Integrating the Nurse Practitioner into the Child Abuse Team

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Disclosures

- No conflicts of interest to disclose

Introduction

- Child Abuse?
- People really abuse their children? What?
- Not my clients, they wouldn't do such a thing.
- There is a field called "child abuse"?

Objectives

- Identify the role of the advanced practice provider within a child abuse team.
- Identify the training required to integrate the NP into the child abuse team.
- Identify three short, medium, and long term benefits that occurred within our institution after hiring an NP.

Child Maltreatment

- Has affected hundreds of millions of children globally with the likelihood of profound long term effects into adulthood.

- In 2015, in the United States alone, 1,670 children died as a result of abuse and neglect.

Felitti et al, 1998

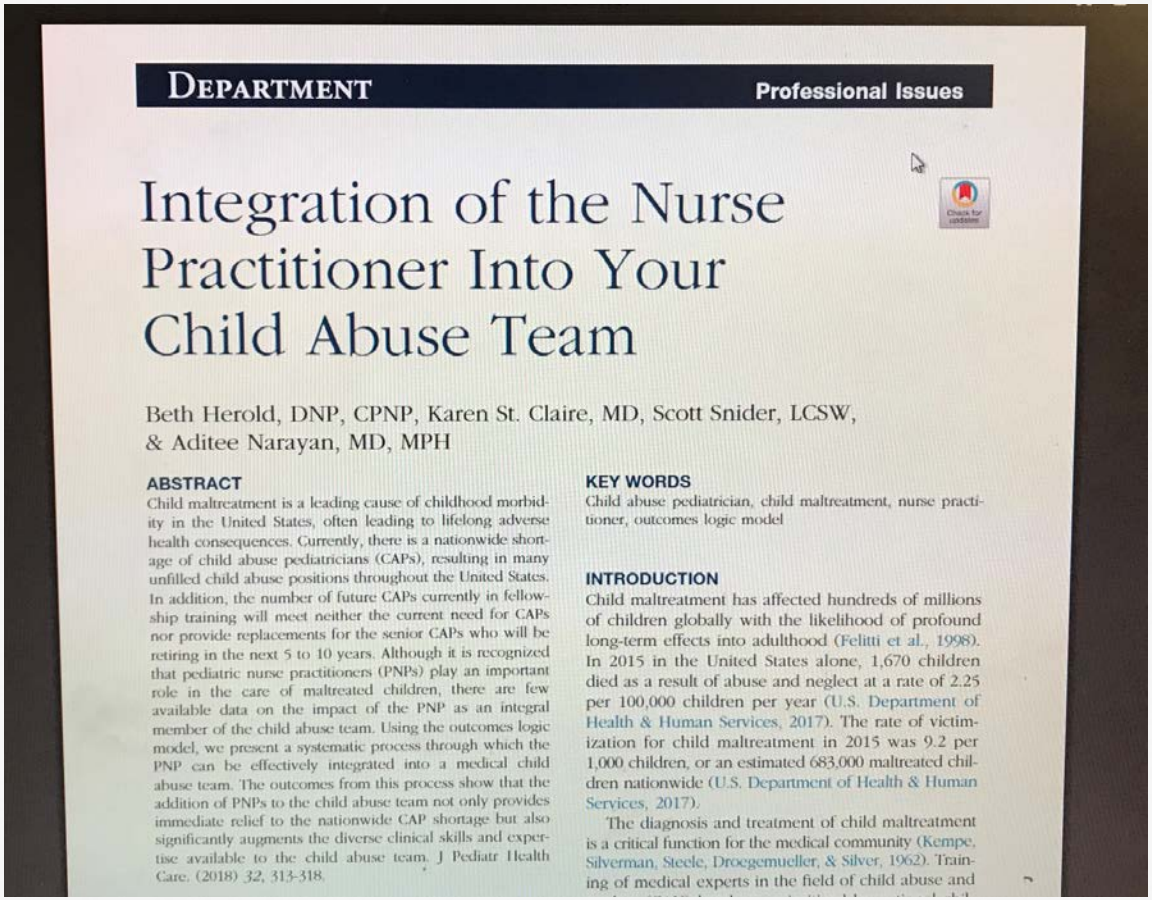
U.S. Department of Health and Human Services

Child Abuse Pediatrics (CAP) became a Board-Certified medical subspecialty within the field of pediatrics in 2009.

- Currently ~ 20 open CAP positons nationwide.
- In 2017, only 13 fellows readying for boards, leaving at least 7 open positions.
- Many fellow positions go unfilled each year.
- 21% of the current 328 board certified pediatricians are over the age of 61 which will make for increased shortages as retirement nears.

