Hospital Summit

Conducted by Midwest Regional Children’s Advocacy Center

August 3-4, 2009
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Staff:
Jane Braun Project Director MRCAC
Kim Martinez, Outreach Coordinator MRCAC
Anne Cherek, Training Coordinator, MRCAC
Lynn Rioth, WRCAC, Colorado Springs, CO
Maria Gallagher, NRCAC, Newtown, PA
Anne Lynn, NRCAC, Newtown, PA
Karen Hangartner, SRCAC, Huntsville, AL

Guest Faculty:
Karen Seaver Hill, NACHRI
Rebecca Gordon, Missouri Kids First
Laurie Blumberg-Romero, CHC of MN

Honorary Guest:
Louann Holland, OJJDP

Participants:
CARES Northwest, Portland, OR
Kevin Dowling, Director kdowling@lhs.org
Leila Keltner, MD
Megan Johnson, Deputy DA

CARES Twin Falls, ID
Kerry Koonzt, LSW Program Coordinator kerryk@mvrmc.gen.id.us
Patricia Billings, PNP
Det. Becky White, Twin Falls County Sheriff’s Dept.
The Chadwick Center, Rady Children's Hospital, San Diego, CA
Charles Wilson, Director cwilson@chsd.org
Cindy Kuelbs, MD Rady Children’s Hospital
John Philips, Chief Deputy County Counsel

Niagara Falls Memorial Medical Center, Niagara Falls, NY
Ann Marie Tucker, Director annmarie.tucker@nfmmc.org
Jack Coyne, MD
Robert Zucco, ADA

CAC at Pinnacle Health Systems, Harrisburg, PA
Teresa Smith, Director tsmith@pinnaclehealth.org
Ellen Dyer, CRN, Medical Director
Gina Pupo, M.Ed., BSN

Aetna Foundation CAC at St. Francis Hospital, Hartford, CT
Regina S. Dyton, MSW, Program Manager rdyton@stfranciscare.org
Audrey Courteney, APRN
Eduardo Rivera, MSW, Dept. of Children and Families Program Supervisor

Cooper-Arthur Mercy CAC, Arkansas
Janice McCutcheon, Director jmccutcheon@htsp.mercy.net
Marcie Hermann, SANE-A/P
Aaron Tripplett, AK State Police- Crimes against children division

Child Abuse Program-Children's Hospital of the Kings Daughters, Virginia
Jane Hollingsworth, Psy.D.Executive Director jane.hollingsworth@chkd.org
Dawn Seaff, R.N. Pediatric Forensic Nurse Examiner
Joanne Glass, LCSW

Child's Voice, Sioux Falls, SD
Monica Maurer, Director MAURERM@sanfordhealth.org
Nancy Free, MD
Lt. Bruce Bailey, Sioux Falls Police Department

Blank Children's CPC- Des Moines, IA
Chaney Yeast, Manager yeastc2@ihs.org
Rizwan Shah, Medical Director
Alena Honeick, Family Advocate

CAC at Nationwide Children's Hospital (CCFA), Columbus, OH
Shari Uncapher, CCFA Program Manager shari.uncapher@nationwidechildrens.org
Ranee Leder, MD
Sonya Harrison, Supervisor, Franklin County Children Services

MCRC- Children's Hospitals and Clinics of MN, St. Paul, MN
Maureen O'Connell, Program Manager Maureen.oconnell@childrensmin.org
Carolyn Levitt, MD
Tina Curry, Supervisor, Ramsey County Child Protection

Women & Children's Hospital- Charleston, WV
Maureen Runyon, MSW LCSW maureen.runyon@camc.org
Lt. Greg Young, Kanawha County Sheriff's Dept
Executive Summary
The hospital based child advocacy center has a unique place in the child advocacy center. While the majority of child advocacy centers are freestanding 501c3 or under umbrella organizations, there is a subset of child advocacy centers that are either government based or hospital based.

The National Children’s Alliance (NCA) has 702 CACs currently (465 accredited and 237 associate/developing). Out of this total of 702, only 48 centers are considered hospital based CACs.

In late spring of 2009, a computerized survey via Survey Monkey was sent out to all 48 hospital- based CAC Directors (as identified by each regional Project Director). CAC Directors were requested to forward the survey on to their multidisciplinary team members and medical provider(s). Once the survey results were collated, a list of CAC responses was gathered. Thirteen teams comprised of the CAC director and representation from both the medical and multidisciplinary teams were invited to attend.
This invitation was as a direct result of responses by these centers on a national survey about hospital based CACs. Only centers that responded to the survey were considered as potential invitees. Each regional then chose two-three teams to invite and a formal invitation was extended to these teams.

On August 3-4, 2009, a Hospital Based Child Advocacy Center Summit was held in Bloomington, MN to look at the unique issues that hospital based child advocacy centers (CACs) face on a day- to-day basis and what makes them different from other CAC structures. The Summit was structured around looking at the feedback from all associate and accredited member hospital-based CACs nationally regarding the NCA Standards for Accreditation, a holistic MDT point of view, and other core issues related to the unique setting of hospital based CACs.

The outcome of this Summit generated the strengths of hospital based CACs, challenges faced by these unique centers, as well as ideas for strengthening/improving the hospital based CAC in the future.
METHODOLOGY:
The Survey was conducted in the Spring 2009 with the intent to look at the strengths and challenges of hospital based CACs.

Procedure:
The survey was distributed to the CAC directors of the 48 hospital based centers (as identified by the regional project directors) to distribute to their multidisciplinary team members and medical director as well as to complete by the director themselves.

Design:
The four regional child advocacy centers decided to look at the unique issues of a hospital based CAC and subsequently developed a survey to be sent out to the 48 programs. Each of the Regionals brainstormed, edited and drafted the questions to be included in the completed survey. The survey was developed on Survey Monkey so that they could be completed electronically and the results were tabulated directly from the electronic survey. The survey itself consisted of 25 questions, looking at basic demographic information as well as asking about the strengths and challenges of hospital based CACs based on the NCA standards of accreditation.

Respondents:
Seventy-five out of 144 possible surveys were returned via Survey Monkey (52% response rate) with 40 of these being completed in their entirety (53%). Respondents included medical providers, CAC directors and members from the multidisciplinary team for each hospital- based CAC.

Limitations:
Because this survey was done on a voluntary basis, not all hospital based centers completed the survey. Only those centers that responded to the survey in its entirety were included in the subsequent results.
Definitions:
What is a Hospital Based Child Advocacy Center?
A hospital based CAC is a child advocacy center located within the hospital campus, either directly within the hospital structure or housed elsewhere in a separate building/location within the hospital campus. Hospital based CACs are unique in that they have direct access to the services provided by the hospital as well as operate under the confines of the NCA Standards. While most child advocacy centers have their own separate board of directors, their own funding streams and operate under their own structure, hospital based CACs are but one department of a larger structure within the organization. Hospital based CACs must comply with both hospital regulations as well as follow the NCA standards.

RESULTS:
Respondents were asked about their length of time in their current position. The average length of time was 8.3 years with a range of 1 year to 27 years. In addition, they were asked about the population service area. The range of service populations by respondents was 10,000-3,000,000 with 7 respondents indicating that they were unsure of the population service area size. Respondents were also asked about the average number of children seen per year. The average number was 820 with a range of 60-1772; 4 respondents were unsure of the number serviced. Respondents indicated that they serve an average of 14.3 counties with a range of counties anywhere from 1-53 counties served. Eight respondents indicated that they do not have specific counties that they work with; they have limited Memorandums of Understanding or did not know how many counties the CAC serviced.

Successes and Challenges Identified from the Survey:
Respondents were asked about their perceived successes and challenges for the hospital based CAC using the NCA Accreditation Standards. The responses reflect all completed surveys with the most common responses listed.
### 1. Multidisciplinary Team

<table>
<thead>
<tr>
<th>Successes</th>
<th>Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well-established</td>
<td>Lack of funds and resources</td>
</tr>
<tr>
<td>Co-location</td>
<td>Personality/MDT conflicts</td>
</tr>
<tr>
<td>Commitment from team</td>
<td>Poor attendance to appointments and meetings</td>
</tr>
<tr>
<td>Expertise</td>
<td>Poor communication</td>
</tr>
<tr>
<td>Reduces number of times child is seen</td>
<td>MDT turnover</td>
</tr>
<tr>
<td>Good collaboration</td>
<td>Board of directors-lack of, poor participation and understanding</td>
</tr>
<tr>
<td>Funding from the Hospital</td>
<td>Lack of space</td>
</tr>
<tr>
<td>Referral Ease</td>
<td></td>
</tr>
</tbody>
</table>

### 2. Cultural Competency

<table>
<thead>
<tr>
<th>Successes</th>
<th>Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diverse staff and families</td>
<td>Updating competency protocol</td>
</tr>
<tr>
<td>Access to on-site interpreters</td>
<td>Hiring diverse staff</td>
</tr>
<tr>
<td>Staff workshops/trainings</td>
<td>Lack of diverse community-how to incorporate that into a CAC</td>
</tr>
<tr>
<td>Positive relationships with outside community resources</td>
<td>Lack of bi-lingual interviewers</td>
</tr>
<tr>
<td>Intra-agency experience</td>
<td>Inflexibility/inability towards diversity</td>
</tr>
<tr>
<td></td>
<td>Providing crisis services</td>
</tr>
<tr>
<td></td>
<td>Interpreter bias</td>
</tr>
</tbody>
</table>

