Medical Child Abuse Services: An Investment in the Future of Texas

by

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The Children’s Hospital Association of Texas (CHAT) is an organization of regional not for profit children’s hospitals in Texas. CHAT’s mission is to advance pediatric health care services for the benefit of children in Texas.

To further its mission, CHAT works to inform and educate the public and state decision makers about issues in pediatric health care. To recognize the leadership of the late Senator Lloyd Bentsen in child health, CHAT supports occasional research reports by public policy students at the LBJ School of Public Affairs on selected pediatric health care issues.

The research and opinions expressed in the reports are those of the authors and are made available by CHAT to further the discussion and understanding of child health public policy issues. The reports do not represent an official statement or position of the CHAT Board or membership.
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## List of Acronyms

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<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AAP</td>
<td>American Academy of Pediatrics</td>
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<tr>
<td>CAC</td>
<td>Children’s Advocacy Center</td>
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<td>CACTX</td>
<td>Children’s Advocacy Centers of Texas</td>
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<tr>
<td>CFRT</td>
<td>Child Fatality Review Team</td>
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<tr>
<td>CME</td>
<td>Continuing Medical Education</td>
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<tr>
<td>COE</td>
<td>Centers of Excellence</td>
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<td>CPS</td>
<td>Child Protective Services</td>
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<td>CPT</td>
<td>Child Protection Team</td>
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<td>CSEC</td>
<td>Texas Commission on State Emergency Communications</td>
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<tr>
<td>CT</td>
<td>Computed Tomography</td>
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<tr>
<td>DFPS</td>
<td>Texas Department of Family and Protective Services</td>
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<tr>
<td>DSHS</td>
<td>Texas Department of State Health Services</td>
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<tr>
<td>EMS</td>
<td>Emergency Medical Services</td>
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<tr>
<td>ER</td>
<td>Emergency Room</td>
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<tr>
<td>FACN</td>
<td>Forensic Assessment Center Network</td>
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<tr>
<td>FTE</td>
<td>Full-Time Equivalent</td>
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<tr>
<td>FVPSA</td>
<td>Family Violence Prevention and Services Act</td>
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<tr>
<td>FY</td>
<td>Fiscal Year</td>
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<tr>
<td>HHSC</td>
<td>Texas Health and Human Services Commission</td>
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<tr>
<td>HRSA</td>
<td>U.S. Health Resources and Services Administration</td>
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<tr>
<td>MD</td>
<td>Doctor of Medicine</td>
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<tr>
<td>MDT</td>
<td>Multidisciplinary Team</td>
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<tr>
<td>MR</td>
<td>Magnetic Resonance</td>
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<tr>
<td>NACHRI</td>
<td>National Association of Children’s Hospitals and Related Institutions</td>
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<tr>
<td>OAG</td>
<td>Office of the Attorney General</td>
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<tr>
<td>RN</td>
<td>Registered Nurse</td>
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<tr>
<td>SANE</td>
<td>Sexual Assault Nurse Examiner</td>
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<tr>
<td>SCCAMRS</td>
<td>South Carolina Children’s Advocacy Medical Response System</td>
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<tr>
<td>SSBG</td>
<td>Social Services Block Grant</td>
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<tr>
<td>TANF</td>
<td>Temporary Assistance for Needy Families</td>
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<tr>
<td>TPCN</td>
<td>Texas Poison Control Network</td>
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Executive Summary

In 2006, Texas had the highest rate of fatalities in the country related to child maltreatment and it is estimated that nearly half of Texans experience some form of domestic violence (including child abuse) at some point in their lives. Health care providers play an important role in evaluating children for abuse, diagnosing abuse, treating the abuse and working with the legal system after abuse has been confirmed. However, there is a shortage of clinicians experienced in this work both here in Texas and nationwide. Although several children’s hospitals in Texas have set up specialized child abuse teams to provide these services to children, the size and diversity of Texas suggests the need for an organized statewide approach to provide access to medical child abuse specialists. The experiences of states such as Florida, New Jersey, South Carolina and Utah can help illuminate the possibilities for expanding access to medical child abuse services in Texas. This document explores the role of diverse service providers in working with victims of child maltreatment as well as the experiences of these model states in order to develop recommendations for better meeting the needs of Texas children with respect to the assessment, diagnosis and treatment of child abuse. The greatest needs identified in Texas are additional funding and reimbursement mechanisms for child abuse medical services, additional child abuse providers and training programs and expanded communication capacity.
Chapter 1. Child Abuse and the Medical Profession

Child abuse is a problem affecting millions of families around the globe each year and is responsible not only for the human suffering of its victims but also immense economic burdens in such forms as health care expenditures, lost work days and law enforcement and social services expenses. While child abuse has been present in different forms for centuries, in recent years, child abuse and other forms of interpersonal violence have been recognized internationally as critical global public health problems and growing attention has been given to the prevention of child abuse and the response to its consequences.

Defining Child Abuse: The Scope of the Problem

Child abuse can be broadly conceptualized as maltreatment relating to one or more of the overarching categories of physical abuse, emotional abuse, sexual abuse and neglect. While each state in the U.S. has its own definition of precisely what constitutes child abuse under each of these categories, the Federal Child Abuse Prevention and Treatment Act passed in 1974 and most recently amended in 2003 broadly defines child abuse as, at a minimum, “any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act which presents an imminent risk of serious harm.” In our state, the Texas Family Code states that child abuse refers to a variety of acts or omissions that result in “substantial harm” or “observable and material impairment” for the child, including those causing physical, mental or emotional injury as well as acts of sexual assault and misconduct.

Although the Texas Family Code requires any individual suspecting abuse to report the abuse to the Department of Family and Protective Services (DFPS) through their abuse hotline, many cases of child abuse, like other types of interpersonal violence, do not get reported. As a result, the exact prevalence of the problem at both a national and state level is unknown. Nonetheless, during the federal fiscal year ending in September 2006, state and local child protective services (CPS) agencies confirmed the suffering of abuse or neglect in nearly one million children in the U.S. with over 1,500 children dying from the abuse or neglect. National surveys tend to find significantly higher rates of abuse than those confirmed by CPS agencies, with one survey reporting that 14% of U.S. children experienced some form of child maltreatment in 2002. With respect to lifetime prevalence, depending on the definition of abuse used, prevalence estimates vary from approximately 25% to 50%.

In Texas, there were 71,344 confirmed victims of various forms of child abuse and neglect in 2007 (see Figure 1.1) and in 2006, the state had the highest incidence of fatalities related to child maltreatment of 48 states providing this data. With a total of 227 fatalities related to child abuse or neglect in 2006, the rate in Texas of 3.96 fatalities per 100,000 children was nearly double the national average of 2.04. It is somewhat challenging to compare this data to other causes of death for children due to the way that deaths are coded on death certificates as well as other factors. Nonetheless,
as Figure 1.2 suggests, child abuse is very significant when compared to other leading causes of death for children in Texas. While there is limited data on the lifetime prevalence of child abuse in Texas, a 2002 survey by the Texas Council on Family Violence found that 47% of Texans had experienced some form of domestic violence (including child abuse) at some point in their lifetime and 31% reported having been severely abused.13

The high rate of child abuse should be of great concern to Texans due not only to the immediate suffering of the victims but also the long-term impact of the abuse on the victims, their families and society at large. Individuals who suffer abuse during childhood are significantly more likely to suffer a wide variety of health problems later in life as well as having a higher likelihood of being arrested, committing a violent crime, suffering abuse again, developing drug and alcohol dependencies, and becoming an abuser themselves.14

The Role of Hospitals and Health Professionals

While child abuse is often thought of as a problem concerning social workers, police officers and prosecutors rather than health care providers, the reality is that child abuse is much more than a criminal justice problem. It is a very real public health threat with concrete health consequences for its victims, making the roles of hospitals and medical professionals in child abuse cases crucial from the moment abuse is suspected until the legal case has been closed. The American Academy of Pediatrics (AAP) describes the essential role of the physician in the detection of child physical abuse as follows:

Child physical abuse is a common problem of childhood. The physician must be able to recognize suspicious injuries, conduct a comprehensive and careful examination with appropriate auxiliary tests, critically assess the explanation provided for the injury or injuries, and establish the probability that the explanation does or does not correlate with the pattern, severity, and/or age of the injury or injuries. The physician is
responsible for reporting suspected abuse, documenting his or her opinions clearly, and providing the necessary information and expertise to investigative and legal personnel and parents, when appropriate. In addition, pediatricians are uniquely qualified to work with parents and caregivers to prevent abuse by providing anticipatory guidance on normal child behavior and its management.\textsuperscript{15}

We will explore the physician’s role in each part of the process in more detail below.

\textbf{Suspicion}

Health care providers are frequently the first professionals to suspect child abuse in an abused child and they are legally required to report any suspicion of abuse to DFPS within 48 hours. Due to the nature of their work, health professionals may be privy to unique information that allows them to better assess the likelihood that abuse is occurring. The medical history, behavioral clues from the children or caregivers, and other observations may all give a physician cause for suspicion.

In cases of a physical injury, physicians may be suspicious if the explanation of the injury is vague, is inconsistent or is incompatible with the degree of injury or the developmental stage of the child.\textsuperscript{16} The location or type of injury itself may also be cause for suspicion as injuries suffered by children who are abused tend to differ from those that are likely to occur by accident. For example, it is more common for children to suffer accidental injury on exposed areas such as the knees and hands than on areas such as the buttocks, thighs or neck.\textsuperscript{17} Furthermore, if there is bruising, the shape of the bruise can indicate whether it was caused by accident or was likely to have been caused by abuse.

