

Responding to Child Maltreatment: A Children's Hospital Perspective

Prevention Webinar Presented by the
Federal Interagency Work Group on Child Abuse and Neglect

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Presenters: Nancy Hanson, Associate Director, Child Advocacy, and Karen Seaver Hill, director, Child Advocacy, National Association of Children's Hospitals and Related Institutions (NACHRI); Dr. Frank Putnam, Director, Advocacy Center at the Mayerson Center for Safe and Healthy Children, Cincinnati Children's Hospital Medical Center

Catherine Nolan: [00:23] Well, good morning or good afternoon, depending on where you are in the country. My name is Catherine Nolan, and I'm the Director of the Office on Child Abuse and Neglect (OCAN) here at the Children's Bureau in Washington, DC. As many of you who have probably been on our various Prevention webinars over the past year or two, you know that we are a part of the Administration for Children and Families within the U.S. Department of Health and Human Services.

So I'm very pleased to welcome all of you to our webinar today on Responding to Child Maltreatment: A Children's Hospital Perspective. We're very grateful that Nancy Hanson, Associate Director, Child Advocacy, National Association of Children's Hospitals and Related Institutions is here with us today to share information about the most recent survey of children's hospitals.

Many of you may know that here in the Office on Child Abuse and Neglect we have a real mandate to not only be the focal point for child abuse and neglect issues across the department and our Federal partners, but also we have a vast network of non-Federal partners. And NACHRI is certainly part of that network. So, thank you, Nancy, for being with us today.

In addition to Nancy talking about the survey, to also share more information about the central role of children's hospitals and the multiple disciplines that they encompass in shaping best practices—both from a treatment and a prevention standpoint, as well as looking at the whole issue of sustainable, effective infrastructure to meet the needs of their communities.

Again, many of you may know this history, but just before we get started with Nancy, I wanted to let you know that we do have a little bit of background on this webinar. Basically, OCAN started hosting these informational webinars in 2008 with support from our Prevention Subcommittee of the Federal Interagency Workgroup on Child Abuse and Neglect, which I chair.

So basically, on that Prevention Subcommittee, we bring together representatives from several different Federal agencies who have a common interest in child maltreatment prevention. And that includes staff from CDC, from the Maternal and Child Health Bureau, from the Substance Abuse Mental Health Services Administration, National Institutes of Health (NIH), Department of Defense, Family Advocacy Program, Head Start, Child Care, Office of Special Education over

in the Department of Education, our own ACF Office of Planning, Research, and Evaluation, and the U.S. Department of Agriculture.

And again, the reason that they all come together is that in their agencies' respective missions, the issue of child abuse and neglect and maltreatment is an obstacle to the successful reaching of their goals and objectives within their missions. And so we work together on this whole issue of prevention.

Last year when the subcommittee first began to meet, we agreed that there was a lot of great work happening at each of our agencies and with those of our National Prevention Partners, and we all agreed that we wanted to learn more about what each other is doing. And so that was the impetus to begin hosting these calls, so that we could learn more about each other's work and promote greater connections across our various systems at the national, State, and local levels.

I know we have many people registered—Jean, do we have a number yet on how many registered for today?

Jean Nussbaum: [04:04] I think we are at about 150.

Ms. Nolan: [04:08] About 150 people, which is fantastic. I love this technology—it's just great that we can have 150 people together for an hour and a half to learn about our partners from NACHRI.

Just a couple of logistical notes: as Jean said, please, if you're not asking a question if you could keep your phone on mute to keep the background noise down; secondly, we've had a couple of technical difficulties in previous calls where people are on the call and then they put themselves on hold, and "hold music" comes across; and so please, if you have to step away from the call, please just hang up and then call back again. Thirdly, this call is being recorded, and it will be posted after the webinar is over.

And Jean, on my staff, Jean Nussbaum, thank you to you for managing the technology of all this for us today, and if you have any questions you can ask her, in terms of technical assistance.

I think that's all from me. I want to thank you again for joining us, and I really look forward to our conversation today; and so Nancy, can I turn this over to you now.

Nancy Hanson: [05:21] Yes, you can; but I am going to first hand it to my colleague, Karen Seaver Hill, who is the director here of Child Advocacy at NACHRI, and she is going to give you an overview of NACHRI and Children's Hospital.

Catherine Nolan: [05:34] Oh, great. Thanks, Karen.

Karen Seaver Hill: [05:38] Wonderful. While we see if I have clicked the right button, I want to thank first of all our host at the Office on Child Abuse and Neglect—Catherine, it's wonderful to hear your voice, I'm pleased that we're able to be here with you; and I do have to give a particular thanks to Jean Nussbaum, who I understand is even home sick today, but is still our shepherd as we go through this presentation.

May I pause now just to get a check that everybody has the same visual image as I? Do you see on your screen a blue and purple leading slide to our presentation?

Ms. Nussbaum: We sure do.

Ms. Seaver Hill: [06:12] Thanks so much. And as I ask about that, I might also pause to give a photo credit. Joining us on your first screen is "Hero in Pressure Suit." He's a little guy that was treated at the Shriners Hospital for Children in Cincinnati, and we give credit to them, and throughout this presentation we'll and highlight the good work and the creative representation of our children's hospitals through our photo exhibit. So we're under the watchful eye of our "Hero in Pressure Suit" this morning. Or this afternoon, depending on the time zone you sit in.

I'd like to in particular welcome my quote "family members" to the call today. There are many of the 150 registered that hail from Children's Hospital, so I'm happy that you're here. Please keep us honest. Dive into the Q&A at the end of the call and when we take our pauses, and we learn from your expertise, so please consider yourself a part of this dialogue.

Lastly, I hope that through this, well, multidisciplinary, national level audience we give you a couple of things. First a view from what it looks like looking out our window as a medical community; and then secondly, I hope that together we're able to add a few items onto our to-do list; that we learn from your questions about things that we could be doing differently or more to work together; and that perhaps some of the things that we present today trigger in you some ideas on where you might move forward with NACHRI and the Children's Hospital Community as your allies. So with that as a preamble, let's get started.

Our agenda is threefold, and first we're going to spend a couple of minutes—which is my role—to recognize that NACHRI is not a household name. We know that there is a varying level of understanding of our association and who we represent, so we'll spend a quick few moments going over that, so we all have the same watchpoint of understanding.

The real meat and potatoes of our presentation will be provided by my colleague Nancy Hanson. We're going to delve into our understanding in the field of child abuse pediatrics, and some very specific data that NACHRI has created and collected to share today.

Lastly, we are going to be joined with a colleague of ours from Cincinnati Children's Medical Center. We have joining us Dr. Frank Putnam, who's the director of the Mayerson Center for Safe and Healthy Families. So hopefully what we'll have is a bit of an iceberg effect. We'll be able to show what we understand to be a national level understanding of our part of a community's response to child maltreatment, as well as a very on-the-ground understanding from a complex community such as Cincinnati Children's Center system.

We hope to be able to pause for questions throughout this presentation, and we'll certainly reserve time at the end.

