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  - CHRISTUS Santa Rosa Children’s Hospital, San Antonio
  - Cook Children’s Medical Center, Fort Worth
  - Dell Children’s Medical Center, Austin
  - Driscoll Children’s Hospital, Corpus Christi
  - Scott & White Children’s Hospital, Temple
  - Texas Children’s Hospital, Houston
  - University of Texas Health Science Center at Houston

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Acronyms
EXECUTIVE SUMMARY

The 81st Legislature, Regular Session, 2009, enacted S.B. 2080 requiring the Department of State Health Services (DSHS) to establish the Texas Medical Child Abuse Resources and Education System (MEDCARES) grant program. The purpose of the program is to help develop and support regional initiatives to improve the assessment, diagnosis, and treatment of child abuse and neglect. Funds are to be awarded to hospitals, academic health centers, and health care facilities with expertise in pediatric health care and a demonstrated commitment to developing basic and advanced programs and centers of excellence.

State funding of regional efforts was recommended by the Advisory Committee on Pediatric Centers of Excellence (PCOE) relating to abuse and neglect. The PCOE report was submitted to the 80th Legislature, 2007.

In addition to enacting SB 2080, the 81st Legislature appropriated $5 million for the grant program for fiscal years (FY) 2010-11 (S.B. 1, 81st Legislature, Regular Session, 2009, Article IX, Section 17.115). In accordance with statute, DSHS is required to report on the MEDCARES program and contractor activities (Chapter 1001, Subchapter F, Texas Health and Safety Code). This report encompasses the first two years of the grant, from June 1, 2010, through May 31, 2012.

Background

Approximately 20 percent of children in the U.S. will be victims of child abuse during their lifetimes according to estimates from various studies. The exact prevalence is unknown for various reasons, including the failure to report all cases. Data from the Texas Department of Family and Protective Services (DFPS) show 65,948 confirmed victims of child abuse or neglect in FY 2011, out of 297,971 alleged victims reported. Parents were responsible for nearly 98 percent of these cases.

Child fatalities from abuse occur in Texas at a rate of 3.22 deaths per 100,000, the third highest in the nation (federal FY2010). Of those deaths, children under one year old accounted for 34.2 percent of the deaths and children younger than age four accounted for 80.1% (FY 2011).

As shown in Table 1, there were a total of 297,971 children in Texas suspected of being a victim of child abuse or neglect reported to the DFPS in FY 2011. Of those, 22.1 percent (65,948) were confirmed victims. The percent confirmed differed by Region, ranging from a low of 16.7 percent in Region 6 to a high of 29 percent in Region 1.
Table 1
Alleged and Confirmed Victims of Child Abuse/Neglect (FY2011)

<table>
<thead>
<tr>
<th>Region</th>
<th>Alleged Victims</th>
<th>Confirmed Victims</th>
<th>Unconfirmed Victims</th>
<th>Percent Confirmed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texas</td>
<td>297,971</td>
<td>65,948</td>
<td>232,021</td>
<td>22.1%</td>
</tr>
<tr>
<td>Region 1</td>
<td>13,550</td>
<td>3,923</td>
<td>9,627</td>
<td>29.0%</td>
</tr>
<tr>
<td>Region 2</td>
<td>9,294</td>
<td>2,537</td>
<td>6,757</td>
<td>27.3%</td>
</tr>
<tr>
<td>Region 3</td>
<td>69,698</td>
<td>15,883</td>
<td>53,815</td>
<td>22.8%</td>
</tr>
<tr>
<td>Region 4</td>
<td>15,117</td>
<td>3,096</td>
<td>12,021</td>
<td>20.5%</td>
</tr>
<tr>
<td>Region 5</td>
<td>11,081</td>
<td>2,168</td>
<td>8,913</td>
<td>19.6%</td>
</tr>
<tr>
<td>Region 6</td>
<td>53,951</td>
<td>9,009</td>
<td>44,941</td>
<td>16.7%</td>
</tr>
<tr>
<td>Region 7</td>
<td>34,797</td>
<td>7,375</td>
<td>27,422</td>
<td>21.2%</td>
</tr>
<tr>
<td>Region 8</td>
<td>37,235</td>
<td>8,382</td>
<td>28,853</td>
<td>22.5%</td>
</tr>
<tr>
<td>Region 9</td>
<td>8,664</td>
<td>2,141</td>
<td>6,523</td>
<td>24.7%</td>
</tr>
<tr>
<td>Region 10</td>
<td>9,246</td>
<td>2,487</td>
<td>6,759</td>
<td>26.9%</td>
</tr>
<tr>
<td>Region 11</td>
<td>35,284</td>
<td>8,934</td>
<td>26,349</td>
<td>25.3%</td>
</tr>
<tr>
<td>Out of State</td>
<td>54</td>
<td>13</td>
<td>41</td>
<td>24.1%</td>
</tr>
</tbody>
</table>

Source: Texas Department of Family and Protective Services, 2011 Data Book, accessed August 7, 2012: 
http://www.dfps.state.tx.us/documents/about/Data_Books_and_Annual_Reports/2011/5CPSAll.pdf

MEDCARES Grant Program Requirements

The Executive Commissioner of the Health and Human Services Commission (HHSC) appointed a nine-member advisory committee in November 2009 to advise DSHS and the HHSC Executive Commissioner in establishing the grant program in accordance with the statute. The MEDCARES Advisory Committee, along with DSHS staff, established the requirements and priorities for grant recipients. The priorities were outlined in an initial open enrollment application released March 2010 and were continued in contract renewals the following year.

DSHS required grantees to meet the following criteria:

- **Staff**: Have at least one full-time equivalent physician experienced and trained in all types of child abuse and neglect, one dedicated social worker, and one project coordinator.

- **Services**: Provide comprehensive medical evaluations for child abuse and neglect patients, including consultations on inpatient and outpatient cases, and access to related subspecialty services (such as pediatric radiology).

- **Prevention**: Participate in community child abuse prevention efforts by serving on community boards concerned with prevention of child abuse and neglect or by developing/disseminating prevention materials.
• **Collaboration:** Collaborate with Child Protective Services (CPS) caseworkers and community organizations such as the local Children’s Advocacy Center, the child fatality review team (CFRT) and law enforcement agencies.

• **Education:** Provide related child abuse and neglect training for medical students and residents (if present at the hospital), community physicians, CPS, law enforcement personnel, and others.

• **Research:** Have a center or program physician who maintains active membership in recognized state and national child abuse organizations in order to provide up-to-date research information to the team.

• **Risk Management:** Maintain and update child maltreatment protocols related to conducting medical evaluations and case reporting.

**Strengthening Regional and Statewide Capacity through Mentoring**

Facilities that met the initial grant requirements also had to commit to developing a basic child abuse program through a mentoring partnership. Support provided from advanced centers or centers of excellence to basic child abuse programs is an integral part of the MEDCARES system goal: to improve the assessment, diagnosis and treatment of child abuse and neglect via a statewide service system of regional medical child abuse programs.

In the first year, contractors had to show proof of their mentoring relationships through monthly reporting of relevant activities such as on-site trainings, assisting with case reviews, and other educational opportunities. The same relationships and reporting requirements continued in the second year. In addition, contractors were required to subcontract with their mentee sites for $25,000 to further develop, support, and improve services at those facilities.

**Contractor Selections and Implementation**

Implementation started June 1, 2010, with the awarding of half the grant money, $2.5 million, to eight contractors across the state, as follows:

- Children’s Medical Center of Dallas
- CHRISTUS Santa Rosa Children’s Hospital, San Antonio
- Cook Children’s Medical Center, Fort Worth
- Dell Children’s Medical Center, Austin
- Driscoll Children’s Hospital, Corpus Christi
- Scott & White Children’s Hospital, Temple
- Texas Children’s Hospital, Houston
- University of Texas Health Science Center at Houston

Contractors consisted primarily of academic and non-profit hospitals throughout the state that were identified as a child abuse and neglect center of excellence or advanced child abuse and neglect program in accordance with the PCOE report.
Contractor Activities and Accomplishments

During the first two years of the MEDCARES grant program, contractors have worked successfully to improve the assessment, diagnosis, and treatment of child abuse and neglect by:

- Expanding clinical hours and capacity by hiring additional child abuse medical specialists and developing new clinics;
- Providing education and training to medical professionals and nonprofessionals;
- Developing and supporting regional initiatives through mentorships; and
- Expanding services to clients in remote areas.

Funds have provided for increased training opportunities for staff within the clinics and for hospital staff who coordinate with the clinic, resulting in increased awareness in assessment and subsequent reporting and referral. Expanded community training opportunities have allowed for prevention information to be provided directly to parents, providers, caseworkers and law enforcement personnel who frequently work with families at high risk. Trainings have covered such topics as recognizing and reporting abuse, abusive head trauma, injury biomechanics, conditions that mimic abuse, and the importance of family history, among many others.

Strengthening regional relationships through mentoring is imperative because of the limited number of board-certified child abuse pediatricians in Texas. Basic level sites, which had some capacity to serve children and families in need, are supported by these specialists so children across the state can be served with the highest quality of care. With advances in telemedicine, support can be provided to the mentee sites via phone and video connections on a more regular basis than would be allowed by face-to-face interactions. Contractors provide support to their mentee sites via case reviews, on-site consultations, equipment and photodocumentation trainings, assistance with difficult cases, and, at some sites, through mini-fellowship education, training, and mentoring.

In addition, mentee sites have been able to purchase some equipment that has allowed them to expand services to clients in more remote areas of the state and attend statewide and national trainings to improve their knowledge related to child maltreatment. Supporting these sites also raises awareness and encourages interest in child abuse fellowships and recruitment of other board-certified child abuse pediatricians to the state.

Other notable activities achieved through MEDCARES funding include:

- Expanding current prevention programs by training community partners on evidence-based interventions which they have, in turn, implemented in their own communities.
- Increasing cooperation with CPS, law enforcement, and the judiciary through consultations, medical case review, and by providing testimony in court.
- Improving research capabilities by adding relevant data elements to current registries, creating new registries specifically designed for child maltreatment and neglect and by creating data workgroups to advise facilities on data collection, research, and data analyses.
MEDICAL CHILD ABUSE RESOURCE AND EDUCATION SYSTEM (MEDCARES) GRANT REPORT
PROGRAM YEARS 1 AND 2 (JUNE 2010-MAY 2012)

INTRODUCTION

The 81st Legislature, Regular Session, enacted S.B. 2080 in 2009, requiring the Department of State Health Services (DSHS) to establish the Texas Medical Child Abuse Resources and Education System (MEDCARES) grant program. The purpose of the program is to develop and support regional initiatives to improve the assessment, diagnosis, and treatment of child abuse and neglect. Funds are to be awarded to hospitals, academic health centers, and health care facilities with expertise in pediatric health care and a demonstrated commitment to developing basic and advanced programs and centers of excellence. State funding of regional efforts was recommended in a report submitted to the 80th Legislature by the Advisory Committee on Pediatric Centers of Excellence (PCOE) relating to abuse and neglect.

The 81st Legislature also appropriated $5 million for the grant program for fiscal years (FY) 2010-11 (S.B. 1, 81st Legislature, Regular Session, 2009, Article IX, Section 17.115). In accordance with statute, DSHS is required to submit a report to the governor and Legislature by December 1 of every even-numbered year regarding program and contractor activities (Chapter 1001, Subchapter F, Texas Health and Safety Code). This report encompasses the first two years of the grant, from June 1, 2010, through May 31, 2012. The statute requires the Executive Commissioner of the Health and Human Services Commission (HHSC) to appoint an advisory committee to advise DSHS and the Executive Commissioner in establishing the grant program. This committee was convened in November 2009 and was instrumental in guiding the agency in creating the program that exists today.

