated claims of maltreatment was 38 per 1,000 children. The median rate of confirmation of these claims was 33%. According to American Community Survey 5- year estimates, there are 279,716 children under age 18 in New Hampshire. Based on these numbers, it is estimated that there may be approximately 3,500 children who would meet the definition of confirmed victims of maltreatment if they lived in a neighboring state, compared to just the 896 confirmed in New Hampshire in 2012.

» More children are likely in need of specialized medical assessment for potential abuse and neglect than are currently receiving those services.

In 2014, a total of 343 children were seen by the two primary child abuse and neglect specialty programs in New Hampshire, CHaD CAPP and the CARE Program. Given the number of investigations (11,415 in 2012), it is estimated that less than 5% of children who are the subject of investigation are receiving specialized medical assessments. While certainly not all children who are the subject of an investigation require specialized medical assessment, it is essential that those involved have access to a specialized medical professional for consultation when needed. For example, if there was a disclosure of sexual abuse that occurred more than a week ago, forensic evidence collection may not be useful, as little physical evidence may exist, but such a patient should still have access to a specialized medical professional for comprehensive assessment, referral, and treatment.[32]

» Serious gaps in services exist in many parts of the state

There is virtually no coverage for medical care, particularly not specialized medical care for abused or neglected children in many parts of the state, particularly rural areas. For example, in large parts of Coos and Grafton counties there is little access to services, and most emergency departments serving these areas report they are not well equipped to respond to cases of abuse or neglect. Further, rates of correlated risk factors such as alcohol and substance abuse are higher in these areas, and the rate of children experiencing abuse or neglect is higher as well. These factors combine to create circumstances where children in these areas are more likely to experience abuse or neglect and less likely to receive appropriate identification, assessment, and response.

RECOMMENDATIONS

Assessment findings suggest several important recommendations for increasing the capacity of specialized medical services for children in New Hampshire suspected of having been abused or neglected.

The Advisory Panel convened for this assessment project determined that there are four main recommendations for addressing the key findings and improving the current system in New Hampshire:

1. Create a central point of inquiry for specialized medical care for potential cases of abuse or neglect.
2. Create a Quality Assurance/Quality Improvement Network.
3. Continue Medicaid Expansion.
4. Identify Options for Funding a Network of Response to Child Abuse and Neglect.

» Create a central point of inquiry for specialized medical care for potential cases of child abuse or neglect

Non-specialized providers, first responders and all other potential case reporters need a resource for consultation. Research participants noted the state lacks a 24/7 line for child abuse inquiries and reports. In other model states, such a line is usually provided by the DCYF-equivalent agency and gives callers direct access to abuse experts. While all non-specialized providers and first responders having access to a local, specialized medical provider is the ideal scenario, the dearth of providers in the state makes that unlikely. As such, establishing a stable 24/7 inquiry line where anyone needing consultation regarding potential cases of child abuse or neglect can call and either receive phone consultation or be connected to someone who can provide specialized medical care or review is essential. Communication gaps, office hours, or multiple points of entry can all result in a child not receiving critical assessment and, if needed, specialized examination. By establishing a central point of inquiry, a "No Wrong Door" approach can be taken, which is to say that regardless of what organization first sees a child, a specialized medical consultation is just a phone call away. This response allows emergency departments to have access to a specialized medical provider, though a "live person" would be preferable. Given that there is neither the capacity nor demand in the state for every emergency department or primary care provider to have their own specialty provider for consultation, assessment, and examination, a central inquiry point ensures access to expertise regardless of location. Further, more than two thirds of emergency departments in the state reported a need for twenty-four hour access to specialized medical care and/ or social services.

With appropriate support from insurers, the State, and healthcare institutions, the CHaD CAPP at Dartmouth Hitchcock Medical Center may be the most feasible option for centralizing medical inquiries pertaining to questions of child abuse or neglect. CHaD CAPP is a multidisciplinary program conceived to evaluate and treat suspected victims of child maltreatment. The CHaD CAPP team conducts a wide variety of evaluations, including inpatient and outpatient, urgent and routine, multidisciplinary evaluations of children who are suspected victims of physical abuse, sexual abuse, and/or neglect. CHaD CAPP conducts these evaluations at the request of medical professionals within and outside of Children's Hospital at Dartmouth-Hitchcock and at the request of others in the child protection sphere. CHaD CAPP works closely with all members of the multidisciplinary team. The main CHaD CAPP office is in Lebanon, New Hampshire, but has other clinics throughout the state. CHaD CAPP is also the home of the Child Advocacy Center for Grafton and Sullivan Counties, and has a working relationship with virtually all other stakeholders in this area from its years as an established center. As part of the Children's Hospital, CHaD staffs a 24/7 line to provide information and referral to specialized healthcare providers on healthcare concerns affecting children, including abuse and neglect. This line is currently recommended to local first responders, but is not widely used beyond the surrounding area. In some cases a child might be better served in his or her own community by a medical provider who is able to access specialized expertise through this line. Increased awareness of this 24/7 resource throughout, in conjunction with support for increased capacity, would allow medical providers access to on-call specialized providers. These on-call providers accessed through the 24/7 line could be available for consultation in decisions related to assessment, care, and follow up for children who may have been abused or neglected, as well as to assist other health centers or emergency departments with immediate need.

» Create a Quality Improvement Network

To address some of the gaps identified across training, leadership, structure, and standards of care, it is recommended that a Quality Improvement Network be created. The Quality Improvement Network should be formed as a community of practice. Using this framework addresses the issues of many organizations working in this sphere in relative isolation. A community of practice is defined as "a group of people who share a concern

or a passion for something they do and learn how to do it better as they interact regularly." The community of practice is comprised of three components: the domain, the community, and the practice.[33] A community of practice in the domain of child abuse and neglect in New Hampshire would include the community of New Hampshire providers that would most often come into contact with pediatric patients who may be victims of abuse or neglect. The specific practices could include trainings on assessment and evaluation techniques, monthly case reviews, and growing referral networks, among others. This approach would allow for collaborative learning and foster opportunities for professional performance improvement in this field.

This Quality Improvement Network should include clinicians and providers, such as nurses, nurse practitioners, emergency department physicians, specialty physicians, and health system administration as appropriate. This group can take steps to facilitate proctored cases for newly certified SANE-A and SANE-P in order to expand overall capacity, facilitate case review for those encountering children who have experienced abuse or neglect, as well as provide on- demand consultation, cross-training opportunities for non-medical factors (i.e. testimony in a criminal case) and policy recommendations, both for institutions and potentially statewide.