This is who you're looking at. This is me. That just helps a little bit to know where we are and who we're talking to. It's much like station identification. So again, my role here as the director of our department is to tell you a little bit about who we are and why this matters to us so much. I don't expect anybody at the end of the call to be able to recite back to me NACHRI's mission, but

the important thing for you to know is that we are here as an association based inside the Beltway to try and support a committed network of pediatric centers in their fourfold mission. NACHRI has a membership of about 200 institutional pediatric units at large medical centers, as well as not-for-profit children's hospitals.

I do want you to take one thing away from this slide if you would: the nonprofit status of the children's hospital community is an important frame for you to remember as we go forward with this talk.

Our membership is diverse. The joke around here is: You've seen one children's hospital, you've seen one children's hospital. I want you to understand when we talk about some of the data moving forward, in some cases we'll delineate who that might specifically represent; but broadly, our membership falls across several categories, and this will help your understanding as we move forward to listen to Nancy's talk.

A cross-section of our hospital membership are freestanding, they are self-governing not-for-profit independent children's hospitals. The smallest subsection of our membership are specialty centers. These, too, nonprofits; they're independent non-acute care centers, psychiatric, orthopedic centers, Shriners friend centers, etc.

The largest subsection of our membership are pediatric units of nonprofit medical institutions, what we nickname "a hospital within a hospital" or a larger health system.

Why is it important to know that our membership spans a variety of different types? I think it's important when we talk about both types of injury—unintentional and intentional injury—because the children's hospital community sees the spectrum of that injury. So whether it is an acute care, emergency, or trauma center on the front line of injury—such as, for example, the Children's Hospital of Michigan, with an average of 92,000 emergency room visits; all the way to a rehab center, orthopedic center, or Shriners Burn Center. These are all places that may see a child along the continuum of care that has been the victim of either an intentional or unintentional injury.

So when I think of a specialty hospital and their unique voice, and how they keep us understanding what it takes to bring that child back to the fullness of its life after an injury or traumatic incident, I think of a visit I took to St. Mary's Children's Hospital in Bayside, Queens. There 40 of their beds—which is fully one-third of the beds in that entire hospital—are dedicated to traumatic brain injuries. These are the long-term stay patients that are in the rehabilitative and traumatic brain injury. As you imagine, some of these are the children that we care about when addressing child maltreatment.

That gives you a sense of how our hospitals fit the range of response to child maltreatment as we talk about it today; but I want to talk specifically about what you see in the blue column of your slide. There's a fourfold mission of the children's hospital, and NACHRI supports the children's hospital in that fourfold mission.

Taking a closer look, what you might be most aware of is the clinical care that a children's hospital provides, perhaps the most obvious of our service. What you might not be aware of is that while a children's hospital is ... The community represents fewer than 5 percent of all

hospitals in the United States, we do account for greater than 40 percent of inpatient stays, and for 50 percent of all costs to hospitalized children. That is a very large market share for a very small cross-section of hospitals in the United States.

Further down in the slide you'll see the volume of urgent emergency departments as well as outpatient visits; you will note that a child suspected of maltreatment could appear in either of those places. It is important to note, because later on we'll talk about the sustainability and the costliness of providing the medical care, that children's hospitals in general are highly reliant on Medicaid as a payer. Greater than 55 percent of our inpatients and 48 percent of outpatients are covered by Medicaid.

So all you need to take away from this slide is that children's hospitals provide a disproportionately larger share of the nation's pediatric clinical care.

The other three missions in that fourfold mission that I spoke about are covered in this slide. Just as I demonstrated the high volume of clinical care, these three remaining components of a children's hospital mission have really sweeping impact on the general public. Pediatric practices as well as residency training programs are bolstered by our institutions as they move on to private practice. Specifically, pediatricians are largely trained out of children's hospitals—you'll see that 35 percent of all the nation's pediatricians, as well as 50 percent of all the subspecialists, are trained at our institutions.

So as I remind the neighbors on my block: if your child sees a pediatrician, chances are that pediatrician is reliant upon the children's hospital first for their residency training, and then their ongoing training and education. This is a part of our contribution to the advancement of clinical care.

Hand in hand with that contribution is our commitment to research, and you'll note that we have a large share of NIH-funded pediatric research that goes on within the children's hospitals, and not only is that commitment to advancing practice important for the bench-to-bedside work that we promote in our own hospitals, we have also become a great ally to government agencies and others that rely on our pioneering research.

The last part of a children's hospital fourfold mission is in the realm of advocacy, and this is really what sets us apart as a nonprofit institution. One of the things that sets us apart. There is a commitment philosophically that children's hospitals have a mandate to advance the health and well-being of all children, not just the children that walk through our door. Because all children need children's hospitals, we make a commitment to public policy advocacy on the Federal, State, and local levels, to make sure that children have access to care, that the providers of that care receive proper reimbursement, and that their health and safety needs are met in the policy agenda of our lead policymaker.

In addition, the advocacy role at a children's hospital advances public health promotion. We want to make sure that those children in our community have as little opportunities to walk through our doors as possible. That they manage their disease well, that they are kept safe, and they are kept from harm. And that is part of the children's hospital role again, on the Federal, State, local, and even ordinance levels, to make sure that we have a voice as a key stakeholder in a

community and a holder of unique expertise, that children remain a top priority in health involvement.

And again, NACHRI supports our children's hospitals in that fourfold mission, and we largely try and echo our work to shadow theirs.

So what you'll see here is the children's hospitals have what amounts to three simultaneous roles. We treat very complex conditions. Among the more sick and more complex pediatric patients will end up at your local or regional children's hospital. These are patients that could not be accommodated and would not find the array of subspecialty care needed in a general hospital.

But we also serve as a community hospital for all children in an area, providing preventative care, primary care, and even acute care, such as the volumes that we see in our emergency departments right now connected to H1N1 and other respiratory illnesses as they jump up in this season of fall.

And lastly, our hospitals fill the third simultaneous role as a safety-net institution for uninsured and underinsured children. Nobody is turned away from a nonprofit children's hospital. Everybody is served and everybody is cared for, and it is a vital service for children in our society and especially those living in poverty; 38 percent of our children are uninsured or depend on Medicaid or other types of public insurance. As I stated earlier, that makes up a large percentage of the population served.

So the point is that children's hospitals are here for all children needing care, not just the serious and chronically ill—a children's hospital is for all children.

So with that as your understanding of who it is that we represent, how is it that NACHRI has a role in this? Yes, I mentioned that we support those hospitals in their fourfold mission, but also, how would we prioritize? What guides our work? As you might imagine, public health and safety interests at the children's hospital are extremely broad and extremely comprehensive. With a narrow staff, NACHRI's work to advance their mission has to be narrow and strategic. And therefore these three areas that you see listed here are our three priorities areas.