Overview

The PCOE report submitted to the Legislature (S.B. 758, 80th Legislature, 2007) identified several key findings with regard to child abuse and neglect. It underscored the importance of a comprehensive approach to preventing, assessing, diagnosing, and treating child abuse and neglect, focusing specifically on the significance of the health care system and its ability to serve children and families. However, according to the report, coordination with the health care system has been limited due to “the shortage of physicians specialized and experienced in child abuse and neglect, low levels of reimbursement for child abuse-related medical services, and the resulting under-diagnosis and misdiagnosis of many children.”

As a result, many child abuse victims may either receive an incorrect medical diagnosis or never receive a medical diagnosis at all. The ability to conduct timely evaluation is minimized and additional statewide costs and resources are expended on furthering investigations and costly legal proceedings. According to the PCOE, the amount of time and money spent for these cases can be reduced if a qualified physician, specialized in child abuse and neglect, collects the
appropriate medical information and interprets it in the early stages of the investigation. The MEDCARES grant program was created to increase access to these medical child abuse experts and improve timely and accurate child abuse diagnoses. The grant augments existing statewide services and strengthens cross-sector relationships to enhance referrals.

In November 2009, the advisory committee and DSHS staff established requirements and priorities for the grant program. The priorities were outlined in the initial open enrollment application released March 2010 and were continued in contract renewals the following year. As a result of the open enrollment opportunity, $2.5 million in the appropriated general revenue funds were awarded and distributed equally across eight contractors for work that began June 1, 2010. Contractors consist primarily of academic and non-profit hospitals throughout the state that were identified as a child abuse and neglect center of excellence or advanced child abuse and neglect program as per the PCOE report. The facilities selected include:

- Children’s Medical Center of Dallas
- CHRISTUS Santa Rosa Children’s Hospital, San Antonio
- Cook Children’s Medical Center, Fort Worth
- Dell Children’s Medical Center, Austin
- Driscoll Children’s Hospital, Corpus Christi
- Scott & White Children’s Hospital, Temple
- Texas Children’s Hospital, Houston
- University of Texas Health Science Center at Houston

The second $2.5 million was again distributed evenly among the same eight contractors beginning June 1, 2011. In the contract renewal, DSHS required contractors to award $25,000 to a mentee site, thus providing the mentee sites with additional support related to growing their medical child abuse and neglect services. The mentoring component is discussed in more detail in the Mentoring Component section below.

MEDCARES GRANT PROGRAM OVERVIEW

**Description of Requirements**

DSHS, with advisement from the MEDCARES Advisory Committee, focused on program awards to hospitals or academic health centers with expertise in pediatric health care currently meeting the following criteria. Criteria were derived from guidance and recommendations provided in the PCOE report:

- **Staff**: Have at least one full-time equivalent physician experienced and trained in all types of child abuse and neglect, one dedicated social worker, and one project coordinator. The physician must be board-certified as a child abuse pediatrician or demonstrate completion of a pediatric child abuse training fellowship or demonstrate five years of at least half-time experience providing child abuse and neglect medical services.

- **Services**: Provide comprehensive medical evaluations for child abuse and neglect patients, including consultations on inpatient and outpatient cases, and access to related subspecialty
services (such as pediatric radiology).

- **Prevention**: Participate in community child abuse prevention efforts by serving on community boards concerned with prevention of child abuse and neglect or by developing/disseminating prevention materials.

- **Collaboration**: Collaborate with Child Protective Services (CPS) caseworkers and community organizations such as the local Children’s Advocacy Center (CAC), the child fatality review team (CFRT) and law enforcement agencies.

- **Education**: Provide related child abuse and neglect training for medical students and residents (if present at the hospital), community physicians, CPS, law enforcement personnel, and others.

- **Research**: Have a center or program physician who maintains active membership in recognized state and national child abuse organizations in order to provide up-to-date research information to the team.

- **Risk Management**: Maintain and update child maltreatment protocols related to conducting medical evaluations and case reporting.

Activities and strategies proposed by eligible applicants may support the following services (Section 1001.152, Texas Health and Safety Code):

- Comprehensive medical evaluations, psychosocial assessments, treatment services, and written and photographic documentation of abuse;

- Education and training for health professionals (including physicians, medical students, resident physicians, child abuse fellows, and nurses) relating to the assessment, diagnosis, and treatment of child abuse and neglect;

- Education and training for community agencies involved with child abuse and neglect, law enforcement officials, CPS staff, and CACs involved with child abuse and neglect;

- Medical case reviews, consultations, and testimony regarding those reviews and consultations;

- Research, data collection, and quality assurance activities, including the development of evidence-based guidelines and protocols for the prevention, evaluation, and treatment of child abuse and neglect;

- The use of telemedicine and other means to extend services from regional programs into underserved areas; and,

- Other necessary activities, services, supplies, facilities, and equipment as determined appropriate by DSHS.
**Mentoring Component**

Facilities that met the initial grant requirements had to commit to developing a basic child abuse program (as defined by the PCOE report) through an existing or proposed mentoring partnership in order to qualify for an award. Support provided from advanced centers or centers of excellence to basic child abuse programs is an integral part of the MEDCARES system goal: to improve the assessment, diagnosis, and treatment of child abuse and neglect via a statewide service system of regional medical child abuse programs.

Mentee sites were chosen by MEDCARES contractors based on: 1) their ability to meet the requirements of a basic level site as determined by the PCOE report, 2) their willingness to work with a MEDCARES contractor, and 3) their relative proximity to the MEDCARES contractor, with the understanding that some relationships would span more miles than others. In the first year, contractors were required to show proof of their mentor/mentee relationships through monthly reporting of their encounters and by tracking relevant activities such as on-site trainings, case review assists, and other educational opportunities via telemedicine or other avenues.

In the second year, the same relationships and reporting requirements continued. In addition, contractors were required to subcontract with their mentee site in the amount of $25,000 during the second year to further develop, support, and improve services at those facilities.

**Services**

The primary support child abuse specialists provide is appropriate assessment, diagnosis and treatment of child abuse and neglect. Providing a link to experienced medical professionals trained in assessing, diagnosing, and treating the injuries associated with child abuse and neglect allows for earlier and more accurate diagnoses. Timely assessments and accessibility to medical child abuse experts is beneficial in determining patterns of abuse, dismissing cases in the early stages of a CPS investigation where abuse is no longer suspected and can also help identify severe cases that require additional safety interventions to prevent further abuse and neglect, and potentially death. Early identification also reduces the costs associated with health care (short and long-term), investigations, legal proceedings, and within the foster care system.

Medical services cover comprehensive medical evaluations in an inpatient or outpatient setting and access to an array of subspecialties such as radiology, toxicology, neurology, trauma care, and burn care. Depending on the type of maltreatment, a child could require access to specialized equipment and/or the care or additional specialized medical professionals. These facilities are equipped to handle such cases and have relationships in place, or sometimes staff on-site, to ensure the child receives the full spectrum of care needed.

Some sites are working toward incorporating mental health services (beyond referrals) into their clinics and most also provide domestic violence and drug and alcohol screening and referrals. A number of sites have the capacity now to provide follow-up care for weeks or months after the child is first seen or provide additional services to families dealing with specific issues, such as failure to thrive. The clinics also provide forensic information through the use of
photodocumentation.

Commonly provided by the forensic nurse examiner (FNE), photodocumentation of children believed to have been abused or neglected can provide additional information on visible injuries. Photographs can assist in a case decision as well as provide the materials needed for a secondary physician review when a face-to-face meeting between doctor and patient is not possible.

In addition to providing direct services, these highly trained professionals also provide education and training to those who work on the front lines with children at risk (such as law enforcement, case workers, members of the judiciary) as well as other members of the public (parents, teachers, students, medical professionals). Information is regularly provided regarding how to identify various types of abuse, reporting requirements, how/where to make referrals, abusive head trauma, photodocumentation, as well as many other topics.

For medical professionals in particular, training sessions that help them differentiate between abuse/neglect and a medical condition are especially helpful. This decreases the likelihood that children are erroneously removed from the home or prohibited from seeing an established caregiver due to suspected abuse. Common prevention trainings and seminars for parents and caregivers include topics like identifying crying patterns in newborns and soothing techniques. Physicians are commonly seen as non-threatening and highly respected authority figures to many families and can prove to be invaluable in providing the tools to prevent child abuse and neglect.

Pediatricians with expertise in the area of child maltreatment also provide case reviews. The one-hour review includes input from physicians, CPS investigators, supervisors and a CPS risk manager. This multidisciplinary approach leads to a better understanding of the severity and timing of the injury and identified risk factors. The additional information helps inform CPS investigators of who should and should not have contact with the child.

**Clients**

Estimates from various studies suggest that approximately 20 percent of children in the U.S. will be victims of child abuse during their lifetime.² However, due to various reasons – including the failure to report suspected abuse – the exact prevalence is unknown. The Texas Department of Family and Protective Services (DFPS), reported 65,948 confirmed victims of child abuse or neglect in FY2011.⁴ Parents were responsible for nearly 98 percent of these cases.⁴ Child fatalities from abuse occur in Texas at a rate of 3.22 deaths per 100,000, the third highest in the nation (FFY 2010).³ Of those deaths, children under one accounted for 34.2 percent of the deaths and children younger than age four accounted for 80.1 percent (FY 2011).⁶

As shown in Table 1, 297,971 children in Texas were suspected of being a victim of child abuse or neglect reported to the DFPS in FY 2011. Of those, 22.1 percent (65,948) were confirmed victims. The percent confirmed differed by Region, ranging from a low of 16.7 percent in Region 6 to a high of 29.0 percent in Region 1 (see map of regions in Appendix B).
<table>
<thead>
<tr>
<th>Region</th>
<th>Alleged Victims</th>
<th>Confirmed Victims</th>
<th>Unconfirmed Victims</th>
<th>Percent Confirmed</th>
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<td>3,923</td>
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<td>29.0%</td>
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<tr>
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<td>2,537</td>
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<td>16.7%</td>
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<td>Region 9</td>
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<td>2,141</td>
<td>6,523</td>
<td>24.7%</td>
</tr>
<tr>
<td>Region 10</td>
<td>9,246</td>
<td>2,487</td>
<td>6,759</td>
<td>26.9%</td>
</tr>
<tr>
<td>Region 11</td>
<td>35,284</td>
<td>8,934</td>
<td>26,349</td>
<td>25.3%</td>
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<tr>
<td>Out of State</td>
<td>54</td>
<td>13</td>
<td>41</td>
<td>24.1%</td>
</tr>
</tbody>
</table>

Figure 1 illustrates that the rate of confirmed child abuse or neglect victims ranged from a low of 6.9 per 1,000 children in FY 1999 to a high of 11.1 in FY 2007. Since 2007, rates declined in successive years to 9.9 in 2011.

![Confirmed Child Abuse/Neglect Victims by Fiscal Year](image)

Rates are per 1,000 children ages 0-17 years.
2011 Population Source: Population Estimates and Projections Program, Texas State Data Center, Office of the State Demographer, Institute for Demographic and Socioeconomic Research, the University of Texas at San Antonio.

Table 2 describes child abuse or neglect by age group, gender, and race/ethnicity in FY2011 for children 0-17 years old. Infants (<1 year of age) had the highest rate of abuse or neglect (24.4 cases per 1,000 population), followed by children 1-3 years of age (13.6 cases per 1,000 population). Rates decreased with age. Infants had a rate nearly five times that of children 13-17 years of age. Children less than four years of age accounted for nearly 40 percent of all confirmed cases.

Females (10.4 cases per 1,000 population) had a higher rate of confirmed abuse/neglect than males (9.3 cases per 1,000 population), accounting for 51.7 percent of all cases reported.