An example of a successful Quality Improvement Network exists in North Carolina, called the Child Medical Evaluation Program (CMEP), based at UNC Chapel Hill. CMEP is a cooperative effort between the UNC School of Medicine's Department of Pediatrics, the N.C. State Division of Social Services, the N.C. Legislature, local Departments of Social Services, and local medical and mental health providers. Payment for services comes from the State Office of Social Services. Some specific services of note that are offered through this program are that they provide uniform funding for medical and child/family evaluations for children and adolescents who are actively being investigated by CPS as possible victims of abuse or neglect (pre-approval is not required for medical evaluations but is required for child/family evaluations). Further, they have an online provider database (login required) to identify CMEP professionals nearby and host monthly video conferences for case reviews and topical updates.

Similar to North Carolina, the recommended Quality Improvement Network could partner with CACs for the evaluation portion and then act as a centralized knowledge base that can continue to review outcomes across the state, ensuring that recommendations are working as planned, and vetting potential changes. One example is that members of this Quality Improvement Network could pilot test telemedicine as a way of providing specialized care without needing to transport the child or family an hour or more from home. Once a Quality Improvement Network has been established, there are a number of other gaps that can and should be addressed through the power of the network:

- Provide cohesive leadership on specialty medical care for abused and neglected children.
- Coordinate with other entities in this area of need including legal, social services, and funders for the purposes of multi-disciplinary initiatives.
- Achieving consensus on model policies and protocols for use in healthcare or social service settings across the state.
- Partnering with Medicaid and Medicaid MCOs to strengthen both services provided by Medicaid, such as case management or care coordination support, and reimbursement from Medicaid for the full breadth of services provided by specialists in child abuse and neglect.
- Participate in recruiting new specialty providers to the state.

» Expand and enhance reimbursement and access to services through Medicaid

The expansion and enhancement of Medicaid and Medicaid reimbursement is critical to the availability of services for potentially abused or neglected children and their families. Though Medicaid reimbursement is only about a third to half of what private payers typically pay for similar services, that funding is still essential to the viability of programs that provide specialized medical care to children who are suspected victims of abuse or neglect. Those in the field estimate 75% or more of patients seen for abuse or neglect are Medicaid recipients, compared with 15-20% of the general population of children in New Hampshire.

Medicaid expansion, or the New Hampshire Health Protection Program as it is known, has successfully insured tens of thousands of New Hampshire residents and requires new adult members to enroll their children. Both Medicaid Managed Care Organizations (MCOs) operating in New Hampshire reported having an activated code for reimbursement of a medical exam for abuse. Because providers specialized in examinations for suspected child abuse and neglect must, through their contracts with the Child Advocacy Centers, see children regardless of the family's ability to pay, it is important to have as many patients with adequate insurance as

possible

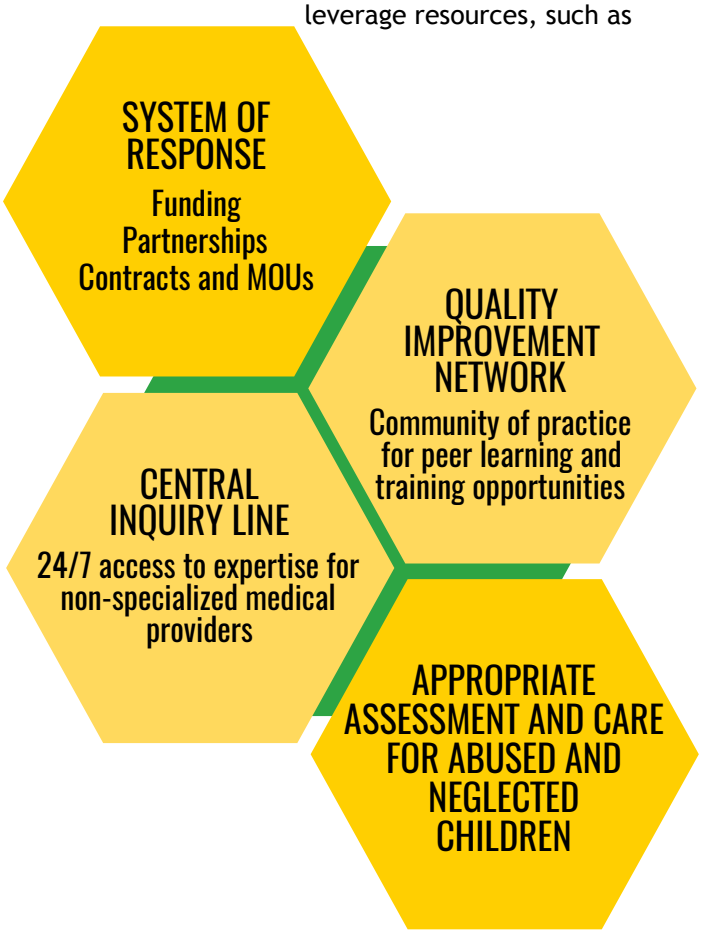
Both MCOs reported providing services in the form of nurse care coordination or other social support depending on what is necessary. One MCO has a dedicated team for children in foster care. All new enrollees in either plan complete a health risk appraisal where individual's concerns and health risks are identified and addressed with referrals to behavioral health or other services. For those in need services can be provided such as transportation can be arranged, cell phones provided, and medical interpreters hired. Other participants noted that while this is helpful, in many ways, these services are still insufficient to address the needs of these families, as many are unstable or in crisis. Case management by phone on a weekly basis and vouchers for transportation do not go far enough in care coordination to ensure that the child gets all the necessary care.

Participants in this assessment including the Advisory Panel strongly recommend that Medicaid reimbursement for the extended, comprehensive office visit necessary to do a specialized assessment be brought to parity with private insurers. Through the CARE Program in 2014, Medicaid reimbursed at about 29% the rate of private insurers for these visits. Approximately 66% of patients seen in the CARE Program were insured through Medicaid. Given these numbers, it is estimated that the CARE Program was reimbursed $64,744 less than if providing the same services to privately insured children. This shortfall only accounts for the discrepancy in funding for comprehensive office visits. Providers report that virtually none of the care coordination, follow up, peer review, or consultation they do is reimbursed at all. This type of shortfall in reimbursement is an equity issue, as all children deserve comprehensive care, particularly when they may have been the victim of abuse or neglect.