### 3. Forensic Interviewers

<table>
<thead>
<tr>
<th>Successes</th>
<th>Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well trained/experienced interviewers</td>
<td>Need for more than one interviewer in rural setting</td>
</tr>
<tr>
<td>Most children are referred to CAC for interview</td>
<td>Lack of funding due to insurance issues</td>
</tr>
<tr>
<td>Provided training</td>
<td>Managing increased work load without increased FTE</td>
</tr>
<tr>
<td>Can be used in court</td>
<td>Interagency cooperation</td>
</tr>
<tr>
<td>Prevents multiple interviews</td>
<td>Lack of specialization-no continuing ed or peer review</td>
</tr>
<tr>
<td>Child understands that their body is healthy when done in the medical setting</td>
<td>MDT cooperation</td>
</tr>
<tr>
<td>High standards in a hospital setting</td>
<td>Problems with technology</td>
</tr>
<tr>
<td>Interviews free of charge</td>
<td>Lack of debriefing protocol</td>
</tr>
<tr>
<td></td>
<td>Maintaining neutrality</td>
</tr>
</tbody>
</table>
Avoiding duplicative interviews
Distance for families to travel
Not videotaping interview

4. Victim Support/Advocacy

<table>
<thead>
<tr>
<th>Successes</th>
<th>Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>On-site staff for services</td>
<td>Budget cuts limiting VA services</td>
</tr>
<tr>
<td>Solid relationships with on/off-site MH/Crisis resources</td>
<td>Increased caseload with limited resources and staff</td>
</tr>
<tr>
<td>Dedicated providers</td>
<td>Multiple advocates-loss of control for quality</td>
</tr>
<tr>
<td>Minimal access to care issues</td>
<td>Limited service area</td>
</tr>
<tr>
<td>Bilingual advocate</td>
<td>MDT valuing VA role</td>
</tr>
<tr>
<td>Distance for families to receive services</td>
<td>Creating VA job within the hospital system</td>
</tr>
</tbody>
</table>

At the hub of a basic program is a physician who has an interest and takes initiative in child maltreatment
*(NACHRI)*

5. Medical Evaluations

<table>
<thead>
<tr>
<th>Successes</th>
<th>Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Available for most children</td>
<td>Appropriate after hour/emergency coverage</td>
</tr>
<tr>
<td>Well trained examiners</td>
<td>Insurance coverage for exam</td>
</tr>
<tr>
<td>On-site</td>
<td>Limited trained/interested staff</td>
</tr>
<tr>
<td>Treating/identifying non-abuse related health issues</td>
<td>Families refusing exam; not understanding why one is needed</td>
</tr>
<tr>
<td>Peer review system</td>
<td>Only examine acute cases or higher risk kids</td>
</tr>
<tr>
<td>Ability to look at other types of abuse</td>
<td>Pressure to see high numbers of children medically</td>
</tr>
<tr>
<td>Create a system where other services can be added</td>
<td>MDT buy-in</td>
</tr>
<tr>
<td></td>
<td>Parent understanding of what exam can “prove”</td>
</tr>
<tr>
<td></td>
<td>Reaching rural areas</td>
</tr>
</tbody>
</table>

8
## Mental Health

<table>
<thead>
<tr>
<th><strong>Successes</strong></th>
<th><strong>Challenges</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Good relationships with off-site resources</td>
<td>Families following through/compliance for MH services</td>
</tr>
<tr>
<td>Specially trained mental health staff</td>
<td>Insurance access</td>
</tr>
<tr>
<td>Standard treatment methods used</td>
<td>Lack of appropriately trained trauma-focused/child abuse specific MH resources</td>
</tr>
<tr>
<td>Wide range of services</td>
<td>Limited on-site access</td>
</tr>
<tr>
<td>Acute/Trauma MH clinic on site</td>
<td>Lack of follow-up system</td>
</tr>
<tr>
<td></td>
<td>Wait lists</td>
</tr>
<tr>
<td></td>
<td>Rural availability</td>
</tr>
</tbody>
</table>

## Case Review

<table>
<thead>
<tr>
<th><strong>Successes</strong></th>
<th><strong>Challenges</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular meetings (weekly/monthly)</td>
<td>Difficult to get all discipline representation</td>
</tr>
<tr>
<td>Well attended</td>
<td>MDT members feel singled out/defensive</td>
</tr>
<tr>
<td>Can clear up misunderstandings</td>
<td>Scheduling</td>
</tr>
<tr>
<td>Information sharing to other MDT members</td>
<td>NCA standards conflict with community needs</td>
</tr>
<tr>
<td>Utilize sub-specialists within hospital if needed (radiology, genetics, etc)</td>
<td>Not always helpful to CPS workers</td>
</tr>
<tr>
<td>Utilize videoconferencing to reach more team members</td>
<td>Personality conflicts</td>
</tr>
<tr>
<td></td>
<td>Case review is the challenge</td>
</tr>
<tr>
<td></td>
<td>Loss of neutrality and objectivity</td>
</tr>
<tr>
<td></td>
<td>Information sharing</td>
</tr>
<tr>
<td></td>
<td>Not all cases are reviewed</td>
</tr>
<tr>
<td></td>
<td>Jurisdiction issues</td>
</tr>
</tbody>
</table>

## Case Tracking

<table>
<thead>
<tr>
<th><strong>Successes</strong></th>
<th><strong>Challenges</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Use NCA Trak</td>
<td>Difficult to follow post-CAC visit</td>
</tr>
<tr>
<td>Local resources to help set up tracking systems</td>
<td>Time consuming</td>
</tr>
<tr>
<td>Ongoing discussion about improvements and needs</td>
<td>Obtaining information from partner agencies</td>
</tr>
<tr>
<td></td>
<td>Identifying a system that meets CAC needs</td>
</tr>
<tr>
<td></td>
<td>Current system does not fit NCA requirements</td>
</tr>
<tr>
<td></td>
<td>Not always utilized</td>
</tr>
<tr>
<td></td>
<td>Cost</td>
</tr>
</tbody>
</table>
Data is never complete
HIPPA issues
NCAtrak is not user friendly or intuitive

9. **Organizational Capacity**

<table>
<thead>
<tr>
<th><strong>Successes</strong></th>
<th><strong>Challenges</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Supportive umbrella agency-hospital</td>
<td>Lack of funding</td>
</tr>
<tr>
<td>Under large health system; great partnership with local MDTS</td>
<td>Hospital administration turnover=inconsistent CAC support</td>
</tr>
<tr>
<td>Human service agency umbrella has oversight</td>
<td>Communication problems</td>
</tr>
<tr>
<td>Strong support from local children’s hospitals</td>
<td>Working within the constraints of various hospital rules that may not be applicable</td>
</tr>
<tr>
<td>No need for external funding</td>
<td>Competition for resources amid other hospital departments</td>
</tr>
<tr>
<td>Provides in-kind services</td>
<td>Poor understanding from hospital about what a CAC does</td>
</tr>
<tr>
<td>Predetermined and set policies and protocols from hospital for some things</td>
<td>External funding not always possible when tied to a larger organization</td>
</tr>
</tbody>
</table>

10. **Child Focused Setting**

<table>
<thead>
<tr>
<th><strong>Successes</strong></th>
<th><strong>Challenges</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Child friendly</td>
<td>Space</td>
</tr>
<tr>
<td>Improved security system</td>
<td>Not keeping up with demand</td>
</tr>
<tr>
<td>Great art</td>
<td>Need more options for teens and older kids</td>
</tr>
<tr>
<td>Variety of activities</td>
<td>Aging facility</td>
</tr>
<tr>
<td>Kid sized furniture</td>
<td>Sound proofing</td>
</tr>
<tr>
<td>Non-clinical atmosphere</td>
<td>Limited in capabilities due to hospital regulations</td>
</tr>
<tr>
<td>Kids want to come back because the setting is fun</td>
<td>Parking</td>
</tr>
</tbody>
</table>
How do Hospital Based CACs fit in with Other National Organizations?

Hospital based CACs must conform to the requirements of not only their own hospital organizations but also the NCA Standards. In seeing how hospital based CACs fit in with other national organizations, two specific organizations were looked at that impact service delivery: National Association of Children’s Hospitals and Related Institutions (NACHRI) and the National Children’s Alliance (NCA).

Karen Seaver Hill presented at the Hospital Based CAC Summit sharing perspectives from NACHRI as it relates to the CACs located within a hospital setting. During the course of her presentation, she stated that all child advocacy centers are programs within the hospital and fall somewhere on their organizational chart. She discussed the different service models currently being used in hospitals, anywhere from only seeing children in the emergency room department by one physician that wears multiple hats, to child abuse teams and subsequent child abuse programs. A child abuse program should have a dedicated team, it’s own cost center, and should be recognized by community partners in the area they are located. As found in the survey conducted by NACHRI of children’s hospitals in 2008 looking at child abuse response, caseload at child advocacy centers are larger than average NACHRI respondents. Hospitals with child abuse programs are reporting an increase in children seen and a need for increased staffing. This is in contrast to recent data showing a decrease in reported child abuse. The question arises-is the data skewed? NACHRI is very cognizant that the children’s hospital community is a very small portion of the hospital wide response to child abuse and a small portion of a national response. Ms. Seaver-Hill’s message is that we don’t exist in a vacuum; we can react to what data we have now. In the survey, 70% reported that they have an increase in full time equivalent staff (FTE) since the establishment of their child abuse programs, teams or services. The majority attributes this growth to both increased volume and expanded services with almost 10% being able to increase capacity relaying on funding from grants. In contrast, 10% reported a decrease in staffing and 20% reports no changes attributing this to lack of funding and budget constraints (2008 NACHRI Survey Findings and Trends, Responding to Child Maltreatment).

Bottom line: when looking at overhead, hospitals lose money when they house a CAC. The average expenses are $1.6 million and average revenue for hospital based CACs is $1.4 million. Hospital based CACs operate with higher revenue and higher expenses than other programs. Some hospital based CACs contract for services; this will affect what services are reimbursable. Trends show staffing increases. How can hospital based CACs sustain their growth and services? The number one payer of hospital based CACs is Medicaid, their funding is going down while expenses are going up. How can they meet the gap in funding? It is not sustainable to have their biggest payer decrease their funding by 21%. Hospital foundations are contributing more into the mix, however the costs of providing services continues to increase. The main revenue sources for hospital based CACs are Medicaid, private payer, hospital foundations and reimbursement for services provided to local, county or state agencies. Most hospitals must substantially underwrite their child abuse services because they receive only partial or no reimbursement for them (2008 NACHRI Survey Findings and Trends, Responding to Child Maltreatment).