In cases of sexual abuse, the finding of a sexually transmitted infection in a child is one important cause for suspicion of abuse, but oftentimes the behavior of the child or the direct disclosure of the child may be the way that sexual abuse is uncovered. For example, while behavior indicating sexual curiosity is normal in childhood, children who have suffered sexual abuse may demonstrate sexual behavior beyond this exploratory level and may act out in a sexual manner that is more adult. More commonly, they may develop what is sometimes referred to as “non-specific behavioral symptoms,” which include such issues as problems in school, problems sleeping, eating disorders or depression.\textsuperscript{18}

In addition to medical and behavioral signals in the child, there may also be behavioral clues among caregivers that may alert the physician to a potential case of child abuse. These may include delays in seeking medical attention, a lack of concern for the child’s injuries or needs, or repeated visits to the hospital for cases of injuries, ingestions or fractures.\textsuperscript{19}

\textbf{Assessment and Diagnosis}

Once suspicious injuries or behavior have been observed, physicians must then be able to investigate this suspicion to determine whether or not abuse has occurred. In cases of physical abuse, they may use a combination of such tests as CTs, MRs and x-rays, including a full body skeletal survey to better understand the injury. In addition to
conducting these tests, experienced pediatricians and pediatric radiologists must interpret the results. Many of the results for young children and babies may be very subtle and thus, it is important for hospital staff to be specialized in pediatrics and child abuse. Furthermore, physicians may test blood and urine or use additional tests to aid in evaluating the likelihood of abuse.

In cases of sexual abuse, a colposcope may be used to evaluate for abuse. A colposcope is a special microscope that permits lighting and magnification of the small pediatric genital structures in order to facilitate visual examination. It also provides the capability to take photographs of the examination. In many cases of sexual abuse, however, there is limited physical evidence of the abuse to be gained from this method as the exams must be done very soon after the abuse has occurred in order to gain physical evidence.

**Treatment**

Treatment of the medical problems associated with the abuse is the next important step for health care providers serving abused children. Abuse can result in a variety of medical problems, including acute physical injuries, mental and sexual health problems and chronic and life-threatening issues such as permanent disability, fibromyalgia, STDs and even suicide. Thus, physicians play a critical role in treating the immediate injuries or physical health problems resulting from the abuse as well as planning for the ongoing treatment of chronic and mental health problems.

Early identification of abuse by medical providers can also help prevent or reduce many of the long-term health effects of abuse such as posttraumatic stress disorder, drug and alcohol addiction, depression, eating disorders, smoking and obesity. Despite the crucial importance of these types of medical attention for child abuse victims, studies have shown that as few as one-third of children suffering physical abuse receive the needed medical attention.

**Working with the Legal System**

In addition to diagnosing and treating an abused child, the physician’s role often becomes important in the legal system as well. Because the medical evidence collected and interpreted by medical professionals can be critical in the civil and criminal cases related to the abuse, physicians frequently have a vital role to play in the courtroom. Physicians may prepare written documentation or appear in the courtroom for civil trials regarding the custody of the child victim or the termination of parental rights and may also testify in a criminal case against the abuser. These responsibilities to the legal system can often demand substantial amounts of time from physicians working in child abuse pediatrics.

**Clinician Training**

Despite the importance of clinicians in providing the above services in cases of child abuse and the wide prevalence of this public health problem, many pediatricians receive little clinical training on child abuse. Although child abuse is a problem that affects
Although some injuries are more likely to be caused by abuse than others, the correct diagnosis of abuse is highly dependent on the training and experience of the physician in interpreting the physical evidence. Research studies on the diagnosis of abuse have shown that the attitudes of providers as well as the hospital type affect the propensity toward diagnosing abuse when patients present with the same symptoms. For example, one study found that children’s hospitals in the U.S. were significantly more likely to diagnose abuse than were general hospitals when children presented with the same injuries. This study also found that the differences in diagnosis were unlikely to be due to real differences in the populations served by these two types of hospitals. Thus, they may instead be due to such factors as differences in provider training, experience or attitude. This means that many children who suffer abuse leave their provider without their abuse being detected and thus, return to situations where their life and safety may be in serious danger.

At present, the most common type of certification for health professionals with respect to evaluating sexual abuse is the Sexual Assault Nurse Examiner (SANE) certification available for nurses to practice as sexual assault examiners. Registered nurses (RNs) with appropriate academic training and clinical experience in performing the forensic examination of sexual assault victims are eligible to receive their SANE certification through the International Association of Forensic Nurses or American Forensic Nurses. In Texas, the Office of the Attorney General also provides SANE certification for RNs completing an approved class and fulfilling certain clinical requirements. Other similar certifications not certified through the OAG include Sexual Assault Forensic Examiner (SAFE), Forensic Nurse Examiner (FNE), Sexual Assault Nurse Clinician (SANC) and Sexual Assault Examiner (SAE).

Forensic nursing is one of the newest specialty areas recognized by the American Nurses Association and the certification programs for these nurses increasingly focus on physical abuse in addition to sexual abuse. Nonetheless, many doctors and nurses specialized in child physical abuse still learn about the field primarily on the job. Recently, however, the American Board of Pediatrics approved a pediatric subspecialty in child abuse and in 2009 the first physicians will be able to sit for the exam. This is expected to significantly increase the number of pediatricians qualified to assess, diagnose and treat cases of child abuse.

Given the key role that health providers play, the next chapter of this report will look in more detail at the way hospitals in Texas are handling cases of child abuse as well as the other major service providers involved in child abuse in the state.
Notes


2 Ibid.

3 U.S. Code, Title 42, Section 5106g.

4 Texas Family Code, ch. 261, sec. 261.001.


12 Ibid.


19 Michelle A. Lyn, “Child Abuse”, Texas Children’s Hospital Center for Telehealth.

20 Interview with Dr. George Edwards, Program Director of Pediatric Residents Training Program, Dell Children’s Medical Center of Central Texas, Austin, TX, December 10, 2007.

22 Telephone interview with Dr. Angelo Giardino, Member of the Child Protection Team at Texas Children's Hospital, Houston, TX, February 28, 2008.

23 Telephone interview with Dr. Beth Nauert, Lead Physician, Child Assessment Program, Dell Children’s Medical Center of Central Texas, Austin, TX, May 5, 2008.


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

28 Edwards interview.

29 Edwards interview.


32 Telephone interview with Dr. Matthew Cox, Children’s Medical Center, Dallas, TX, December 18, 2007.


35 Flaherty et al, “Pediatrician Characteristics Associated With Child Abuse Identification.”

36 Trokel et al, “Variation in the Diagnosis of Child Abuse.”

37 Ibid.

38 Ibid.


Chapter 2. What Happens to Abused Children in Texas?

When a child suffers abuse or is suspected of suffering abuse in the state of Texas, s/he may be involved with a variety of different government and not-for-profit agencies whose tasks range from determining whether abuse has occurred and treating the emotional and physical consequences of abuse to prosecuting the abuser and protecting the safety of the child. We saw in Chapter 1 that health professionals have an important role to play in cases of child abuse, but there are many other agencies that typically get involved in cases of child abuse and with whom health professionals need to communicate. For this reason, many areas around the state and country have created multidisciplinary teams to facilitate communication between these different actors. This chapter will explore the different actors involved in the process and how they work together as well as the remaining challenges for providing comprehensive medical services for abused children in Texas.

Service Providers

Law Enforcement
Because child abuse is a crime, law enforcement is involved in a wide range of activities related to cases of child abuse. Law enforcement’s role may begin with determining if a violation of criminal law has occurred and if so, arresting the abuser, collecting evidence, taking the statements of witnesses and suspects, and filing appropriate criminal charges. In many cases law enforcement officers are also the individuals who discover the abuse and take the child into temporary custody while they get in touch with child protective services or the local children’s advocacy center. In many areas of the state, there are units set up within the police department that specialize in child abuse and consist of employees with additional training on child abuse issues that may assist the victims in getting access to such services as follow-up counseling or victim’s compensation.

Child Protective Services
Child Protective Services (CPS) is the division within DFPS that is responsible for investigating reports of abuse and neglect of children by caregivers or household members, as well as providing case management, foster care, adoption and other services to children and families. In 2007, the CPS hotline in Texas received 241,125 calls alleging abuse or neglect. The largest numbers of cases of abuse for completed investigations were reported by school officials (19.7%), medical personnel (16.8%), and law enforcement (14.5%).

After receiving a report of suspected abuse, CPS conducts an investigation, which often involves referring the case to outside medical, psychological and forensic interview experts to further investigate the suspicion as well as collect evidence for prosecution. After the investigation, CPS may close the case, work informally with the family or take the family to court to ensure the family’s participation in services or to remove the child from the home. Many times, the evidence and testimony of a medical professional experienced in child abuse can be a vital part of the court case.
Children’s Advocacy Centers

Children’s Advocacy Centers (CACs) are another important type of service provider for abused children in the U.S. and in the state of Texas. Suspected child abuse cases get referred to CACs by either law enforcement agencies or CPS and the CACs then provide support and services to CPS, law enforcement and the alleged victim as the case is being investigated. CACs are designed to be a “one stop shop” for families, providing for a full array of services and facilitating multidisciplinary collaboration by providing a location for forensic interviews that can be observed by all the relevant players in addition to mental health services, crime victims’ compensation assistance, and referral to social services and support agencies. All CACs are also required to have a medical component, which may be provided on or off-site, and involves connecting individuals to medical professionals who can conduct the necessary exams to evaluate health concerns and assess whether abuse has occurred. Most CACs in Texas refer children to a hospital or doctor off-site for these services.