» Identify Options for Funding a System of Response to Child Abuse and Neglect

It is key that the partners involved in responding to suspected cases of child abuse and neglect have stable, consistent, and adequate funding. Currently, the majority of the care provided by specialized medical providers is unfunded, as are nearly half of the CAC budget needs. Gaps are filled by private-sector fundraising and by cutting services. DCYF and County Attorneys reported that staffs have gotten much leaner and positions have gone unfilled because of budget shortfalls. It was widely reported that pediatric mental or behavioral health care is very scarce, particularly for those with Medicaid. Given these large and ever growing gaps in services for child victims of abuse and neglect across the state, dedicated resources are needed to enhance and strengthen the system, ensuring that children everywhere in the state can access a basic, acceptable level of care.

Creating a system that supports the recommendations of this needs assessment and a culture of care for abused and neglected children will require the state or its agencies to allocate funds specifically for this purpose. It is the recommendation of this assessment that this network be established with at least one dedicated staff person, whose position is consistently funded and whose roles is to provide coordination, support, and leadership. Other states have established similar structures by leveraging grant funds available either through foundations with a focus on protecting children, universities or through the federal government. For example, one model state reported that they were able to leverage Department of Safety funds that were made available at a federal level. Another established their network by working with a university in the state and sharing both resources and responsibilities. All model states reviewed required partnership between the state, at least one providing entity (such as a hospital system), and payers, that includes both adequate funding and appropriate contractual agreements to create a sustainable system. This system can then work with other providers and stakeholders to streamline care and leverage resources, such as



in-kind support, assigning staff or physical resources to establishing and maintaining the 24/7 central inquiry line or Quality Improvement Network activities as outlined above, for example, or financial, to close existing funding gaps.

CONCLUSION

Historically, New Hampshire ranks high on indicators of child health and well-being, suggesting that most children have the opportunity to thrive, have stable environments, and are able to reach their potential. However, underneath these numbers are situations and cases in which hundreds of children are neglected and abused each year. Many of these children and families are socially vulnerable and rely on a system of publicly funded services for the timely and effective assessment and intervention. This system is critically threatened as the number of professionals qualified to perform the medical evaluations for all children is at an all-time low. At the current time, the loss of just one provider has the potential to disrupt the services provided to potential victims of child abuse and neglect throughout the state. This assessment examined the multiple factors contributing to this shortage of providers and identified more sustainable models for providing care. Efforts to remedy this situation in New Hampshire should include:

1. Create a central point of inquiry for specialized medical care for potential cases of abuse or neglect that allows non-specialized providers access to twenty-four hour expertise for consultation and decision-making support.
2. Create a Quality Improvement Network that brings together medical providers in a community of practice to learn from one another and create training opportunities.
3. Continue Medicaid expansion to expand reimbursement for providers who conduct assessments and cover patients and families that are potentially in crisis.
4. Identify options for funding a sustainable system of response to child abuse and neglect that includes a partnership between the state, at least one central health care entity, and payers as well as at least one staff person to coordinate and champion system-wide efforts.

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Appendix A

Commission to Study Public-Private Partnerships to Fund Medical Care for Abused and Neglected Children HB 572 Report

SUMMARY:

New Hampshire children, like children everywhere, need to be protected from abuse and neglect. Their families need to be shielded from incorrect accusations of maltreatment and anyone who hurts a child must be stopped and face the consequences. But there are insufficient medical resources in the state and this makes it difficult or impossible to assure these outcomes. Our state has a well-developed child protection system (The Division for Children, Youth and Families) which responds to reports of suspected abuse and neglect and our law enforcement community investigates and prosecutes those who are responsible, so that justice is served. But neither child protection nor law enforcement can be assured unless there are knowledgeable medical professionals available to assist with evaluating and responding to abuse and neglect. This is because medical expertise is required to make an accurate diagnosis of maltreatment. Without that, and without the cooperation of medical providers with child protection and law enforcement investigations, the state cannot fulfill its mandated duties and children will suffer.

There is currently a shortage of specialized medical care in New Hampshire for children who are identified as possible victims of abuse or neglect. This report presents the findings of a legislative Commission that was charged with addressing this problem and studying how to develop a public-private means of funding a solution.

BACKGROUND:

Every year in New Hampshire, thousands of children are suspected of having been abused, neglected or victimized by crime. A comprehensive response requires the active participation of knowledgeable medical professionals who can accurately diagnose maltreatment and then work cooperatively with child protection and law enforcement personnel to assure that children at risk are protected and that justice is meted out to those who have hurt them. New Hampshire does not have an adequate supply of such medical providers. As a result, mistreated children in many parts of the state are not correctly identified and are further harmed because they remain in abusive or neglectful environments. Other children are mislabeled as abused or neglected with severe consequences for them and their disrupted families. Staff members at district offices of The Division for Children, Youth and Families and law enforcement officials at local police departments and county attorney's offices are hampered in their investigations and prosecutions of possible maltreatment crimes. A major reason for the lack of a comprehensive state-wide system of medical personnel who have the training and experience in this specialized medical field is the lack of sufficient funding. Unlike other medical services, such as primary care, orthopedic treatment for trauma patients or cardiac interventions to reverse the damage of heart attacks, services for possible child abuse or neglect victims are not comprehensively covered by insurance companies, hospitals, private offices and clinics. This is because traditional medical systems are designed to cover services such as office visits and inpatient care, not the other kinds of services required of professionals who care for possible victims of child maltreatment: interfacing with social services, child protection workers, law enforcement personnel and the court system. These time-consuming tasks require specialized training, support and supervision in order to assure the quality of the work. But these services are not necessarily covered by health insurance because they will not necessarily fall within the scope of covered services that are defined as medically necessary. Providing these services requires alternate funding and at the present time there is no comprehensive funding system in New Hampshire to guarantee that all children are appropriately cared for when maltreatment is the concern. A sustainable means to provide these services would include a combination of private and public funding.

Consider this scenario: an infant is brought to an emergency department because of persistent crying. The nurse asks some questions about signs of illness, the doctor does an examination and tests are ordered. The baby can't let the medical providers know and the caretakers don't admit that the crying has caused one of them to repeatedly injure the infant, resulting in just a tiny bruise on the skin but multiple broken bones and serious brain injury inside the skull. How that baby fares next will depend on the medical providers' abilities to consider the diagnosis of abuse (in addition to the other possibilities such as colic), recognize the significance of even minor bruising in an infant and know to order the x-rays that will show healing fractures and bleeding on the surface of the brain. Even if the nurse or doctor aren't experts themselves in child abuse, having that expertise available will make a tremendous potential difference in out-

come. Medical studies show that about a third of babies with abusive head injuries (Jenny et al 1999) or broken bones (Thorpe et al 2014) are missed the first time they are brought for care. And without intervention, half of them return with worse injuries. Sometimes they return dead. A victim of severe abusive head injury is estimated to cost society over $1 million in costs for medical, rehabilitative, educational and custodial care and in lost productivity (Fang et al 2012). If the correct diagnosis for the baby in our scenario is made, will the doctor be able to eliminate other potential causes for broken bones and bleeding in the head? Will that provider be able to explain to investigators what degree of force was necessary to cause the injuries and how long ago they happened? Will the doctor provide comprehensive and timely reports? Meet with multidisciplinary teams to assist in the development of safety plans for the infant and his siblings? Come to legal hearings and depositions prepared (or come at all)? And provide effective testimony in a courtroom?