Today's topic will only talk about the programs and assets we've tried to build in child abuse and neglect both for our community and children's hospitals and for the communities with which they work. So today's talk will really focus on the children's hospital as mandated and recorded this opportunity as home to the majority of child abuse expertise and treatment and research, and as the institutions that have a unique and timely opportunity to take on a mantle of leadership to advance the next best practice, as there are many interesting changes in the field of child abuse medicine going on.

So with that 30,000-foot view, I'd like to try and move on to the meat of our presentation, and turn the reins over to my esteemed colleague, Nancy Hanson.

Nancy Hanson: [18:43] Thank you, Karen. I need to ask your patience here at the beginning of my talk, as I am recovering from an upper respiratory bug. So you may hear me cough into my elbow intermittently, and pause to take a sip of water or clear my throat. I am armed here with two glasses of water and one cup of hot tea laded with honey; my colleague Karen Hill has

agreed to step in and save the presentation should I collapse in a fit of coughing. So thank you very much for bearing with me during the snuffles here.

First, I don't need to frame for you as an audience of child abuse professionals, the nature of child maltreatment as a larger public health problem that crosses across all disciplines in the community. It doesn't belong to just one profession. As Karen just talked about, all children's hospitals have a fourfold mission, and one part of that mission is child advocacy, which can be viewed as health promotion. So really, children's hospitals have a philosophical mandate to protect the children in the communities they serve—all the children in the communities they serve.

By virtue of being a children's hospital, they see a good deal of child abuse cases. Additionally, as Karen mentioned earlier, children's hospitals are the training ground for over half of the nation's pediatric subspecialists. So that there are resources such as pediatric ophthalmologists, pediatric radiologists, pediatric neurologists, and the like, that child abuse teams have access to. So these two factors combined have led to a natural evolution of a development of expertise in child maltreatment housed in children's hospitals.

And NACHRI is in the unique position of representing all of these children's hospitals where child abuse expertise is housed, and so we can collect data from our members and share it with the field at large.

I am going to often use the analogy of a three-legged stool ... It is apt here: the three legs being law enforcement, social services, and medicine, that prop up the entire community response to child abuse. And as the analogy goes, if one of those legs breaks or isn't strong, then the entire system falls apart or doesn't function well, or suffers. And this is my attempt at injecting drama into the three-legged stool analogy, is showing you the broken stool.

But we, NACHRI, are here today to talk about just the medicine leg of this three-legged stool that is the community response to child abuse. And the medicine leg has strengthened dramatically over the last 30 years. There have been great advances in diagnostic technology, such as x ray, MRI, improvement in interview techniques, a greater understanding of who to collaborate with and how to collaborate, and all of this strengthens the medicine leg so that the right diagnosis is made, and this enables all of the members of the stool, all three legs, to be able to make the right decision. And that's what is so important, is that the right decision get made in the end, and that those that need to be prosecuted for their actions do so, and others are not needlessly and wrongly accused.

All our health-care professionals in the community and other professionals that work with children—like police officers, teachers, and others—probably received some training on the identification or detection of child abuse and where to report it, and how to make a report. What sets child abuse pediatricians, the experts, apart, is they received extensive training to the tune of three years of training. So they are trained clinically not only to detect and substantiate child abuse, but also, just as importantly, to disprove allegations of child abuse, so that children and families don't suffer further needless emotional trauma.

They're also trained in genetic conditions and disorders that mimic child abuse, that can be tools used either to substantiate or disprove. In addition to the extensive clinical, both didactic and hands-on training, that they do, they also are trained in how to work with other community members to document findings meticulously so that their cases can withstand legal scrutiny, and that they can follow the case through to its conclusion. That they don't just see them in the hospital and then set them free; that they can make sure that the child and the family is able to successfully navigate the system to get the services that they need.

And throughout this presentation I have shared photos from our photo exhibit—our NACHRI photo exhibit of children in children's hospitals—along with quotes from the free-form answers on our 2008 Child Abuse Survey.

And I'm going to read this to you: "We are a well-known subspecialty within the hospital on which most of the medical staff rely on to evaluate and educate on the difficult issues regarding child abuse cases. This saves the medical staff hours of time in diagnosis, treatment, investigation, and testimony."

And this quote from this respondent just illustrates beautifully the point that I'm trying to make, and that is that child abuse pediatricians are not only good for children and their families, they're also good for their colleagues in the hospital and the community, for their organization, and for the entire community.

There has been a sea change in the field of pediatrics over the last several years, and that is the acceptance of child abuse pediatrics as a subspecialty, a boarded subspecialty of the American Board of Pediatrics. This is a big deal. The American Board of Pediatrics doesn't willy-nilly approve subspecialties. There are only 16 of them; it requires years of work. It's an arduous lengthy process that requires consensus of the field in order to be approved, and this was finally achieved a couple of years ago.

What this means is that all people claiming to be or practicing as child abuse pediatricians will need to sit for an exam and become certified. So initially we will have a large cohort next month of the 200 to 300 physicians currently practicing in the U.S.—we don't know what portion of those will decide to become certified, but some will—and followed by the initial certification, one will be required to complete an accredited training program. These accredited training programs will all be 3 years in length, and they will all include a scholarly project component or a research component. So they are very rigorous programs.

And what this means for you, who are out in the community or within children's hospitals but aren't necessarily working on the child abuse team [online interruption] increased access to education and training from child abuse pediatricians, increased access to resources, more places to make referrals.

And the hope of the field is, of course, that by having the acceptance of this subspecialty that more people will join the field. This defines a desirable career path that now will be recognized by other subspecialist peers and physicians at large; it will give greater recognition to the fellow that completes this program; it will give greater served party payer recognition, so that child abuse programs with these physicians can bill at a higher rate. And eventually we are also hoping

that because there is a scholarly component to the program that the body of original research will be increased as the result of the fellows joining the field.

And so it's this change in particular that over the last several years has really strengthened the medical leg of the three-legged child abuse stool that we talked about.

This is a NACHRI document [Defining the Children's Hospital Role in Child Maltreatment]. And I preface my presentation of the survey findings with this document because it is useful to use this with any data that we have collected on child abuse programs. You will receive a hard copy of this in the mail along with the survey findings, and essentially this is a blueprint for child abuse teams in children's hospitals and those within the community to either set up or enhance an existing child abuse team. I should point out that it is not an accrediting document—NACHRI is not an accrediting agency—but it is a lengthy booklet of very specific suggestions and guidance. A road map, if you will, for improving your program.

It has been endorsed by the American Academy of Pediatrics (AAP), as well as the National Children's Alliance.

And within this document, you can see here the table of contents and the type of very specific information that you can obtain. Karen very succinctly talked about our membership mix earlier and how varied our members are. And so this document was really developed with all of our members in mind. From freestanding hospitals to smaller hospitals that may have smaller child abuse programs to specialty hospitals that may only choose to adopt one or two items in these chapters. And they might not have a child abuse program, but they need to adapt this information so that they have good protocols and policies for referring cases of abuse.

And, in particular, I wanted to draw your attention to the Chapter 6: Prevention and Advocacy—I thought that this audience might be especially interested in that.