Texas’s 61 CACs have service areas reaching 92% of the child population in the state and each CAC in Texas functions differently depending on the needs of its community and the size of its service area (see Figure 2.1 for a map of CAC services in Texas). While many CACs serve only one county, others serve several and the CAC with the largest service area serves 26 counties. Staff size at CACs in Texas ranges from one or two individuals to dozens depending on the service area. CACs also differ with respect to who is eligible to receive their services. While most CACs serve children from ages 0 to 17, some do not serve the youngest children. Also, most CACs focus the majority of their efforts on sexual abuse and serve significantly less physical abuse victims. In 2007, 76% of the individuals served by CACs in Texas suffered sexual abuse, while only 11% suffered physical abuse.

In FY 2007, 37,198 children in Texas received services from a CAC. Although CPS received over 240,000 calls and confirmed abuse in almost 70,000 cases, many of these children did not pass through a CAC. This may be because they were not referred to a CAC, even though they were eligible to receive CAC services, or because they were not eligible to receive CAC services due to being in an area not served by any CAC or not meeting other criteria set by the local CAC. Of those who did receive CAC services, only 2,363 received a forensic medical exam on-site at the CAC, 3,531 received an exam off-site and 504 received a non-forensic medical exam and/or additional medical treatment.

Child Fatality Review Teams

Child Fatality Review Teams (CFRTs) are another actor that plays a role in child abuse. The 31 active teams throughout the state review child deaths in their area with the goal of reducing the amount of preventable child fatalities, which includes those related to child abuse as well as natural deaths and deaths from unintentional injuries. At a state level, the Texas Child Fatality Review Team State Committee is a multi-agency committee mandated by state law to oversee the work of these local teams and assist them in their work as well as study the scope and magnitude of childhood mortality statewide. There are a few areas of the state that are not covered by a CAC, but are covered by a Child
Fatality Review Team (See Figure 2.1) and these teams may often include some of the most experienced child abuse providers in the community.\textsuperscript{17}

**Prosecution**

The local District Attorney and County Attorney are the two primary types of governmental offices involved in prosecuting the perpetrator in a criminal child abuse case in Texas. Many counties in Texas have both a District Attorney’s office and a County Attorney’s office. In these counties, the County Attorney’s office prosecutes misdemeanor child abuse offenses, while the District Attorney prosecutes felonies. The majority of child abuse crimes are prosecuted by the District Attorney’s office as there are very few misdemeanor child abuse offenses.\textsuperscript{18}

In many counties in Texas, there is no County Attorney’s office and the District Attorney handles all criminal matters related to child abuse. In either case, these offices work closely with law enforcement and other service providers to determine whether a criminal case should be prosecuted, what the proper charges against the defendant will be and whether to plea-bargain or take the case to trial. Either the District Attorney or County Attorney will also represent DFPS in civil suits affecting parental rights. In order to make a convincing case against the abuser, prosecutors are highly dependent on the data collected by CPS, CACs and law enforcement as well as the results of the child’s medical evaluation, making close collaboration between these agencies very important.\textsuperscript{19}

**Hospital Staff and Health Care Providers**

Hospital staff and health care providers are the final crucial service provider interacting with children suspected of suffering abuse and, as noted in Chapter 1, they play a key role by providing the medical expertise needed to examine possible victims. In cases of severe physical abuse, frequently ER doctors are the first medical professionals to see an abused child, but private physicians and nurses often see these children as well. Because of the vital role of health care providers in diagnosing abuse and treating victims, many children’s hospitals in Texas and around the country have developed specialized teams who focus exclusively on these efforts. The remainder of this chapter will explore how these teams function throughout the state as well as the remaining challenges in Texas to providing comprehensive medical exams for children suspected of suffering abuse.
Hospital-Based Child Abuse Teams

A multidisciplinary child abuse team is a team of professionals with diverse expertise that collaborate to provide a wide gamut of services to child abuse victims. While CACs host multidisciplinary teams to facilitate collaboration among the different actors, including medical providers, medical services represent a fairly small part of their activities. For this reason as well as others, many medical providers emphasize the need for a separate medically-oriented team focused primarily on the medical exam and medical concerns.

First of all, medically-oriented child abuse teams have been shown to assist in accurately determining if a child’s injuries are due to abuse, which may save time and money for governmental agencies charged with investigating cases of reported abuse. Furthermore, an accurate analysis by the child abuse team can prevent unnecessary expenses and trauma for the children associated with an out-of-hospital investigation and out-of-home placement for children who have not, in fact, suffered abuse.

While there is little comprehensive data on how frequently these teams determine child abuse has occurred in the cases referred to them, rough estimates from some teams in the state indicate findings of abuse in only about half of the cases they receive, while finding significant medical evidence against abuse in the other half of their cases. If these children had not been referred to them, it is likely that, in many cases, CPS would have dedicated significant efforts and resources to investigating the case. By making this discovery early, however, CPS can dedicate more effort to the cases where abuse is, in fact, occurring, as well as avoiding unnecessary trauma for the children.

A final benefit to these teams is that contact with CPS and other service providers is streamlined through the team, allowing other doctors in the hospital to dedicate their time to their other medical responsibilities and not be distracted by obligations to meet with CPS, law enforcement and prosecutors. Many doctors that do not regularly work on child abuse cases also tend to be reluctant to get involved with the legal aspects of a child abuse case, so these teams can provide a great service for them.

Team Structure and Activities

The child abuse teams based in children’s hospitals around the state are concentrated in the largest cities in Texas. While these teams share similar goals of improving the medical examinations that abused children receive, properly diagnosing abuse and ensuring that children get the highest level of medical care, they are by no means homogenous. The diverse programs have varying levels of staffing and experience in diagnosing and treating children suspected of suffering child abuse. Although each hospital-based child abuse team in Texas is unique, in all cases there is at least one pediatrician specializing in child abuse who leads the team and is supported by a variety of professionals including SANEs, nurse practitioners, social workers and others. These individuals are all important in the assessment and diagnosis of the child.

Teams in Texas differ significantly in the volume of patients they see and the composition of their staff. While some teams may see only two or three child abuse cases a week and not have any staff members working on child abuse cases full time,
other teams have several pediatricians as well as other program staff working with child abuse cases full time and may see up to two thousand cases a year. As a result, the annual operating budgets for the teams around the state also range widely from around $50,000 per year in the smallest programs to over $1 million in the larger programs.

Teams also have diverse protocols for the roles of each team member, such as who conducts the medical exams and who serves as the liaison with CPS, as well as their interaction with others in the hospital. Some hospitals have mandatory referral protocols requiring that anyone in their hospital suspecting abuse send the case to the child abuse team, whereas others allow each doctor to determine when they would like to call on the child abuse team for a consultation.

Another distinction between teams is the extent to which they handle different types of abuse cases and the services they provide. While most of the teams handle both sexual and physical abuse cases, many began their work with one or the other and provide more consultations in that area. Some teams also serve significant numbers of cases of neglect. For the most part, the hospital-based child abuse teams in Texas focus their work on the evaluation of cases of abuse, but some hospital-based child abuse teams also dedicate considerable resources to prevention, research and treatment and rehabilitation services for abuse victims.

**Funding**

Child abuse teams in Texas hospitals are supported in a variety of ways. Some of the services offered by the teams are reimbursed by private insurance providers or Medicaid. In some cases, law enforcement or the prosecutor’s office will provide support for the services and in some cases the teams receive additional support through research funding, donations and other grants. In all cases, however, the hospital provides major financial support for the child abuse team infrastructure. The annual operating budgets for the teams in large urban areas such as Dallas, Fort Worth, Corpus Christi and San Antonio are around $1 million, although there is wide variation among teams.

**Areas without a Child Abuse Physician**

While many of the major metropolitan areas of the state have these hospital-based teams with highly qualified child abuse pediatricians, there are still tens of thousands of children in Texas each year who should see a child abuse pediatrician and do not have the opportunity to do so because there is simply no one in their area with that expertise. Thus, an ER doctor or the child’s regular pediatrician may end up checking the child and may not have the level of expertise or the appropriate equipment and support staff to make an accurate diagnosis.

Experienced child abuse providers are able to more effectively use the equipment they have available and more critically interpret test results to determine if abuse has occurred. For example, when conducting x-rays to check for physical abuse, child abuse specialists advise taking approximately 20 different x-rays, but less experienced providers oftentimes use just one full body x-ray instead, which may cause them to miss important findings. One Texas doctor reported seeing a case where five rib fractures were missed.
for this reason, clearly demonstrating why the availability of child abuse specialists is so vital.\textsuperscript{25}

A study of children referred to the San Antonio team of child abuse experts by CPS found that in over 40\% of cases the assessment by a non-specialist physician regarding the likelihood of abuse was incorrect and that an incorrect diagnosis was three times more common when the children were from rural areas.\textsuperscript{26} The study also found that non-specialists were more likely to diagnose abuse when no abuse was occurring than to conclude that there was no abuse when, in fact, there was.\textsuperscript{27} These findings again demonstrate the importance of the involvement of child abuse specialists in this diagnosis, both for the best interests of the child as well as for the potential to reduce government investigative costs for cases where abuse has not occurred. Furthermore, they reinforce the problem of deficient access to expert assessments for children in rural areas.

\textbf{Legislative Action}

Given the importance of child abuse specialists, the Texas legislature has taken some steps in recent years to begin providing broader coverage of the required medical services related to child abuse and neglect, most notably through Senate Bill 6, the omnibus DFPS reform bill, in the 79\textsuperscript{th} Texas Legislature and Senate Bill 758 in the 80\textsuperscript{th} Texas Legislature.