Proposed solution to the shortage of CAP providers….

Augment the team and collaborate with the advanced practice provider.



DEPARTMENT Professional Issues

Integration of the Nurse Practitioner Into Your Child Abuse Team

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ABSTRACT

Child maltreatment is a leading cause of childhood morbidity in the United States, often leading to lifelong adverse health consequences. Currently, there is a nationwide shortage of child abuse pediatricians (CAPs), resulting in many unfilled child abuse positions throughout the United States. In addition, the number of future CAPs currently in fellowship training will meet neither the current need for CAPs nor provide replacements for the senior CAPs who will be retiring in the next 5 to 10 years. Although it is recognized that pediatric nurse practitioners (PNPs) play an important role in the care of maltreated children, there are few available data on the impact of the PNP as an integral member of the child abuse team. Using the outcomes logic model, we present a systematic process through which the PNP can be effectively integrated into a medical child abuse team. The outcomes from this process show that the addition of PNPs to the child abuse team not only provides immediate relief to the nationwide CAP shortage but also significantly augments the diverse clinical skills and expertise available to the child abuse team. J Pediatr Health Care. (2018) *32*, 313-318.

KEY WORDS

Child abuse pediatrician, child maltreatment, nurse practitioner, outcomes logic model

INTRODUCTION

Child maltreatment has affected hundreds of millions of children globally with the likelihood of profound long-term effects into adulthood (Felitti et al., 1998). In 2015 in the United States alone, 1,670 children died as a result of abuse and neglect at a rate of 2.25 per 100,000 children per year (U.S. Department of Health & Human Services, 2017). The rate of victimization for child maltreatment in 2015 was 9.2 per 1,000 children, or an estimated 683,000 maltreated children nationwide (U.S. Department of Health & Human Services, 2017).

The diagnosis and treatment of child maltreatment is a critical function for the medical community (Kempe, Silverman, Steele, Droegemueller, & Silver, 1962). Training of medical experts in the field of child abuse and

PNP

- PNP's provide care to children from birth through young adult with an in-depth knowledge and experience in pediatric primary health care including well child care and prevention/management of common pediatric acute illnesses and chronic conditions. This care is provided to support optimal health of children within the context of their family, community, and environmental setting

National Association of Pediatric Nurse Practitioners, 2018

What is the role of the PNP within a child abuse team?

- Totally dependent upon each individual team needs.

Our Team's model

- Medical model.
- Our team was looking for a medical provider who could perform both in patient and out patient medical evaluations and take call every third week.

Proposed Framework

- Framework NOT a policy
  - Guide for programs to adapt
  - All programs are unique
- Presenting general principles
  - Will always be exceptions
  - NOT a blanket statement

Roadmap

- Step 1 – Determine your team's need
- Step 2 – Screen and interview for candidate (who to look for)
- Step 3 – Train NP (adapt fellowship approach)
- Step 4 – Integrate NP (how to win friends and influence people)

Step 1

Determine your team's need

Develop a job description based on those needs

What type of provider does your team need?

Do you need a CAP?
Do you need a NP?
Do you need a SANE?
Do you need a LCSW?

Other Questions to Refine your Candidate Search

- Will they see patients inpatient, outpatient, or both?
- Will they be an educator? For trainees? Community members?
- Will they lead program sections?
- Will they participate in research and scholarship?
- Will they perform diagnostic interviews of children/teens?
- Will they collect forensic evidence?

Develop a Job Description

Specifics…hours, duties, call, etc etc etc

Step 2

Screen and Interview for best candidate

Tips for screening

- Value Pediatric experience
- Value Primary care experience
- Value ICU experience
- Value Child Abuse experience

What if minimal experience?

- May decide to invest
- Recognize upfront and set expectations accordingly
  - Minimum of 3 months for experienced PNP
  - 6 months to one year for little experience, with one year being most likely.

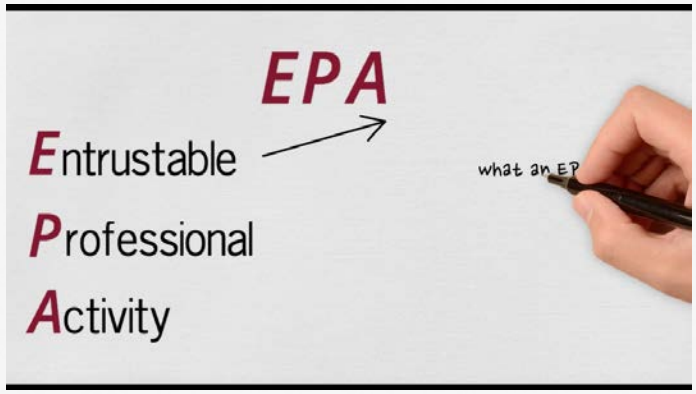
Do they understand what they're getting into?