Or consider a different scenario: a little girl tells her teacher that she is sore "down there." Someone looks and sees bruising. The little girl denies falling or being hurt by anyone but, still, bruises mean injury and unexplained injury is probably sexual abuse. The state child protection office and the local police department are called and the child is taken for an emergency medical exam. Will the provider mistake this for a sexual assault? Or will the true problem, a skin condition that is easily mistaken for abuse, be correctly identified? We know that when children are examined by medical providers with specific training and expertise in child maltreatment, the accuracy of the diagnosis is significantly better. In a case like this one, it can mean the difference between going home with relieved caretakers or being sent to a foster home.

All children in NH who are known or possible victims of abuse or neglect deserve access to high-quality medical evaluations and treatments. Such care should be coordinated with the care the children receive from their primary care providers, comprehensively delivered in a patient-oriented, community-based medical setting, a "medical home". Because child abuse and neglect are not only medical diagnoses but also indicators of larger issues within families, communities and our society, treatment and prevention should be targeted beyond immediate health concerns. The medical providers who diagnose and help to manage these problems need specialized training, experience and peer review. In order to supply and maintain a high-quality workforce, providers should be adequately compensated. Billing for the medical visits they provide is already addressed by standard office- or hospital-based practice. But this compensation is inadequate. One reason it's inadequate is because of the high proportion of children who are insured by Medicaid. In New Hampshire, although 15-20% of children are insured by Medicaid overall, the percentage of those presenting for evaluations of possible abuse or neglect is 80% or higher in some centers. Medicaid payments are only 31-57% of those of private insurance for the same medical visits for child maltreatment evaluations. As a result, child abuse specialists receive much lower compensation for providing that specialized care than providers who see a more typical mix of patients. For example, last year, one practice devoted exclusively to children needing evaluations for possible abuse and neglect saw a population of which only 23% had private insurance; the other patients would have generated $56,000 in additional billing income had they also been privately insured. Furthermore, much of what a medical provider does when caring for a possible victim of abuse or neglect (the interaction with multiple disciplines and participation in child protection and law enforcement activities) is not considered a contracted service by health insurance (Medicaid or private) and thus is not paid for. This means that the provider who does that work has one of two options: the first is to provide the services for free. This is what commonly happens when providers see low numbers of child maltreatment cases. They provide the services and consider that their contribution to society. Providing free care is honorable but it is not an equitable or sustainable approach. The other option is for the provider to be compensated in some other way. This is what usually happens when providers are specialists in child maltreatment and have no other professional activities to supplement their work with abused and neglected children. In New Hampshire, any supplementary compensation comes from the provider's employer and most providers are employed by hospitals. This means that a significant proportion of the services provided by medical providers to support the state functions of child protection and law enforcement are being paid for by private hospitals. This is not equitable or sustainable either. Some hospitals are providing considerable financial contributions and others provide none. Many of the state's hospitals are facing serious financial constraints. Some bear the expense for providers who see children not just in the immediate vicinity but from the service areas of other (non-contributing) hospitals. One hospital which has been supporting a child abuse physician for years recently reduced its contribution and does not plan to continue with financial support indefinitely.

WHY SPECIALIZED MEDICAL CARE MATTERS:

Child abuse and neglect are common. In a recent review, (Wildeman et al 2014), analysis of national data showed that

1 in 8 children suffers some form of abuse or neglect before turning 18. The greatest risk is for infants in the first year of life, over 2% of which experience physical abuse (Maguire 2010). Two-fifths of all youth experienced an assault in the past year, 10% with injury. Two percent of children experienced sexual abuse or sexual assault each year; for girls aged 14-17 the figure rises to 10.7% so that by the time a girl leaves childhood there is a 1 in 4 chance she will have experienced contact sexual abuse; for boys the risk is 1 in 10 (Finkelhor et al 2013).

Child abuse and neglect are serious. On average, 4 American children are killed by maltreatment every day. The long-term effects of abuse and neglect commonly extend for the life of the individual and include mental health disorders, poorer physical health, higher rates of substance use and earlier death. Physical, emotional and sexual abuse are adverse childhood experiences which, along with neglect, domestic violence, parental substance abuse and abandonment have been called the biggest known determinants of public health. (VanNiel, 2012).

Children who have been victimized are more likely to have injuries recognized and more likely to have comprehensive follow-up care provided when seen by providers with specific training in maltreatment. This is true whether there has been suspected sexual abuse/assault (Adams et al 2012, Edinburg 2008) or physical abuse (White et al 2008.) When child abuse medical specialists provide medical reviews of cases for child protection workers, 40% of the time there is a different interpretation of the findings, usually resulting in a lower concern for abuse. This could lessen the numbers of child protection assessments and findings at a considerable cost savings for the state and far less distress for families. (Anderst et al 2009).

Child abuse has both short- and long-term consequences, medical and financial. There is value in investing in a system that would prevent and ameliorate these effects. Society has a moral as well as a financial responsibility to effectively prevent and respond to child maltreatment.

CURRENT SERVICES:
There are 26 acute care hospitals in the state that provide medical services to children. The last survey of emergency departments, in 2008, showed significant problems with services to possible victims of abuse and neglect, an unacceptable situation that should be reassessed and, if persistent, addressed. In 2008, most hospital emergency departments did not follow guidelines from the American Academy of Pediatrics (AAP) for assessing possible physical abuse, many lacked the equipment necessary to record physical findings in cases of child assault, more than 1/3 had no one available 24/7 to perform an acute evaluation in cases of adolescent sexual assault and more than half had no one when the patient is a child. Seventy-four percent requested more education on child abuse topics and 58% requested round-the-clock ability to consult a child abuse specialist (Gladstone, unpublished data 2008). The Child Advocacy and Protection Program at Children's Hospital at Dartmouth provides consultative services but awareness that it does is not optimal. Also, the number of providers in the Dartmouth program is small, so to lose even one would have significant implications for care state-wide.