The passage of Senate Bill 6 in 2005 required a variety of reforms at DFPS related to the functioning of CPS and other agencies as well as the provision of services for individuals in their care. However, the bill’s focus on greater access to medical services for child abuse and neglect is one of the most relevant aspects for child abuse specialists. Most notably, the bill requires “the designation of health care facilities with expertise in the forensic assessment, diagnosis, and treatment of child abuse and neglect as pediatric centers of excellence” as well as the establishment of a statewide telemedicine system to link DFPS staff with these centers or other medical experts.\textsuperscript{28}

While some action to advance the provisions above was taken when the Forensic Assessment Center Network (FACN) was created in 2006, much work remains. The FACN was designed to provide a statewide network of resources that would allow CPS better access to medical professionals with expertise in child abuse and neglect and to “fill in the gaps” for cases where local expertise in these areas was not available.\textsuperscript{29}

The FACN was developed through a DFPS contract with the University of Texas system, which is administered by UT Health Science Center in Houston, but also includes UT Health Science Centers in Galveston, Dallas and San Antonio.\textsuperscript{30} This network for forensic medical consultation currently provides CPS with access to medical professionals specializing in child abuse and neglect 24 hours a day to provide expert medical opinions based on a review of his/her medical records, a review of statements made by the children’s caregivers and/or a physical examination of the child.\textsuperscript{31}
Senate Bill 758 refined some of the DFPS reforms of Senate Bill 6 and also provided for the creation of an Advisory Committee on pediatric centers of excellence relating to abuse and neglect, among other provisions. The bill specified the composition of the 10-member committee, which includes representatives from the OAG, DSHS, DFPS, HHSC and a CAC as well as three pediatricians specializing in child abuse, a representative from a children’s hospital and a representative from a medical school with expertise in forensic consultation (See Appendix A).

The duties of the Advisory Committee include developing guidelines for designating regional pediatric centers of excellence to provide medical expertise and assist DFPS in evaluating and interpreting the medical findings, developing recommended procedures and protocols for health care providers when evaluating suspected cases of child abuse and neglect, and recommending methods to finance the centers of excellence and related services. The committee began meeting in January, 2008 and will report their findings and recommendations to DFPS and the Texas Legislature by December, 2008.32

Remaining Challenges in Texas
While the recent legislative activities and the work of individual hospitals have begun to lay the groundwork for comprehensive medical services for abuse victims across the state, there are still many challenges to providing high quality care to all child abuse victims in Texas. The most pressing needs cited by a variety of health care providers around the state include funding for programs, the availability of a greater number of highly trained providers and the state’s geography.

Funding/Reimbursement
Funding is a major concern for Texas multidisciplinary child abuse teams due to the low reimbursement for billable services and the high quantity of services that are not billable. Although medical professionals play an important role in the investigation and prosecution of abuse cases, much of the time spent on these activities does not represent a direct medical service to the patients and thus, is not billable to patients and their insurance provider. Furthermore, oftentimes teams only receive reimbursement for a fraction of the services they bill. While larger hospitals with larger budgets have been able to provide financial support for these types of activities, smaller hospitals and individual medical providers generally do not have the funds needed to provide these types of services without receiving any revenue.

Supply of Trained Providers
Another important challenge to providing effective child abuse assessment, diagnosis and treatment in Texas is the limited number of clinicians with adequate training on child abuse issues. Despite its prevalence, we have noted that many clinicians receive very little training on child abuse while they are in medical school and in continuing education programs throughout their career. As a result, many clinicians in Texas – as well as throughout the United States – do not have sufficient knowledge about how to recognize and handle cases of child abuse and do not feel confident in their ability to do so.33 Although the major metropolitan areas tend to have well-developed programs, many
programs in the state who would like to hire additional experts find that there are simply not enough skilled clinicians to do so.

In addition to the concern of training clinicians, a related concern is that when medical professionals suspect child abuse, they do not automatically think they need a specialist in the same way they would automatically refer a patient with cancer to an oncologist or a patient with heart disease to a cardiologist. If this did occur, this would potentially allow for a greater number of children suffering abuse to receive an exam from a highly qualified professional, although the challenges of funding and provider supply would remain.

**Geography**

A final challenge that is intimately connected to funding and human resource challenges is that of making services available across the state due to the state’s geography. As the state has several large urban centers where there is a larger population and thus, larger volume of child abuse patients, the qualified child abuse physicians are concentrated in these areas, while rural areas have very little access to child abuse pediatricians. Rural areas are also not likely to see the volume of patients necessary to support a full time child abuse pediatrician or team, so it is challenging to develop a feasible plan to cover these areas, although the higher rate of misdiagnosis in these areas make this a pressing need.

A few states in the U.S. have been able to address some of the challenges faced by Texas and have developed systems for more comprehensive coverage throughout their state. The next chapter will explore some of their experiences in order to begin envisioning the possibilities for more comprehensive medical services for abused children in Texas.
Notes


3 Ibid.


5 Interview with Selena Muñoz, Director of Program Services, Children’s Advocacy Centers of Texas, Inc., Austin, Texas, October 18, 2007.

6 Children’s Advocacy Centers of Texas, Inc., 2006 Annual Report for the period September 1, 2005 through August 31, 2006, Austin, TX.

7 Muñoz interview.

8 Muñoz interview.

9 Children’s Advocacy Centers of Texas, Inc., 2007-2008 Directory, Austin, TX.


12 Children’s Advocacy Centers of Texas, 2007 Annual Report.

13 Ibid.

14 Ibid.


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

18 Telephone interview with Jay Lapham, Associate Executive Director, Shaken Baby Alliance, Dallas, TX, April 30, 2008.

19 Ibid.


21 Ibid.

22 Telephone interview with Dr. Nancy Harper, Director, Child Abuse Resource and Evaluation Team, Driscoll Children’s Hospital, Corpus Christi, TX, February 15, 2008.

23 Telephone interview with Dr. Matthew Cox, Children’s Medical Center, Dallas, TX, December 18, 2007.


25 Cox interview.
26 James Anderst, Center for Miracles – Christus Santa Rosa Children’s Hospital, San Antonio, TX, manuscript in submission.
27 Ibid.
28 Texas Family Code, ch. 266, sec. 266.003. Medical Services for Child Abuse and Neglect Victims.
30 Ibid.
31 Ibid.
32 Texas Senate Bill 758, 80th Legislature, regular session (2007).
33 Cox interview.
Chapter 3. Medical Child Abuse Services Around the Country

Children’s hospitals throughout the U.S. face numerous challenges and obstacles to providing the full gamut of services required by children suffering abuse. Nonetheless, there are a few states in the country that have made significant progress in coordinating child abuse services in order to provide high quality child abuse diagnostic and treatment services throughout their state and overcome some of the challenges to providing these services. This chapter will explore the experiences of Florida, New Jersey, South Carolina and Utah in an effort to illuminate the diverse possibilities for Texas.

Florida
Florida is one of the leading states in the United States with respect to establishing a statewide system to coordinate child abuse assessment services and may serve as one of the best models of the steps to take in developing statewide services. Although Florida receives approximately 190,000 child abuse reports annually in comparison to approximately 250,000 in Texas, as a large and diverse state, its experience has much to offer the process of expanding medical child abuse services in Texas.

How They Did It
The roots of the Florida system began in 1978 when a pediatrician created the first Child Protection Team (CPT) in Jacksonville to provide for greater collaboration among healthcare professionals when evaluating injuries that may have been caused by child abuse. A legislative appropriation for this first pilot site was provided in the same year. As other regions began to observe the benefits of the Jacksonville CPT, several more individual teams were created and the capacity in each was built one by one. Once the state reached a critical mass of teams, legislation was passed to cover every child in the state with a CPT through a statewide system that receives funding through annual appropriations.

Setup and Services
In the Florida system, the entire state is divided into 23 regions with each region being covered by a multidisciplinary CPT that is in charge of child abuse services. There is also a state medical director that provides oversight and support to all regions. When a case of suspected child abuse is called into the state child abuse hotline, it is referred to the CPT serving the area where the child is located. Florida sets a legal requirement in the state code that the CPTs must serve victims meeting certain mandatory criteria, which include such injuries as burns, fractures or bruising on the head or neck for any child, and the presence of a sexually transmitted disease in a prepubescent child.

Each CPT is medically-led and consists of individuals meeting specific required qualifications and representing a variety of disciplines including pediatricians, psychologists, and attorneys. Each of the 130 trained medical evaluators in the state of Florida is prepared to conduct the required interviews or exams using the protocols established by the system. The statewide medical director serves as both a formal and
informal support to these providers by providing training and consultation services when individual physicians have concerns about a case and also by making the final judgment of whether a case constitutes abuse when physicians disagree or it is a high profile case.10

The CPTs in Florida are dedicated primarily to the evaluation of suspected child abuse cases, but not treatment. When ongoing treatment is required for a victim of sexual or physical abuse, each CPT has a referral network of appropriate providers in their area. Most Child Protection Teams are housed within a CAC or a university, although these organizations just serve as the hosting agency, but are not in charge of the exam process.

The service area of each CPT ranges greatly from one to eleven counties and potential patients may be as far as four hours away from their nearest CPT.11 For this reason, the state has adopted a sophisticated telemedicine network to be able to conduct exams at a distance for areas such as the Florida Keys and other remote parts of the state. The CPT housed in Gainesville, for example, conducts over half of its exams by telemedicine.12

Funding

With a current annual budget of approximately $20 million, Florida’s system is housed under the state Department of Health, which then distributes funding to each CPT. This funding includes financial support for the statewide medical director as well as the physicians serving as medical directors in each of the 23 regions.13 Because many important child abuse related services may not be reimbursable by third party payers, this is an important element of the system. As an example, the Jacksonville medical director is paid 16 hours per week for work that does not involve seeing children directly.14 Instead, these hours may be devoted to such activities as making court appearances, interacting with CPS and law enforcement, or administrative tasks related to coordinating the program.15 If he were only paid for the time spent seeing patients, it would be very challenging to allocate adequate time and attention to these important tasks.