Question: Do hospitals let the community know of the substantial costs to the public? Do they let them know what they give to the community by operating these centers? Currently Senator Grassle from Iowa and others have launched an inquiry into nonprofit organizations, including children’s hospitals. This could jeopardize the nonprofit status of how they operate. They are questioning the nonprofit status and requirements to report to the Internal Revenue Service very rigorously. They are asking that nonprofit organizations show a 5% defined community benefit. There is a silver lining in this inquiry for hospital based CACs. Most hospitals have community building and offer uncompensated care; these, however, are not community benefits. All hospital CEO’s need to care about this as it affects their ability to collect
dollars and billing. Hospital based CACs provide an answer to this as they already have a built-in needs assessment and can show that child maltreatment is a public health problem. Law enforcement and child protective services bring children to the hospital based CACs, showing the community need and benefit of having children seen at the center. The hospital can count this particular program as a 100% benefit to the community which reflects positively on the hospital.

Hospital based CACs also must conform to the ten NCA standards, including: multidisciplinary team, cultural competency, forensic interviews, victim support/advocacy, medical evaluation, mental health, case review, case tracking, organizational capacity and child-focused setting. As previously described, there are successes and challenges to hospital based CACs in meeting these standards, and meeting these standards are the focus of this paper.

How Are the Challenges Perceived by Hospital Based CACs:

During the course of the two-day Hospital Summit, attendees were divided into smaller groups (CAC directors, medical examiners and MDT members) to discuss the challenges with each of the ten NCA standards. Each group was asked to look at the successes and challenges identified during the course of completing the online survey and to identify the top two to three standards that they view as a challenge in the hospital based CAC.

**The Medical Provider Group**

*The medical provider group* identified their most challenging standards as:
1. Organizational capacity
2. The medical and mental health standards
3. The multidisciplinary team, to include case review and case tracking.

Cultural diversity was a common thread interwoven throughout.

In their words, the medical provider group felt that without the *organizational* structure in place, nothing else for the center could work. The lack of funding was cited as a number one challenge; it was felt that external funding is not a priority for the hospital on behalf of the CAC and depending upon where the CAC falls within the organizational structure, it affects their ability to raise funding. In addition, awareness needs to be raised that the CAC is not just another clinic, but is a separate program of the hospital that provides services to the community at large.

*Medical evaluations* also presented a challenge. The medical group felt a criterion needs to be established for who receives the medical exam, who makes this decision and buy-in by the parents and the MDT. The medical provider group felt that the standard should be that all children have access to a medical evaluation. Hospital based CACs service more than sexual abuse cases, so protocols need to be established regarding triaging acute cases including: physical abuse and in-patient hospital consults for physical abuse, neglect, Munchausen Syndrome by Proxy (MSBP), drug endangered children (DEC) and sexual abuse. In order to provide services to all of these groups, reimbursement needs to be addressed as well as providing 24/7 coverage and having consistent medical providers to perform the exams.
Mental health services are also of concern, including finding trained therapists, long waiting lists to be evaluated and receive treatment; insurance/billing issues, and providing trauma-focused therapy. Issues raised were: concern about follow-through for appointments by parents and educating them about the importance of follow-up with mental health services as well as helping to decrease the stumbling blocks to accessing these services. Cultural competency was seen as a major issue with this particular standard, as therapists must understand the client they are working with from not only the abuse standpoint, but also how this plays into their ethnicity, religion and cultural beliefs. Interpreter and cultural bias were of concern as well as reaching out to the community on their own turf.

The multidisciplinary team also presents unique challenges to the hospital based CAC. There is a sense that the hospital is the place with the money and this is a misperception. The hospitals are not very transparent. There are always funding issues, and federal dialogue has pushed CPS to respond in a different fashion. They push services but don’t use the CAC, as they don’t have the funds to pay for these services. There is chronic MDT turnover and often-poor attendance at case review meetings. Communication is a major issue, with poor follow-up, lack of understanding of the role and responsibilities of the team case coordinator and difficulty with case tracking.

The Multidisciplinary Team Group

The Multidisciplinary Team Member group (MDT) listed their top challenges as:
1. Organizational capacity
2. The multidisciplinary team and case review.

The MDT group felt that the multidisciplinary team partners were not as invested in the accreditation standards as the child advocacy center itself and that they leave it up to the hospital. The team members know how to cooperate but not collaborate and it is difficult to get buy-in from the MDT partner agencies. It is difficult to know whose team it is- does the MDT belong to the hospital or to the community? Who do they report to? Does it belong to the prosecutor’s office that may run it?

They reiterated the issue as previously stated by the medical provider group that organizational capacity is a major barrier at times for hospital based CACs and also case review. For case review, case selection criteria and procedures are often not agreed upon. At times there are multiple jurisdictions, so getting team members to come is often difficult. Some team members feel that they have more “clout” than others. There are often issues with confidentiality among the team members regarding what they are allowed to share.

CAC Director Group

The CAC Director group listed the following as their top challenges:
1. Organizational capacity
2. Multidisciplinary team

The CAC director faces the day to day challenges of dealing with hospital bureaucracy, with barriers being posed anywhere from purchasing equipment to getting job descriptions or hiring. There are issues about how to get directly to the hospital foundation, or at times, around them. How is the CAC seen to the hospital? Is it a core value? Where is the CAC on the organizational chart? There are restrictions placed on CAC directors in dealing with local state legislature for funding, yet without this active interaction with the legislature, the CAC cannot tap into outside dollars. Cash flow is another issue as monies come in through the hospital but don’t always flow directly to the CAC. The director’s feeling is that “the hospital’s problems are not the CAC’s problems” and yet it somehow becomes so. When the center is successful in getting outside monies, the hospital will often come to the center to share the wealth. The CAC director is often faced with conflicting missions.
The multidisciplinary team was also seen as a challenge for the hospital based CAC from the director perspective. The CAC directors see that the team can lend expertise, that the medical component lends credibility when stated from a physician, and that other team members tend to give medical issues more weight. There also is an increased understanding of the team member roles. In addition, philanthropic support can be expanded due to increased donor numbers because of the CAC. During times such as financial transitions, being located within the hospital helps the center ride these transitions out. The challenges, however, go back to who is in charge? Is the team an internal CAC team or a community team? The medical director may not want the team involved in the day- to- day operations; the doctor is seen as always in charge, which can be intimidating and cause ‘turf’ issues. It is important to get administration to pay attention and clarify roles and responsibilities. Depending upon where the MDT Case review is held, there may be parking issues, as the hospital may not be a convenient location for the MDT to meet. The hospital carries “clout’ and there needs to be a “leveling” of the playing field.

Summary of Challenges from the Three Breakout Groups:

After the three breakout groups discussed the unique challenges they perceived for hospital based CACs, all groups were brought back together to share their information and to chose the top three challenges for all groups combined. As a summary, the multidisciplinary team group felt that there were turf issues, a lot of concern about case selection and protocol for case review as well as issues related to the MDT and case review, including information sharing issues, who can sit on the team, mental health providers being part of the team and their role, multiple jurisdictions as well as who has the clout to make things happen.

The CAC directors felt that organizationally, getting access to the hospital foundation was an issue as well as how the CAC is seen by the hospital and where they fit within the organizational structure; dealing with legislatures and hospital bureaucracy. For the team, concerns were of who was in charge of the team, internal review versus outside agencies; having medical directors who don’t see the team as part of the decision making process, and leveling the playing field.

For the medical group, main concerns were organizational with lack of funding and fundraising. The challenge of getting buy in for all children to have medical exams was raised as well as mental health issues where there is lack of follow-through, buy-in by the parents and team, and decreasing stumbling blocks to get access to mental health services, i.e. insurance, waiting lists, skilled therapists.

Finally, for the multidisciplinary team, they expressed concerns regarding lack of funds, lack of community resources, MDT turnover, attendance, and lack of communication and case coordination.

The large group discussion focused on three main challenges: organizational, case review and case tracking.

For organizational, the group felt that it makes a difference organizationally where you place the CAC within the hospital structure. How do you get your hospital board to think that your CAC is a success if they don’t hear about the successes you have? The hospital based CAC needs to be essential to the hospital’s vision. The hospital concerns itself with the business side; it is the CACs job to show the partnerships it has with the outside community and its benefits, and why they need to be a priority to the hospital.
For Case Review, leveling of the playing field must take place. Many team members are intimidated by physicians and so power differentials are vastly wide on MDTs. Many hospitals had existing internal teams long before the MDT was functioning, so there is an issue of ownership—who does the MDT belong to? Once the playing field is leveled, everything else should fall into place. It was felt that the hospital should not chair the meeting—community partners should chair it. Everyone is a colleague of one another and no one should be addressed by their title, but instead, by their name. This allows everyone to leave his or her ego at the door. There should be an order in which everyone presents so that there is a process. All team members should help decide on the criteria for MDT Case Review. Child protection should go first, so there is an expectation on how to present and what to present. Physicians should go last. When it comes to the next person’s turn to speak up, they speak up to share their information, this way everyone gets a chance to speak and share their information. There should be neutrality at the table. Case review should include not just reviewing cases, but looking at the system.

For Case Tracking, it was felt that this standard is difficult for hospitals, as they have to use multiple computer based systems for things such as registration, input of cases, ordering of tests, charting, etc. There needs to be the issue of accountability for people to enter information so that there is a person assigned to enter the case information.