When a child is suspected of being the victim of a crime (such as sexual abuse or severe physical abuse) or may have witnessed a crime, a multidisciplinary evaluation is conducted, including a specialized interview at one of the Child Advocacy Centers which are located in every county in the state. All children interviewed at a Child Advocacy Center should be offered a medical evaluation and in order to achieve and maintain national accreditation, these centers need to have formal working relationships with a specialized medical provider. That provider agrees, among other things, to accept all children referred for care regardless of the family's ability to pay. The provider also agrees to participate in multidisciplinary case evaluations, attend monthly case review meetings, obtain ongoing medical education on child abuse topics and have medical findings of cases peer reviewed in order to maintain competence. There is no system for compensating providers who work with Child Advocacy Centers (either for visits not adequately covered by insurance or for time spent in consultations, meetings or peer review) and no system of peer review. Medical coverage for the Child Advocacy Centers in New Hampshire's ten counties is stretched among few providers and one center does not have medical coverage at the present time.

In the western part of the state, at Children's Hospital at Dartmouth, and the southeast, in Manchester, Exeter and Dover, there are a nurse practitioner and a physician who exclusively practice child abuse medicine as part of the Dartmouth Child Advocacy and Protection Program. There are 3 part-time providers who provide part-time assistance. These providers are all supported by the hospitals for which they provide services but at least one hospital has recently

reduced its funding and does not plan to provide support indefinitely, making this funding approach unsustainable. Providers at the two Child Advocacy and Protection Program sites provide medical evaluations for children seen in multiple local hospitals, the two major referral hospitals doing pediatric care in New Hampshire and the Child Advocacy Centers in 6 of New Hampshire's 10 counties plus the one in Manchester. This means very few providers are providing these essential services, leaving the care susceptible to major disruption if even one person stopped work for health or other reasons. The state's second child abuse physician left in January of 2014 and attempts to find a replacement have so far been unsuccessful. The physician in the southeast has attempted to train 5 different individuals over the past 6 years to assist in (and eventually take over) the provision of specialized medical services in cases of possible maltreatment but each provider has declined to continue, chiefly because of the lack of funding to support the work. In Nashua, Wolfeboro and Gorham (serving Hillsborough County South, Carroll and Coos County Child Advocacy Centers) there are physicians who provide medical evaluations for possible abuse and neglect victims but for none of these providers is there anyone being trained as part of succession planning. Cheshire County is attempting to find someone to serve that function. In short, there are few providers currently providing services, no effective system to support them with financial, mentoring and peer support, and no means of assuring anyone to replace them in the future. New Hampshire needs an organized system in place to address where new providers are most urgently needed around the state and how to get the funding necessary for their training, supervision and quality assurance.

Another valuable resource for the medical care of child sexual assault and abuse victims are Sexual Assault Nurse Examiners. These are registered nurses who have received extensive specialized training in the evaluation and care of patients who report sexual assault and abuse. The expanded practice role of the Sexual Assault Nurse Examiner includes working collaboratively with emergency room and other physicians to comprehensively care for patients. Having Sexual Assault Nurse Examiners with additional training focused on pediatric patients at more hospitals in New Hampshire would improve the state's response to child sexual assault. Although the initial training for pediatric Sexual Assault Nurse Examiners is provided by the New Hampshire Coalition Against Domestic and Sexual Violence, funding is needed to provide the necessary clinical pediatric experience, case review and ongoing education to maintain the quality of care.

There are some sources of payment specifically intended for medical evaluations in cases of possible child abuse and neglect in New Hampshire. These include funding from the federal Victims of Crime Act which was designed to provide limited funds for crime victims, including victims of child maltreatment. This money is administered by the Attorney General's office. In cases of acute sexual assault, money will be paid for medical care to the treating provider provided they are in compliance with the sexual assault billing protocol without the need for the victim to apply; this is paid at the Medicaid rate. Another source of funds for victims is the Victim Compensation Fund which can make payments after considering a formal application from families (http://doj.nh.gov/grants-management/victims-compensation-program/index.htm) . These funds come from various sources including restitution payments and fines; last year some $50,000 was apportioned for child victims. The state's child protection agency, The Division for Children, Youth and Families, has a budget line item to cover medical evaluations for uninsured children who may have been maltreated. This provided about $2300 last year.

Compensation for medical providers to appear in court do exist but are usually very low. Medical providers who are called to court to testify as "fact" witnesses (meaning that they relate the facts of an encounter they had with a patient) are compensated by the court system like any other fact witness: at the rate of $32 a day. Medical providers who are called to court to testify as "expert" witnesses (meaning that they have additional knowledge over that of the average person and are therefore allowed to voice an opinion related to the case) may charge a fee. Some employers (hospitals) compensate their employees (medical providers) their usual hourly rate for time spent going to court.

HISTORY OF ADDRESSING THE NEED FOR MEDICAL CARE FOR CASES OF POSSIBLE ABUSE OR NEGLECT:
In February of 2013, legislation was proposed which called for a study of how the state might draw on public and private funding sources to address the needs for these services. The House referred the proposal to the Child and Family Law Committee which advised further study by a subcommittee. From April to October the subcommittee met and developed two specific recommendations: one for the provision of $20,000 from the state budget to provide ongoing case review for pediatric Sexual Assault Nurse Examiners and the other for the formation of a Commission to study private-public partnerships for funding medical evaluations in cases of possible abuse and neglect. The request for funding did not pass because it was not a state budget year. The study Commission was approved and members were appointed from the NH House and Senate, the state's child protection agency (the Division for Children, Youth and Families), the

state Medicaid office, the state's insurance department, the Attorney General's office, the New Hampshire Hospital Association, the state's Child Advocacy Centers, the New Hampshire Coalition Against Domestic and Sexual Violence, the New Hampshire Pediatric Society and the state's Chiefs of Police as well as a school nurse. As soon as it was formed the Commission started meeting twice a month (except for required hiatus in July). The Commission has made remarkable progress given that it effective had only 4 months to deliberate on an enormously complex issue. This report is the product of that work.

WHAT SPECIFICALLY DOES NEW HAMPSHIRE NEED?