And another item I would like to point out is that this document also calls for any change in child abuse services to first have the reader conduct either a formal or informal look at what else is going on in the community, so that they can best integrate into what is already existing. That this document does not say that the child abuse program at the children's hospital necessarily needs to be the lead in all responses to child abuse but to use existing resources and to collaborate with other community partners.

Each chapter is divided into three parts, so that it describes elements, actual elements, that a basic child abuse program should have, an advanced child abuse program, and a center of excellence. And then it follows those three levels of needed elements to classify yourself as one of those with solid examples. So you can translate theory into how it actually has been actioned [*sic*] in communities.

And here's another quote from our Child Abuse Survey, and this is a prescient remark for the survey findings that I'm about to present: "Recognition and support by the hospital administration has been the most important factor in building and sustaining the program. Additionally, the Center of Excellence template was instrumental in charting the course for us. The next significant challenge for us will be to increase funding for expansion of the program."

And I would like to pause for a moment to find out if anyone has questions on the field of child abuse pediatrics in general, or recent changes in the field, or the NACHRI guidelines that I just described.

And hearing none, I will go ahead and move on to what's really here, and that is to present our latest survey findings. As I said, you will be receiving a hard copy of this document along with the guidelines document in the mail in a couple of weeks. Give us a couple of weeks.

We believe that this latest data gives currency to the guidelines and undergirds the three-tier system that we've laid out within that document. This is an inside look at our world and what is happening in child abuse programs at children's hospitals. And everything I've told you thus far is to put this data in context.

The survey findings document is divided into two parts. The first part is what we call the Snapshot, and it is a look at data from fiscal year 2007. We have a response of over 50 percent, well over 50 percent, and which we were very pleased with. This is not an easy survey to fill out. Not only was the survey tool somewhat cumbersome this year, but it requires going around the hospital and obtaining financial figures from various people, which as you know can be hard to do once you start involving other offices in questions that you're trying to answer.

It is representative of our entire membership, so it is not skewed toward just freestanding hospitals, or children's hospitals within hospitals, which tend to have the largest and longest-running child abuse programs. But it does represent all NACHRI members.

The first question on the survey is what we call "the definition question," and it asks the respondent to classify their hospital's response to child abuse according to a list of definitions that we have given them. And this is the list of definitions—everything from "no services," to "child abuse services," which would be the loosest form of a child abuse response, where there may not be dedicated staff or a dedicated budget; and then a more sophisticated response would be a "child abuse team," to have additional staffing and budget; and then finally a "child abuse program," which is its own recognizable standalone unit that has clearly defined staff, budget, and protocols for outreach into the community and regular collaboration with other partners.

This pie chart illustrates how that question was answered. As you can see, 40 percent of our members identify themselves as child abuse programs; while roughly the other half divides themselves between child abuse teams and child abuse services. You see there on the blue pie square that 8 percent of respondents replied that they do not provide any services—this is not alarming, since we do know that we have specialty hospitals, for example, answer this survey. And so that they are included in this response, and it may not be appropriate or desirable for them to have a child abuse team in place.

And we also looked at how our responses were stratified according to membership category, and we can say that what you see here is also representative proportionally to the makeup of our membership, which is reassuring.

I'm going to share with you a caseload from *teams* and *programs* only—those are the two categories that have better defined staff and funding—and *teams* and *programs* treat almost all of the cases. And the average caseload is over 1,000 patients; and just so we're all talking about the

same thing, when we talk about caseload we're talking about physical abuse, sexual abuse, and neglect most often; and all most all of our respondents—and we know all children's hospitals, most of them—provide inpatient and outpatient services.

We believe that, as you will see from this pie chart, this nice symmetrical pie chart with five almost equal pieces, that there's a wide range of caseload. And because of that wide range, I think that median might be a better descriptor of what's really happened in caseloads for children's hospitals, the median was closer to 650. So that's very different from over 1,000 patients, but nevertheless, large.

Some reasons for the variants in caseload that you see are because many of our hospitals, in fact 58 of the 67 that responded to this question, provide services systemwide, or via an established network. And what that means is that they may provide services in densely populated urban areas, as well as many services over vast rural areas and in some cases multistate areas.

We heard from members that not only provide under the umbrella of their hospital system, but also throughout their counties, regions, and States; and not just to medical professionals, but also to child protective services [interruption] and others.

Contracted services can also increase caseloads. I believe we had 24 that responded that they have contracts to care for the children in foster care in that region. So you can imagine that that ups the caseload quite a bit.

I want to share a couple of examples of those who gave us some great qualitative data about services they provide systemwide:

- Children's Hospital of Wisconsin operates six children's advocacy centers in Wisconsin.
- Here in Washington DC, Children's National Medical Center, their referral sources include DC's multidisciplinary team member agencies, regional CPS agencies—and regional in DC means Maryland and Virginia and DC—other physicians, mental health providers and parents.
- Children's Health Care of Atlanta is in the process of piloting a statewide telemedicine program.
- In Missouri, St. Louis Children's Hospital provides training and consultative services, hospital and statewide, through their Safe Care Network to law enforcement and medical personnel.
- And Children's Memorial Hospital in Chicago is part of a three-part network that provides chart review and second opinion to the Illinois Department of Child and Family Services on all children who present with certain serious injury. And the other hospitals in that network actually generally transfer children to Children's Memorial if they show up with a suspected abuse injury.
- And a final example is Levine Children's Hospital in North Carolina sees adolescents involved with juvenile justice.

Actual information on caseload was followed by a yes/no question where we simply asked: Have you experienced a change in caseload? And as you can see, two-thirds have experienced the increase; this yes/no question was followed by an opportunity to share with us the reason that they've seen a change, and nowhere in this data does it point to increased incidents. It is all about better recognition in the community with the services available, and of abuse in general. So I suppose, in a sense, that that's good news, and that shows that programs are growing and reaching more children.

And I have a quote here actually that illustrates this nicely. "Although some services were initially reluctant to accept our expertise, they now appear grateful for what we provide and frequently seek our advice, which has resulted in increased demand for services."

And at the end of our talk, our colleague, Dr. Frank Putnam, will speak about this a little more, and the increase that he's seen in his community, and perhaps he will be able to draw some parallels to what's going on in your own community.

And I'd like to pause here, not only for me to take a sip of water, but also to find out if anyone has any questions about the data thus far. Moving right along then ...

Next I'd like to address staffing, the essence of a child abuse program in a children's hospital that is multidisciplinary. There is a range of administrative and clinical talent. You can see here the most frequently reported positions. We also ask a yes/no question along the same lines of the caseload question of: "Have you seen staffing increase?" And you can see here that the majority of respondents said that yes, staffing has increased since the establishment of our program. We can't say whether that staffing drives caseload increase, or whether caseload increase drives staffing increase, but certainly it makes sense that if a program is growing, both of them are increased, and they may be related in some sense.