Although Hispanics accounted for the largest proportion (45.1 percent) of confirmed abuse or neglect cases reported, African Americans had the highest rate (16.7 cases per 1,000 population) among races/ethnicities examined. The rate of child abuse and neglect for African American children was twice that of White children (8.3 cases per 1,000 population).
Table 2
Confirmed Child Abuse/Neglect Victims by Gender, Race/Ethnicity and Age (FY2011)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Total</th>
<th>Percent</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texas</td>
<td>65,948</td>
<td>100.0%</td>
<td>9.9</td>
</tr>
<tr>
<td>Age Group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;1 Year</td>
<td>9,987</td>
<td>15.1%</td>
<td>24.4</td>
</tr>
<tr>
<td>1-3 Years</td>
<td>16,355</td>
<td>24.8%</td>
<td>13.6</td>
</tr>
<tr>
<td>4-6 Years</td>
<td>13,386</td>
<td>20.3%</td>
<td>11.4</td>
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<td>7-9 Years</td>
<td>9,920</td>
<td>15.0%</td>
<td>8.9</td>
</tr>
<tr>
<td>10-12 Years</td>
<td>7,653</td>
<td>11.6%</td>
<td>7.4</td>
</tr>
<tr>
<td>13-17 Years</td>
<td>8,626</td>
<td>13.1%</td>
<td>5.0</td>
</tr>
<tr>
<td>Unknown</td>
<td>21</td>
<td>0.0%</td>
<td>--</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>34,078</td>
<td>51.7%</td>
<td>10.4</td>
</tr>
<tr>
<td>Male</td>
<td>31,730</td>
<td>48.1%</td>
<td>9.3</td>
</tr>
<tr>
<td>Unknown</td>
<td>140</td>
<td>0.2%</td>
<td>--</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>20,167</td>
<td>30.6%</td>
<td>8.3</td>
</tr>
<tr>
<td>African American</td>
<td>13,470</td>
<td>20.4%</td>
<td>16.7</td>
</tr>
<tr>
<td>Hispanic</td>
<td>29,761</td>
<td>45.1%</td>
<td>9.3</td>
</tr>
<tr>
<td>Other</td>
<td>2,550</td>
<td>3.9%</td>
<td>10.1</td>
</tr>
</tbody>
</table>


Rates are per 1,000 children ages 0-17 years. 2011 Population Source: Population Estimates and Projections Program, Texas State Data Center, Office of the State Demographer, Institute for Demographic and Socioeconomic Research, The University of Texas at San Antonio.7

Contractors and Mentoring Sites

Each of the contracted facilities partnered with other hospitals to provide mentoring services and help each facility increase their capacity to assess, diagnose and treat child abuse and neglect. Providers at mentoring sites had access to expanded training opportunities through providers with a wide range of targeted expertise in the field. The mentoring sites that the eight contractors partnered with are located in the following Texas cities/locations:
<table>
<thead>
<tr>
<th>Contractor</th>
<th>Mentee Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s Medical Center of Dallas</td>
<td>Tyler</td>
</tr>
<tr>
<td>CHRISTUS Santa Rosa Health Care Corporation – Center for Miracles in San Antonio</td>
<td>El Paso, Kerrville</td>
</tr>
<tr>
<td>Cook Children’s Medical Center in Fort Worth</td>
<td>Abilene</td>
</tr>
<tr>
<td>Dell Children’s Medical Center of Central Texas in Austin</td>
<td>Waco</td>
</tr>
<tr>
<td>Driscoll Children’s Hospital in Corpus Christi</td>
<td>Harlingen</td>
</tr>
<tr>
<td>Scott &amp; White Memorial Hospital in Temple</td>
<td>Fort Hood, Killeen</td>
</tr>
<tr>
<td>Texas Children’s Hospital in Houston</td>
<td>Beaumont</td>
</tr>
<tr>
<td>University of Texas Health Science Center at Houston</td>
<td>Galveston, Lubbock</td>
</tr>
</tbody>
</table>

Each MEDCARES site is involved in several activities to fulfill the requirements of the program. A summary of each site’s structure, program objectives and supported activities and major outcomes is described in Appendix A in more detail. A map showing the locations of the sites is included in Appendix B.

**SUMMARY**

**Contractor Activities and Accomplishments**

During the first two years of the MEDCARES grant program, contractors have worked successfully to improve the assessment, diagnosis, and treatment of child abuse and neglect by expanding services within their own facilities to those directly affected by child abuse and neglect, providing education and training to medical professionals and nonprofessionals, and developing and supporting regional initiatives through mentorships. The hiring of additional child abuse medical specialists has allowed for expanded clinical hours, increased capacity during clinic hours, and even the development of new clinics.

In addition, funds have provided for increased training opportunities for staff within the clinics and for hospital staff who coordinate with the clinic, resulting in increased awareness in assessment and subsequent reporting and referral. Community training opportunities have expanded as well, allowing for prevention information on various topics to be provided directly to parents, providers, caseworkers, and law enforcement personnel, who frequently work with families at high risk. Prevention materials cover a wide range of topics, including child safety, infant care, and Period of PURPLE Crying (POPC). Trainings have also covered such topics as recognizing and reporting abuse, abusive head trauma, injury biomechanics, conditions that mimic abuse, and the importance of family history, among many others.

The opportunity to mentor basic level sites has allowed the contractors to focus their attention on developing regional initiatives, which is one of the core goals of MEDCARES. Because there are
only 16 board-certified child abuse pediatricians in Texas\(^1\), it is imperative that the basic level sites, with some capacity to serve children and families in need, are supported by these specialists so children across the state can be served with the highest quality of care. With advances in telemedicine, support can be provided to the mentee sites via phone and video connections on a more regular basis than would be allowed by face-to-face interactions.

Contractors provide support to their sites via case reviews, on-site consultations, equipment and photodocumentation trainings, assistance with difficult cases, and sometimes through mini-fellowships. Mentee sites have been able to purchase some equipment that has allowed them to expand services to clients in more remote areas of the state and attend statewide and national trainings to improve their knowledge base related to child maltreatment. Building these sites also brings awareness and encourages interest in child abuse fellowships and recruitment of other board-certified physicians to the state.

Other notable activities achieved through MEDCARES funding include:

- Increasing the knowledge of community partners through education and training on assessment and treatment of maltreated children.
- Expanding current prevention programs by training community partners on evidence-based interventions.
- Increasing cooperation with CPS, law enforcement, and the judiciary through consultations, medical case review, and by providing testimony in court.
- Improving research capabilities by adding relevant data elements to current registries, creating new registries specifically designed for child maltreatment and neglect and by creating data workgroups to advise facilities on data collection, research, and data analyses.

**MEDCARES-Specific Data**

Table 3 shows the number of inpatient consultations and outpatient exams across all eight of the MEDCARES sites. These data were collected on a monthly basis from each site and inpatient consultations are separated out by final determination made by the lead physician. While the majority of patients seen in the MEDCARES sites are seen in an outpatient setting, a significant number of children must be admitted to the hospital due to their injuries. Among those admitted, more than half (53.1 percent) had injuries caused by abuse or neglect.
Table 3
Inpatient Consultations and Outpatient Exams
March 2011-May 2012

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of inpatient consultations (not including ER)</td>
<td>1,777</td>
<td>100%</td>
</tr>
<tr>
<td>No allegation of abuse</td>
<td>104</td>
<td>5.9%</td>
</tr>
<tr>
<td>Unable to determine due to case characteristics</td>
<td>240</td>
<td>13.5%</td>
</tr>
<tr>
<td>Accidental explanation likely</td>
<td>342</td>
<td>19.2%</td>
</tr>
<tr>
<td>Unable to determine due to insufficient information</td>
<td>147</td>
<td>8.3%</td>
</tr>
<tr>
<td>Definite or probable cause</td>
<td>944</td>
<td>53.1%</td>
</tr>
<tr>
<td>Number of outpatient exams (includes ER)</td>
<td>12,636</td>
<td></td>
</tr>
</tbody>
</table>

Table 4 shows further breakdown of the type of abuse seen among those 53.1 percent of children admitted to the hospital for abuse-related injuries. MEDCARES contractors provided services primarily to children who were the victims of physical abuse (61.3 percent) and neglect (35.3 percent).

Table 4
Definite or Probable Abuse Consultations by Type of Abuse
March 2011-May 2012

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient consultations of definite or probable cause</td>
<td>944</td>
<td>100.0%</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>579</td>
<td>61.3%</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>32</td>
<td>3.4%</td>
</tr>
<tr>
<td>Neglect/other</td>
<td>333</td>
<td>35.3%</td>
</tr>
</tbody>
</table>

MEDCARES sites provided support above and beyond direct services to children requiring medical attention. A substantial amount of physician and staff hours are spent providing case reviews, training, and support to the judicial process. Table 5 shows the numbers and hours of support provided by type.
Table 5
Additional Support Provided
March 2011-May 2012

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of case reviews provided</td>
<td>3,559</td>
</tr>
<tr>
<td>Number of staff hours spent providing education/training</td>
<td>1,943</td>
</tr>
<tr>
<td>Number of court appearances</td>
<td></td>
</tr>
<tr>
<td>Civil</td>
<td>182</td>
</tr>
<tr>
<td>Criminal</td>
<td>393</td>
</tr>
</tbody>
</table>

**Contractor Challenges**

MEDCARES contractors report primary challenges in the areas of funding, shortages in specialized medical staff, and providing education and outreach to expand services and expertise throughout the state. These areas are all interrelated and help to point out the dichotomy exposed as the awareness and need for services grows and the expertise in the field and funding to support such programs remains limited.

While MEDCARES funds help supplement many salaries at contractors’ sites, they report a significant lack of financial resources to support clinic staff, especially physicians. Limited funding has also prevented sites from hiring additional staff to provide much needed community education and outreach. Positions, such as nurse educators, play a critical role in starting evidence-based shaken baby prevention programs in local newborn nurseries, for example. To ensure coverage of additional needed training and skills, existing staff have been trained and taken on new job duties, and staff schedules have been rearranged accordingly.

With the increased number of services and patients served, space is at a premium. Contractors reported refurbishing existing and small spaces to meet their needs, but report that some space is still suboptimal. Most contract sites receive additional funds to support services in their clinics; however, those funds are limited and sites report programs at risk of being ended due to a reduction or discontinuation of funding.

As patient volume has increased and the patient mix has changed to include more adolescents, the number of patients with acute medical and mental-health needs has also increased. This has put a greater burden on providers, particularly social workers and psychotherapists. The pool of available qualified child abuse physicians is very small, and will remain so until more fellows are trained across the country. There are also insufficient specialized staff to fill the void in the more remote areas of the state. The basic level sites and sites with even fewer resources must either rely on physicians or nursing staff without specialized training or work to develop a relationship with one of the few sites around the state who have the capacity to take on a referral. The addition of fellowship programs will contribute to the national effort to train more child abuse
pediatricians and may be one way to develop more specialists, who may have an incentive to practice in these areas of scarcity.

Providing education and outreach to expand services and expertise throughout the state has been challenging due to the difficulty of getting buy-in from the local doctors at mentee sites. It is important to find a physician champion for child abuse and neglect, and to find one available to spearhead the development of a child abuse program proved to be difficult. Some contractors reported difficulty in getting initial commitment because of the uncertainty of long-term funding and trouble changing mindsets and work ethics that are believed to be effective, even though this is incongruous with information provided by investigators and law enforcement. In addition, telemedicine services proved to be a challenge in that it is still very new technology and is a service that not many health care staff and providers have embraced.

With regard to outreach to the community, due to ongoing turnover in CPS, law enforcement, and even among health providers (e.g., school nurses and emergency physicians), outreach must be a continuing activity; the need to plan for and carry out such activities does not diminish over time.

CONCLUSION

The MEDCARES program provided funds to eight primary contractors during the first two years of the program (June 1, 2010 through May 31, 2012). A small sub-award was given to mentee sites during the second year. The activities reported by the eight MEDCARES contractors demonstrate the benefits of the MEDCARES program and funding.

In the short time the MEDCARES program has existed, contractors have been able to accomplish the following:

- Expand direct services to patients and their families,
- Provide thousands of hours of outreach and support to other medical professionals, case workers, law enforcement, the judiciary, and nonprofessionals;
- Mentor basic level sites to help improve and expand services in more rural areas; and
- Explore research opportunities to improve this highly specialized field.
RESOURCES


6. Data obtained from personal communication with CPS Disproportionality Specialist, Texas Department of Family and Protective Services. Data retrieved at 9:11am on 9/25/12.