- MEDICAL CARE: The children of New Hampshire need round-the-clock access to medical care in cases of possible abuse or neglect. In order to assure this service, all medical providers need to know how to care for children when maltreatment is a concern. Research into why providers don't recognize or report child abuse shows that the principal reasons are insufficient education and confidence in how to manage such cases (Flaherty and Fingarson 2012). Specialized services can be provided at a local level with telephone consultation from a specialist or may necessitate transfer to another facility for consultation within a reasonable time frame. These services should be available regardless of the families' ability to pay.
- CHILD PROTECTION: Every district office of the Division for Children, Youth and Families should be able to request specialized medical assistance in the evaluation of children it is evaluating for possible maltreatment. This assistance may include review of records or actual medical appointments.
- LAW ENFORCEMENT: Every police department should be able to obtain medical assistance in the evaluation of children who may have been the victim of a crime. Prosecutors' offices and Public Defenders should have similar access to such expertise.
- CHILD ADVOCACY CENTERS: As the location where most cases evaluated by the agencies mentioned above receive multidisciplinary team evaluations, every CAC should work with an appropriately trained medical provider to participate in the comprehensive care of child victims.
- A COORDINATED APPROACH: Medical evaluations for children who may have been abused or neglected must be available on a timely basis and coordinated with state-mandated responses to concerns about child safety and law enforcement. This requires medical providers who have received specialized training and mentoring as they transition from education to practice. Additionally, there is a need for quality improvement and peer review systems to decrease the probability of misdiagnosis, increase adherence to protocols, improve recognition of findings and their relevance and advance collaboration with multidisciplinary teams. Employment of this approach will also decrease attrition of appropriately trained providers.

WHERE DOES THE RESPONSIBILITY LIE FOR PROVIDING THESE MEDICAL SERVICES?

The responsibility for funding these services falls to entities both private (the health care system which includes hospitals, providers and insurers) and public (the state). Hospitals are responsible for addressing the medical needs of the patients who live within their service areas. Services may be provided locally or at another hospital(s) when the care is specialized, the providers scarce and the resources are limited. Insurers are responsible for providing access to care for those children enrolled in their plans. The state is responsible for assuring that evaluations for possible child maltreatment are accurate and timely and that investigations of possible crimes includes access to high-quality medical opinions about child injury. It is estimated that as much as 2/3 of the time spent on a given case involves activities beyond direct patient care. Some of these activities are not within the scope of covered services under a child's health insurance contract (whether Medicaid or a private carrier) and therefore are not paid for. Medical providers should have additional financial compensation for these services.

HOW DO OTHER STATES FINANCE EVALUATIONS FOR POSSIBLE CHILD ABUSE AND NEGLECT?

Some states have highly developed, experienced systems to formally address the medical component of a coordinated response to child maltreatment. Florida has legislation requiring specialized medical evaluations for specific clinical conditions (such as head injuries in young children) and provides those evaluations at 23 centers state-wide. The state budget covers almost all expenses. New Jersey has a network of 4 child abuse medical centers and these centers receive enhanced payments for the evaluations plus additional operating funding from the state budget. These two states have the most comprehensive systems. Other states rely on enhanced Medicaid payments to medical providers, direct support of child abuse programs at children's hospitals, and payments to child protection agencies and CACs to allow them to contact with medical providers for services. New Hampshire should plan and implement a similar comprehensive approach that would best suit the needs of New Hampshire's children. At the same time, it is imperative to address the most critical needs immediately.

Nationally, Children's Hospitals that have programs to address child maltreatment have to provide almost 50% of direct expenses for team members and 62% rely on funding from other agencies. (See National Association of Children's Hospitals and Related Institutions report at: http://www.childrenshospitals.net/AM/Template.cfm?Section=Child_Abuse_and_Neglect&ContentID=64529&template=/CM/ContentDisplay.cfm ; also available in poster format: http://www.childrenshospitals.net/Content/ContentFolders34/EducationMeetings2/AnnualMeeting/2012/Posters/2012_Survey_Findings_of_Child_Abuse_Services_at_Childrens_Hospitals.pdf)

RECOMMENDATIONS:

1. The needs for services around the state vary tremendously and current sources of funding are a patchwork that inadequately addresses the need for a comprehensive plan. In the 4 months that this Commission has evaluated where New Hampshire is and how to get to a cost-effective solution to provide necessary services for possibly abused and neglected children, it became clear that as a first step there should be a formal needs assessment to clearly identify the following:
    - where service gaps exist that lead to lack of care for children in some parts of the state: this requires better ways to measure how many children need medical services for possible maltreatment. Figures from the Division for Children, Youth and Families do not include situations where the perpetrators of abuse and neglect are from outside the child's home and police records do not provide age-specific data on victims of crime. Furthermore, Child Advocacy Centers do not all keep data on the numbers of children evaluated or the numbers referred for specialized medical exams as compared with referrals for primary care. A clearer understanding of how many children need this specialized care is key to developing a comprehensive budget to provide for them. Also included in this assessment should be a plan to provide transportation services for children who live far from services and whose families don't have the resources to bring them for care.
    - how many physicians and nurses need specialized training and support to provide these services
    - what are the sources of funding potentially available to provide care for these children
    - how funding streams will change as Medicaid transitions from a fee-for-service to a managed care model and as private insurers adopt capitation strategies for their enrollees; there is currently an oversight system for the Managed Care Organizations that contract with the state Medicaid office to report specifically on mental health services; the same should be instituted for services in cases of child abuse and neglect
2. Such a needs assessment could be accomplished with a grant from a private foundation without the need for state funding.
3. There is an immediate need to train and support a provider in Cheshire County. A physician would require immediate training requiring $2400 (sexual assault exam training, on-line training through the Midwest Child Advocacy Center website and a 1 week child abuse course) followed by 10 supervised cases ($2000), monthly per review ($3600) and a journal subscription to review important child abuse medical literature($150). Total = $8150.
4. There is also an immediate need for additional providers in Coos and Belknap Counties, some of which could be pediatric Sexual Assault Nurse Examiners, provided they are adequately supported after their initial training at the NH Coalition Against Domestic and Sexual Violence. Initial nurse support includes 25 supervised well child evaluations [10 hours x $50/hr = $500] and 10 supervised acute sexual assault cases [$2000] a total of $2500. Ongoing support includes monthly case review [18 hours x $50/hr = $900] plus a journal subscription to review important advances in forensic nursing [$129]. Total = $3529.
5. Ongoing support and case review should be available state-wide to all medical providers. The most effective way to do this is via a secure Internet-based conferencing. As previously requested, this would amount to $20,000 in start-up expenses.
6. Child Advocacy Centers should be supported so that capable medical providers are available to evaluate cases, participate in multidisciplinary team meetings and attend case review. This is estimated to cost $19,800 per year for provider time (a mix of physicians and nurse practitioners).
7. Medicaid compensation for services to children with possible abuse and neglect should increase to at least those of private insurance. This will require language in the managed care contracts that the increased fees, if funded, will be adopted by the managed care organizations. It will also require a better estimate of what the demand for services will be. We know from experience that once front-line workers in health care, child protection and law enforcement learn the value of such services, the demand for them will increase. As an example, one primary care provider who saw maltreatment cases several times a month changed to a practice devoted exclusively to child who were potential victims of maltreatment and saw the numbers of patients seen increase by a factor of 5.