Quality Assurance and Impact

Florida makes an ongoing effort to assure quality services amongst all teams and team members. First of all, all teams must send reports on the cases they serve, which is then integrated into a statewide data system. Also, there are ongoing on-site peer reviews where a multidisciplinary team of specialists reviews the CPT as well as ongoing reviews of compliance with the contract standards that are managed by the Department of Health. Furthermore, all providers are required to attend a semiannual statewide meeting that provides continuing education for the Child Protection Team members and the state also conducts weekly peer review telemedicine conferences. These detailed quality assurance procedures help make sure all providers are performing according to best practices and provide the opportunity for ongoing education and exchange between providers in the state.16

While the Florida system has not undergone a comprehensive evaluation, it is widely recognized to be among the most advanced systems in the U.S. with significantly more coordinated services than most states.17 According to the state medical director, the multidisciplinary nature of the program as well as the coordination between the State
Department of Health and the Department of Children and Family has also led to better results when it is necessary to take a case to court.\textsuperscript{18}

\textbf{New Jersey}

\textbf{How They Did It}
As in Florida, a child abuse pediatrician in New Jersey took the lead in advocating for the creation of a statewide system in New Jersey. Recognizing that CPS had a need for specialized medical and mental health professionals in order to be able to do its work, in the 1980s, Dr. Martin Finkel began asking the state to take responsibility for sponsoring the services. One of his first successes in this area was negotiating a special rate for Medicaid to reimburse a larger portion of the costs for the child abuse examination services, increasing the rate from about $18 in reimbursement per three-hour exam in the 1980s to $150 and eventually to $600 for some hospitals and providers.\textsuperscript{19}

In his testimonies before the legislature, Dr. Finkel emphasized that the state had an obligation to protect its children and could not continue to rely on the good will of providers who were providing their services at highly discounted rates. He advocated for providing base funding to the hospitals housing providers who could do this. In 1998, the New Jersey Regional Child Abuse Diagnostic and Treatment Center Network was officially established when the New Jersey legislature authorized appropriations to allow for the support of four hospitals in the state that would serve as regional centers of excellence in diagnosing as well as treating child abuse.\textsuperscript{20}

\textbf{Setup & Services}
Like Florida, New Jersey has set up a system of protocols to determine when suspected cases of child abuse received by CPS should be referred to one of the centers of excellence. For example, for certain types of physical injuries, such as when a child has been burned or seriously injured, referral is mandatory. For other cases, it may be up to the discretion of CPS as to whether or not to seek the services of a center of excellence.\textsuperscript{21} However, in many ways the New Jersey system differs significantly from the system in Florida.

First of all, New Jersey’s strategy has been to use a centers of excellence model and have fewer locations around the state where children can be served, but have high level experts in each of these locations. Then, they make an effort to educate community doctors to use the centers of excellence as a resource so that the primary care physicians and ER doctors everywhere in the state are not required to have the expertise necessary to make a child abuse diagnosis in a strong and defensible way that would allow them to testify in court to their opinion. Instead, they educate doctors about the availability of the centers of excellence where there are doctors with these skills.\textsuperscript{22}

Another distinction between New Jersey and Florida is that there is no statewide medical director overseeing the work at all centers in New Jersey. Although the four centers of excellence communicate, each one is administered independently.\textsuperscript{23}
New Jersey’s services are also unique in that the centers of excellence are dedicated not only to the evaluation of suspected abuse, but also to evidence-based treatment programs for children after they have been diagnosed with abuse. Once a child at one of the centers has been found to suffer abuse, the child may receive ongoing treatment and rehabilitation services at the same center instead of being referred elsewhere.24

**Funding**
The services of the New Jersey Regional Child Abuse Diagnostic and Treatment Center Network are supported through a combination of legislative appropriations and per case contractual fees. The annual appropriation of nearly $2 million from the state government is divided evenly between the four regional centers in the state and serves as base funding for the four centers to cover the basic infrastructure and core elements of the team as well as the testimony of medical professionals in civil cases.25 However, there are many services that still require CPS or the requesting agency to pay fees to the center or provider according to the terms laid out in the contract between the center and CPS.26 For example, prosecutors must pay $2,000 per day for a provider’s testimony when it is needed for criminal court proceedings.27

The annual state appropriations to maintain the basic structure of the centers can be seen as a good investment as they have allowed the centers to provide a great deal of services beyond that which is provided for in the appropriations. The appropriations provide the needed funding to be able to support the basic administrative expenses of the center that allow it to provide other vital services for a fee or through grants and donations. For example, one of the New Jersey centers comments that, although it only receives approximately $400,000 in annual appropriations, this base funding allows the center to receive funding from a variety of other sources, including federal grants, which brings the center’s total operating budget to $5 million.28

**Quality Assurance and Impact**
Although the state system is decentralized, New Jersey has set up a structure for ongoing quality assurance throughout the state through an advisory board for the regional diagnostic and treatment centers and regular meetings. The child abuse teams at each center typically meet every two weeks to discuss cases and ensure appropriate and thorough investigations are done and the four regional centers also get together on a regular basis to share experiences and facilitate mutual learning and collaboration.29 The quantity of abuse evaluations and mental health services provided in the New Jersey centers has increased substantially since they began receiving state appropriations.30

**South Carolina**

**How They Did It**
South Carolina began trying to set up a statewide system in 2003 to better meet the needs of children requiring forensic medical exams. Before creating a system for their state, leaders in South Carolina did research on different programs around the country and decided to base their program on the Florida model. They received support through a grant from the Duke Endowment to set up the South Carolina Children’s Advocacy
Medical Response System (SCCAMRS) and hired a doctor, who had been working within the Florida system, to help get the system going.31

Setup & Services
In South Carolina the four children’s hospitals located in Charleston, Columbia, Florence and Greenville each serve as a center of excellence in child abuse pediatrics and SCCAMRS aims to provide training and assist these hospitals as well as CACs in the state in providing high quality care in cases of potential maltreatment.32 Led by Florida’s example, South Carolina has developed and implemented statewide protocols and guidelines in such areas as the medical management of child abuse and neglect, when hospitals should consult with their local Child Abuse Pediatrics healthcare provider, when child welfare agencies and law enforcement should refer children for medical evaluations, standards for primary health care providers willing to participate in the assessment of child abuse and neglect and a curriculum for resident training in Child Abuse Pediatrics.33

Unlike the systems in Florida and New Jersey, in South Carolina there is no mandate that CPS send cases to SCCAMRS providers and the Department of Social Services makes the determination of what cases will require a medical exam.34 Nonetheless, SCCAMRS requires providers to meet certain qualifications in order to be able to receive reimbursement through the system and provides scholarships to child abuse training academies as well as direct training and CME programs to help prepare providers. Currently the state only has two forensic pediatricians, but hopes to reach the goal of having one forensic pediatrician per center.35

Funding
SCCAMRS was initially funded through a three-year seed grant from the Duke Endowment.36 Since then, it received $1.4 million in funding from the state for an additional year of work.37 The funding is administratively managed through the University of South Carolina Department of Pediatrics through a contract with the South Carolina Department of Health and Human Services.38 While a portion of this funding goes to funding for the medical director, an administrative assistant for the program and overhead expenses, the bulk of the funding is used to reimburse providers for rendering services.39 While providers previously received only $120 in reimbursement from the State Office for Victims Assistance for a child abuse assessment, SCCAMRS now offers providers approximately $200 in additional reimbursement.40

South Carolina still faces many challenges in institutionalizing the funding over the long term and providing access to the breadth of services required. For example, SCCAMRS has worked with other agencies in the state on legislation requiring a forensic exam in certain cases and providing reimbursement for these exams to providers, but thus far they have been unable to get widespread support for this initiative. Another challenge with respect to funding is that the state is unable to reimburse providers for court time, which can represent a significant period of time and quantity of work for providers. Although the state Department of Social Services allows paying providers for testimony,
SCCAMRS simply does not have sufficient funding to be able to do that at the present time.