The Department of State Health Services (DSHS) awarded grants to eight contractors in 2010 to implement the Texas Medical Child Abuse Resources and Education System (MEDCARES), as directed by the 81st Legislature, Regular Session, 2009 (Chapter 1001, Subchapter F, Texas Health and Safety Code). The purpose of the grant program is to help develop and support regional initiatives to improve the assessment, diagnosis, and treatment of child abuse and neglect. Activities carried out during the first funding period, June 1, 2010, to May 31, 2012, are summarized in aggregate in the main body of the report. This appendix provides an overview of the structure, program objectives, grant-supported activities, and major outcomes for individual MEDCARES contractors based on self-reported information.

CHILDREN’S MEDICAL CENTER DALLAS

The Referral and Evaluation of At-Risk Children (REACH) program at Children’s Medical Center (CMC) was established in the early 1980s with the mission to provide comprehensive interdisciplinary evaluation, medical care, and support services for maltreated children and those in substitute care. The programs are aimed at ensuring that all vulnerable and victimized children receive the care they need at each stage, from initial evaluation to establishing a medical home. The program’s clinical services include the evaluation of children who are suspected victims of maltreatment, providing comprehensive assessment, medical care, psychosocial support, and a health care home for children in substitute care.

The REACH program provides a strong voice for victimized children by documenting medical concerns, providing testimony in court proceedings, and working closely with law enforcement and Child Protective Services to promote child health and well-being and access to needed services. REACH provides medical care for more than 2,000 children each year. Staff include: one board-certified child abuse pediatrician, two general pediatrics/child abuse pediatrics fellows, two child psychologists, three social workers, one registered nurse, three program coordinators, one medical assistant, and one child life specialist.

Grant Objectives and Supported Activities

1. Establish a clinic to treat patients with Failure to Thrive (FTT), a diagnosis frequently associated with neglect at home and/or poor bonding between patient and primary caregiver.
The creation of an FTT Clinic has served as a resource for hospital physicians and child protective services agencies by providing on-going, close medical follow-up and access to multispecialty services in one location. The clinic is staffed by a child abuse pediatrician, registered nurse, clinical social workers, dietician, child psychologist and therapy service staff as needed.

The clinic staff might follow a child/family for several weeks to ensure improved or appropriate weight gain. There are also circumstances in which the clinic regularly follows a case more closely when there remains an on-going concern of neglect, in order to provide additional support and guidance for these families. The nurse coordinates this clinic and is the reason for the program’s success. The program evaluates six to ten children each week for failure to thrive.

The following is an example of one of the many FTT clinic success stories:
A 15-month-old was hospitalized at CMC for failure to thrive. She had been followed by her primary care provider for nine months with poor weight gain without any additional interventions. After hospitalization, she was seen weekly in the clinic. Due to continued noncompliance with medical needs, the child was placed with a relative for six weeks. During this time, she began gaining weight appropriately and upon return to her parents care continued to gain weight. The visits were sometimes challenging due to parental frustration, but overall the outcome has been great with a child now physically and developmentally thriving.

2. Create a nurse case management system to coordinate services for suspected victims of child abuse who are identified within the hospital setting.

Children who have required hospitalization for abusive injuries are initially placed in foster care or with a relative. They can change homes and providers frequently during the most important period in their recovery from injuries. A registered nurse (RN) position was developed to ensure abused children have appropriate medical follow-up with the REACH program and help families access the other subspecialty services needed. The addition of this nurse has increased follow-up appointment compliance by more than 50 percent and is another tool used to ensure the young victims receive all the medical services and care they need.

Described here is one of many examples confirming the benefit of this new system:
A 22-month-old sustained a devastating traumatic brain injury (TBI) while in the care of his mother’s boyfriend. He was discharged into the care of his paternal family with multiple special needs. The REACH RN assisted the family in locating a local home health agency, getting a helmet to protect his head from further injury, and coordinating his numerous appointments (they live several hours from Dallas).

The nurse has provided case management and support services to help improve the outcome for this family. Based on the RN’s assessment of the common issues identified in TBI patients, the program initiated a head trauma support group to further assist families similarly affected. The support group is becoming synergistic and is developing plans to get the word out about the devastating effects of abusive head trauma in an effort to reduce the associated risks.
3. Provide psychological assessments and intervention programs aimed at improving the recovery of maltreated children.

Two staff psychologists assist in the medical and psychosocial evaluation of outpatient and inpatient REACH patients. From acute crisis intervention (suicidality, acute stress) to long-term behavioral issues, the psychologists are able to help the families create a framework of support for these children.

The following is a case example of how psychologists can assist in the recovery process:

A 3-year-old was hospitalized for 17 days with bruises, a head injury, and abdominal injuries. The REACH psychologists worked with him and his relatives in the hospital to help him understand the recovery process and help the family address the behavioral and emotional issues that were identified after the trauma. The psychologists continued to provide support and guidance to the family after hospital discharge until he was able to have a dedicated therapist. He has made a remarkable recovery from the abuse. The REACH psychologists provided much needed immediate guidance and support to the family during the acute phase of his illness.

4. Expand basic child abuse training in North Texas by establishing mentoring relationship with Trinity Mother Francis Hospital.

Trinity Mother Francis (TMF) Hospital in Tyler is the basic child abuse program that Dallas has mentored. The program has provided sexual abuse and physical abuse medical evaluations in the community. The mentorship of the REACH team has given the TMF providers increased access to educational programs and consultative services.

By partnering with TMF Hospital, the REACH clinic aims to serve as a clinical resource for complicated cases and provide on-going educational and peer review opportunities. The hospital commonly refers inflicted physical injuries cases to CMC’s trauma center and the two facilities commonly share a patient population. CMC is hopeful that the partnership will improve medical evaluations and child abuse assessments for victims in East Texas.

Education and Collaboration

REACH emphasizes educational programs. Staff train medical students from the University of Texas Southwestern Medical School on a weekly basis, educate pediatric residents during required and elective rotations with the child abuse program and provide clinical training to Pediatric Emergency Medicine fellows. The REACH Program puts on a monthly multidisciplinary lecture series, known as Child Abuse Grand Rounds, regularly attended by medical staff, Child Protective Services (CPS) workers, law enforcement personnel, Court Appointed Special Advocates (CASA), law students from Southern Methodist University and community physicians.

The program provides continuing nursing education (CNE) and continuing medical education (CME) units for attendees. REACH members present at local, regional and national conferences related to child abuse. In addition, REACH members help plan and participate in the annual Crimes Against Children (CAC) conference sponsored by the Dallas CAC. The REACH
Appendix A

program is developing a subspecialty fellowship training program in child abuse pediatrics and is currently training second- and third-year fellows.

CMC Dallas has a multidisciplinary child abuse prevention committee created to design hospital- and community-based education programs geared toward secondary and tertiary child abuse prevention efforts. CMC also has representatives on the board of directors of the CACs in Dallas and Collin County, the leaders in child abuse prevention in their respective communities.

The REACH Program is well-integrated into the Dallas County Child Protection system by participating as an active partner at the Dallas CAC, working with the local CPS agencies regularly, providing training and case reviews with local law enforcement agencies, and participating in twice weekly case reviews at the Dallas CAC. The team is also involved with the CAC of Collin County and CPS agencies throughout North Texas.

REACH collaborates with law enforcement agencies, local District Attorney’s offices, and CASA to ensure the best efforts are made to protect and seek justice for victimized children. The program is an active participant in the trauma program and emergency department morbidity and mortality conferences, which critically review all cases of child abuse with an untoward event or child death to ensure quality medical practices are utilized.

Outcomes Summary

MEDCARES has allowed the program to expand services by having dedicated staff psychologists working with the patients in clinic and hospital settings. In clinic, the psychologists have proven an invaluable tool for screening for acute mental health crises that these patients commonly encounter – suicidality, feelings of hopelessness, and poor self-image. The psychologists have also been able to work with physical abuse victim’s families to educate and provide the families with tools to help the young child victims recover from the traumatic experiences.

MEDCARES has also enabled CMC to utilize the skills of a dedicated nurse to run the FTT clinic and ensure follow-up visits for hospitalized children. The nurse has been able to ease the problems commonly encountered as children transition from hospital setting to foster care setting and then from foster home placement to family placement. The close contact with the families and the daily tracking has led to improved clinical outcomes and helped strengthen the clinical relationship with the families. Overall, the clinical additions to the team have been invaluable in CMC’s efforts to provide comprehensive and effective multidisciplinary care to the victimized children of the community.

CHRISTUS SANTA ROSA HEALTH CARE CORPORATION

CHRISTUS Santa Rosa Children’s Hospital Center for Miracles (CFM) is a multidisciplinary clinical facility established six years ago to provide comprehensive evaluation and treatment of suspected victims of child abuse and neglect. CFM’s mission is to promote the health and safety of children who are at risk for, or traumatized by, abuse or neglect. CFM opened in May 2006 in
response to the community’s need for a comprehensive, coordinated, medical assessment of possible abuse and neglect of children.

CFM works closely with CPS and other local agencies to optimize the services at-risk families need to keep their children safe and healthy. Comprehensive services include acute and follow-up medical evaluations for physical abuse, sexual abuse or assault, and neglect, including photo-documentation, X-rays and lab work, psychosocial evaluation, physician consultations, inpatient consultations, and short-term counseling. CFM provides services within a 30-county area, with the majority of referrals from Bexar County. CFM has served 11,282 children from May 2006 through May 2012.

CFM staff include: two board-certified child abuse pediatricians, one pediatric nurse practitioner, one sexual assault nurse examiner (SANE), two social workers, one program coordinator, one division administrator, one community liaison/prevention specialist, one receptionist, and one medical assistant.

**Grant Objectives and Supported Activities**

1. **Increase the number of qualified child abuse pediatricians at CFM from two to three.**

Since opening in 2006, CFM has experienced steady increases in all aspects of clinical activity: outpatient exams, hospital consultations, and case review consultations. In addition, a goal of CFM from the beginning was to host Texas’ first accredited Child Abuse Pediatrics Fellowship. MEDCARES funding has provided up to 40 percent of the financial support needed to secure a third faculty position to meet the center’s growing needs.

2. **Supplement or replace expiring current funding to ensure continuity of services.**

CFM was established with funding provided by a local philanthropic foundation. That funding ended in early 2010, and the MEDCARES grant allowed the center to continue providing its clinical services, particularly its direct services to abused and neglected children. MEDCARES funding also allowed CFM to add new services, including weekly case reviews with the San Antonio Police Department child crimes detectives and quarterly case reviews with the Methodist Children’s Hospital child abuse response team.

3. **Improve and expand CFM clinical services, specifically medical sexual abuse services.**

Prior to 2012, medical services for maltreated children were divided between ChildSafe (the Bexar County Child Advocacy Center, which focused on sexually abused children) and CFM (which focused on physical abuse and neglect). In January 2012, negotiations began to consolidate all medical services for abused children at CFM. In March 2012, the transfer was completed. Now, all children who require medical examination or treatment for abuse are seen in one facility centrally located in the city. Here they are offered a greater depth of provider availability and ancillary services (e.g., laboratory availability and proximity to the hospital emergency department).
4. Utilize outreach methodology to enhance awareness of CFM services in the local medical community and increase referrals from hospitals, medical professionals, Child Advocacy Centers (CACs), SANE programs, and community service agencies.

CFM initiated a concerted effort to contact medical professionals and community agencies in order to impact the lives of more abused children in the region. Utilizing methods with proven effectiveness in promoting child abuse awareness among professionals, CFM faculty and staff visited and/or gave presentations to several clinical departments at the University of Texas Health Science Center in San Antonio, the local pediatric society, the area bar association, other area hospitals, and numerous individual physicians. To expand its referral base, CMF hosted several collaborative meetings with community organizations such as foster agencies, Boysville, Sunshine Foundation, and other service agencies.