So What are the Unique Strengths of Hospital Based CACs?
All in attendance agree that hospital based CACs need to raise the bar, to look at their perceived challenges and proposed solutions. With the sheer depth of expertise in staff and team members, the challenge is how will hospital based CACs respond to the next generation of hospital based CACs, including rural and satellites? Most centers will not have the capacity that the current hospital based CACs have today; how can the existing centers roll this forward knowing the current challenges? The purpose is overarching: how can we help these people get a foot forward and how do we move forward at all?

Proposed Solutions
The final step in the two-day Summit was to provide proposed solutions to the challenges set forth by the attendees. The three standards identified as the most challenging were addressed.

Organizational:
The child advocacy center can promote itself within the hospital organization through a several different venues. The center needs an “elevator speech”, where in a minute or two, it can quickly list what the center stands for and what it can offer the hospital and community at large. All staff members should be oriented to the same speech so that everyone is delivering the same message to promote the center. It is helpful to have a media event, such as public service announcements being shown on a television monitor, brochures for the CAC and the services it offers as well as Blue Ribbon campaigns or Pinwheel projects, etc. at the hospital entrance with information on the center and someone present to answer questions, especially during the month of April, which is child abuse prevention month. It is the responsibility of the center to highlight the CAC. Activities such as having the local prosecutor make a proclamation to the hospital
acknowledging their contributions to the community or handing out awards to community members who have helped make a contribution to the center. It is imperative to always have the CEO available to receive any awards for the center, always putting them aware of the recognition that the center receives from others. When promoting the CAC to the outside community, it is important to tie the hospital to the CAC so that there is name recognition and branding, i.e. The Children’s Advocacy Center of American Hospital. Other suggestions to help solidify the bond between the center and the hospital includes advocating in the emergency room department, collaborating on programming and grant applications, developing a strong relationship between the development and hospital auxiliary departments, and showing the hospital boards the community benefits of the center. Most importantly, however, is making sure that the CAC is positioned well on the hospital’s organizational chart. It is important where the center falls on the chart as to chain of command and whom they report to. And finally, it would be beneficial for the hospital based CACs to create a benchmark to establish hospitals as centers of excellence for protecting children. Just as hospitals as a whole are recognized for their work as trauma centers or centers of excellence in national magazines such as US News and Report, they also should have best practices to propel them upward as centers of excellence for protecting children, including providing child abuse services.

**Multidisciplinary Team:**
The most important message for the multidisciplinary team is that people outside of the team know that they exist, what their mission is and have clear, consistent leadership. The center should not work in isolation of the team. It was felt that staff should never be hired at the center without the input of the team. Also important is to have a separate supervisory group to look at systems, not just cases. This group should have representatives from the hospital to hear concerns of the MDT agency leaders so that it is not just the CAC director answering to MDT members. A six-sided diagram can be used to show where the center is at on the diagram in comparison to other systems i.e. triage, registration, ERD, CAC, district attorney’s office, child protection, etc.

The team needs an identity and roles need to be assigned. The team needs to be seen as a unified group, not simply as a task group of the director. All communications should be signed “by the team”, not just the director. Each team member should feel that they make important contributions to the team as a whole as well as to the center. The underlying theme is to provide the MDT with legitimate, substantial opportunities to make contributions to the center, offer a substantive role, and allow the team to make some of the decisions for the center outside of the hospital management and prevue. Conflict resolution strategies are helpful.

Benchmarks for excellence were discussed. The medical profession already has benchmarks that they strive to achieve, but this does not exist for the other disciplines. It was felt that even with benchmarks for the other disciplines, it would be hard to enforce. How do MDT members have conversations about best practices? It was felt that the NCA Accreditation standards set the bar for benchmarks that all team members should meet. These ten standards should be used as the benchmark for CACs to aspire to. In addition to the CACs having benchmarks for their team members and the center itself, hospitals also should
have benchmarks to achieve. Hospitals already have certain benchmarks, such as different levels for trauma services or neonatal services, and specific criteria that they must meet to achieve the label of a Trauma Level III Center, etc. already exists. These benchmarks differentiate the hospital from others as a center of excellence in a certain area.

The question was then asked, “why can’t hospitals strive to achieve the status of Center of Excellence for the Protection of Children?” It was felt that by a hospital having a hospital based CAC program within their confines, this leads to the hospital gaining recognition for its’ service and benefit to the community. By the CAC program excelling in what it does, it highlights the hospital overall. The hospital then can advertise itself on the merits of the hospital based CAC as being one of their programs. Hospitals that provide these programs can show that they benefit the community and provide a much needed service. There are not many programs that can show a direct benefit to the community with regards to protecting children. Hospital based CACs can propel their hospital into a new category where it can be recognized with other hospital based CACs as Centers of Excellence for the Protection of Children. This benefits not only the hospital itself, but the CAC. This can help both entities financially by drawing grants and donations towards it as well as earning a reputation in the community and nationally for the services it provides. Hospital based CACs can carry two badges of honor—that of NCA Accreditation and that of being a program within a hospital known as a Center of Excellence for the Protection of Children.

Finally, discussion centered around providing luncheon meetings and offer once or twice a year an opportunity for the prosecutor to sit down with the other team members to explain charging criteria and the decision making process, so that all team members understand what happens to the information they gather and provide on these cases.

**Case Review:**
Case review can be very challenging, and yet, is imperative for hospital based CACs. Team members need to agree to share outcomes and understand that outcomes will not be released to other entities without prior team consent. There should be rules of etiquette for case review and a skilled team coordinator who is viewed as neutral. Team coordinators should attend team facilitator training and separate meetings should be held to address system issues so as not to cloud the purpose of the MDT Case Review meetings.
Historically, hospital based CACs run at a big loss. It is important to let the hospital take pride in what the CAC is doing. It is a balancing act in giving the hospital credit for all the successes and yet acknowledging the individual team members.

**Summary:**
Hospital based CACs have some unique strengths and challenges, but overall, share many more characteristics in common with other CAC structures than differences. The strengths of the hospital-based components allow the medical and mental health responses to be strong to these centers and increase recognition of the center within the community. Hospitals work daily with outside agencies to troubleshoot and coordinate services. Overcoming hospital bureaucracy is one of the biggest challenges, but can be overcome.

This paper has looked at the uniqueness of this type of CAC structure with the input of multiple hospital-based centers. While we recognize that hospital based CACs may be more costly, the services that they can provide to the community can be far reaching. Medical care for all child abuse victims is essential, and this is one venue where it can be guaranteed.
Throughout the course of this Summit, there was a common thread of how to offer services to the client with the best outcome. A medical evaluation at a hospital-based clinic not only assesses for child abuse findings, but for all findings on a child who may not otherwise have access to medical care in a different venue. Hospitals have a unique position where they can pull in multiple resources at the same time from the medical system, mental health system and community system, to work together on one common cause. This is a unique benefit of this type of structure.

In addition, it was clear that the team members feel that the medical professionals often take charge of the team, thus not creating an atmosphere for free expression or sharing of thoughts. It was felt that it is best for the medical professional to take a back seat approach to the team and allow other team members to take the lead.

NACHRI has agreed to work with this group of centers to help them create a benchmark to aspire to so that a new group of recognition for hospitals can be achieved, that of “centers of excellence for protecting children”. With current proposed legislation in Washington D.C., now is the time for hospital based CACs to rise to the occasion and show how they not only impact the community at large, but also how they benefit the community that they are located in and serve. What currently exists as 501c3 structures may be challenged and changed if the proposed legislation goes through. Free standing 501c3 centers may not be able to continue to exist and receive funding as they currently do if they cannot show benefit to the community. The hospital based CAC is already there! The needs assessment has been done—the community is coming to the hospital asking for this unique service and has already identified the need in the community. Now is the time for these centers to rise to the challenge, position themselves in a high profile location on their organizational charts so that they can affect to whom they report and document their benefits to the community so that the hospital recognizes the value of the CAC not just to the community but on behalf of the hospital as well. And finally, hospital based CACs need to position themselves through benchmarking strategies so that their hospitals can be recognized as “centers of excellence for the protection of children”.

Addendum A:

During the hospital based CAC Summit, the large group looked at topic specific issues including: extended forensic evaluations, testifying as an expert on non-CAC cases, and how to nurture and sustain team members.

Forensic Evaluations: four centers shared that they conduct extended forensic evaluations with one center stating that they bill for this under mental health billing. There is a published model on how to conduct the extended forensic evaluation. A masters level evaluator is the preferred degree. It was felt that written criteria is essential to conduct these evaluations.

Testifying as an Expert Witness: Many attendees stated that they have been asked to testify as an expert witness, including cases not seen by them or at their CAC. It was felt that there should not be an issue with being declared an expert witness as long as the witness testifies to the truth. It was also felt that there could be some ramifications from some prosecutors. However, if this is done under the venue of a subpoena, it should not be an issue.

How to sustain and nurture team members: it was felt that monthly vicarious trauma workshops would be helpful. One center stated that they use an instrument to measure where they were both at the beginning and end of a workshop and felt this to be useful. Simply having one’s own staff meeting covering areas of trauma could help, or by bringing in someone who specializes in working with trauma, trying to match expertise to staff early in the process could also help. Other suggestions from centers in the past have been: bring in a massage therapist afterhours; bringing out sand trays or other art venues, a day off after being involved in a difficult case; acknowledging to staff that they are not alone. Another option is to provide flex time and/or scheduling around each other, acknowledging that it may be difficult to interview a child the
same age as interviewer’s child, etc. There needs to be an environment where it is okay for people to talk about difficult cases and to say that they have had a hard case. The CAC needs to be an empathetic place not only for the clients it serves, but also for its employees and team members.

The large group then shared how their center handles a case from referral to discharge allowing all attendees to get a glimpse of how protocols and procedures vary amongst hospital based centers.

