Children's Hospital of Philadelphia
PolicyLab

Variation in care among adolescents treated for sexual assault

Health Equity

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I'm a child abuse pediatrician and as part of my work, I help ensure the health and safety of adolescent sexual assault victims. The sexual abuse/assault of children occurs in our communities and our neighborhoods, regardless of religion, education, ethnicity or economic status. Approximately one in four girls and one in seven boys will experience sexual abuse/assault before they reach age 18.

Adolescents come to pediatric emergency departments all around the country every day, yet, the medical care a child receives following sexual assault varies depending on which emergency department. Pediatric emergency physicians routinely care for sexually assaulted adolescents, and appropriate diagnostic testing and treatment for sexually transmitted infections and pregnancy in this setting is important. To that end, the American Academy of Pediatrics and the Centers for Disease Control and Prevention have published recommendations regarding testing and treatment of sexually assaulted adolescents. For adolescents, testing should be done for chlamydia, gonorrhea, and pregnancy. Preventative medications should be offered for chlamydia, gonorrhea, and pregnancy. Preventative medication for HIV should be considered based on the nature of the assault and the characteristics of the alleged perpetrator.

With this is mind, we set out to study pediatric emergency department care practices of adolescents who have been sexually assaulted. Using a large administrative database containing hospital and patient information, we studied over 12,000 adolescents who were evaluated for sexual assault at 38 pediatric emergency departments over a 10-year period. We looked at the percent of children that received the recommended tests and treatments. We also interviewed each hospital to learn if/when during the 10-year period they had a specialized clinical team or pathway (i.e., standardized care process) for children presenting with sexual abuse.

The variability is striking. Across emergency departments, the unadjusted rates of recommended testing ranged from 6-89% and the rates of recommended treatment ranged from 0-57%. Altogether, rates of children receiving appropriate medical care were poor: 44% of children received recommended testing and 35% received recommended treatment. The presence of a pathway was associated with increased rates of treatment even after adjusting for other patient and hospital factors.

This significant between-hospital and within-hospital variation raises great concern over the quality of care provided to adolescents diagnosed with sexual assault, and highlights the importance of identifying and implementing changes to improve their care. Families who are experiencing the victimization of their adolescent are in crisis. When families present to a pediatric emergency department for medical care during this crisis, ensuring appropriate tests and preventative treatment for the child reassures the family that future impact to the child's health has been minimized, reducing stress in an already challenging situation. We can do

a better job supporting these families.

Many studies have shown that evidence-based guidelines can decrease care variability and improve clinical outcomes. Our study supports this conclusion, showing improvements in care when specialized clinical pathways were present. Adopting evidence-based pathways for evaluating children with acute sexual assault is an important first step. In addition to using clinical pathways, hospitals must allocate resources and train physicians and nurses to become competent and knowledgeable in conducting these medical evaluations. I am hopeful that with such investments, we can promise high quality medical care to ALL adolescents diagnosed with sexual assault.

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