5. Identify a basic or other child abuse medical program and offer mentoring and educational interventions.

Dr. Nancy Kellogg, director of CFM, has had a longstanding mentoring relationship with the Sexual Assault Nurse Examiner program at Peterson Regional Memorial Hospital in Kerrville. Through the MEDCARES program, CMF faculty have offered guidance, mentoring, and peer review support to the hospital’s established Sexual Assault Nurse Examiner program as it expands into a Forensic Nurse Examiner program serving physical abuse victims as well as sexual assault victims.

Dr. Kellogg serves as the medical consultant to Peterson Regional Memorial Hospital’s Forensic Nurse Examiner program. She reviews all child examinations performed by the FNEs. CFM child abuse pediatricians also provide regular in-services to the FNE staff and the Kerrville area’s child abuse Multidisciplinary Team.

Education and Collaboration

CFM houses the oldest postgraduate fellowship in child abuse pediatrics in Texas. CFM also provides regular educational experiences to pediatric and family medicine residents, medical students, and learners in other health care professions; frequent seminars and workshops to medical, law enforcement, CPS, and other professionals; and presentations to community organizations. In addition, all cases with active or ongoing CFM involvement are peer-reviewed by CFM professional staff each week.

CFM staff actively participate as board or committee members in numerous community organizations devoted to child abuse prevention and collaborate with area child abuse investigators and treatment providers, including CPS, local law enforcement agencies (especially the San Antonio Police Department and Bexar County Sheriff’s Office), ChildSafe, the Bexar County Child Fatality Review Team (CFRT), and many other agencies.

Professional staff have developed several important child abuse prevention materials, including a video for new parents (in English and Spanish), a citywide poster campaign with anger management strategies and hotline numbers, and a website for professionals and for parents with
resources on child abuse prevention. CFM also provides two face-to-face consultation sessions for case review with Region 8 CPS investigators and supervisors each week and one face-to-face consultation session with San Antonio Police Department child-crimes detectives. The reviews with CPS are known as Serious Abuse/Neglect Staffings and have become integral to the DFPS Region 8 risk management process (resulting in changes to service plans in 25 percent of cases).

**Outcomes / Summary**

MEDCARES funding is now CFM’s chief source of funding, in place of philanthropic funding that has expired. Without MEDCARES funding, CFM’s service offerings would have undergone substantial reduction by the end of 2010.

MEDCARES funding has allowed CFM to considerably expand its service offerings: most notably providing additional funding to help secure a third child abuse pediatrician and allowing the weekly staffings with San Antonio Police Department child-crimes detectives and the transfer of medical services formerly performed at the area CAC to CFM.

Following is an example of the impact CMF’s MEDCARES-funded program has had: On one of the first days CMF’s new sexual abuse service was operating, a 14-year-old girl and her mother walked in without an appointment for an examination. The girl had been sexually assaulted by stranger two months earlier, and she revealed detailed plans to kill herself. After a crisis mental health assessment, CFM professionals escorted her to the CHRISTUS Santa Rosa Children’s Hospital Emergency Department, where she was admitted for psychiatric treatment.

With MEDCARES funding, extensive outreach efforts to area physicians, hospitals, and organizations have taken place. Regular meetings with the CARE child abuse response team at Methodist Children’s Hospital, an unaffiliated facility in San Antonio, are also held as a result of MEDCARES support. Children referred to CFM as a result of these efforts include: an infant referred by a children’s dentist who noticed a torn oral frenulum (the infant also had four fractures when a skeletal survey was obtained, and due to the serious nature of the injuries he was emergently removed into CPS custody); a 14-year-old boy with strange skin markings (the parents were convinced he was engaged in inappropriate sexual activity but CFM physicians referred him to a genetics specialist, where he was confirmed to have a hereditary skin disease); and a 2-year-old girl referred by her physician for suspected genital warts who was diagnosed with a skin condition not related to abuse.

**COOK CHILDREN’S MEDICAL CENTER**

Cook Children's Medical Center created the Child Advocacy Resource and Evaluation (CARE) Team in 1994 in response to a community need for a place to conduct a comprehensive evaluation of child abuse victims. Located in a child-friendly environment within Cook Children's Medical Center, the CARE Team helps abuse victims early on through treatment and counseling.
The CARE team’s mission is to provide specialized clinical care to address child maltreatment in the Fort Worth area and surrounding communities. It strives to be nationally known for how community-wide child maltreatment health services are delivered. Highly qualified and experienced staff conduct medical interviews, medical and forensic evaluations, sexual abuse screening examinations, psychological assessments, preventive education, and multidisciplinary reviews.

In 2004, the CARE Team began seeing only the most severely injured of the abused children – those who had been admitted to the pediatric intensive care unit. The team’s efforts gradually expanded to offering consultative services to all inpatients. In 2008, staff offered outpatient physical abuse evaluations on a limited basis and have been gradually increasing the inpatient and outpatient services as personnel and space allows. In 1994, there were 368 patient visits. This number escalated to 1,434 in 2011.

The Cook Children’s CARE Team includes: one board-certified child abuse pediatrician (medical director), one staff child abuse pediatrician, two pediatric nurse practitioners, three sexual assault nurse examiners, one medical assistant, one licensed clinical social worker, one bachelor’s level social worker, one office manager, and one CPS liaison.

Grant Objectives and Supported Activities

1. Expand the number of abused children treated by the program by adding staff and expanding hours of service.

There has been a steady increase in visits from 1,246 in 2009 to 1,434 in 2011. Sexual abuse clinic appointments are now available until 8 p.m. on weekdays. A second child abuse pediatrician was hired in July 2010, allowing for an increase in patients served.

2. Add the evidence-based prevention program Period of Purple Crying (POPC) for area hospitals and primary care offices.

A bachelor’s level social worker was added to the team as a result of the grant. She provides POPC education to community agencies and parents. A SANE and pediatric nurse practitioner provide additional POPC education for medical offices and hospitals.

3. Partner with a basic mentoring program in Abilene and improve medical evaluation of children in outlying areas.

The SANEs at Hendrick Medical Center provide photodocumentation on cases and review possible abuse cases seen in the emergency department there, as well as follow up on patients to assure adequate evaluation. These cases were discussed on a quarterly and as-needed basis with Dr. Jayme Coffman, CARE Team medical director. The SANEs were sent to two national and one state conference to improve child abuse assessments and photodocumentation. Camera equipment was purchased for the Hendrick Medical Center SANE program. Because of the relationship between the CARE Team and the SANE program at Hendrick Hospital, a SANE
was able to call Dr. Coffman from court prior to testifying with specific photodocumentation questions and child injuries.

4. The physicians and nurse practitioners will provide education and awareness to medical personnel as well as partner agencies.

The CARE Team has provided more than 300 hours of education to medical and community agencies in the past year. Lectures are routinely given at University of Texas in Arlington’s Pediatric Nurse Practitioner and Registered Nurse programs, at University of North Texas Health Science Center for medical students, and at John Peter Smith Hospital Family Practice Residency Program. The physician and nurse practitioner provide trainings for law enforcement and child protective services throughout the region’s CACs.

5. Improve prevention efforts by expanding outreach.

A CARE Team staff member attends all multidisciplinary meetings at partner and outlying CACs, such as Eastland and Stephens counties via conference call, providing almost 90 hours of service in the past six months. This casts a safety net to ensure appropriate and thorough evaluations were completed for cases investigated by area CACs.

Education and Collaboration

The CARE Team provides education via grand rounds, state and national meetings, and at statewide trainings for CPS, law enforcement, medical professionals and others. The CPS/law enforcement trainings are part of the “Advanced Techniques in Joint Child Abuse Investigations,” organized by the local Shaken Baby Alliance. Classes are taught at the University of Texas at Arlington for undergraduate nurses and master’s level nurse practitioners and at the University of North Texas Health Science Center for master’s level physician’s assistants.

Additionally, CARE Team staff members have provided lectures for the Emergency Nurses Association and school nurses. Clinical training for SANEs is also provided. Fourth-year medical students from the Texas College of Osteopathic Medicine can spend an elective month with the CARE Team. Dr. Coffman has given lectures for family practice residents at John Peter Smith Hospital, at the Tarrant County Dental Society, local, state, and national medical conferences, and at state conferences for defense attorneys and the State Bar of Texas.

The CARE Team is involved in the Citizen Review Team, the Tarrant County Alliance for Drug Endangered Children, Teaming/Resource Net Project, and the Child Fatality Review Team (covering Tarrant, Parker, Denton, and Johnson counties). The Teaming/Resource Net Project’s purpose is to facilitate collaboration among community agencies that serve abused children and their families. Registered nurses facilitate the POPC abusive head trauma prevention program. Both social workers are trained as facilitators of Stewards of Children sexual abuse prevention training program, which educates adults to prevent, recognize, and react responsibly to child sexual abuse. The CARE Team is the medical component for nine CACs in the region. The CARE Team participates in all the multidisciplinary meetings for the CACs covering Tarrant,
Team staff members routinely collaborate with CPS investigators and law enforcement by providing affidavits and detailed explanations of the medical evaluation and diagnosis. The CARE Team physicians and nurse practitioners review abuse cases and photos electronically submitted by CPS staff. In addition, the physicians and nurse practitioners receive and respond to phone calls and e-mails from CPS, law enforcement, and prosecutors with medical questions about cases that may or may not involve Cook Children’s patients. All of these services are provided as a courtesy and the Team is not reimbursed.

**Outcomes / Summary**

A child abuse pediatrician and a bachelor’s level social worker were hired, allowing for more children to be seen, enhanced crisis management, and improved psychosocial assessments. Monthly multidisciplinary case reviews are occurring at a CAC in an area where no child abuse specialty services are available. The CARE Team has assisted the program in addressing problems and responding to the needs of the children, families and investigative agencies.

In addition, the CARE Team’s partnership with the basic program in Abilene is growing. Staff provided training to Hendrick Medical Center emergency room physicians and staff on the recognition of abuse and the need for a complete evaluation. MEDCARES has allowed the SANEs to attend national and state meetings to better educate them in the recognition and assessment of abuse, including photodocumentation. Dr. Coffman has visited with many of the pediatricians in Abilene to ensure they are aware of child abuse statistics and resources available.

In collaboration with Alliance for Children, two of the social workers have been trained in Stewards of Children sexual abuse prevention program. The CARE Team will also teach the POPC program for the prevention of abusive head trauma to area hospitals at an upcoming trauma conference, and have purchased materials for parents delivering at those hospitals. All of Cook Children’s Neighborhood clinics, many of the Cook Children’s primary care offices, Cook Children’s Northeast Hospital, Cook Children’s Medical Center NICU, emergency department, and inpatient units, and Texas Health Harris Methodist Hospital Southwest have received training in POPC and been provided DVDs for their new parents.

**DELL CHILDREN’S MEDICAL CENTER OF CENTRAL TEXAS**

Dell Children’s Medical Center of Central Texas is considered a center of excellence for Central Texas. It consists of a strong alliance of expert personnel, facilities, and other specialty resources dedicated to the care of children and adolescents within a 46-county referral region. The mission of the Child Abuse Resource and Education (CARE) Team at Dell Children’s Medical Center (DCMC) reflects a multifaceted approach to addressing child abuse.

The CARE Team strives to be a strong part of the community Child Protection Team; to provide comprehensive, evidence-based care to child abuse and neglect victims; to provide education and resources to the community and outlying health care associates and other members of the child
Appendix A

protection teams; and to analyze child abuse data for the purpose of contributing answers and best practice in the field. Dell Children’s believes that improving the quality of life and health of children requires the prudent application of resources, as well as the support of the Central Texas community.

The DCMC CARE Team includes: two certified child abuse pediatricians, one registered nurse/pediatric nurse practitioner, one dedicated pediatric social worker, and one dedicated coordinator/registered nurse.