- Assess for resiliency
  - Prior experiences requiring resiliency?
    - “Peace Corps volunteer”
    - “Women’s shelter”
  - Ask for history of resiliency strategies
- Consider trial period

Step 3

How the heck do we train the new provider?

What is the training required?



Entrustable Professional Activities (EPA) for Subspecialties

https://www.abp.org/subspecialty-epas#Child%20Abuse

Developed through the American Board of Pediatrics (licensing body who writes the Boards)

Adapted from Fellowship Principles

- Fellowship Review
  - 3 years accredited Child Abuse Fellowship
    - 2 years total clinical training
    - 1 year min total research training
      - Additional training in
        - Quality Improvement
        - Evidence Based Medicine
        - Teaching Skills
        - Administrative skills
- NOT equivalent to completing fellowship training

First Child Abuse EPA

Provide subspecialty medical evaluation for child and adolescents who are **suspected victims of sexual abuse or assault.**

https://www.abp.org/subspecialty-epas#Child%20Abuse

- Competencies may include:
  - Interviewing patients.
  - Complete medical exams.
  - Procedures.
  - Education.
  - Communication with patient and family.

Second child abuse EPA

Engage in behaviors and use coping strategies that will mitigate the emotional stress of caring for patients that have been abused, neglected, or maltreated.

Secondary trauma(vicarious trauma) is a risk to the well being of providers if the exposure is chronic (such as the case with child abuse providers)

Competencies may include:

- Managing personal biases
- Engage in help=seeking behaviors
- Use healthy coping mechanisms
- Dealing with uncertainty

Third Child Abuse EPA

Provide subspecialty medical evaluation for cases of suspected **child neglect** and other forms of maltreatment.

Neglect may include, but not limited to:

- Failing to provide supervision.
- Failing to protect a child from harm.
- Failing to provide basic needs.
- Failing to meet medical, mental, and emotional needs.
- Exposing child to dugs
- Medical child abuse

Fourth Child Abuse EPA

Provide subspecialty medical evaluation in cases of suspected **child physical abuse.**

Competencies may include:

- Performing exams.
- Communicating with health care professionals.
- Consultative role.
- Dealing with uncertainty.

Select each area and develop an orientation checklist

Example – Physical abuse evaluations

- Determine which content within the EPA applies
- Review curricular components and competencies with NP
- Review necessary skills or procedures

Provide educational resources

- Pub med articles
- The Quarterly

What are the goals?

- To progress from “direct supervision” to “indirect supervision”
  - Direct – “eyes on”
  - Indirect
    - In person review
    - Phone/telemedicine
- Fine Balance

What are the goals?

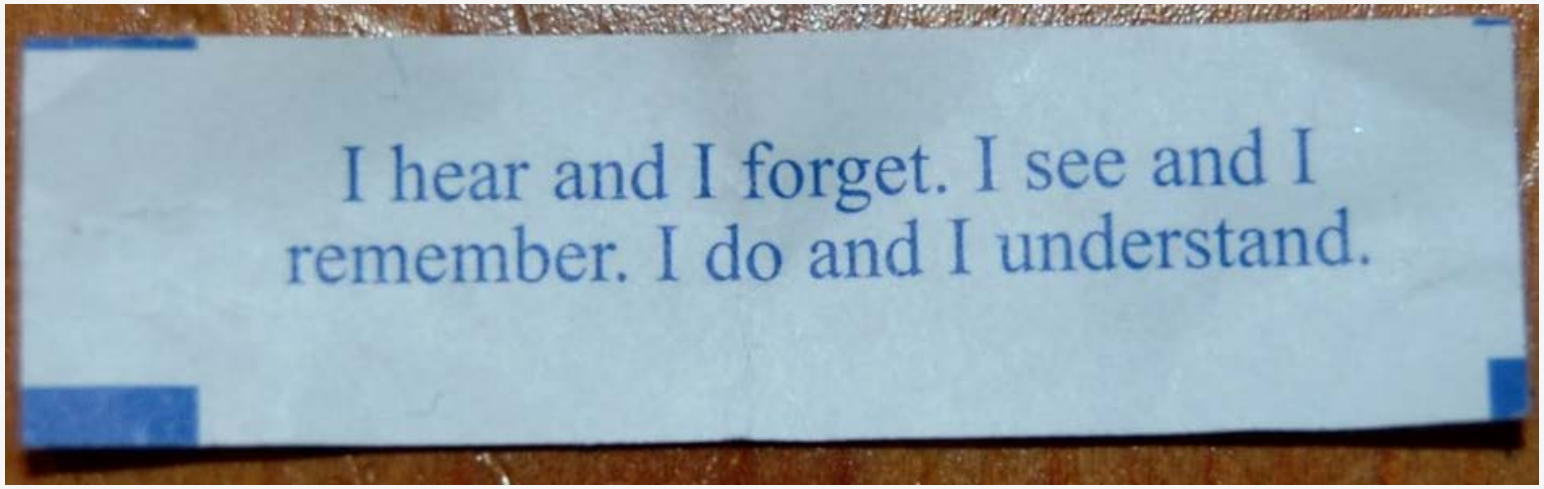
Collaboration with the CAP provider to provide quality care/evaluations to children who are allegedly abused and/or neglected.