This illustrates the detailed information that we asked from respondents around staffing. You can see here the long list of those that may be employed by a children's hospital. It is listed in descending order of frequency, so that medical directors at the top there were most frequently reported to be part of the child abuse program or team, and lawyers were least frequently.

Following the colored bars over to the right you can see the average FTE [full-time employment] for those that did report those positions. And I think that it also makes clear the point that for those that don't work within child abuse teams and programs, the people in these programs, aside from the child abuse pediatrician—there are people out there, this is their full-time job that they're doing: child maltreatment. And not only just one person, but you can see the average FTE for some of these positions are two and three people who are doing this full time. So that really speaks to the volume of cases and the thoroughness of the team. And I should point out that this data was only collected from those who identified themselves as teams and programs because by definition they have the most staff.

However, I'd like to share with you a quote from one of our hospitals that describes themselves as a service. And you can really hear the frustration in the quote as they try to get to this level. And the question that we asked them to respond to was: "What challenges have you seen in the past year?" And they quote as their challenge: "Getting the department and other doctors in the

hospital to recognize a child abuse as its own specialty in its own division. I'm tired of being a full-time general peace officer with all that entails, and trying to do child abuse on the side."

And while folks like that aren't included in this graph, it goes to show that there's a lot of good work out there being done where a team or program might not be well recognized.

And here's another picture from our photo exhibit, and another quote from a children's hospital, and this sets us up nicely for the financial data that I am about to present. "We get a lot of respect for what we do and our plans to improve services such as develop a fellowship, but funding to actually implement these changes is ephemeral." And I particularly appreciate the ease of which this respondent uses the word "ephemeral."

The next few slides are going to cover financial data, and I start with the most depressing one. As you can see, three-quarters of child abuse teams and programs that answered this question operate in the red. We asked respondents to provide us detailed financial figures, expenses and revenue, and we calculated a shortfall by subtracting the revenue from expenses.

The average subsidy here, while there is a wide range as you can see, from a few, \$10,000, to over \$1 million, was \$238,000. A lot of money. And I'm sure that many of you are aware of the increased scrutiny of the IRS, the Internal Revenue Service, on the tax-exempt status of not-for-profit hospitals. And this support that a hospital gives child abuse programs is a solid example of the community that benefits, that it's provided to help justify their tax-exempt status.

As this puts into context a little further the deficit slide that you just saw showing the range of expenses of budget, and as you can see, it is also widely and fairly evenly varied here. We're working on some more comparative analysis where we can show subsidy as a percentage of overall budget, looking at the overall financial health of some of these hospitals to see what else we can glean from this data.

And this quote really speaks for itself: "Patient revenue is entirely insufficient to establish an adequate child abuse program."

All child abuse programs, hands down, rely on a variety of sources. In fact, a number have been expressed the importance of really keeping the revenue sources varied in order to maximize funding coming in. You can see here from this graph, like the other graphs it's ordered in terms of frequency with the most frequent source at the top and the least frequent source at the bottom. Respondents were able to select multiple sources. We know that in general, as Karen talked about earlier, Medicaid pays for the health care of one-fifth of all the children in the U.S., and more than 40 percent of patient care in children's hospitals. So it follows that Medicaid is the most frequently cited and most important source of funding for child abuse programs.

We don't know what the outcome of health-care reform will be, but we can definitively say that if Medicaid is affected, then children's hospitals will be affected. And that will affect the services that are available in the community. And I share this with you because this is a financial weakness of children's hospitals that you should know about. That they depend so heavily on reimbursement through Medicaid to stay open.

So the takeaway of all these financial slides is that they are expensive to sustain, they're resource intensive, and they are usually provided at great expense to the hospital.

One more quote: "The continued inadequate reimbursement from the medical model (insurance) and from State agencies stifles growth of services for child abuse programs. We are a money-losing program for the hospital. For now, the hospital is willing to provide this service. As hospital reimbursements continue to decline, we will be the prime target for program cutting."

And it's an unpleasant balancing act that hospitals engage in, but at some point you have to look at—or they do, I'm not sure if you have to—look at sacrificing some of mission in order to balance budget.

This busy slide shows you the different clinical and nonclinical services that you can expect from child abuse teams and programs, or most child abuse teams and programs. You can see the frequency with which they are provided by the little hospitals on the right, and then the colored bars show whether those services are reimbursed.

I think it's useful, without even looking at the bars, just to look at the list of services, to know that those services are out there; and then to, if you look at all the blues, the blue represents fully reimbursed—there's not a whole lot of blue, there's more yellow—yellow is partially reimbursed, green is not reimbursed at all; and I think this audience will be interested that second from the bottom there, prevention and public awareness services, are not reimbursed almost 70 percent of the time, although well over half of our children's hospitals provide these very important services.

Another service that our children's hospitals provide is education and training to a variety of professionals both within the hospital and in the community at large. Some of this will not surprise you at all: residents, medical students. Others, you may be surprised, get training from their child abuse programs. Much of this training is not funded. In fact you can see that in this case the yellow bars represent not funded, and it's sort of bleeding yellow. That not only are these programs under great financial duress in the services that they provide, the clinical and nonclinical services, but education and training also takes a bite out of the resources, and they are not rewarded for that in any way.

Children's hospitals conduct research. Of those that have the most evolved response in child abuse, you can see over 60 percent; you can see here the list of examples of what our children's hospitals are researching. I would say the overwhelmingly common topic is abusive head trauma, also sometimes known as shaken baby syndrome, and in particular we've seen from the qualitative data on this survey that the children's hospitals conducting this research are actually using the results of that research in particular to translate into prevention efforts.

Most of this research is not funded. We got a couple of surveys where they've got some great NIH funding or something like that for child abuse. But in general, they are doing this on their own dime.

And also we partner—we, NACHRI—partner with other member organizations and outside allied organizations on using our data. We're currently working with a member hospital on their study that is looking at adherence to occult injury guidelines. And looking at whether the

administrative structure of the child abuse team has anything to do or can be predictive of whether or not the child is screened for occult injuries. And I would urge anyone in the audience, if you have ideas about how you might use our data or how we might partner to please contact us. We would love to hear from you.

And so to summarize, there is a great variety of children's hospitals. And it would follow that child abuse teams at children's hospitals are also varied. They offer a wide variety of services and training, and they do all of this at a cost to the hospital but of great benefit to the community.

That concludes everything I'm going to say about the 2008 Snapshot, and I'm going to briefly tell you about the Trend Data. We first fielded this survey in 2005, and then we did it again in 2008. It was essentially the same survey in 2008 with a few minor modifications, so we were able to directly compare most of the data points. We have a subset of 67 hospitals that responded both years, so that we can measure change that way.

And we can see, in terms of caseload, that caseload has increased by about 200 patients over the last 3 years, that's a 20 percent increase... We have 37 teams and programs that give us that information for both years, and in my mind this finding supports the 2008 Snapshot finding of increased caseload as well.