**Quality Assurance and Impact**

The state has implemented statewide healthcare provider roundtable meetings as a tool for quality assurance and a forum for peer review as well as a statewide database system to track children receiving child abuse medical services, to identify areas in need of these services and to assess the quality of the services provided.41

Since the establishment of SCCAMRS in 2003, South Carolina has added six additional accredited CACs and made several improvements in the level of services provided to child abuse patients. Most notably, the state has been able to serve a much larger number of patients, serving 3,100 in 2006, up from 1,900 in 2003. Although the state estimates that it is currently meeting only 42% of the need, this represents a significant increase from the less than 25% it was able to meet in 2004.42

**Utah**

Medical child abuse services in Utah are unique and do not follow the model of any of the other states we have discussed. Although Utah is a very large state in terms of land mass, the population of the state is rather small with nearly 75% of the population living within a 60 mile radius of the capital. As a result, services in the state are centralized around Salt Lake City and the state’s only medical school and only children’s hospital are located there.43

**How They Did It**

While providers in Utah continue to strive for the centralization of their medical child abuse services in order to provide access to high quality care around the state, there is currently no comprehensive program that covers all areas of the state. Nonetheless, because of the sparse population, Primary Children’s Medical Hospital in Salt Lake City serves most of the population as well as serving parts of neighboring states. In the 1980s, the hospital set up its child protection team known today as the Center for Safe and Healthy Families in order to provide medical evaluation of child physical and sexual abuse. Recognizing the hospital’s specialized expertise in child abuse, in the 1990s, the Office of the Attorney General approached the hospital to provide them with a contract to manage the medical aspect of the work of the state’s CACs known as Children’s Justice Centers.44

**Setup and Services**

Because there is only one children’s hospital in Utah, there is no network of hospital-based teams working on child abuse. However, at Primary Children’s there are four pediatricians (about three FTEs) dedicated to child abuse in addition to other medical staff. In addition to child abuse assessment services, the hospital also has highly developed mental health and treatment services for children suffering abuse. Primary Children’s also manages medical exams for five of the 15 CACs in the state. The exams are carried out by a part-time or full-time nurse practitioner or physician assistant on-site at each of the CACs, although they are employees of Primary Children’s.45
The program managed by Primary Children’s sees about 800 cases annually at the hospital as well as about 800 additional cases outside the hospital at the five CACs. In both cases, the overwhelming majority of cases are sexual abuse cases, representing over 90% of the cases seen at the CACs and about 80% of the cases seen at the hospital.46

Primary Children’s is managed by a corporation that operates 15 hospitals in the state of Utah that are all able to share information electronically and are located in almost every area where there is a CAC in the state. If more funding were available, the program at Primary Children’s would like to develop a network to cover the entire state, taking advantage of this ability to share information electronically. However, as the services coordinated at Primary Children’s do not presently cover the whole state of Utah, the other CACs in the state independently determine how to provide the required medical services, usually by recruiting a pediatrician in the community.47

**Funding**

Funding for the services covered under the CAC program managed by the children’s hospital comes primarily from the Office of the Attorney General in the form of $500,000 in annual appropriations that is primarily dedicated to salaries and benefits. The hospital services for the child abuse program that is not associated with CACs are funded primarily through Medicaid, private insurance billing and crime victim’s compensation funds, although a significant portion of the services are underwritten by the hospital. Law enforcement and prosecutorial agencies do not provide payment for any of their services.48

**Quality Assurance and Impact**

Utah doesn’t presently have any quantitative data on the impact of their medical evaluation services for child abuse victims, although they are currently working on developing systems to better collect and analyze this data. The state does have several procedures in place to ensure the medical integrity of the program, however. The medical director of the child abuse program at Primary Children’s reviews 100% of the cases seen by the nurse practitioners and physician assistant off-site using telemedicine tools to review the images and medical findings. Furthermore, Primary Children’s provides training and pro-bono consultations to physicians in areas not covered by their providers to ensure that children throughout the state get the highest level of medical care.49

**Discussion & Challenges**

Statewide systems such as the ones above are praised for their ability to provide needed services to children in their state as well as to other providers in the state. As noted in Chapter 2, when a larger proportion of children suspected of suffering abuse are evaluated by a highly qualified medical provider, the results are likely to be more accurate and thus, save money for the state in investigative and court costs while better serving the children. For this reason, more states are developing initiatives similar to those undertaken by Florida, New Jersey, South Carolina and Utah. Most notably, Maryland recently began a statewide initiative known as the Child Abuse and Neglect Centers of Excellence Initiative to improve services in its state by such activities as
improving local clinical expertise, developing multidisciplinary teams and using teleconferencing and on-site training and consultation. Missouri and Washington also have developed similar statewide efforts. Although these state systems are diverse, the challenges they face are often very similar and they are also similar to many of the issues faced by the multidisciplinary teams in Texas. Provider shortages and funding stand out as the most significant challenges shared by all the programs.

**Funding/Reimbursement**

Although the programs we have discussed here are among those with the most stable funding sources, funding remains a challenge in nearly all of these programs as well due to the challenges in not being reimbursed for billable services as well as not receiving enough funding to cover non-billable services. In South Carolina, for example, although the program has secured state funding in the short term, it is unclear whether the state funding will continue, which will be essential to institutionalizing the program. Even in Florida, where the program has been institutionalized and receives much higher state support than any other state program, the state medical director describes the need for increased funding to continue to meet the growing need. Furthermore, the increasing costs of operation paired with stable levels of collections and stable state funding means that programs often end up with less funding in real dollars over time.

**Supply of Trained Providers**

In the words of one state coordinator, one of the largest challenges is the “basic shortage of providers who want to do the work and programs to train them.” The short supply of pediatricians specializing in child abuse leaves many programs with an insufficient number of providers to meet the needs. For example, South Carolina has only two board-eligible forensic pediatricians in the entire state, which means that children may need to wait several weeks to get a forensic medical exam from an individual with adequate qualifications and experience. Since the 2006 NACHRI report entitled “Defining the Children's Hospital Role in Child Maltreatment” encouraged children’s hospitals to look more deeply at the way services are provided in their area, there has been an even larger demand for pediatricians with specialized knowledge in child abuse.

Some hospitals also face challenges in maintaining other staff for child abuse programs. Because many nurses and social workers might not be exposed to working on these issues during their education, they require heavy training when joining a multidisciplinary team. However, they many times leave the field of child abuse relatively soon after they begin as they discover that the work is not what they want to do.
Notes

1 Telephone interview with Karen Seaver Hill, Associate Director, Child Advocacy, National Association of Children’s Hospitals and Related Institutions, Alexandria, VA, October 19, 2007.
2 Telephone interview with Dr. Randell Alexander, Statewide Medical Director, Child Protection Team, Jacksonville, FL, October 29, 2007.
3 Telephone interview with Maggie Michaels, Director of Advocacy and Public Policy, Children’s Hospital Collaborative, Charleston, SC, December 19, 2007.
6 Alexander interview.
9 Alexander interview.
10 Ibid.
11 Ibid.
12 Ibid.
13 Ibid.
14 Ibid.
15 Ibid.
16 Ibid.
17 Ibid.
18 Ibid.
19 Interview with Dr. Martin Finkel, Medical Director, Child Abuse Research Education & Service (CARES) Institute, Stratford, NJ, February 5, 2008.
20 Ibid.
21 Ibid.
22 Ibid.
23 Ibid.
24 Ibid.
25 Ibid.
26 Ibid.
27 Ibid.
28 Ibid.
29 Ibid.
31 Michaels interview.


Michaels interview.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

South Carolina Children’s Advocacy and Medical Response System, *Before SCCAMRS and After: Accomplishments to Date*.

Ibid.

Telephone interview with Dr. Lori Frasier, Medical Director, Center for Safe and Healthy Families, Primary Children’s Medical Center, Salt Lake City, Utah, April 24, 2008.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.


Michaels interview.

Michaels interview.
Chapter 4. Developing Pediatric Centers of Excellence on Child Abuse in Texas

After exploring the diverse areas contained in this volume, the question remains as to how to provide access to high quality child abuse services statewide and how the recently-established Advisory Committee will develop guidelines for designating and financing centers of excellence in child abuse in Texas. We have seen that although many of the major metropolitan areas of the state have expert child abuse teams handling their cases of suspected abuse, there are many areas that do not have physicians with this type of expertise and the state is in need of a robust system that provides access to consultation around the state for broader and deeper coverage of all children. Services will need to be developed on a regional basis, but will also need to serve all areas of the state, including remote areas far from the urban centers.

Efforts to develop guidelines for designating and financing child abuse centers of excellence in Texas will need to address the fundamental challenges identified in the state associated with program funding, provider supply and geography. The remainder of this chapter will discuss strategies for addressing each of these needs through increasing human resource capacity, increasing funding and reimbursement mechanisms and investing in communication capabilities.

Developing Capacity to Train Future Child Abuse Providers and Increase Education for All Providers

In order to better meet the needs of children across the state, we need a larger number of pediatricians with specialized experience in child abuse pediatrics. As there is a shortage of qualified providers around the country, Texas needs to develop capacity in-house with expanded training opportunities and fellowship programs. Currently, UT Health Sciences Center in San Antonio hosts the only recognized fellowship program in child abuse and neglect in Texas.

In addition to training child abuse specialists, all health care providers need to be provided with a higher level of training on these issues. As mandatory reporters, physicians need to better understand both their obligation to report as well as the warning signs that indicate that a child may be suffering abuse. Furthermore, health care providers as well as other service providers may need education on the benefits of sending a child suspected of suffering abuse to a child abuse specialist and the importance of receiving a medical exam. Some of these educational and training needs could be met by providing greater training in these areas during medical school as well as making regular child abuse training a part of the continuing education requirements for all physicians, nurses, social workers, and other professionals who are likely to see cases of abuse.
Increasing Funding and Reimbursement for Services

National surveys have found that the “health care financing system does not adequately reimburse hospitals for the range of services needed by abused and neglected children” and that the majority of medically-oriented child abuse teams are unlikely to survive financially based solely on “patient care revenue for child maltreatment medical evaluations.” We have seen that this national reality is also a reality in Texas.

Hospitals in Texas need stable sources of funding to be able to develop and grow their medical child abuse services. Hospitals with smaller operating budgets will never be able to develop the robust services available at some of the larger hospitals if there is not a greater opportunity for these services to be reimbursed by Medicaid and private insurance providers as well as opportunities for ongoing funding to cover services that will never be reimbursable through these sources. Similarly, the larger hospitals will not be able to grow their services if they continue to operate at a loss.

State formula funding that would cover the base operating costs of these services could be an important way to allow more hospitals to provide the needed services. We have seen in New Jersey that this type of funding has allowed centers of excellence to significantly expand their services and budgets far beyond the amount provided by the state appropriations.