Grant Objectives and Supported Activities

1. The CARE Team will increase volume and scope of services in the DCMC catchment area.

A pediatric nurse practitioner was hired in March 2011. She has assisted in increasing capacity for inpatient and outpatient child abuse consultations. Besides hiring additional provider staff, community education was done with local and regional CPS and law enforcement personnel in order to disseminate information about expanded services.

2. The CARE Team will expand educational outreach efforts to DCMC staff and other community and medical partners.

Educational events were held in Waco, including an all-day conference in October 2010. The conference provided basic child abuse education to 77 clinical staff from Providence Healthcare Network (PHN) in Waco. The topics included information about accidental versus inflicted injuries, radiologic findings, telemedicine, and the social worker’s role in child abuse. An evening conference was held for 15 Waco physicians in May 2011. The topics presented during the educational dinner meeting were telemedicine, forensic radiology, abusive head trauma, and case study review.

During Child Abuse Prevention Month in May 2012, a booth was set up at PHN and child abuse prevention materials were distributed in order to bring awareness to the issue. Additionally, CARE Program materials were made available to increase awareness of the service provided by DCMC. It was estimated that over 200 PHN staff visited the booth.

3. The CARE Team will provide a telemedicine linkage between DCMC and PHN as well as the Center for Child Protection (CCP).

DCMC coordinated delivery of a telemedicine cart to PHN in August 2010 and provided the emergency department a brief orientation on how to use the equipment. Complete education to physicians and guidelines for use is planned to continue during the next grant year. The CCP also received a telemedicine cart. There was some delay in creating a connection to DCMC because of networking difficulties. However, DCMC fully intends to continue the telemedicine project for the CCP until its projected completion date in July 2012.
4. The CARE Team will improve capacity for data collection and analysis.

DCMC formed a group that meets quarterly to discuss research and data regarding child abuse. A retrospective study of infants with rib fractures was approved by the institutional review board and is currently being conducted. The study compares whether or not the fractures were diagnosed using X-ray versus CT scan technology. Additionally, a database was completed in spring 2012 exclusively for child abuse cases. It is being beta tested and will act as a depository as well as a vehicle for data and analysis.

5. The CARE Team will partner with PHN as a mentor site.

In addition to educational events held in Waco, there were “child abuse champions” identified from PHN who received education and training from the CARE Team. There were three inpatient clinical champions identified: two registered nurses, one who manages the Pediatric Unit and one who is the nurse educator for the emergency department, and an inpatient social worker. DCMC sponsored these three champions to attend the Crimes Against Children Conference in August 2011.

In addition, one of the champions spent two days at DCMC with the CARE Team learning about the processes involved in recognizing, assessing and providing recommendations for children with suspected child abuse. She also attended a Travis County Child Protection Team meeting and a CARE Team multidisciplinary case review meeting. Three radiology technicians at PHN were invited to spend two days in November 2011 at DCMC with the pediatric radiology technicians to learn special techniques on getting quality radiographs in children.

Education and Collaboration

DCMC is a teaching facility for both residency and medical student education. Child abuse and neglect training is integrated into the curriculum for both. The UT Southwestern Austin Pediatrics Residency based at DCMC has 51 pediatric residents. It also provides required experiences to family practice, psychiatry, emergency medicine, and transitional residents. About 20-25 percent of all University of Texas Medical Branch third-year students have their required student clerkship at DCMC.

Through grand rounds, medical staff newsletters, seminars, and workshops, education is provided to community physicians, CPS, law enforcement, and others. DCMC, in collaboration with the Travis County Medical Examiner’s Office, developed a safe sleep flyer that is distributed to all new mothers in the Seton Healthcare Family system. DCMC sponsors the Injury Prevention Coalition and Safe Kids Project. The Injury Prevention and Advocacy Program at Dell Children’s includes educational sessions on the five major causes of injury in small children (safe sleep, child passenger safety, drowning, home safety, and traumatic brain injury/Shaken Baby Syndrome).

DCMC has developed an extensive network of community collaboration which includes CPS, CCP, Any Baby Can, the Travis County CFRT, and law enforcement. DCMC hosts two CPS caseworkers on-site. There is an interagency agreement among DCMC, CCP, CPS, multiple law
enforcement agencies, and the Travis County District Attorney’s Office that promotes collaboration and allows for unrestricted flow of pertinent information regarding child abuse and neglect.

The agencies who are party to this agreement constitute the Child Protection Team, and there are two forums where members of the team meet regularly. All agencies meet weekly at DCMC to review inpatients that have been assessed for abuse and/or neglect. There is also a twice monthly multidisciplinary meeting at CCP to review all cases of abuse and/or neglect that include a civil and criminal component.

Many of the Child Protection Team agencies participated in the making of a documentary regarding child maltreatment in Travis County called *Visionaries*. The documentary aired nationally during the fall of 2011. DCMC also sends several representatives to the Travis County CFRT. The CFRT reviews all deaths in Travis County of children under 18 years old and makes recommendations regarding prevention strategies for abuse and neglect based on fatalities the previous year.

**Outcomes / Summary**

While a team of DCMC staff has been in existence since 1996 to address child abuse for the inpatient victims, the MEDCARES grant provided the fundamental support needed to create a distinct hospital department dedicated to the prevention, identification, treatment and education of child abuse. DCMC now has a dedicated medical team, the CARE Team, devoted to specifically address the issue of child abuse as part of the larger Travis County Child Protection Team.

The CARE Team is able to reach out and provide services to the surrounding counties in the DCMC catchment area and serve as experts in the field of child abuse. In addition, an outpatient clinic was established to care for children with suspected non-accidental injuries that did not need emergency attention in August 2010.

**DRISCOLL CHILDREN’S HOSPITAL**

An outcry from the medical community led to the inception of the Child Abuse Resource and Evaluation (CARE) Team in 1995. The CARE Team is recognized as the Center of Excellence (COE) for evaluation of child abuse in South Texas. The mission of the CARE Team at Driscoll Children’s Hospital in Corpus Christi is to provide comprehensive medical forensic evaluations of children who are suspected victims of any type of violence. This includes sexual assault, physical abuse, neglect, drug exposure, starvation, torture and homicide. To improve patient care, the CARE Team also educates medical and community partners, participates in regional and state prevention activities, and collaborates in national research initiatives.

The CARE Team at Driscoll Children’s Hospital is among a handful of teams staffed with full-time positions, available 24 hours a day/365 days per year. The team receives referrals and transfer of patients from 33 surrounding counties for expert evaluation of child maltreatment.
concerns. The CARE Team serves approximately 1,800 children a year in the inpatient and outpatient settings regardless of economic status.

The majority of the children evaluated by the team are Hispanic, which is congruent with the population. The CARE Team frequently cares for children who are noncitizens or have uncertain immigration status, in addition to human trafficking victims. The CARE Team’s full-time professional staff includes: one board-certified child abuse pediatrician (medical director), one board eligible child abuse pediatrician, one clinical coordinator/SANE, four master’s prepared medical social workers (two LCSW, two LMSW), five SANEs/FNEs (three full-time, one part-time, one pool-certified), one medical office specialist, and one medical secretary.

Grant Objectives and Supported Activities

1. Provide community support to multidisciplinary investigative partners regarding child abuse investigations and judicial processing.

The opportunity to meet this goal presented itself weekly during the previous two years. Case consultations are routinely provided with outside medical providers, CPS investigators and ongoing case workers, law enforcement and the judicial system. Case review and support is provided either in person at the center, by phone, or in person at multidisciplinary case staffings.

2. Increase education and training opportunities to nonprofessional and professional audiences concerning child abuse.

Professional members of the team have provided an average of four trainings per month during the past two years. The audiences have been both nonprofessional and professional, but all are potential jurors. Team members provided education on the following topics with presentations ranging from 30 minutes to 4 hours: overview of signs and symptoms of child abuse; medical treatment and resources available within the community for evaluation of abuse; abusive head trauma; medical response to patients who have been sexually assaulted; Shaken Baby Syndrome, advanced child abuse training; response to child abuse for school personnel; importance of documentation; failure to thrive; signs and symptoms of child abuse for day care personnel; and importance of screening children for abuse.

The trainings were tailored to each audience, but the audiences were still amazed at the prevalence of child maltreatment. For many of the audience members, the education they received also met education requirements for their occupation.

3. Improve and expand direct clinical services to patients of the South Texas valley region.

The CARE Team provides outreach for patients in the South Texas valley region via chart reviews, phone consultation with on-site medical providers, direct transfers of patients to Driscoll, and follow-up examinations for concerns of abuse. The following are case examples of children provided with follow-up evaluations. Both children were initially evaluated at other hospitals in the South Texas valley region prior to being referred to Driscoll.
A 10-year-old female was referred for physical abuse with patterned facial bruising (slap mark) and neck bruising, with a history of physical assault by a caregiver. Physical injuries were present on examination. The CARE Team was able to diagnose neglect and malnutrition in addition to the physical abuse injuries.

In another case, a 3-year-old male who fell from a chair presented with vomiting and was found to have a traumatic brain injury. In addition, the referring hospital noted multiple fractures of the legs and right hand. The Driscoll CARE Team saw the child three days after diagnosis and repeated X-rays. No fractures were found. It appears that the initial fractures were due to equipment malfunction. Because the CARE Team was able to rule out additional injuries, the child was returned to home from foster care.

4. Provide mentoring to Valley Baptist Medical Center-Harlingen as a basic child abuse program.

Mentoring has been provided through phone, email, and in person. Currently, the team at Valley Baptist comprises four full-time and three part-time FNEs and a medical director who is also the medical director for the emergency department. Additionally, 24-hour a day phone support has been provided to the Child to Adult Abuse Response Team at the site as well as to primary care providers and investigators in the region of the site.

The clinical coordinator provides: on-site mentoring two to five times a month, which includes an evaluation of each patient record, and education to the medical team and to nonprofessional and professional members of the community for improved recognition and response to child abuse. This also serves to educate the jury pool in the region. The coordinator attends the multidisciplinary team meetings to assist in the review and recommendations. In addition, phone consultation with the team physicians and outpatient medical evaluation, consultation and transfer of medical care to Driscoll is provided when needed.

The medical director has provided education to the Pediatric Intensive Care Unit and Emergency Room physicians on the complexity surrounding the medical evaluation of these children and has provided timely appointments for expert consultation. The team’s coordinator and medical director provide several lectures at a conference and participate in a four-hour peer review of case histories and images.

**Education and Collaboration**

Professional members (physicians, forensic nurses and social workers) of the CARE Team provide clinical education to pediatric, emergency medicine and family medicine residents and medical students as well as workshops to law enforcement, CPS, and community organizations. Education on different topics surrounding child abuse is also provided locally, regionally, statewide, nationally, and internationally. The CARE Team participates in community, regional, and statewide child abuse prevention efforts. Education is provided to children and their families that is developmentally age-appropriate in inpatient and outpatient settings.
The CARE team screens and provides education to children and their families that are seen in the emergency department for a multitude of preventable injuries. This includes, but is not limited to: bike and helmet safety, car seats, burn safety, water safety, babysitter safety, medication and environmental hazard exposures, and safe sleep. The team’s clinical coordinator chairs the Coastal Bend CFRT that serves 13 counties. The CARE Team participates in local and regional multidisciplinary teams through on-site attendance and telemedicine support. In addition to all the medical staff working on behalf of the children and their families, staff work side-by-side daily with Child Protective Services, local/regional/national law enforcement agencies, the Coastal Bend CAC, the Ark Assessment Center & Emergency Shelter for Youth, as well as many other emergency shelters.

The CARE Team took the lead in establishing the Coastal Bend of Texas Coalition against Human Trafficking. The team collaborates daily with the Department of Family and Protective Services (DFPS) caseworkers and special investigators, law enforcement agencies, CACs and other agencies throughout the team’s 33-county service area by providing detailed explanations of the medical findings, mechanics of injury, and diagnosis. Both team physicians serve on the Citizen’s Review Team hosted by DFPS. Dr. Harper also serves on the State Child Safety Review Committee at DFPS and has received the honor of being selected to serve on the Governor’s Blue Ribbon Task Force to Reduce Child Abuse & Neglect for a second term.