And I share this graphic with you showing the increased caseload as an example of what all the graphics look like in the booklet you will receive for the trended data. It shows change on a per-hospital basis instead of a percentage, so you can see there that in 2005 there were nine hospitals that had a caseload of under 300, and then that went down to four in 2008; and then of those hospitals that had a caseload of over 1,500, that increased from five in 2005 to eight in 2008.

Other findings included a staffing increase... It wasn't surprising to see FTE increase for fellows given the acceptance of the subspecialty and that change in the field; but we also saw increase in staffing for nursing assistants, admin directors, and case managers. And again, this coupled with the increase in caseload; I think also supports the increase in caseload and staffing that we saw on the 2008 Snapshot.

Expenses in revenue both increased similarly, sort of 30-ish percent. What's alarming is the hospital subsidy created as a rate that was much higher, almost 60 percent. We see that there has been a shift in revenue sources, and I purposely describe it as a shift because we can tell from 2005 to 2008 that the same number of revenue sources were selected both years. So it's not a matter of numbers being off, it's a matter that Medicaid and local foundations were reported less frequently than hospital foundations, and they were reported more frequently. So that would suggest that as those sources become unavailable that there's increasing reliance internally to support the program. And that's not sustainable. And that's why we are alarmed by that finding, along with the increase, the dramatic increase in hospital subsidies.

That concludes my presentation of the NACHRI data. We are very conscious that it is fiscal year 2007 data so that it's already old. A lot has happened over the last two years, most visibly and dramatically the financial crisis of the U.S. economy; and Dr. Frank Putnam, our colleague in Ohio—he's a child abuse pediatrician there—is here to give you some local perspective of changes he's seen in his community, and also some currency to our data, and he also has a

personal interest in the poor economy and child maltreatment, and has been tracking news stories around the nation about the relationship between child health and the poor economy.

And Frank, if you'd bear with me for one second, I just need to pull up your slides here. Frank?

Dr. Frank Putnam: [54:00] I'm here! I'm bearin' with ya!

Ms. Hanson: [54:04] My heart skipped a beat!

Dr. Putnam: [54:06] Let me just introduce myself a little bit while you're pulling up my slides. Actually, I'm a child psychiatrist. I'm director of the Children's Advocacy Center here at Cincinnati Children's Hospital. We're, as advocacy centers go, fairly large. We see about 2,000 children a year. We have 12 county child protection workers on site, and two supervisors and four police officers assigned to us, and two prosecutors, when we're at full strength.

However what I would say is that the county child protection people have been cut back 68 percent, so we've lost supervisors and workers ourselves; and potentially the whole child protection system in the county and much of the State of Ohio has been seriously cut back as a result of a serious budget layoffs, budget deficits in the State of Ohio, which are still ongoing at this point in time.

We also run a telemedicine system with child advocacy centers around Ohio. We have 12 child advocacy centers elsewhere in the State that are linked to us, and we run a number of peer review and training programs through a telemedicine net, and so we're in touch with a lot of what goes on around the State also.

And so what I wanted to talk a little bit about is the impact of the economy. Because right now we're looking at 2008 data, for example, but it's 2009, and 2009 is very different than 2008. If I could have the next slide ... you there, Nancy? Yeah.

These are one of the ways we've been struggling to capture this. Because I think it's very important that people know that it isn't just that there's a trend upward, as we've seen over many years, but actually that we are experiencing really something of post-epidemic proportions around the country.

Every month we do a sweep through all of the news media looking at stories that particularly address the increase in child abuse reports, in domestic violence, in children in foster care, in suicide, in calls to hotlines around the country, and what we see is pretty uniformly huge increases being reported in local news media about what's going on in their areas. And often report something to the effect that there's twice as many domestic violence calls answered by the police, or that the foster care system is overwhelmed in a particular setting.

The problem is, is that this is all sort of local and largely anecdotal data. You've got the second slide up there I guess? These are just headlines from our surveys. The survey is just a ... we just have the headline, the URL where we picked up the news story, and about the three lines in relatively small type, and it's over 100 pages of just, you know, case after case after case. This isn't really good enough. Can I have the next slide please? There we go...

These are the kind of data that right now the system—nationally, research, funding, and locally—is operating on. These recently came out, and it says, "Gee, you know, in 2009 we learn that there's an increase in child abuse in 2007." Well that's lagged 2 years, and it doesn't really tell us very much about what's going on now. Next slide?

Thank you. What we know now is that the economic conditions are the worst that they've been in many, many years. If you listen to the news, people typically bring up comparisons with either the recession in 1950, or particularly the 1930s and the Great Depression. And many people are calling this "the Great Recession."

We have research—it's not a huge body of research, but it's a growing body of research—showing a pretty strong relationship between poverty and economic hardship, and rates of child abuse and neglect. And I'm aware of unpublished research that actually is in the process of being reviewed that shows a very strong statistical relationship between unemployment rates and child abuse rates; basically, what we would statistically call a strong relationship here. That as unemployment rates go up, child abuse rates go up also.

And we know right now that nationally we are running fairly high unemployment rates; they're higher than they've been at any time in many ways ... into the 50s, and we can pretty much be sure that the child abuse rates are probably also much higher. But the problem has been capturing them in any kind of timely way.

Many of us have a pretty strong impression that the numbers of child maltreatment and neglect are going up in the country as a result of this economic impact, and there's a sort of whole sociological model of family stress and child maltreatment that's reasonably well-supported by empirical studies. Next slide.

At the same time all this is going on, what we're seeing in our State and other States where I talk to people, is that often a significant cut in resources, both for child abuse prevention—for example, home visiting programs in Ohio have been cut 40 percent and may be cut additionally, because the State budget and balances still haven't been solved at this point in time. And at the same time we are probably—and I say probably because right now we don't have the data in hand to prove it—experiencing a pretty significant increase in child maltreatment as a result of this economic hardship.

And I think one of the things that ... We wouldn't tolerate the situation with the flu, we don't actually tolerate this even with cancer. We have a number of surveillance systems in this country that are relatively timely, concurrent. That is, they are able to pick up increases in cases pretty quickly so that we can get a lead on things ... [on] what's happening. And you see it right now, for example, with the flu—you can go to the CDC website, and you can see what's going on in Atlanta, what's going on in national, what's going on in San Diego. Why don't we have this kind of surveillance going on with child maltreatment?

Next slide please... is something about the costs here. Again, we really don't have great cost studies, but these are three studies out there looking at the cost of child maltreatment, and roughly \$100 billion a year, at least in 2007 dollars, and one index is for inflation, and those are

probably pretty conservative figures that don't count a lot of things that should be counted in the long-term costs.

What we know is that child maltreatment is probably the most preventable cause of mental illness. Particularly depression, which is the second most costly illness according to the World Health Organization, plus traumatic stress disorder. It's also, certainly in women, there's a great deal of the data demonstrating that it is the single biggest predictor of a substance abuse and substance dependence disorder. It's probably true for men; the data aren't quite as clean. But basically some studies show that it increases a woman's risk for developing a substance dependence disorder about fivefold. That's a huge increase in risk.