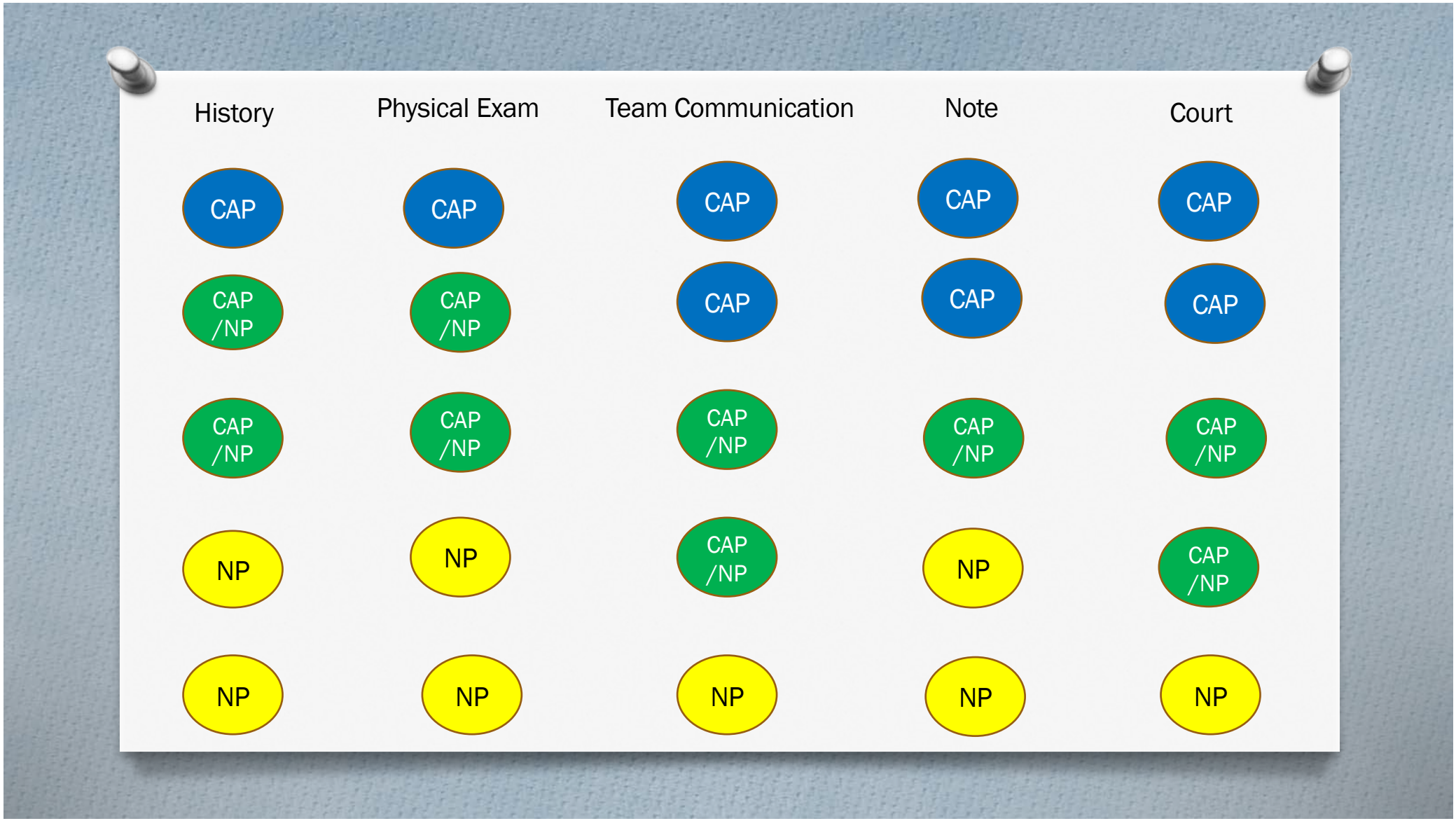
We do NOT support/encourage NPs to practice solo in the field of Child Abuse Pediatrics