**Outcomes / Summary**

MEDCARES funding and support has facilitated the growth of the services that the CARE Team provides. The Driscoll CARE Team has been able to expand the number of children they serve as well as the types of child maltreatment they medically evaluate (e.g. medical neglect for obesity). The CARE Team was able to hire a second child abuse pediatrician, who is now an active member of the team. This additional pediatrician provides clinical, educational, and advocacy services within the hospital and in the community.

The CARE Team has also expanded services to include the examination of “children at risk” who were exposed to the same conditions (e.g. siblings or contacts in the same environment). This has allowed the team to identify additional children who have been abused and provide comprehensive medical care to those children and, as always, strive for prevention of further abuse. As evidenced in grant objective summary #3, the ability to provide support for a mentor site and the ability to have children examined at a COE can be the difference between life and death.

**SCOTT & WHITE MEMORIAL HOSPITAL**

The Child Abuse Support Center (CASC) at the McLane Children’s Hospital at Scott & White opened in January 2009. The CASC was developed to coordinate all existing child abuse/neglect services provided by Scott & White in one central location. In October 2011, Scott & White opened the McLane Children’s Hospital with the mission to provide the most personalized, comprehensive, and highest-quality pediatric health care to the children of Central Texas. The CASC referrals for abuse evaluations have increased from 429 in 2009 and 495 in 2010 to 556 in 2011. For 2012, there have been 317 exams as of June.
In addition to providing comprehensive patient care, the CASC provides education to the public and the regional health care community and actively participates in prevention programs. The number of child abuse cases in Bell County in 2011 placed it in the Top 12 among Texas counties; therefore, outreach and prevention are of utmost importance.

The CASC Team includes: one pediatric intensive care/ child abuse pediatrician (from January 2009 to October 2011), one general pediatrician with experience in child abuse (currently runs the center), the chief of pediatric surgery at McLane Children’s Hospital, a hospital-based social work team, two FNEs, ten PRN nurses, and one outreach coordinator.

Grant Objectives and Supported Activities

1. Expand the CASC at Scott & White by increasing the number of qualified staff. This includes adding forensic nursing coverage and adding a second pediatrician with expertise in child abuse.

A dedicated forensic nurse has been hired for the new McLane Children’s Hospital at Scott & White. The pediatric ER is staffed by a forensic nurse during daytime hours and after hours. There is a forensic nurse on call 24 hours per day for the evaluation of suspected child abuse or neglect victims. A second general pediatrician was hired. The principal investigator, the CASC’s child abuse trained pediatrician, retired during the grant period. A search is underway for another child abuse pediatrician as well as a dedicated social worker to join the current team.

2. Improve prevention capacity by hiring an outreach coordinator for the center and by expanding the POPC prevention program.

An outreach coordinator was hired in March 2011. She has initiated, designed, and implemented multiple education programs in the local community. Training and needed supplies have been provided to initiate and sustain the POPC Shaken Baby Syndrome prevention program in four local hospitals, with a fifth program in development. The outreach coordinator has networked with other community agencies to provide needed education and resources to members of the community.

The CASC is currently coordinating a walk dedicated to the prevention of child abuse for fall 2012. Programs were designed for the community on topics including Shaken Baby Syndrome, domestic violence, domestic violence and how it affects children, healthy relationships, stress management, do’s and don’ts of the courts, parenting, and other important issues.

3. Provide educational opportunities for health care professionals, CPS team members, law enforcement, and other community partners involved in child abuse and neglect.

A full-day lectureship was provided in March of 2011 on child abuse at the annual Myers Leadership Conference at Scott & White for physicians, nurses, medical residents, medical students, social workers, CPS, law enforcement, and chaplains. Members of the team have continued to participate in conferences and have given lectures to other health care professionals, CPS team members, and members of law enforcement over the past two years.
4. Partner with Health Care Team at Carl R. Darnall Army Medical Center, the Center’s basic mentoring site, to increase the recognition, identification, and treatment of child abuse victims.

The center’s relationship with the initial basic site, Carl R. Darnall Army Medical Center was unable to be maintained; however, a new relationship with a basic site, Metroplex Hospital in Killeen, was started in 2011. Education, materials, and support were provided to implement the POPC prevention program. Approximately 225 parents per month receive this education prior to discharge with their newborn at the basic center. Parenting education classes have been started and were scheduled to roll out September 2012.

**Education and Collaboration**

The CASC staff members provide training to local CPS, law enforcement, medical professionals at local institutions and give lectures to medical students at Texas A&M Health Science Center and physicians in residency training programs within the pediatric, family medicine, and emergency medicine departments. In addition, staff members provide child abuse education at regional and statewide conferences.

The outreach coordinator works with community agencies, provides resources at community events and works closely with community hospitals to expand prevention programs within those settings. Examples for programs designed to educate the community are listed above under Objective/Activity #2. Staff continue to work to implement the POPC prevention program to provide education to all parents of patients in the immediate service area before they are discharged from the hospital with their newborn(s). Since its initiation in 2007, only one documented case of abusive head trauma has occurred to an infant whose parents received the training. The program serves over 10,000 parents per year.

The CASC works with surrounding CACs to provide medical evaluations for children seen at the centers. The forensic nursing team is available at all times for these evaluations. All cases are examined or reviewed by a physician member of the team. The CASC works with CPS from the 18 surrounding counties to provide medical consultation, chart reviews, and training/education opportunities. Bimonthly multidisciplinary team meetings are held to discuss issues related to child maltreatment and peer review cases.

Center staff are also members of the Bell County Domestic Violence Task Force. Their mission is to identify opportunities to collaborate with existing services and organizations to decrease domestic violence and support victims. Staff members also participate in the local CAC multidisciplinary team meeting, Local Trauma Regional Advisory Council, local Pediatric Committee, and local Child Fatality Review Committee.

**Outcomes / Summary**

The MEDCARES funding has allowed the CASC at Scott & White the opportunity to expand services. Expansions supported by the MEDCARES grant include increasing the number of
qualified team members, establishing an outreach program with a dedicated outreach coordinator, and having 24-hour per day coverage by supporting additional forensic nurses.

A formal multidisciplinary team meeting has been established in addition to previous peer review meetings. A follow-up clinic for suspected child abuse and neglect victims was started in 2012. The clinic sees children discharged from the hospital, from outside facilities, in the care of CPS, at risk for abuse, or in need of evaluation or long-term follow-up. These expanded services, have allowed McLane Children’s Hospital at Scott & White to better serve the children of Central Texas.

**TEXAS CHILDREN’S HOSPITAL**

Texas Children’s Hospital/Baylor College of Medicine’s Child Abuse Pediatrics (CAP) Program was inspired by a community pediatrician in 1978. It has provided comprehensive medical evaluations for child abuse and neglect for Houston’s children the past 32 years. For most of those years, these children were served by a team of two social workers and a part-time physician director. Over the past eight years, the program has grown significantly to include two full-time fellowship-trained child abuse pediatricians, several dedicated physicians who participate in child abuse in addition to their full-time positions, an inpatient and outpatient consult service, a full-time sexual abuse outpatient clinic at Harris County’s CAC, and an outpatient child protective health clinic focused on physical abuse and neglect.

The focus of the CAP Program is to evaluate and collaborate in the treatment of victims of suspected abuse or neglect. It is committed to the advancement of education, patient care, community outreach, and research. The goal is to identify and prevent child abuse and neglect.

In comparison to the number of evaluations and outpatient services cited in National Association of Children’s Hospitals and Related Institutions’ (NACHRI) 2008 Children’s Hospitals Child Abuse Services Survey, Texas Children’s child abuse program is one of the largest in the nation. It sees more than 2,000 patients annually.

The CAP Program has three physicians with the new board certification of child abuse pediatrician. The CAP Program includes: one chief of child abuse pediatrics (medical director), two full-time fellowship-trained child abuse pediatricians, three pediatricians, one pediatric nurse practitioner, one assistant director/registered nurse, three social workers, one pediatric SANE coordinator, twelve pediatric SANE nurses, one licensed vocational nurse for the sexual abuse outpatient clinic, one registered nurse/case manager, and one community outreach coordinator.

**Grant Objectives and Supported Activities**

1. **Provide mentoring to the basic partner site, St. Elizabeth Hospital, Beaumont.**

St. Elizabeth Hospital and Texas Children’s CAP Program have a history of informally partnering in child protection through the shared management and referral of suspected child abuse cases. To initiate the MEDCARES project, members of the CAP team had a series of planning meetings with the St. Elizabeth Emergency Center and Nursing leadership, the forensic
nurse coordinator, and a local pediatrician who voiced an interest in heading up the child abuse program in Beaumont. The St. Elizabeth team then spent two days shadowing the CAP team, attending weekly CAP staffing meeting, and observing daily activities, including patient care and consultations.

Next steps included training emergency center and pediatric nursing and medical staff; training community pediatricians; providing guidance in policy; and developing the budget for use of the sub-grants funds. Training for the nursing staff was completed in March 2011. As a result of the training sessions at St. Elizabeth, the CAP was asked to provide child abuse/neglect training at Baptist Beaumont Hospital.

2. Grow the Texas Children’s CAP Program by increasing the number of hours and patients seen.

In order to grow the program, it was determined that hiring a nurse practitioner, nurse, and social worker would be necessary. Texas Children’s Hospital did not hire personnel with MEDCARES grant funding the first grant year. The CAP Program filled the nurse practitioner position in the second grant year, in August 2011. At that time the outpatient child abuse clinic was only seeing patients every Tuesday afternoon and every other Thursday morning. Currently, the clinic is seeing patients three half-days each week. The average weekly schedule of 15 patients is up from an average of 3-4 per week. Some of this growth is due to redirecting the work of a nurse case manager to allow for follow-up care for patients seen in the hospital.

3. Provide training and innovative collaborative educational projects for health care professionals and community partners involved with child abuse and neglect.

The CAP provided the educational program Suspecting Child Abuse and Neglect (SCAN) to local community pediatricians and outlying community hospitals from Cleveland to Wharton. SCAN also has been presented to daycare and Head Start teachers and over 500 school nurses throughout southeast Texas. A project was initiated with the Houston Fire Department to train first responders in “Recognizing Child Maltreatment.” Hundreds of emergency medical technicians in Houston have been trained. The CAP partnered with Houston Rescue and Restore Coalition to develop training specifically for health care providers in recognizing victims of human trafficking.

4. Plan and implement family violence and child abuse prevention activities.

The CAP organized awareness activities for Teen Dating Violence Awareness Month in February, Domestic Violence Awareness Month in October, and Child Abuse Awareness Month in April. Activities included a bridge event with community partners, themed T-shirt sales, and a luncheon presentation for hospital staff by an FBI agent on the dangers of the internet for children and adolescents.

The Community Pediatrics Intimate Partner Violence Planning Coalition was formed with members from the CAP, the Texas Children’s Health Plan and a community pediatrician to begin to explore the role primary care practitioners play in protecting children from domestic violence.
The project was a grant-funded initiative to determine pediatricians’ comfort in screening for family violence and knowing how to intervene.

**Education and Collaboration**

The CAP offers SCAN to physician practices and community hospitals in the Greater Houston area. The SCAN program discusses the various signs and symptoms of child maltreatment, the basic biomechanics of how some injuries can be indicative of abuse, the importance of the family’s history of the illness or injury, some conditions that mimic abuse, and how to document injury findings. SCAN also provides lists of local resources for medical consultation or service referrals. The program has been remodeled to include versions for first responders, law enforcement personnel, child protective services professionals, and teachers.

SCAN has trained over 8,000 professionals. The CAP received approval for a Child Abuse Pediatrics Fellowship effective July 2012. The CAP Team also offers comprehensive rotations to pediatric and family practice residents, and pediatric emergency medicine and child psychiatry fellows. Over 70 physicians-in-training rotate in the child abuse elective annually. CAP team members routinely provide training for medical students, nursing students and residents on a variety of child abuse and neglect topics.