And you think about drug abuse as a public health problem, you think about mental health as a public health problem. We also know that child maltreatment is the single best predictor of HIV risk behaviors. Things like sexual promiscuity and use of intravenous drugs.

And so just picking those three, you've got three huge public health problems that we spend billions and billions and billions of dollars on, both in terms of services, but also in terms of research and prevention, and we're spending—next slide, please—a teeny, teeny, teeny-weeny little fraction, less than \$1 million here, on child abuse and neglect through this NIH translational NIMH budget.

And here we have this very costly epidemic going on, and we're spending almost nothing, both in terms of surveillance and in terms of services and prevention. Next slide ...

I think one of the tragedies here, actually, is that we actually have some pretty good things that we can do. In the last decade we have a good generation of evidence-based prevention programs. CDC has estimated home visiting: the median reduction is about 40 percent, in the best programs there's an 80 percent reduction. There was a recent, basically community, intervention called Triple P that was randomized to counties in South Carolina, basically found a very reasonable effect size—about .5—so we have evidence-based interventions that are preventative and that are say good for maybe 40 percent of the cases or more.

We also have pretty effective treatments now for children who are abused, in terms of the mental health issues. These are, again, moderate-effect sizes. Metanalyses find that they're about .5, which is a moderate effect size; it's like calling these penicillin. We're at the age where we have penicillin as an antibiotic—we don't have all the fancy things yet, but it's not as if we can't do something. We, in fact, have reasonable first-generation, evidence-based interventions for prevention and treatment that could be funded, and we could do something about it.

Last slide, I think? There we go.

So I think one of the needs we have right away is: how do we document the immediate need that we have now? Particularly in the context of this poor economy, which as we know has a strong statistical relationship with increases in maltreatment. And we need a surveillance system that can pick this up and respond to this. And I think this is one of the roles children's hospitals can play, and I'm very grateful for NACHRI for doing the work that you're doing.

And let me just parenthetically say that I love your report, I've left a copy with every vice president in the hospital, and with the chairs of the departments, and the presidents of the hospital, and I even leave copies on the tables outside in their waiting rooms. Just in case somebody else might be sitting there who might have some ability to influence the situation.

I've also sent it on to a number of electives, to let people know that most of these programs are in fact running a deficit. I run that median deficit somewhere around \$300,000 a year for our program here that sees about 2,000 kids. We lose about \$220 for every kid we see, on average.

We need to think about linking together all the child advocacy centers that we have in the country—about 450 of them—and use them to generate sort of statistics, and particularly this immediate surveillance system that we need.

It's also possible to look at the incidence using somebody's computerized random digit dialing surveys. When they did this, the classic studies of the Theodore et al study of the pediatrics in 2005, [Epidemiologic Features of the Physical and Sexual Maltreatment of Children in the Carolinas, Theodore et al., *Pediatrics*] they looked at child abuse in the Carolinas, North and South Carolina, and they did a random digit dialing of mothers, and interviewed mothers with children in the home, and asked them about physical abuse, sexual abuse, inflicted head injury, etc.

And what they found was by maternal report: physical abuse was 40 times higher than the official statistics for the same period; sexual abuse was 12 times higher; and that for every shaken baby that showed up in the medical system, 152 babies were shaken. So again, even if we're looking at official statistics—which unfortunately are lagged by about 2 years or so—we're still missing a lot of kids, and we're really only still seeing the tip of the iceberg.

So we really need a much better surveillance system in this country. We need to be indexing our resources and our spending to these surveillance systems, so that when we see cases go up we increase services, not cut them back as we're doing now. And we need to be investing in those prevention programs that we do know work, and in those treatments that we do know work.

And with that, I thank for this opportunity to have a little bit of a soapbox here. Thank you.

Are there questions?

Caller 1: [1:08:33] I have a question.

Dr. Putnam: Sure. Go ahead.

Caller 1: [1:08:36] I was wondering if you could describe some of the relationships between experts that you've been describing and also the work of NACHRI and child death review.

Dr. Putnam: [1:08:49] Well, I would have to defer to the NACHRI people about the child death review part of it because I'm not sure what they've done there. NACHRI do you have ... Karen, or Nancy, do you have any comments on that?

Ms. Seaver Hill: [1:09:04] Thank you, Frank, this is Karen. And thanks to the caller. I know that recently there have been upwards of three different child death review meetings here in the DC area, and I know that there is a group that's trying to get some Federal legislative attraction specifically hinging around child death, so we've got a beat and an affiliation with other organizations that have that as their primary function.

As you might imagine, children's hospitals serve on their local, State, or regional child death review boards; both our colleagues that are experts in child abuse, as those who are expert in trauma and emergency medicine fill that role.

To the person who has that question, I wonder if you have a specific idea on from what you've heard today, there is an intersection that we might take better advantage of?

Caller 1: [1:09:59] Sorry, I'm muting and un-muting. You know, I've heard a lot today that I think that there are a lot of places where we in the public health community can share and compare data. I work for the Children's Safety Network National Injury and Violence Prevention Resource Center. Child maltreatment is an issue that we are dealing with as well, as much as we possibly can on the primary prevention side.

So I think having us all work together, just as you've been saying, and on this call, based to what everybody's doing, is a great idea. It would take up probably too much time, but I think as this whole project continues, we can ... you know, brainstorm, and maybe Catherine, in your role, can help us figure out how we can all play better together. I think there's a lot, as you well know, a lot of opportunity. Sorry, that's the dog. I'm going to mute.

Catherine Nolan: [1:11:02] Hi. This is Catherine Nolan from the Office on Child Abuse and Neglect. Karen, I don't know if you're familiar with Teri Covington and her work in child death review, but HRSA [Health Resources and Services Administration] funds her to run a National Resource Center on Child Death Review. And there's also a listserv, childdeathreview.org, that that resource center kind of manages. So, I mean, that might be a nice connection, and I'd be happy to facilitate that. NACHRI getting to know the National Death Review folks.

Ms. Seaver Hill: [1:11:39] Thank you, Catherine. I do stay in contact with Teri every now and again, so it's important to be re-reminded of the ways that our circles need to continue to cross. I'd like to just encourage other callers—whether we have the time now for you to ask the question or maybe a little bit later—as the last slide suggests, we're really hoping that we get some ideas on how to partner, and this is a great example of that. That beyond Teri Covington and I staying in intermittent contact, there might be a specific hook that we could pursue. And hopefully this quick snapshot of who we are and what we do is a teaser to you to think how we might better employ our resources to work collaboratively with you.

There are clear examples of where we might be able to fuel your individual research, where we might collaborate on research, since we have a couple of data sets that might be of interest to you, and clearly we could be a portal at NACHRI to the level of expertise like we enjoy in joining Frank Putnam's conversation. So we did want you to be aware of the assets that we have and our willingness to try and figure out ways to better partner.

That being said, are there other specific questions to what we laid out, or specific ideas on things we might follow up together? Star-6 to un-mute your line.