In addition to the above discussions, two presentations were given looking at issues facing CAC directors. Laurie Blumberg-Romero, Research Administrator at Children’s Hospitals and Clinics of Minnesota, presented on Funding and Fiscal Management. Rebecca Gordon, CFRE, Missouri Kids First, presented on Public Relations and Communication: A Child Advocacy Center’s Journey to Capacity Building. Both of their presentations are attached as addendums B and C.
Power Point Presentations
Hospital Based CAC Summit
August 3-4, 2009

Survey Results
Purpose

To gather feedback from all Associate and Accredited member hospital-based CACs nationwide related to:

- NCA Standards for Accreditation
- A holistic MDT point of view
- Other core issues related to the unique setting of hospital-based CACs
2008 CAC Organizational Capacity

2008 NCA Membership by Program Organizational Capacity and Region

- 501(c)3
- Umbrella 501(c)3
- Hospital-based
- Government-based
- Tribal

Info from 2008 GAP Analysis Report, WRCAC
Method

- Regional CACs brainstormed, edited and drafted the completed survey.
- Survey was sent via email, utilizing Survey Monkey, to the 48 hospital-based CAC Directors in the United States, as provided by each regional Project Director.
  - Directors were instructed to forward the survey to their MDT and Medical Providers.
RESULTS
Survey Return Rate

- 75 surveys were returned via Survey Monkey out of a possible 144 (Average of 3 possible responses x 48 CACs = 52% return rate)
- 53% (40) of the 75 returned surveys were completed in its entirety
  - All data presented refer to the 53% completed surveys
Length of Current Position

The average length of a respondent’s current position was:

- 8.3 years
  - Range 1 year- 27 years
CAC Setting

- 35% of hospital-based CACs reported to be in URBAN settings
- 2.5% reported to be in SUBURBAN settings
- 7.5% reported to be in RURAL settings
- 55% reported being a combination of Urban/Rural/Suburban
Total CAC Service Population

The range of service populations by responding hospital-based CACs was:

- 10,000- 3,000,000
- 7 respondents indicated “unsure”
Number of Counties Served by CAC

The average number of counties served by responding hospital-based CACs:

- 14.3 counties
  - 8 respondents indicated that they do not have specific counties they work with; have limited MOUs; or did not know how many counties they service.
- Range of counties served: 1-53
Number of Children Seen per Year

The average number of children seen per year by responding hospital-based CACs:

- 820 children
  - Range of 60-1772
  - 4 respondents indicated “unsure”
Successes and Challenges

All lists are combined responses for all completed surveys, with the most common responses listed.
MDT: Successes

- Well-established
- Co-location
- Commitment from team
- Expertise
- Reduces number of times child is seen
- Good collaboration
- Funding from the hospital
- Referral ease
MDT: Challenges

- Lack of funds and resources
- Personality/MDT conflicts
- Poor attendance to appointments and meetings
- Poor communication
- MDT turnover
- Board of directors—lack of, poor participation and understanding
- Space—lack of
Cultural Competency: Successes

- Diverse staff and families
- Access to on-site interpreters
- Staff workshops/trainings
- Positive relationships with outside community resources
- Intra-agency experience
Cultural Competency: Challenges

- Updating competency protocol
- Hiring diverse staff
- Lack of diverse community - how to incorporate that into the CAC
- Lack of bi-lingual interviewers
- Inflexibility / inability towards diversity
- Providing crisis services
- Interpreter bias
Forensic Interviews: Successes

- Well trained/experienced interviewers
- Most children are referred to CAC for interview
- Provided training
- Can be used in court
- Prevents multiple interviews
- Child understands that their body is healthy when done in the medical setting
- High standards in a hospital setting
- Interviews free of charge
Forensic Interviews: Challenges

- Need for more than 1 interview in rural setting
- Lack of funding due to insurance issues
- Managing increase work load without increasing FTE
- Interagency cooperation
- Lack of specialization- no continuing ed or peer review
- MDT cooperation
- Problems with technology

- Lack of debriefing protocol
- Maintaining neutrality
- Avoiding duplicative interviews
- Distance for families to travel
- Not video-taping interview
Victim Support/Advocacy: Successes

- On-site staff for services
- Solid relationships with on/off-site MH/Crisis resources
- Dedicated providers
- Minimal access to care issues
- Bi-lingual advocate
Victim Support/Advocacy: Challenges

- Budget cuts limiting VA services
- Increased case load with limited resources and staff
- Multiple advocates - loss of control for quality
- Limited service area
- MDT valuing VA role
- Distance for families to receive services
- Creating VA job within the hospital system
Medical Evaluation: Successes

- Available for most children
- Well-trained examiners
- On-site
- Treating/identifying non-abuse related health issues
- Peer review system
Medical Evaluation: Challenges

- Appropriate after hour/emergency coverage
- Insurance coverage for exam
- Limited trained/interested staff
- Families refusing exam- not understanding why one is needed
- Only examine acute cases or higher-risk kids

- Pressure to see high number of children medically
- MDT buy-in
- Reaching rural areas
- Parent understanding of what exam can “prove”
Mental Health: Successes

- Good relationships with off-site resources
- Specially trained mental health staff
- Standard treatment methods used
- Wide range of services
- Acute/Trauma MH clinic on site
Mental Health: Challenges

- Families following through/compliance for MH services
- Insurance access
- Lack of appropriately trained trauma-focused/child abuse specific MH resources
- Limited on-site access
- Lack of follow-up system
- Wait lists
- Rural availability
Case Review: Successes

- Regular meetings - weekly and monthly
- Well attended
- Can clear up misunderstandings
- Information sharing to other MDT members
- Utilize sub-specialists within hospital if needed (radiology, genetics, etc)
- Utilize videoconferencing to reach more team members
Case Review: Challenges

- Difficult to get all discipline representation
- MDT members feel singled out/defensive
- Scheduling
- NCA standards conflict with community needs
- Not always helpful to CPS workers
- Personality conflicts
- Case review is the challenge
- Loss of neutrality and objectivity
- Information sharing
- Not all cases are reviewed
- Jurisdiction issues
Case Tracking: Successes

- Use NCAtrak
- Local resources to help set up tracking systems
- Ongoing discussion about improvements and needs
Case Tracking: Challenges

- Difficult to follow post-CAC visit
- Time consuming
- Obtaining information from partner agencies
- Identifying a system that meets CAC needs
- Current system does not fit NCA requirements
- Not always utilized
- Cost
- Data is never complete
- HIPPA issues
- NCAtrak is not user friendly or intuitive
Organizational Capacity: Successes

- Supportive umbrella agency- hospital
- Under large health system; great partnership with local MDTs
- Human services agency umbrella has oversight
- Strong support from local children’s hospital
- No need for external funding
- Provides in-kind services
- Pre-determined and set policies and protocols from hospital for some things
Organizational Capacity: Challenges

- Lack of funding
- Hospital administration turnover = inconsistent CAC support
- Communication problems
- Working within the constraints of various hospital rules that may not be applicable
- Competition for resources amid other hospital departments
- Poor understanding from hospital about what a CAC does
- External funding not always possible when tied to a larger organization
Child Focused Setting: Successes

- Child friendly
- Improved security system
- Great art
- Variety of activities
- Kid sized furniture
- Non-clinical atmosphere
- Kids want to come back because the setting is fun
Child Focused Setting: Challenges

- Space
- Not keeping up with demand
- Need more options for teens and older kids
- Aging facility
- Sound proofing
- Limited in capabilities due to hospital regulations
- Parking
I DON'T MEAN TO FRIGHTEN YOU, BUT YOU'LL HAVE TO DO SOME ACTUAL WORK.

THAT'S CRAZY TALK.
Hospital-based CAC Summit
St. Paul, MN
August 3-4, 2009

Responding to Child Maltreatment
2008 Survey Findings and Trends

NACHRI
National Association of Children’s Hospitals and Related Institutions
Champions for Children’s Health
NACHRI’s Mission

NACHRI works to ensure all children’s access to health care and children's hospitals continuing ability to provide services by supporting the four-fold mission of children’s hospitals.

1. Clinical Care
2. Research
3. Education
4. Advocacy
About Children’s Hospitals

Defining the Children’s Hospital Role...

Across America, Children’s Hospitals treat:
• 2.3M emergency department visits
• 13M outpatient visits

Safety Net of Care
• On avg. >55% of inpatient are covered by Medicaid
• 48% of outpatient are covered by Medicaid
About Children’s Hospitals

Clinical Care
• Children’s hospitals represent < 5% of all hospitals in the U.S.
• Yet, account for > 40% of inpatient days and 50% of costs for all children hospitalized in the U.S.
• Provide $10 billion worth of care annually

Research
• Children’s hospitals and pediatric departments of university medical centers = 35% of all NIH-funded pediatric research

Education
• Children’s teaching hospitals train 35% of all pediatricians and 50% of all pediatric sub-specialists
Child Advocacy at NACHRI

The association’s work in health promotion is driven by Board of Trustees-level commitment in three priority areas:

- Injury Prevention
- Child Abuse & Neglect
- Childhood Obesity
Defining the Children’s Hospital Role

Offers a three-level system

- Level 1: Basic
- Level 2: Advanced
- Level 3: Centers of Excellence

- Provides 50 examples from children’s hospital programs across each level and a blueprint to advance a service or program

- Appendixes include: resource listing, lobbying guidelines for nonprofits, sample program reports and sample contract and service agreements
Responding to Child Maltreatment
Children’s Hospitals Child Abuse Services

2008 Survey Findings and Trends
Ninety-two percent of children’s hospitals provide services to abused and neglected children.