In addition to training provided in the hospital setting, team members routinely are asked to lecture in the classroom for medical, physician assistant, and nursing students at Baylor College of Medicine and local nursing schools. Texas Children’s provides both CMEs and CNEs for the program. In the community, the CAP has participated in an ongoing training program regarding child deaths that CPS and the Houston Police Department Homicide Division developed to facilitate cooperation and collaboration among various agencies involved in child death investigations.

As the medical services provider for Harris County’s Children’s Assessment Center in Houston, the CAP Program advocates for sexual abuse victims through the Child Sexual Assault Response Team case reviews, CAC’s Partner Council planning the annual Protecting Texas Children Conference, and collaborating on individual cases. Through a grant-funded pilot project and collaboration with The Bridge, a local domestic violence shelter, the CAP initiated screening mothers of patients in the emergency center for intimate partner violence.

The CAP also provides the Happy Baby Program, directed at high school students who are parents or soon-to-be parents and provides them with education about normal infant crying as well as how to soothe a crying infant with the ultimate goal of shaken baby prevention. The CAP provides classes on safe sleep, toilet training, and behavior redirection as part of foster parent training required by CPS. CAP team members serve on several local community boards, including the Children’s Assessment Center, Children At-Risk, and the Harris County Child Abuse Task Force.

Weekly meetings for child maltreatment victims treated at Texas Children’s involve CAP members, the consulted medical subspecialties, CPS, court professionals, and law enforcement personnel. Monthly multidisciplinary meetings are held for complex cases, including law
enforcement, CPS, district attorneys, child advocates, and the medical examiner’s office.

The CAP members are also active members of the Harris County/Houston CFRT for deaths involving suspicion of maltreatment. The CAP team has worked collaboratively with CPS caseworkers, supervisors, and program director over the past year to provide targeted education for the newly formed CPS units focused on serious child abuse for children under the age of three. The CAP provides monthly trainings to the various CPS units on topics such as fracture, abusive head trauma, medical child abuse and cutaneous injuries. CAP members also participate on the CPS special needs task force providing expertise in the care and evaluation of special needs children with CPS involvement. The CAP Team also partnered with Houston Rescue and Restore to develop a program targeted at identifying human trafficking to be presented to health care providers.

Outcomes / Summary

As stated above, the Texas Children’s Child Abuse Pediatrics Program has had the ability to grow as a direct result of the MEDCARES grant. While this is a time of uncertainty for the health care industry, the hospital approved the hiring of a pediatric nurse practitioner for the team. Without this vital position, the CAP Program was limited in its ability to see patients in an outpatient setting. The clinic expanded its hours to three days of the week, and it expects to add additional days in the next several months. The CAP has been able to provide abuse evaluations for children suspected to be victims of child abuse and neglect by a child abuse pediatrician rather than going to a primary care doctor or spending hours in the emergency center.

The ability to provide quality child abuse assessments by multiple providers and subspecialists has been significantly enhanced with the diagnostic equipment that was purchased with MEDCARES funding. Retinal hemorrhages are one of the most important diagnostic signs of abusive head trauma and retinal photography is an important component of the evaluation for both educational and legal purposes. With the MEDCARES grant, the ophthalmologists now have the ability to easily and effectively document their exam findings.

UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT HOUSTON

The Child Abuse Resource and Education (CARE) Center at the University of Texas at Houston was recently named the Division of Child Protection Pediatrics in recognition of the importance of the specialty and the contributions of the CARE Center team to the University. CARE Center physicians are recognized locally, nationally, and internationally for their expertise in the field.

The center’s mission is to provide comprehensive care to child abuse and neglect victims; educate future physicians, other medical providers, and the community about child abuse and neglect; and study important clinical questions. The CARE Center serves children from all areas of the state through its inpatient and outpatient services and via the statewide Forensic Assessment Center Network (FACN) program. The majority of the CARE Center catchment area is therefore rural, although approximately three-quarters of CARE Center families live in urban Harris County.
Approximately 25 percent of children in Harris County are uninsured, and nearly 15 percent of households subsist below the federal poverty level. Through the statewide FACN network, the CARE Center also serves children from the Rio Grande Valley and far West Texas (Health Service Regions 11 and 10), whose residents are predominantly rural, Hispanic, and poor. Households in poverty are at risk for family violence, including child physical abuse and neglect.

The numbers of children served each year by the CARE Center continue to increase, and currently totals about 5,600. The staff at the CARE Center include: two board-certified child abuse pediatricians (one full time/one part time), one board-eligible child abuse pediatrician, one child abuse pediatrics fellow, one pediatric nurse practitioner, one pediatric social worker, one coordinator, and one administrative assistant.

**Grant Objectives and Supported Activities**

1. **Provide ongoing coordination of child maltreatment services with sister hospitals.**

   The CARE Center now employs a full-time social worker who is dedicated to outreach efforts and outpatient coordination of care. Over the past year and a half, the social worker and program director provided a series of trainings to physicians, nurses, and social workers at the sister hospitals. The purpose of the trainings was to raise awareness of the problem of missed cases of abuse and provide resource information. These sessions were favorably received, and resulted in several phone consultations with providers regarding management of maltreatment cases.

2. **Increase availability of psychiatric services for CARE Center children and families.**

   MEDCARES funding enabled the CARE Center to increase the availability of a child psychiatrist in the CARE Clinic and to furnish a dedicated space for play therapy and family counseling.

3. **Increase availability of inpatient and outpatient clinical services.**

   MEDCARES provides needed salary support for the physicians and staff who manage the inpatient consult service (30-45 patients per month). The grant monies also support the operations of the CARE Clinic, which now has its own dedicated space and is available to the community five days per week. MEDCARES funds will continue to be used to help support the personnel, rent, and supply costs of the clinic. Clinic patient numbers continue to grow, from approximately 50 children and families per month prior to MEDCARES funding, to approximately 100 per month currently.

4. **Provide support for basic child abuse programs.**

   The program at University of Texas Medical Branch (UTMB) used MEDCARES support to provide outreach trainings at area schools and to start the POPC child abuse prevention program. Texas Tech University augmented educational activities as well as clinical services, and also began the POPC program. In support of these efforts, the CARE Center conducted periodic case reviews with both mentees, reviewed staffing needs and expectations for UTMB, and provided
mentorship in the structuring of educational curricula and development of a new outpatient clinic for Texas Tech University. Both UTMB and Texas Tech University continue to be involved in MEDCARES to further efforts to achieve COE status.

5. Education of a child abuse fellow.

The CARE Center began a child abuse fellowship training program in 2011 with the initiation of its first official fellow on July 1, 2011. The fellow’s time is divided between clinical, research and other scholarly activities according to Pediatric Board guidelines. The program became accredited in April 2011.

6. Education of medical students and pediatric residents.

The CARE Center has hosted medical students and residents who were interested in a two or four week rotation in child maltreatment. This learning experience has consisted of hospital rounds and outpatient clinical care alongside a child abuse pediatrician, attending court testimony when available, and time for reading and other self-taught exercises. During the coming biennium, the center will develop a more structured set of educational materials for this learning group.

Education and Collaboration

The CARE Center engages in primary and secondary child abuse prevention, working jointly with Children’s Memorial Hermann Hospital to provide education for new parents, post-traumatic counseling for victims, and parenting advice for families at risk of maltreatment. New parents are provided information on child safety and infant care, and teen parents receive additional targeted counseling regarding parenting skills and community resources.

The center’s fellowship program was accredited by the Accreditation Council for Graduate Medical Education in April 2012. The CARE Center offers 2- and 4-week clinical rotations for interested medical students and pediatric residents. The CARE Center provides frequent in-person and web-based trainings for DFPS caseworkers and other non-medical professionals (e.g. law enforcement officers, attorneys, and judges) about child maltreatment and related topics. The center also provides periodic educational talks for credit to medical professionals, mental health providers, and social workers.

Collaboration occurs within and outside the medical system to ensure optimal care for all affected by child maltreatment. Board-certified child abuse pediatricians from the CARE Center provide inpatient consultations at Children’s Memorial Hermann Hospital, a Pediatric Level I Trauma Center whose referral base reaches over 87 percent of the area population. Center physicians also provide consultation services and forensic nurse oversight for the Harris County Hospital District, which is the area’s primary indigent care system. The CARE Center is closely aligned with the Fort Bend County CAC, providing clinical services for Fort Bend County child maltreatment victims and educational presentations for CAC-related professionals. The CARE Center has also developed a collaborative relationship with the DePelchin Children’s Center in Houston, which provides foster and adoption services and counseling for children who are...
victims of or at risk for maltreatment.

In addition to its local mission, the CARE Center serves as the hub for the FACN, a coordinated effort of state medical schools to provide expert consultation and forensic assessments for children from all areas of the state who are the subject of investigation by the DFPS. The FACN has developed a sophisticated web-based system for case tracking, reporting, education, and peer review.

**Outcomes / Summary**

MEDCARES support for the program encouraged the university’s designation of the CARE Center as the Division of Child Protection Pediatrics. Child Protection is now officially recognized by the institution as a pediatric subspecialty on par with others (e.g. Pediatric Cardiology, Adolescent Medicine, etc.).

The goal to create an accredited child abuse fellowship training program was achieved in 2012 with significant support from MEDCARES. The program is approved to accept one new fellow each year.

Grant support for the CARE Center’s mentee sites has contributed to the expansion of child maltreatment clinical services and professional education in Lubbock and surrounding counties. This is significant since West Texas has been severely underserved with respect to services for child abuse victims and families at risk.

MEDCARES funds are a significant support for the CARE Center’s clinical services, many of which could not be covered by other funding sources. Child abuse victims and families at risk of maltreatment typically require intensive, ongoing psychological and social services. These services are inadequately reimbursed by current standard payment sources. The funds also enable the center to provide medical care to children and families irrespective of their insurance status. The salary support for the psychiatric, social work, and medical staff facilitates close collaboration between these specialties, leading to coordinated clinical care, education, and potential research.
APPENDIX C: ACRONYMS

ABC ................. Any Baby Can
CAC ................. Child Advocacy Center
CAP .................. Child Abuse Pediatrics Program (Texas Children’s Hospital)
CARE ............... Child Abuse Resource and Education (Dell Children’s Medical
                  Center/University of Texas Health Science Center at Houston)
CARE ............... Child Abuse Resource and Evaluation (Driscoll Children’s Hospital)
CARE ............... Child Advocacy Resource and Evaluation (Cook Children’s Medical Center)
CASA ............... Court Appointed Special Advocates
CASC ............... Child Abuse Support Center (Scott & White Hospital)
CCP ............... Center for Child Protection
CFM ............... Center for Miracles (CHRISTUS Santa Rosa Children’s Hospital)
CFRT ............... Child Fatality Review Team
CMC ............... Children’s Medical Center
CME ............... Continuing Medical Education
CNE ............... Continuing Nursing Education
CPS ............... Child Protective Services
DCMC ............ Dell Children’s Medical Center
DFPS ............... Department of Family and Protective Services
DSHS ............ Department of State Health Services
FACN ............ Forensic Assessment Center Network
FNE ............ Forensic Nurse Examiner
FTT ................. Failure to Thrive
IRB ............... Institutional Review Board
MEDCARES ....... Medical Child Abuse Resource and Education System
PCOE ............... Pediatric Centers of Excellence
PHN ............... Providence Health Network
POPC ............... Period of PURPLE Crying
REACH ............ Referral and Evaluation of At-Risk Children (Children’s Medical Center)
SANE ............... Sexual Assault Nurse Examiner
SCAN ............... Suspecting Child Abuse and Neglect
SB ................ Senate Bill
TBI ............... Traumatic Brain Injury
TMF ............... Trinity Mother Francis
UTHSC ............ University of Texas Health Science Center
UTMB ............ University of Texas Medical Branch