Caller 2: [1:12:55] I have a question. I'm trying to better understand the relationship in different programs across the country between the children's hospital, per se, and the Association of American Medical Colleges because so many of the children's hospitals aren't necessarily owned by the university with which they're affiliated. And that has been [noise interruption] in my community, is understanding how much of the financial burden of child abuse services needs to be, or could be borne by the children's hospital as opposed to the academic center, as opposed to government.

I'm just curious from the NACHRI folks, anybody else on the call, Dr. Putnam. There doesn't seem to be one model, it seems to be done differently in every community. And I'm curious if anyone has any thoughts about how the children's hospital and the affiliated academic centers work together on child maltreatment.

Ms. Seaver Hill: [1:13:52] This is Karen. I'll jump first from our point of view, and then maybe Dr. Putnam could talk how that plays out in Cincinnati.

You are absolutely right, Caller, that there is a mishmash of where the financial lines are drawn among different children's hospitals and their financial institutions, including who pays for whom. During one case, your medical staff, their "boss" quote/unquote is the pediatric department chairman and then university [inaudible]. Who pays their bills, that is who employs them? Not the CEO of the hospital. Sometimes that is a split function. So you find that the financial burden is split in that case.

Clearly the data that Nancy put out is the hospital's investment in child protection. That does not include overhead. So keeping your lights on; keeping housekeeping; keeping security, IT, etc., to keep a hospital-based child protection team, or a multidisciplinary child advocacy center like the Mayerson Center is an investment of the hospital.

The last thing where we'll see a lot of play and a lot of change is this advent of the child abuse pediatric subspecialty. As we talk about a 3-year rigorous academic fellowship training program, that is expensive. And we're already hearing from the field that in some cases they're coming up with an inventive shared-cost arrangement; that perhaps, for example, the hospital might come up with philanthropic dollars to endow the research leg of that 3-year program, while the university underwrites traditionally the standard training components. And in other cases that is solely the burden of the university; and in some cases it will solely be the burden of the hospital.

What we do on our side, in the provision of that third leg, that medical stool, have a variety of approaches. The data that you saw collected here is not reflective of what a medical school might say they bear as a burden for supplying their portion of the medical leg of that stool.

Caller 2: Thanks.

Ms. Seaver Hill: [1:15:50] Frank, I don't know if you wanted to run a specific example as to how that financing falls down in Cincinnati.

Dr. Putnam: [1:15:55] Well, we are ... The hospital is the prime of the pediatrics for the medical center. And the head of the ... We have a split, as you mentioned. We have a CEO of the hospital, and then we have a chair of the department. So there is a split there. And we get money from both sides. We have number of staff, like our nurses, are carried on the hospital budget, and so they actually fortunately don't cost me money.

But I pay for social workers on the other side of that, and of course the physicians and psychologists and everybody, we have to carry through either hospital funds, revenue generated, allowed gifts, and philanthropy is required every year to run this... on the average of about \$300,000-plus has to be raised in the community on a yearly basis to keep the program sort of not even at a breakeven level but at reasonable loss level.

We do have some grant funding through SAMHSA and some other kinds of organizations, some foundation funding, but it's a real struggle. And looking at this fellowship, it's going to be a real struggle, because the AAP requires 18 months of research off the clinical track, so that the fellows aren't even generating clinical income for you, and you're basically covering their research. And honestly, at this point in time, I don't know how we're going to fund it.

We've always had one or two fellows in the past, and they were 2-year fellows. As we move to this official AAP 3-year fellowship, it looks very difficult, like it's going to be very difficult to sustain unless we can find some Federal training moneys, or some sort of other kind of training money.

And I know a number of other people are scratching their heads going: It's great to have an official fellowship, but I don't know how we're going to support our fellows.

Caller Beth: [1:18:05] Excuse me. This is Beth Malchus, and I am curious, has the American Pediatric Association, have they identified a skill set for the fellowships? Or is that ...

Ms. Hanson: [1:18:23] This is Nancy Hanson from NACHRI, and yes. There has been a great deal of collaboration between the American Board of Pediatrics and the American Academy of Pediatrics, and the Associated Residency Review Committees, whereby criteria has not only been developed for the certification exam but also accreditation standards for the program.

Ms Malchus: [1:18:45] And where would this be found?

Ms. Hanson: [1:18:49] I can ... on the ABP website I can send you a link—you said your name is Beth Malchus?

Ms. Malchus: Yes.

Ms. Hanson: [1:18:57] OK, I'll go ahead and send you a link to the program requirements afterwards.

Ms. Malchus: Thank you.

Ms. Hanson: You're welcome.

Ms. Seaver Hill: [1:19:13] We're happy to entertain other questions if you have them; as a reminder on your screen, these are some of our ideas of how we might be able to continue to work together. We wanted to bookmark your calendar now. We plan to field the same study that we were able to share with you again in 2011, further elongating this longitudinal dataset. We wanted to remind you that there are other datasets that NACHRI manages here, and we thought in particular you might be interested in what we could do together.

Through our Case Mix Program right now is an inpatient discharge-level dataset with about 6½ million cases spanning over 6 years with about 90 children's hospitals participating; at the beginning of next year we'll also start collecting outpatient data. That could be a very good resource for us to try and work with you around some of the cases that we see specific to how they're coded, is how we would get at that Case Mix Program; and then lastly I wanted to remind you the document that we started with, that guidelines document, was really very much a collaborative effort among different national organizations and agencies with which we work.

We clearly wanted to set out some best practices for our hospitals to drive the quality of care and infrastructure support that they need to do as the best part they can, but recognize that it is a community-level response. So enjoyed working with the likes of the AAP, and the Network of Child Advocacy Centers, [inaudible], and others.

So I do want to reemphasize that we are interested in that type of collaboration. So would ask that you think, after this call, of ways that we might be able to do that together, and you might be able to asset some of the resources we have available.

And before I close and thank our host one last time, I would pause to see if there are any other questions that anybody would like to ask?

Then, Catherine, hearing none, the gavel is yours once again.

Ms. Nolan: [1:21:14] OK, thanks so much. I really, really enjoyed all of your presentations—Karen and Nancy and Frank—and the slides were excellent, and I think you've really just given all of us on the call today a lot to think about and some wonderful resources to be able to refer back to.

So thanks again for taking the time to spend with all of us today, and thanks for everyone who participated. I hope this met some of your needs for learning some more information about the children's hospitals in the United States and particularly the organization, the NACHRI organization.

Just to let you know, too, you mentioned the American Academy of Pediatrics, and we do work very closely with them as well, as another one of our many non-Federal government organization partners. So that was nice to hear your linkages with them, and the wonderful accomplishment of getting board certification through. That was great.

So anyway, again, Jean Nussbaum on my staff, thanks for coordinating the webinar today; and also to the Child Welfare Information Gateway, and to the FRIENDS National Resource Center for archiving and posting this information after we are done today.

So take care everyone, keep an eye out for our next notice of our next webinar, and I really enjoy the opportunity to spend time with you through this webinar technology. OK, take care everyone, and thanks again.

[End webinar audio.]