PART 1

2008 Snapshot
Part 1: 2008 Snapshot

Response

- 140 hospitals (62% of NACHRI membership)
- Representative of diverse NACHRI membership:
  - Freestanding
  - Children’s hospital within a hospital
  - Specialty
  - Children’s services
  - Other
Part 1: 2008 Snapshot

Q1: The “definitions” question

Which of the following statements below best describes your hospital's services?

a) No services
b) Child abuse services
c) Child abuse team
d) Child abuse program
e) Other
Part 1: 2008 Snapshot

- **No services:** all suspected cases are referred out
- **Child abuse services:** provides clinical response either through the ED or a designated child abuse specialist; staff are trained to detect, treat and document child abuse cases
- **Child abuse team:** dedicated child protection team provides medical assessment, referral and diagnostic services; includes, at minimum, a pediatrician, an administrative coordinator trained in child abuse and social work services provided on an as-needed basis
- **Child abuse program:** administrative unit that provides assessment, referral and diagnostic services; coordinates with community agencies involved in child protection and assesses availability of medical staff to consult; meets regularly to present and review child abuse cases.
Part 1: 2008 Snapshot

Figure 1
Defining Children’s Hospital Services 2008
n=196

- Child abuse programs: 40%
- Child abuse services: 27%
- Child abuse teams: 20%
- No services: 8%
- Other structures: 5%
Part 1: 2008 Snapshot

Child Advocacy Center Response - Type

- 32 respondents indicate that their hospital houses a Children’s Advocacy Center

- 29 are NCA accredited; 3 are not

- 31 identify as a “program”

- 1 as a “team”
Part 1: 2008 Snapshot

Caseload

FY 2007 data

- *Teams* and *programs* treat vast majority of cases (95%)

- Average caseload of 1,061 patients (*teams* and *programs* only)

- All responding hospitals treat a broad range of types of maltreatment, but most often treat children for physical abuse (99%), sexual abuse (95%) and neglect (93%).
Part 1: 2008 Snapshot

Figure 2
Caseload for Teams and Programs 2008
n=79
Part 1: 2008 Snapshot

Child Advocacy Center Response - Caseload

- Average caseload: 1,490
  Median: 1,048
  Range: 202 to 6,158

- 28 provide services in both inpatient and outpatient settings.
- 1 to inpatient only.
- 3 to outpatient only.
Part 1: 2008 Snapshot

Change in Caseload

- Increase - 67%
  - higher visibility of child abuse teams (awareness of their availability and value of specialized services)
  - more staff/increased capacity
  - better recognition and referral by clinicians and partner agencies
  - growing awareness
  - societal influences
- Decrease - 5%
- No change - 19%
- Do not track/don’t know - 9%
Part 1: 2008 Snapshot

Child Advocacy Center Response - Caseload

- 27 CACs indicate caseload increase (84%)
- 1 decrease in caseload
- 4 no change in caseload (12%)

Caseload type
- Drug exposure: 21
- Munchausen by proxy: 28
- Neglect: 29
- Physical abuse: 31
- Sexual abuse: 32
- Witness to violence: 24
National Perspective

- 2007 federal data show 12% decrease in victimization (but increase in fatalities)

- Discussion within children’s hospitals whether it reflects a “real” decrease (data skewed by outlier?)

- Challenge as the nation’s experts in child abuse: we know children’s hospitals aren’t assessing all suspected cases, even with caseload increase

- Comments?
Part 1: 2008 Snapshot

Staffing

- 70% report increase in staffing since establishment
- Most frequently reported personnel:
  - medical director (79%)
  - admin support (74%)
  - physician (67%)
  - social worker-medical (53%)
  - admin director (53%)
  - NP/PA (52%)
Part 1: 2008 Snapshot

Child Advocacy Center Response - Staffing

- 30 indicate an increase in FTE since establishment of program
- 2 indicate decrease

(n=32)
Part 1: 2008 Snapshot

Figure 4
Staffing for Teams and Programs 2008
n = 85

STAFF TYPE

Medical director 79%
Administrative support 74%
Physician 67%
Social worker-medical 53%
Administrative director 53%
Nurse practitioner/physician assistant 52%
Coordinator/manager 46%
Registered nurse 39%
Forensic interviewer 32%
Social worker-therapist 31%
Psychologist 31%
Intake coordinator/case manager 22%
Nursing/medical assistant 26%
Child/family advocate 25%
Child abuse fellow 22%
Billing 22%
Educator 20%
Child life specialist 16%
Lawyer 13%

AVERAGE FTE

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
PERCENTAGE OF HOSPITALS EMPLOYING STAFF TYPE

.80
1.81
1.10
1.90
.98
1.28
1.31
1.81
2.25
3.27
1.71
1.28
1.01
1.43
1.22
.63
1.47
.79
.55
Part 1: 2008 Snapshot

Figure 6
Budget Deficits
2008
n=50

- Positive bottom line: 16%
- Neutral bottom line: 12%
- Negative bottom line: 72%

PERCENTAGE OF HOSPITALS UNDERWRITING EXPENSES BY SUBSIDY AMOUNT
- 3% $1 mil+
- 8% $500-800K
- 14% $400-500K
- 14% $300-400K
- 11% $200-300K
- 28% $100-200K
- 22% $0-100K
Part 1: 2008 Snapshot

Underwritten Expenses

- Subsidy calculated by subtracting operating budget (expenses) from revenue
- 72% report negative bottom line
- Average subsidy of $238K
Part 1: 2008 Snapshot

Figure 7
Operating Budgets
2008
n=61

- $2 mil+ 18%
- $0-$100K 8%
- $100K-$200K 13%
- $200K-$400K 15%
- $400K-$600K 13%
- $1 mil-$2 mil 15%
- $600K-$1 mil 18%
Part 1: Snapshot

Child Advocacy Center Response - Budget

- 27 report having a budget. Three report having no budget. Two left blank.
- 13 report that the budget includes overhead. 12 report that the budget does not include overhead.

- Average expenses: $1.6 million (n=26)
- Average revenue: $1.4 million (n=23)
- Average deficit: $250K (n=23)
Part 1: 2008 Snapshot

Figure 8
Revenue Sources 2008
n=85

<table>
<thead>
<tr>
<th>Revenue Source</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>59%</td>
</tr>
<tr>
<td>Private payer</td>
<td>54%</td>
</tr>
<tr>
<td>Reimbursement for svc.s.</td>
<td>54%</td>
</tr>
<tr>
<td>Hospital foundation*</td>
<td>49%</td>
</tr>
<tr>
<td>Victims of Crime Compensation</td>
<td>36%</td>
</tr>
<tr>
<td>Individual donation</td>
<td>34%</td>
</tr>
<tr>
<td>Local foundation</td>
<td>28%</td>
</tr>
<tr>
<td>SCHIP</td>
<td>26%</td>
</tr>
<tr>
<td>National Children’s Alliance</td>
<td>25%</td>
</tr>
<tr>
<td>Court fees</td>
<td>25%</td>
</tr>
<tr>
<td>CHAMPUS/TRICARE</td>
<td>22%</td>
</tr>
<tr>
<td>State budget line item</td>
<td>18%</td>
</tr>
<tr>
<td>U.S. Dept. of Justice</td>
<td>16%</td>
</tr>
<tr>
<td>State attorneys general</td>
<td>15%</td>
</tr>
<tr>
<td>National foundation</td>
<td>12%</td>
</tr>
</tbody>
</table>

PERCENTAGE OF HOSPITALS REPORTING REVENUE SOURCES

*Different than operating budget subsidized by the hospital
Part 1: Snapshot

Child Advocacy Center Response - Revenue Sources

Preliminary data show:

- Medicaid is also the biggest payer to a hospital-based CAC
- Other sources shift up notably in importance as a revenue source including:
  - VOCA
  - States Attty General
  - Department of Justice
Part 1: 2008 Snapshot

Figure 9
Contracted Services 2008
n=100

<table>
<thead>
<tr>
<th>SERVICE TYPE</th>
<th>FULLY REIMBURSED</th>
<th>PARTIALLY REIMBURSED</th>
<th>NOT REIMBURSED</th>
<th>UNKNOWN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical exam</td>
<td>27%</td>
<td>64%</td>
<td>18%</td>
<td>75%</td>
</tr>
<tr>
<td>Inpatient medical care</td>
<td>22%</td>
<td>62%</td>
<td>4%</td>
<td>12%</td>
</tr>
<tr>
<td>Phone consult</td>
<td>6%</td>
<td>9%</td>
<td>75%</td>
<td>10%</td>
</tr>
<tr>
<td>Written expert opinion</td>
<td>24%</td>
<td>35%</td>
<td>25%</td>
<td>16%</td>
</tr>
<tr>
<td>Psychological assessment</td>
<td>20%</td>
<td>28%</td>
<td>44%</td>
<td>8%</td>
</tr>
<tr>
<td>Second opinion medical consult</td>
<td>14%</td>
<td>48%</td>
<td>16%</td>
<td>22%</td>
</tr>
<tr>
<td>Mental health services</td>
<td>24%</td>
<td>46%</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Forensic interview</td>
<td>27%</td>
<td>38%</td>
<td>27%</td>
<td>8%</td>
</tr>
<tr>
<td>Telemedicine second opinion consult</td>
<td>9%</td>
<td>5%</td>
<td>50%</td>
<td>36%</td>
</tr>
<tr>
<td>Court testimony</td>
<td>20%</td>
<td>31%</td>
<td>37%</td>
<td>12%</td>
</tr>
<tr>
<td>Prevention/public awareness</td>
<td>6%</td>
<td>14%</td>
<td>68%</td>
<td>12%</td>
</tr>
<tr>
<td>Home visiting</td>
<td>23%</td>
<td>23%</td>
<td>23%</td>
<td>31%</td>
</tr>
</tbody>
</table>

Percentage of hospitals reporting specific reimbursement levels by service.