8. Hospitals should continue to support the medical providers who provide these services. This may include providing office space, administrative support, support personnel and some training and continuing education support.
9. Improved billing and coding are potential ways for hospitals to increase compensation from health insurers.
10. Despite the challenges inherent in estimating costs for medical services for an unknown number of children, the Commission preparing this report attempted to formulate a rough idea of costs to help decision-makers understand what order of magnitude the expense might be. To run a comprehensive state-wide program for medical evaluations of possible child abuse and neglect in New Hampshire will likely approach $950,000-$975,000 of which the costs for training new medical providers, supporting participating providers and increasing compensation for medical services above existing insurance payments is about $650,000.
11. Because of the fact that the needs assessment has not yet been performed, the commission is not in a position to make a recommendation as to what portion of this total should come from the state budget.

CONCLUSION:

We all have moral and ethical obligations to protect children and assure that justice is served. New Hampshire has the opportunity to advance its response to children who are possible victims of abuse and neglect with the enactment of these recommendations. We owe it to the youngest citizens in our state to provide care that, at a minimum, meets not just medical standards but also those for the state-mandated responsibilities of child protection and law enforcement. To achieve this goal will immediately reduce the impact of maltreatment on our most vulnerable population, strengthen families and result in significant savings in medical, social, educational and vocational costs over time.

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Appendix B

Emergency Department Survey

Child Abuse Needs Assessment - 2015 Emergency Department Survey

Introduction

This survey is designed to find out what resources the emergency departments in New Hampshire hospitals have to address cases of child abuse and neglect. You will have an opportunity to explain your current ED resources, and what you would like to see made available.

Child Abuse Needs Assessment - 2015 Emergency Department Survey

Section 1 - Respondent Information

* 1. What is the name of your hospital?

* 2. What is your role?

- ED Director, Nursing
- ED Director, Physician
- Other (please specify)

* 3. How many patient visits does your ED have per year?

patient visits to ED per year

4. Of those ED visits, how many patients are under the age of 18 years?

* 5. Approximately how often does your ED see a case of possible child abuse or neglect?

- less than once a week
- 1-3 times a week
- about once a day
- several times a day

Comment (optional)

Child Abuse Needs Assessment - 2015 Emergency Department Survey

Section 2 - Assessment

* 6. When child maltreatment is suspected, how often does your staff interview parents/caretakers separately from each other?

- Rarely or never
- Sometimes
- Usually
- Always

Comment (optional)

* 7. When child maltreatment is suspected, and the child has the required verbal skills, how often does your staff interview children separately from the parent/caretaker?

- Rarely or never
- Sometimes
- Usually
- Always

Comment (optional)

* 8. How often are parents/caretakers asked about violence with others at home?

- Rarely or never
- Sometimes
- Usually
- Always (at every visit)

Comment (optional)

* 9. How often is an unclothed complete physical examination performed for all children presenting to the ED with an injury?

- ◯ Rarely or never
- ◯ Sometimes
- ◯ Usually
- ◯ Always

Comment (optional)

* 10. Does the ED staff make an assessment of the age of any bruises?

- ◯ Yes
- ◯ No

Comment (optional)

Section 3 - Photodocumentation

* 11. Which of the following kinds of equipment does your ED have for documenting non-anogenital (body surface) injuries?

- [ ] Polaroid camera
- [ ] Single lens reflex (SLR) camera
- [ ] Digital camera
- [ ] Digital video camera
- [ ] No equipment
- [ ] Other (please specify)

* 12. Which of the following kinds of equipment does your ED have for documenting anogenital injuries?

- [ ] Polaroid camera
- [ ] Single lens reflex (SLR) camera
- [ ] Digital camera
- [ ] Digital video camera
- [ ] Colposcope (with photo or video capability)
- [ ] No equipment
- [ ] Other (please specify)

Child Abuse Needs Assessment - 2015 Emergency Department Survey

Section 4 - Specialized Resources

13. Which of the following resources exist in any kind of availability at your facility?

- [ ] Pediatrician (with specialty in child abuse)
- [ ] Nurse Practitioner or Physician's Assistant (with specialty in child abuse)
- [ ] Pediatric trained Sexual Assault Nurse Examiner (SANE)
- [ ] Adolescent/Adult trained SANE
- [ ] Social work
- [ ] Mental health services

* 14. When is a hospital social worker available to come to your ED to meet with family members in cases of possible child abuse or neglect?

- [ ] Day shift
- [ ] Evening shift
- [ ] Night shift
- [ ] On-Call
- [ ] Not available

* 15. When is a mental health provider available to come to your ED to meet with a patient under the age of 18?

- [ ] Day shift
- [ ] Evening shift
- [ ] Night shift
- [ ] On-Call
- [ ] Not available

* 16. When is a medical provider with child abuse/neglect expertise available to come to your ED to consult on cases?

- [ ] Day shift
- [ ] Evening shift
- [ ] Night shift
- [ ] Only available by phone
- [ ] Not available

17. If you have a provider with expertise in child abuse pediatrics, who is s/he? (Please include first and last name)

Section 5 - Diagnostic Imaging

* 18. In your ED, is it possible to do a skeletal survey on an infant (looking for occult fractures) and get an immediate report from a radiologist 24 hours a day, 7 days a week ?

- Yes
- No

Comment (optional)

* 19. In your ED, is it possible to do a head CT on a child and get an immediate report from a radiologist 24 hours a day, 7 days a week?

- Yes
- No

Comment (optional)

* 20. Does your facility have in place any protocol or guidelines for child maltreatment assessment of children who present with injuries?

- Yes
- No

Comment (optional)

Section 6 - Sexual Assault/Abuse

* 21. In cases of sexual assault of an adolescent, is a medical provider with expertise in the collection of forensic evidence available 24 hours a day, 7 days a week?

- ◯ Yes
- ◯ No

Comment (optional)

22. What level of training does that person(s) have? (choose as many as apply)

- [ ] ED physician
- [ ] ED nurse practitioner or physician's assistant
- [ ] Sexual Assault Nurse Examiner (SANE)
- [ ] Hospitalist
- [ ] Staff obstetrician/gynecologist
- [ ] Staff pediatrician
- [ ] Staff family practitioner
- [ ] Other

Other (please specify) & Comment (optional)

* 23. In cases of sexual assault of a pre-adolescent, is a medical provider with expertise in the collection of forensic evidence available 24 hours a day, 7 days a week?