Here in Texas, there are also statewide initiatives and specialty services for children for which state formula funding forms the necessary baseline support to maintain operations, while facilitating the expansion of services through grants from other funding sources. Appendix B provides additional information on the funding sources and operation of programs as diverse as family violence shelters, CACs, trauma centers and poison centers in Texas. Elements of each of these programs can help inform decisions on the most appropriate management and financing strategies for child abuse centers of excellence.

Expanding Communication and Networking Capacity

As a large state with a diverse landscape and many rural areas, it would be impossible for Texas to attain the necessary level of child abuse expertise in every community where child abuse occurs. Thus, an investment in telemedicine is an important strategy to allow for a greater level of access to high quality care in remote areas. Other states, such as Utah and Florida rely significantly on telemedicine both for conducting exams as well as providing for quality assurance through case conferences. Expanded telemedicine capabilities could also provide benefits to state agencies, health care providers, and patients for a variety of other health care issues.

Many providers also report that there is a need for greater contact between different programs in the state as well as a more formal mechanism for the providers involved in the child abuse evaluation to connect with those who provide ongoing care for the children. For example, for the many children evaluated for child abuse that end up in the foster care system, the providers of their follow-up care often do not communicate directly with the providers conducting the evaluation and thus, important information can
be lost. Improved communication channels and programs could help maintain continuity of care in these cases and reduce duplication of efforts.

**Conclusion**

The State of Texas has a responsibility to provide for its children and invest in the future of Texas. Although many of the costs of child abuse cannot be precisely calculated, it is widely recognized that the economic and social costs of child abuse in the state are enormous and growing. A fundamental way to contain some of these costs is through an investment in early and accurate child abuse diagnosis that can better protect for the needs of children while promoting a more efficient use of limited state resources.

Increases in provider capacity and training, expansions in infrastructure and greater financial investment in child abuse services will help Texas get one step closer to meeting the vast needs of its children. Furthermore, these efforts will contribute to improved health and quality of life for Texas children while increasing their opportunities to live successful, productive futures and make positive contributions to their state and their community.
Notes


Appendices
### Appendix A. Centers of Excellence Committee Roster

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization/Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vincent Fonseca, MD, MPH</td>
<td>Texas Department of State Health Services</td>
</tr>
<tr>
<td>Angelo Giardino, MD, PhD, FAAP</td>
<td>Texas Children’s Health Plan</td>
</tr>
<tr>
<td>James Rogers, MD</td>
<td>Texas Department of Family and Protective Services</td>
</tr>
<tr>
<td>Rebecca Girardet, MD</td>
<td>UT Medical School, Houston</td>
</tr>
<tr>
<td>Karen Hilton</td>
<td>Texas Health and Human Services Commission</td>
</tr>
<tr>
<td>Richard Wayne, MD</td>
<td>Christus Santa Rosa Children’s Hospital</td>
</tr>
<tr>
<td>Jamye Coffman, MD</td>
<td>Cook Children’s Hospital</td>
</tr>
<tr>
<td>Nancy Kellogg, MD</td>
<td>UT Health Science Center - San Antonio</td>
</tr>
<tr>
<td>Mathew Cox, MD</td>
<td>Children’s Medical Center</td>
</tr>
<tr>
<td>Nancy Harper, MD, FAAP</td>
<td>Driscoll Children’s Hospital</td>
</tr>
<tr>
<td>Herman Millholland</td>
<td>Office of the Attorney General</td>
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</tbody>
</table>
Appendix B: Administration and Funding of Four Public Health Programs in Texas

This appendix provides background information on the operation and funding sources for family violence shelters, children’s advocacy centers, trauma centers and poison centers in Texas. We explore the administration and funding sources for each of these activities through the chart below and the narrative which follows. Each program is funded in part by state formula funding.

<table>
<thead>
<tr>
<th>Activity &amp; State Office(s) Administering</th>
<th>Annual State Program Funding</th>
<th>Funding Sources for State Program</th>
<th>Distribution of State Program Funding</th>
<th>Other Funding Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Violence Shelters (HHSC Family Violence Program)</td>
<td>$24 million</td>
<td>20% Federal funding under FVPSA 45% State General Revenue 35% TANF funds transferred into SSBG</td>
<td>• Non-competitive annual renewals of 72 shelter contracts • Combination of equal base funding and discretionary funding</td>
<td>• HHSC funding = 30% • Other sources: grants and donations</td>
</tr>
<tr>
<td>Children’s Advocacy Centers (OAG)</td>
<td>$6 million</td>
<td>67% Compensation to Victims of Crime Fund 33% State General Revenue</td>
<td>• OAG provides funding to CACTX to distribute to the 61 CACs • Combination of equal base funding and direct service funding</td>
<td>• OAG funding = 15% • Other sources: state and federal grants, local government, local individuals and corporations</td>
</tr>
<tr>
<td>Poison Centers (Commission on State Emergency Communications; DSHS)</td>
<td>$8 million</td>
<td>100% Statewide Equalization Surcharge</td>
<td>• CSEC distributes funding to the 6 Poison Centers based on the population size in the center’s service area.</td>
<td>• Other major source: HRSA granted approximately $1.4 million to Texas Poison Centers in FY 2007.</td>
</tr>
<tr>
<td>Trauma Centers (DSHS Office of EMS/Trauma Systems Coordination)</td>
<td>$50 million</td>
<td>98% Driver Responsibility Program 1% Statewide Equalization Surcharge 1% Alcohol surcharge</td>
<td>• DSHS funds 243 designated trauma centers and centers “in active pursuit” of designation. • Combination of equal base funding and discretionary funding based on % of uncompensated trauma care</td>
<td>• Other major source of assistance with uncompensated care for trauma centers is Disproportionate Share Funds.</td>
</tr>
</tbody>
</table>
Family Violence Shelters
Texas currently has 72 family violence shelters that provide emergency refuge for victims of family violence as well as additional services, such as legal advocacy, counseling assistance in obtaining medical care and referral to other services.

Organization and Administration
The Texas Health and Human Services Commission Family Violence Program serves as a major source of funding for family violence shelters in Texas. For FY 2008, the program received funding of approximately $24.1 million to provide grants and contracts to the 72 shelters, 8 nonresidential centers and 20 special nonresidential center projects around the state dedicated to family violence. Of this funding, $19 million was provided to shelters for shelter services, $2.6 million was dedicated to other family violence projects and a relatively small portion was dedicated to the costs of administering the program. While the special nonresidential center projects receive funding through a competitive application process that occurs every three years, the funding for family violence shelters is generally not provided through a competitive process after the first year as it is intended to provide ongoing long-term funding for the shelters.

Each shelter in the state receives a certain base funding amount ($115,000 for FY 2008) and then receives an additional allocation of funds based on a formula dependent upon a variety of other factors such as the number of service days provided by the shelter in the previous three years and whether the shelter is located in an urban or rural area. In order to protect funding for rural areas seeing a smaller number of clients, there is also an annual cap to how much funding one shelter can receive from HHSC, which is currently $700,000. HHSC also requires that their funding make up a lesser portion of the total shelter funding each year that a shelter is funded, dropping from 75% in the first year of HHSC funding to 50% after seven or more years of funding. On average, however, HHSC funding only makes up about one-third of the shelter budgets in Texas.

Funding Sources
Funding for these grants and contracts comes primarily from three sources. The first source of this funding is from the Family Violence Prevention and Services Act (FVPSA), which is federal funding that is earmarked for crisis shelter services that the state has been receiving since 1986. In fiscal year 2007, FVPSA funding was approximately $4.8 million or 20% of the total Family Violence Program budget. The remaining funding for the Family Violence Program in FY 2008 came from state general revenue ($10.9 million) and Temporary Assistance for Needy Families (TANF) funds ($8.4 million). Federal policy allows a small percentage of TANF funds to be transferred into Title 20 Social Services Block Grants and, in Texas, a portion of these funds are used to fund the Family Violence Program. Shelters receiving these funds must provide documentation to demonstrate that the individuals receiving their services are income-eligible for TANF, although they do not need to be receiving TANF.
At other moments in its history, the family violence program also received funding from the Compensation to Victim’s of Crime Fund (composed of fees charged to individuals who commit crimes), through the Office of the Attorney General, as well as funding directly through the Title 20 Social Services Block Grants. The state general revenue funding for family violence shelters has been increasing recently, increasing by $1 million for each year in the 2006-2007 biennium as well as $1 million for each year in the 2008-2009 biennium.

**Children’s Advocacy Centers**
Texas has 61 CACs that provide services to child abuse victims and service providers. They bring together varied professionals in order to aid investigators and prosecutors without causing further harm to the child as well as helping the child’s healing by referring them to appropriate medical and mental health services.

**Organization and Administration**
CACs in Texas receive much of their start-up funding and base funding for general operating costs through annual appropriations from the Office of the Attorney General (OAG). The OAG contracts with Children’s Advocacy Centers of Texas, Inc. (CACTX), the state CAC membership organization, and CACTX then contracts with local CACs to provide direct services. The annual legislative appropriations were approximately $4 million in fiscal year 2007, but were increased to $6 million for fiscal year 2008. Of the $6 million appropriation for FY 2008, $5.2 million went directly to CAC programs. The remaining $800,000 was spent on CACTX administrative costs and the provision of training, technical assistance and support for the local CACs. No funds from this $6 million were used to cover OAG administrative costs. Statute limits the CACTX administrative costs to 12% of the total appropriations.