Percentage of hospitals providing each service.
Part 1: 2008 Snapshot

Figure 11
Funding for Education and Training 2008
n=81

<table>
<thead>
<tr>
<th>TRAINING TYPE</th>
<th>FUNDED</th>
<th>NOT FUNDED</th>
<th>UNKNOWN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident</td>
<td>33%</td>
<td>55%</td>
<td>12%</td>
</tr>
<tr>
<td>Medical student</td>
<td>26%</td>
<td>63%</td>
<td>11%</td>
</tr>
<tr>
<td>Social worker</td>
<td>38%</td>
<td>51%</td>
<td>11%</td>
</tr>
<tr>
<td>Child protective services</td>
<td>43%</td>
<td>47%</td>
<td>10%</td>
</tr>
<tr>
<td>Pediatric/family practices</td>
<td>33%</td>
<td>57%</td>
<td>10%</td>
</tr>
<tr>
<td>Law enforcement</td>
<td>28%</td>
<td>65%</td>
<td>7%</td>
</tr>
<tr>
<td>Prosecution</td>
<td>28%</td>
<td>63%</td>
<td>7%</td>
</tr>
<tr>
<td>Pediatric fellow</td>
<td>42%</td>
<td>48%</td>
<td>10%</td>
</tr>
<tr>
<td>Psychologist</td>
<td>39%</td>
<td>46%</td>
<td>15%</td>
</tr>
<tr>
<td>Childcare/daycare</td>
<td>14%</td>
<td>79%</td>
<td>7%</td>
</tr>
</tbody>
</table>

PERCENTAGE OF HOSPITALS REPORTING REIMBURSEMENT LEVELS BY TRAINING TYPE

PERCENTAGE OF HOSPITALS PROVIDING EACH TRAINING TYPE
Part 1: 2008 Snapshot Summary

Recap:

- Children’s hospitals come in different shapes, sizes
- Child protection services do, too
- Child protection teams/programs may offer
  - Medical evaluations
  - Forensic interviews
  - Mental health services
  - Education and Training
  - Prevention programs
- In general, child abuse services provided at a cost to the hospital
The two datasets from 2005 and 2008 have enabled us to measure change in efforts by children’s hospitals to address child maltreatment.

PART 2
Trend Data
2005-2008
Part 2: Trended Data 2005-2008

The two datasets from 2005 and 2008 have enabled us to measure change in efforts by children’s hospitals to address child abuse.

Caseload trends:

- 37 teams and programs report caseload for both 2005 and 2008
- Mean caseload increased by 195 patients from 945 in 2005 to 1,140 in 2008
- Increase of 21% over the last 3 years
Part 2: Trended Data 2005-2008

Figure 12
Caseload for Teams and Programs: 2005 and 2008
n=37
Part 2: Trended Data 2005-2008

Trended data also show . . .

- Staffing increase - double FTE for fellows and >50% for:
  - Nursing/medical assistants
  - Administrative directors
  - Intake coordinators/case managers
- Operating budget has increased by 34%
- Revenue increase of 29%
- Hospital subsidy increased by 59%
- Shift in revenue sources
  - Medicaid decreased 21%
  - Local foundations decreased 19%
  - Hospital foundations increased 23%
Emerging Trends

- National Incidence Study-3 shows connection between family income and incidence rates in nearly every category of maltreatment.
  - Families >$30,000 per year vs. < $15,000 annual income
  - Poorer are 22x more likely to experience some form of maltreatment

- In the Washington, DC metro area child abuse investigations (July- Oct 07 vs. July - Oct 08)
  - 23% in Fairfax County
  - 29% in Montgomery County
  - 38% in Arlington County
  - 18% in DC
Emerging Trends

- ChildHelp USA’s national hotline cites increased duration/severity of calls and increased referrals
- Boston Globe story on April 16, 2009 which led to a broader Reuters story
- Reports of increased severity: CBS news feature in May 2009 (Phoenix, Seattle, Cincinnati, Boston concurring)
- Ultimately no report or data that can get at perpetrator motive, e.g. did you shake the baby because you lost your job?
- Qualitative information vs. quantitative data just presented in the previous slides
Contact Information

Karen Seaver Hill
Director, Child Advocacy
NACHRI
khill@nachri.org
703-797-6035

Nancy Hanson
Associate Director, Child Advocacy
NACHRI
nhanson@nachri.org
703-797-6091
Hospital Based CAC Summit
August 4, 2009

Laurie Blumberg-Romero
Research Administrator

PHONE: (612) 813-7628
FAX: (612) 813-7883
laurie.blumberg-romero@childrensmn.org

MOB 17-750

Children's Hospitals and Clinics of Minnesota
What are your expectations?

• Identify resources needed to craft a winning grant proposal

• List opportunities available for grant funding
Topics of discussion

• What is a grant?
  ✓ What are the different types of grants?

• Where to find out about grant opportunities:
  ✓ Internal, Foundation, Industry, Government
More topics of discussion

• Grant proposal packet

• Proposal review, signatures, mailing

• Were you awarded? Why not?

• Supplementary Materials
For every grant, you need to look at 3 things:

- Sponsoring Agencies’ Guidelines
- Federally Mandated Requirements
- Internal Policies and Procedures
Grants

Here are the subtypes that will be addressed today:

- Matching
- Research
- Training/education
Matching grants

Some funders are reluctant to be the sole resource. A matching grant requires that a portion of the proposal’s total funds will be contributed by the grantee, either in dollars or in-kind contributions, or obtained from an alternative source.
Research grants

For projects such as investigating important societal questions, carrying out needs assessment, and conducting surveys

• Pure or Scientific Research
  ✓ Control Group
  ✓ Controlled variables

• Applied Research
  ✓ Behavioral or organizational change
  ✓ Process studied

➢ NIH, Foundation, Industry
Training / Education grants

- Training grants either allow an agency to conduct training for others in the field or allow an agency’s staff to attend training provided by others.

- Grants for development of or attendance at conferences, symposia, or workshops are fairly common applications.
Where to find about grant opportunities?

Whether you are searching for federal, state, foundation, or corporate grant opportunities, there is a wealth of information available from a variety of sources:

- Internet
- Periodicals
- Library
- Agency mailing lists
- Ask a colleague/friend
Foundation grant opportunities

The Foundation Center

http://www.fdncenter.org/
State grant opportunities

State Register (MN)
http://www.comm.media.state.mn.us/bookstore/state_register.asp

Department of Health (MN)
http://www.health.state.mn.us/grants/
Federal grant opportunities

The Big Sites

The Catalog of Federal Domestic Assistance
http://www.cfda.gov

Federal Register
http://www.gpoaccess.gov/fr/index.html

Grants.gov
http://www.grants.gov/Find
Federal grant opportunities
continued

GrantsWeb
http://www.srainternational.org/newweb/grantsweb/index.cfm

GrantsNet
http://www.grantsnet.org

National Institutes of Health
Internal funding opportunities

Hospital Foundation

Internal department

CHA equivalent
When reading an announcement for funding, always highlight the following information:

✓ Description and purpose of the grant program
✓ Funding agency
✓ Eligible applications – type of organization (not-for-profit, profit)
Funding Announcements

continued

- Letter of Intent?
- Funding period
- Average award amount?
- Contact person
- Deadline: 6-8 weeks - Can you complete on time?
- Grant amount
- Required attachments
Grant proposal packet

• Cover letter
• Abstract/executive summary
• Introduction/organizational capability
• Problem statement
• Goals and objectives
 Grant proposal packet
 continued

• Work plan, specific activities, solution, plan of operation, or action plan
• Applicant’s commitment and capacity and/or collaborations
• Budget and budget narrative (justification)
• Evaluation
• References
• Appendices or attachments
Cover letter

• Clear and concise overview or summary of proposal and visual framework of the project/program

• Usually only one page long
Be sure to include

- Applicant name and credibility
- Need/problem
- Objectives
- General description of methods
- Total project cost
- Amount requested
- Statement of how proposal furthers the funder’s mission
- Statement of how proposal matches funder’s application guidelines
Formatting of the document

• Read the grant application for requirements (e.g., margin size)
• Try to use 12 point font even if 10 point is allowed
• Heed space limitations as defined in the grant application
• Use spell check!!!!
• Have someone read the grant IN ITS ENTIRETY before you submit
• Write in the 3rd person, rather than in 1st person
• (no “I” or “We”)
• Use only one side of the page
• Insert references as you go
• Be sure to include everything that the application says will be rated
Abstract / executive summary

* Usually only one page

✓ Clear concise summary of the proposal, addressing all sections or content headings

✓ Write it last, but it goes first

✓ *Important:* May be used as a screening device by the funder so it needs to summarize everything that the funder wants to know
Abstract / executive summary
continued

Be sure to include:

✓ Problem statement/evidence of need
✓ Program/project objectives
✓ Major components
✓ Methods/activities
✓ Evaluation
✓ Use nouns and verbs – drop adjectives and adverbs
Introduction / organizational capacity

• Usually one to two pages
• Purpose: to build credibility and motivate the reader to read further
• Clearly establish who is applying for funds
• Describe the purpose of your organization
• Describe your organization’s clients or constituents
• Describe existing pertinent programs
• Give service statistics
• Give evidence of previous accomplishments
• If appropriate, indicate how the proposed program “fits in” with the organization’s mission
• Emphasize that the program is aimed at answering a specific need
Problem statement

• Usually three or four pages
• Make a compelling case
• Stay focused: objectively concentrate on the specific situation, opportunity, problem, issue, need and the population the proposal addresses
• X is where you are; Y is where you want to be. This is a statement on how to get from X to Y.
• Make sure the problem/need relates to the interests and priorities of the funder

• Support your statements with qualified 3rd party research/evidence to justify the need or problem, e.g. professional literature, current statistics from reports, newspapers, etc.

• Include a description of the target population
Program goals and objectives

• Usually one to two pages
• This section describes what you are planning to achieve through the stated activities
• Overall goals: a minimum of one goal for each problem or need in the problem statement
• You must describe the outcome(s) of the grant in MEASURABLE TERMS
Program goals and objectives

• Process objectives are milestones by which progress toward completion is judged

✓ For example: The work plan will be developed by July 1.