- ( ) Yes
- ( ) No

Comment (optional)

24. What level of training does that person(s) have? (Choose as many as apply)

- [ ] ED physician
- [ ] ED nurse practitioner or physician's assistant
- [ ] Adult trained Sexual Assault Nurse Examiner (SANE)
- [ ] Pediatric trained SANE
- [ ] hospitalist
- [ ] staff obstetrician/gynecologist
- [ ] staff pediatrician
- [ ] staff family practitioner
- [ ] Other

Other (please specify) & Comment (optional)

25. In cases of non-acute suspected sexual abuse of a child or adolescent, is the patient routinely referred to a medical provider with expertise in this area?

- ○ Yes
- ○ No

Comment (optional)

26. Who is that person(s)?

27. Who determines the acuity of the sexual abuse incident?

- [ ] Triage nurse
- [ ] ER physician
- [ ] ER nurse
- [ ] Social worker

Other (please specify)

28. Does the professional determining the acuity of the abuse receive training for this role?

- ◯ Yes
- ◯ No
- ◯ Uncertain

29. When it is determined the child can be referred because the abuse is not acute, who determines it is safe for the child to leave (i.e. that the child does not reside with the suspected offender)?

- [ ] Triage nurse
- [ ] ER physician
- [ ] ER nurse
- [ ] Social worker
- [ ] Other (please list)

Child Abuse Needs Assessment - 2015 Emergency Department Survey

Section 7 - Ancillary Supports

* 30. Does your community have services to assist families in which the parent(s) are having difficulty managing their child's behavior (e.g. an infant with excessive crying or an uncontrollable toddler)?

- ◯ Yes
- ◯ No

Comment (optional)

* 31. Is the Division for Children, Youth and Families always contacted in cases of suspected abuse or neglect?

- ◯ Yes
- ◯ No

Comment (optional)

* 32. What are the reasons why?

- ◯ DCYF is not available 24 hours a day, 7 days a week
- ◯ The response in the past has not been helpful
- ◯ This is not the ED staff's responsibility (e.g. social service or the primary care provider reports)

Other (please specify)

33. Is the police department always contacted in cases of suspected sexual abuse or serious physical abuse?

- ◯ Yes
- ◯ No

Comment (optional)

34. What are the reasons why?

- ◯ The police department in our town is not available 24 hours a day, 7 days a week
- ◯ The response in the past has not been helpful
- ◯ This is not the ED staff's responsibility (e.g. social service or the primary care provider reports)

Comment (optional)

* 35. Is inpatient admission to your hospital for a child available if a safe plan following discharge from the ED cannot be made?

- ◯ Yes
- ◯ No

Comment (optional)

Child Abuse Needs Assessment - 2015 Emergency Department Survey

Section 7 - Follow Up

* 36. Are children seen in your ED with abuse concerns routinely referred back to their primary care provider for follow-up?

- ◯ Yes
- ◯ No

Comment (optional)

* 37. Are children seen in your ED who do not have a 'medical home' (regular source of coordinated medical care) routinely assisted in establishing with one?

- ◯ Yes
- ◯ No

Comment (optional)

Child Abuse Needs Assessment - 2015 Emergency Department Survey

Section 8 - Needs

38. Which of the following (check any number) does your ED need to better care for children with suspected abuse/neglect?

- [ ] More education or peer review for our staff (indicate which topics in 'comment' section below)
- [ ] Diagnostic imaging available 24/7
- [ ] Social service available 24/7
- [ ] DCYF open 24/7
- [ ] Medical provider with abuse/neglect experience available 24/7
- [ ] Medical provider with sexual assault experience available 24/7
- [ ] Equipment for photodocumentation of injuries
- [ ] Mental health available 24/7
- [ ] 'Hot line' for child abuse medical consultation available 24/7
- [ ] Community services for families (indicate which services in 'comment' section below)
- [ ] Inpatient admission an option for children with no safe plan following ED discharge
- [ ] Better communication between the ED and the child's PCP

Comment (optional)

Thank you for completing this survey. Your participation is most appreciated.

Appendix C

Methodology for Rating Emergency Room Preparedness to respond to Potential Child Victims of Abuse or Neglect

Using the survey conducted, emergency departments were scored on overall preparedness to respond to potential instances of child abuse or neglect. Responses that align with the American Academy of Pediatrics guidelines for Care of Adolescent Sexual Assault Victims/Evaluation of Suspected Child Physical Abuse, and the NC State Guidance for Emergency Departments were given a point value. Those responses that did not align with the value were assigned no points. The total possible score was 44 points.

Questions included in the scoring process:
Q6, Q7, Q10, Q11, Q12, Q13, Q14, Q15, Q16, Q18, Q19, Q20, Q21, Q23, Q25, Q28, Q31, Q33, Q35, Q36, Q37

Weighting Process

Questions regarding minimum standards of care for verbal assessment of possible cases of abuse or neglect
- Q6, Q7 (Always =3, Usually = 2, Sometimes = 1, Rarely or never = 0)

Questions regarding minimum standards of care for documentation of the physical assessment of possible cases of abuse or neglect
- Q10 Q18*, Q19* (Yes = 1, No = 0)
- Q11, Q12 (1 or more pieces of appropriate equipment = 2, 1 or more pieces of equipment, not always appropriate (i.e. lacking colposcope) =1, No equipment = 0)

Questions regarding minimum number of qualified staff to assess possible cases of abuse or neglect
- Q13 (2 or more appropriately trained medical & behavioral health provider(s) = 3, 1 appropriately trained medical provider + behavioral health= 2, 1 appropriately trained medical provider only OR behavioral health staff only = 1, No staff trained =0)
- Q20 (Yes = 3, No = 0)
- Q21 Q23 Q25 (Yes = 3, No = 0)
- Q28 (Training received = 2, Uncertain = 1, No training = 0)

Questions regarding availability of qualified staff to assess possible cases of abuse or neglect
- Q14, Q15 (Day, Evening, Night shift = 3, Day, Evening, on-call, or 1 shift + on call =2, one time only = 1, not available =0)
- Q16 (Day, Evening, Night shift = 3, Day, Evening =2, one shift only OR only available by phone= 1, not available =0)

Questions regarding availability of community/non-medical resources to assist in management of possible cases of abuse or neglect
- Q31 Q33 (DCYF/Police contacted = 1, DCYF/Police not contacted = 0)
- Questions regarding immediate and long term safety plans
- Q35 (available in-patient admission if unsafe = 1, no available in-patient admission if unsafe = 0)
- Q36 (Referral to PCP for follow-up = 1, No Referral to PCP for follow-up = 0)
- Q37 (Medical home assistance if not currently enrolled = 1, No enrollment assistance for Medical home =0)