**Funding Sources**
Funding for CACs in FY 2007 came entirely from monies appropriated to the OAG from the Compensation to Victims of Crime Fund (No. 469), but the additional $2 million awarded for FY 2008 came from state General Revenue. CACTX provides equal baseline funding to each center in addition to direct service funding which is based on the total population living in the CAC’s service area. In fiscal year 2007, the baseline funding for each center was approximately $32,000. As CACTX rules require that funding provided through CACTX make up no more than half of the total budget for a CAC, CACs in Texas receive their funding from a variety of sources in addition to the state appropriations, including state and federal grants (20%), local government (19%) and local individuals and corporations (46%). Funding through the OAG/CACTX only represented 15% of the annual budget for CACs in Texas in FY 2007.

**Trauma Centers**
There are currently 243 trauma centers in Texas that receive state funding and are equipped to provide emergency medical services to patients suffering traumatic injuries.
Organization & Administration

The statewide emergency medical services (EMS) and trauma care system was created in 1989 by the Omnibus Rural Health Care Rescue Act. As a result, the Texas Department of Health (now Texas Department of State Health Services) developed a system for designating trauma facilities based on the level of care they provide as well as a trauma registry to monitor the system and provide statewide data on costs and epidemiological statistics. The state was divided into 22 regions called Trauma Service Areas (TSAs) and a Regional Advisory Council (RAC) was established in each region to conduct strategic planning and coordinate services locally. In 1999, the Governor’s EMS and Trauma Advisory Council (GETAC) was established to provide “recommendations on EMS and trauma regulations to the Texas Board of Health and expert input on EMS/Trauma Systems to [DSHS] staff.”

Trauma facilities are designated on a scale ranging from Level I to Level IV based on the level of care they provide. A Level I trauma facility provides the most sophisticated services and is required to have the capacity to provide comprehensive care 24 hours a day and furthermore, to be a leader in research, continuing education and trauma prevention programs. A Level IV facility, on the other hand, may only be able to offer the most basic services, such as initial evaluation, assessment and resuscitation.

Trauma facilities are designated by the Department of State Health Services (DSHS) based on standards set by the American College of Surgeons. In order to be designated as a trauma facility, the facility must first submit an application to the Office of Emergency Medical Services/Trauma Systems Coordination Office of DSHS. The office will review the application and make a recommendation regarding whether to designate the facility as a trauma center and at what level. Finally, the DSHS Commissioner will review the recommendation and make the final determination.

The state currently funds 243 designated trauma centers as well as some centers that are “in active pursuit” of designation. Fifteen percent of the funds are divided equally among all eligible applicants (with an annual cap of $50,000 per applicant) and the remaining 85% are distributed based on the percentage of uncompensated trauma care a hospital provides in relation to the total uncompensated care provided by all the eligible hospitals that apply for funds. All eligible hospitals that applied received a minimum of approximately $30,000 annually for FY 2005, 2006 and 2007.

Funding Sources

Although the initial trauma system legislation in 1989 did not provide for any funding for trauma centers, in 1997 the EMS/Trauma System fund was established and surplus 911 funds in the amount of approximately $4 million have been allotted to this fund by the legislature each biennium since then with the primary purpose of funding EMS firms and RACs in order to promote system development. A small percentage of the funding was earmarked for uncompensated trauma care and DSHS was also provided $100,000 to administer the program.
The funding program set up in 1997 provided very limited support to the trauma centers and the centers continued to sustain operating losses due to delivering a large amount of uninsured and uncompensated care. For this reason, two additional sources of funding were developed in 2003. Firstly, an additional alcohol conviction fee was established under SB 1131 and, more significantly, the Driver Responsibility Program was created under HB 3588 so that drunk or reckless drivers would be required to pay surcharges on their fines that would be dedicated to trauma centers. One half of the funds collected under the Driver Responsibility Program are deposited into the Designated Trauma Facility and Emergency Medical Services Account and 96% of the funds in this account are distributed to hospitals for uncompensated care. The remaining 4% is distributed to EMS providers (2%), Regional Advisory Councils (1%) and DSHS’s administrative costs (1%). Although the Driver Responsibility Program was expected to generate approximately $220 million per year in revenue, the program has not generated as much funding as expected due to problems in collecting the funds from the drivers. For fiscal year 2008, the Office of EMS and Trauma System Coordination at DSHS received approximately $50 million to be dedicated to trauma centers. Nearly all of this funding ($49.2 million) comes from the Driver Responsibility Program, with only $424,000 coming from the Statewide Equalization Surcharge and $575,000 from the alcohol conviction fees. Aside from these state appropriations, the other major source of funding for uncompensated trauma care in Texas is Disproportionate Share Funds.

Poison Centers
Texas has six regional poison centers located in San Antonio, Temple, Galveston, Dallas, Amarillo, and El Paso. The poison centers provide emergency treatment information to both health care providers and the general public in Texas for cases of poisonings or toxic exposures in order to reduce the morbidity, mortality, and costs associated with poisonings in the state.

Organization and Administration
The Texas Poison Control Network (TPCN) was created in 1993 by Texas Senate Bill 773 and is jointly administered by the Bureau of Epidemiology, Texas Department of State Health Services (DSHS) and the Commission on State Emergency Communications (CSEC). The CSEC is the funding and administrative agency for all activities relating to the TPCN and the DSHS disseminates funding for the day-to-day operation of the six regional poison centers.

The Texas Health and Safety Code § 777.001 establishes the six regional poison centers and details the requirements of these centers, which include meeting the standards of the American Association of Poison Control Centers. These standards require such services as providing a 24-hour toll-free telephone referral and information service, coordinating public and professional education programs, and providing technical assistance and consultation services. The law also established the Poison Control Coordinating Committee to advise the Texas Board of Health and the Commission on State Emergency Communications.
A collaboration between the American Association of Poison Control Centers and the Centers for Disease Control and Prevention led to the creation of a nationwide telephone number for poison control that connects callers to the nearest poison control center where callers will have access to a network of health professionals who have training and expertise in the field of toxicology. In addition, DSHS and TPCN try to prevent poisonings before they happen through public education efforts aimed at both children and adults as well as professional educational opportunities for health care providers in Texas. Epidemiologists at DSHS analyze the information collected through calls to the poison hotline in order to identify trends and patterns of poisonings in Texas and subsequently target these education and prevention innovations and services to best reduce the impact of poisoning in Texas.

**Funding Sources**

State funding for the Texas poison control system is funded entirely through the Statewide Equalization Surcharge, which is a 1% charge on intrastate long-distance fees that also funds 911 services in the state and is collected by the Commission on State Emergency Communications (CSEC). A portion of the total collected for this surcharge is dedicated to TPCN and the funding of the Poison Centers. In FY 2007, the CSEC distributed $6.1 million to the six poison centers based on the population size in the center’s service area. Additionally, CSEC received $1.1 million for maintenance of the network and the administrative costs at the agency and DSHS received $250,000 for administrative costs associated with the program at that agency. In addition to state funding, another major source of funding for the poison centers is federal funding through the Health Resources and Services Administration (HRSA) Poison Control Center Stabilization and Enhancement Program. HRSA granted a total of approximately $1.4 million to support Texas poison centers for FY 2007, with grant amounts ranging from $80,000 and $450,000. Both the state and federal funding are distributed based on the size of the population in the region served by the poison center.

Although most other states fund poison control centers through general appropriations, some states have begun using alternative funding approaches. For example, Utah imposes an emergency services telephone charge of seven cents per month on certain telephone services, and Florida uses some of the funds accrued from the sale of certain license plates. According to the National Conference of State Legislatures, “overall, states provide about 45 percent of the poison control center budgets.”
Notes

1 Interview with Maggy McGiffert, Policy and Planning Manager, Texas Council on Family Violence, Austin, TX, March 21, 2008.
2 Email from Ofmara Contreras, External Relations Division, Texas Health and Human Services Commission, “HHSC Family Violence Program,” to Erin Daley, March 26, 2008.
3 Ibid.
4 Ibid.
5 Ibid.
6 Ibid.
8 McGiffert interview.
9 Ibid.
10 Ibid.
11 McGiffert interview.
12 Ibid.
13 Ibid.
14 Contreras email.
17 Ibid.
19 Email from Nancy Carrales, Deputy Chief, Grants Administration Division, Office of the Attorney General of Texas, “Question on Children’s Advocacy Centers,” to Erin Daley, March 31, 2008.
20 National Children’s Alliance, National Children’s Alliance News, Fall 2007.
21 The Attorney General of Texas, Grants and Contracts.
22 Carrales email.
23 Interview with Selena Muñoz, Children’s Advocacy Centers of Texas, Austin, TX, October 18, 2007.
24 Ibid.
25 Ibid.
27 Ibid.
29 Petty interview.
31 Online.


34 Charles Begley, Sharron Cox, Arlo Weltge, Cindy Gunn, and Munseok Seo, “Code Red…”

35 Office of EMS and Trauma Systems Coordination, Funding Sources for Texas EMS/Trauma System, 6/15/2006.

36 Online.

37 Charles Begley, Sharron Cox, Arlo Weltge, Cindy Gunn, and Munseok Seo, “Code Red…”

38 Telephone interview with Kim Petty, Manager of the Office of EMS and Trauma System Coordination, Department of State Health Services, Austin, TX, March 24, 2008.

39 Ibid.

40 Ibid.

41 Ibid.


43 Email from Donna McCain, Admin Staff Services Officer, Texas Commission on State Emergency Communications, “Follow-Up on Texas Poison Control Network Questions,” to Erin Daley, March 27, 2008.

44 Ibid.

45 Interview with Norma Valle, Poison Program Administrator, Texas Commission on State Emergency Communications, Austin, TX, March 27, 2008.

46 Ibid.

47 McCain email.


49 McCain email.