✓ For example: Twenty patients will be treated by month four.
Program goals and objectives
continued

• Product objectives or outcomes: to determine whether project/program is a success
• Relate directly to the expressed needs or problems
• Specify the target group
• Must state how you will know the objective is accomplished
Program goals and objectives
continued

• Ambitious and Attainable
• Use the SMART technique for writing objectives
  ✓ Specific
  ✓ Measurable
  ✓ Achievable
  ✓ Results oriented
  ✓ Time specific
Fundable objectives

A well-defined objective should:

• Tell Who
• Is going to be doing What
• When (or by When)
• To What Degree
• How it will be measured.
Is going to be doing what?

The *What* is where many people trip up. To develop the *What*-part of a measurable objective, begin with an Action Verb that requires the *Who* to do something, such as write, install, solve, act, apply. Here are a few examples of the *What*-part of an objective:

- Translate a paragraph of Spanish into English
- Create a database spreadsheet using Access
- Construct a staircase
Work Plan / methods

• Usually three to four pages
• Describe the process used in a rational, direct chronological description of the proposed project/program
• Describe the actions that will accomplish your objectives
• Describe the impact of the activities and how they benefit the agency or organization
• Detail who will carry out the activities, i.e. key personnel, newly hired or currently on staff, their qualifications and achievements

• Present a reasonable scope of activities that can be conducted within the limits of the time and resources

• Don’t promise to do too much; be realistic with your timeframe

• If your budget requests money for an activity or resource, be sure to discuss how it is important to your program
• Time table of events and activities

  ✓ Many funders require a chart for your time table, e.g. a Gantt Chart (www.ganttchart.com) showing events by beginning and completion dates

  ✓ If you create your own schedule grid, be sure to show start and completion date

  ✓ Provide a time table for each year of the proposal, whether one year or three years

  ✓ Indicate each task that must be accomplished as outlined in your work plan
Management plan

• Not always required in smaller grants
• If not required, include this information in the work plan section
• Describe the relationship of the program to the host organization
• Describe the organizational structure of the program
Management plan
continued

• Clearly describe program staffing and give a clear sense of who will be doing what
• Describe the role of volunteers, advisory boards, etc.
• Provide schedule of management and/or administrative activities for the program year, such as the fiscal and reporting schedule
Jane Geever, author of The Foundation Center's Guide to Proposal Writing, conducted interviews with a number of grant makers and found that many do, in fact, consider the budget to be the best way to get a feel for the project without a lot of verbiage and hype. When asked the question, "How do you usually read a grant request?" here's what some of the respondents had to say:

• "I look at the budget. Over the years I've learned that narrative can be enriching, but the numbers are stark and straightforward. I want to see that the money is doing the job described in the proposal."
  
  Joel Orosz, W.K. Kellogg Foundation

• "I skip around the document in the following way: first the budget, to see if the request is appropriate and to see the agency's financials; then the project section, to see what they want to accomplish; then the board list."
  
  Lynn Pattillo, The Pittulloch Foundation, Inc.

• "I often look at the budget and then read the proposal backwards."
  
  Michael Gilligan, The Henry Luce Foundation, Inc.
• Outline personnel
  ✓ Who is doing the work?
• List every program activity and its costs
  ✓ Supplies? Equipment? Travel?
  ✓ Patient Care? Lab? Pharmacy?
• All costs must be justified and related to the activities to be performed
• Follow the funder’s required budget format
Budget and budget narrative
continued

Personnel and their percent of time

1 FTE = 100% (40 hours)

½ day (4 hours) = 10% 1 day (8 hours) = 20%

• Effort reporting is a federal requirement. As a condition to receive federal funds, institutions must maintain an accurate system for reporting the percentage of time (effort) that employees devote to federally sponsored projects.

• Federal and state agencies, private foundations, organizations, and industry provide funds to enable Children’s to conduct research, public service, and training projects. Children’s effort reporting system assures sponsors that funds are properly expended for the salaries and wages of those individuals working on the projects they sponsor. It provides the principal means for certifying that the salaries and wages charged to sponsored projects are consistent with the effort contributed. All employees involved in certifying effort must understand that severe penalties and funding disallowances could result from inaccurate, incomplete, or untimely effort reporting.
• Fringe Benefits

✓ If a salary or a portion of a salary is being paid through a grant, it is important to include that proportion of the fringe benefits. Fringe benefits include such costs as social security taxes, health insurance, dental insurance and long-term disability insurance.
What are indirect costs?

- Overhead, indirect costs (IDC), facilities and administration (F&A)
- Dollars that are recoverable for expenses not explicitly itemized in a budget (use of computers or other resources, accountants to manage the grants, utilities, etc.)
- Many funders have policies regarding the percentage of overhead that they will allow in a project budget. Some do not allow any overhead at all to be included, while others allow overhead to be a specific percentage of total costs or personnel costs.
Budget and budget narrative
continued

Example Budget

Personnel

Principal Investigator/Program Director
(10% of full time expense) $10,000
Fringe Benefits (@ 27%) $2,700

Co-Investigator
(5% of full time expense) $5,000
Fringe Benefits (@27%) $1,350

Total Personnel Costs $19,050

Non-Personnel
Consultant
(15 hrs/week @ $15 per hr) $11,700
Office Supplies $1,100
Staff Travel (flight, hotel, posters) $1,000

Total Project Expense $32,850

Indirect Costs (34%) $11,169

Total Project Costs $44,019
What happens after the proposal is approved?

• It is important to remember that while preparing the budget, you often will be required to report back to the funder on a line item basis. In other words, at the completion of the project, you may need to include a comparison between the budget you submitted with the proposal, and the amount of money you actually spent. Some funders will require that you explain variations of a significant greater or lesser amount.

• Above all, the project budget is a document that will live with you for the entire duration of the project. Preparing it accurately and presenting it as a well-organized component of the proposal can be essential in the success of your fundraising campaign.
The budget narrative (justification)

• Use narrative form to explain the budget
  ✓ Use sentences
  ✓ Itemize everything
• Include all items requested for funding and all items to be paid by other sources
  ✓ Remember all of these must be reported on and tracked!!
Evaluation plan

• Determine how you will measure the effectiveness of your project/program

• State who will be involved in evaluating and how the evaluator will be used in the process

• Your evaluation plan should include:
  ✓ A plan for evaluating the accomplishment of the objectives

  Note: if objectives are measurable, then it is easier to complete the evaluation
What:

• Quantitative Results
  ✓ Percents, statistics, survey results

• Qualitative Results
  ✓ Focus groups, free text comments

• State your criteria for a successful program
  ✓ Outcomes
  ✓ Cost effectiveness
  ✓ Satisfaction
Appendices / attachments

• What must be attached varies by grant application

• Some examples of attachments:
  ✓ Verification of tax-exempt status
    • IRS determination letter
  ✓ Certification of incorporation and by-laws
  ✓ Listing of officers and board of directors
  ✓ Most recent audited financial statements for last completed fiscal year
• Examples of attachments (continued)

✓ References
✓ Listing of clients served
✓ Listing of other current funding sources and uses
✓ Biographies/resumes of key personnel
✓ Support letters or endorsements
✓ Letters of Commitment
Proposal review / signatures / mailing

• Three areas of proposal to review:
  ▪ General quality of the proposed program
    ▪ Grammar, language, ideas
  ▪ Specific criteria of the funding source
    ▪ Did you provide what funder asked for?
  ▪ Appearance and technical correctness of the document?
    ▪ Margins, font size, number of pages
Proposal review / signatures / mailing continued

• Copying
  ✓ How many originals and copies does the funder require?
  ✓ Check the copying when completed
    • Pages missing?
    • Blank pages?
    • Figures look ok?

• Mailing / delivery
  ✓ Overnight (fedex)
The long wait

• You may wait up to six months or more to hear about whether or not you were funded
You weren’t awarded? Why not?

Rejection due to the following problems:

✓ Proposed tests, or methods, or scientific procedures are unsuited to stated objective
✓ Description too nebulous
✓ Program design not carefully thought out
✓ Statistical aspects not given enough consideration
You weren’t awarded? Why not?

Rejection due to applicant’s abilities:

✓ Inadequate training or experience
✓ Unfamiliar with recent pertinent literature
✓ Previous work does not inspire confidence
✓ Too much reliance on inexperienced associates
✓ Spread too thin; too many projects
✓ Need to collaborate with others in the field
You weren’t awarded? Why not?

Rejection for other reasons:

- Requirements for equipment, supplies, or personnel are unrealistic
- Organization setting is unfavorable/unsupportive
- Current grants to the applicant are adequate to cover the proposal
- You did not follow funder’s instructions
You weren’t awarded? Now what?

• Seek other funding
• Revise application where appropriate
• Reapply
  • Reapplications are funded at a higher rate!
Thank you!

Any questions?
PR and Communications

Rebecca Gordon
Missouri Kids First

To obtain a copy of this presentation please go to: http://www.slideshare.net/my-slidespace
Organizational Charts
Nationwide Children's Hospital
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Facilities

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Chair, Dept.
Pediatrics

Richard Brill, MD
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Dann Mann
VP Operations

Donna Teach
VP Marketing

Grant Morrow, MD
Medical Director

Kathy Millem
VP Business Svcs

Jamie Phillips
VP Heart Center

Bruce Meyer, MD
Chief Ambulatory Officer

Luke Brown
VP & Controller

Okey Eneli
VP Eng. Services

Mike Brady, MD
Physician-in-Chief

Bruce Meyer, MD
Admin. Med. Dir.

Terry Davis, MD
Admin. Surgical Director

Donna Caniano,
MD
Surgeon-in-Chief

Leslie Mihalov, MD

Karen Heiser
VP Education
Institute

Karen Allen
Special Assistant to
the Medical Staff

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Duane Kusler
VP Emergency Services

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VP Neonatal Svcs

Michelle McKissick,
RN
VP ICU/Surg. Svcs

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Vacant
VP Human Res.

Wanda Stackpole
VP Homecare

Jack Clark
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Jeff Ziegler
VP Physician Svcs

Bev Farinelli*
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Eric Vaughn*
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Strategic Initiatives

*These Service Line Admins report jointly to physician Chief, COO and CNO

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