- Same as Pediatric Oncology
- Encourage presence as valuable member of interdisciplinary team

Graduated responsibility

- See one, do one, teach one




History
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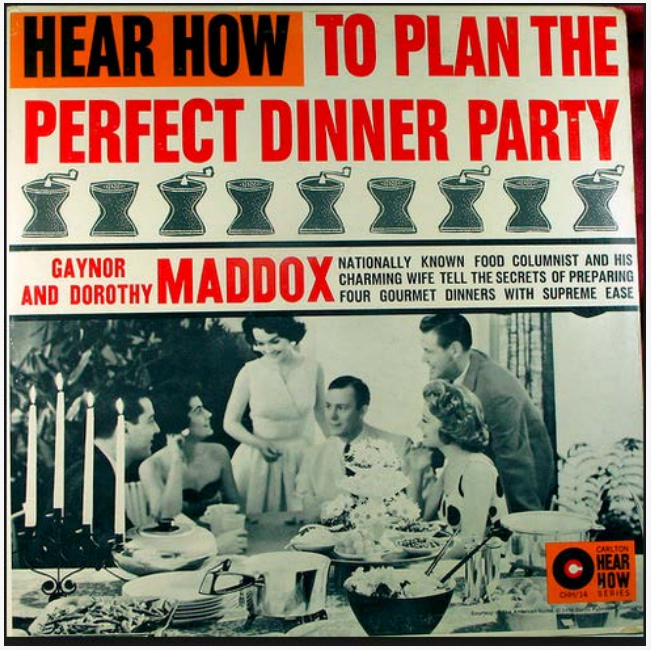
Tips on implementation

- Start with scenario that has
  - Some familiarity
  - Simple
  - Minimal controversy
  - “Low stakes”
- Examples
  - Linear parietal skull fracture
  - Isolated bony injury
  - Out patient evaluations
- Avoid
  - Abusive head trauma at first

Step 4

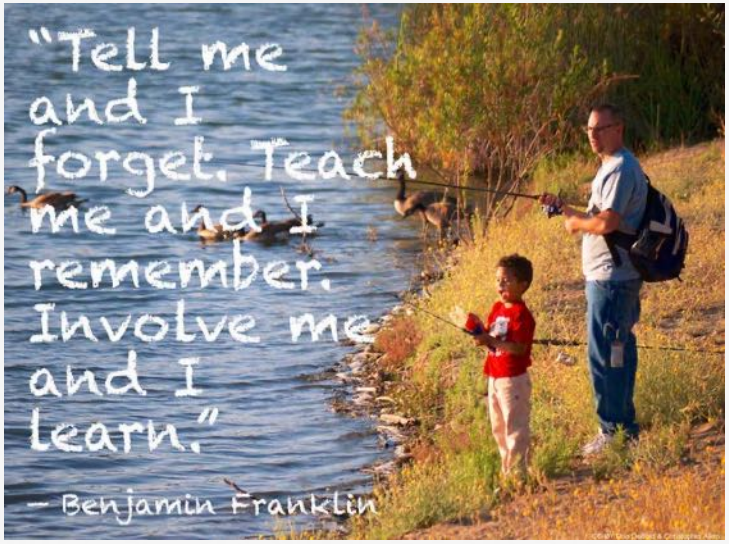
Integrate the NP

Be a good host



Show your involvement/Sustaining the NP

- Provide ongoing feedback
- Case reviews culture
  - Timely
  - Make process known
- Program plus community
  - Your good word goes a long way
  - Share court load
- Continuous education
  - Attend meetings



Short Term Outcomes for our team hiring an NP

- On call coverage changed from every two weeks to every 3 weeks.
- The number of on call weekend coverage decreased from 26 per year to 17.
- The responsibility of accommodating high numbers of outpatient referrals was distributed across 3 rather than 2 providers.

Medium Term Outcomes

- Completed outpatient appointments increased from 381 in 08-09 to 543 14-15.
- Wait times for appointments decreased from 3-4 weeks to 1-2 weeks.
- RVU's increased from 706 to 1155 with increased revenue.

Long Term Outcomes

- PNP improved professional/personal life balance….decreasing risk of burnout.
- PNP involvement with medical professionals and community members enhanced collaborations and scholarly activities.
- Several peer institutions have requested information regarding our child abuse team’s PNP model.

Future possibilities/dreams

- National toolkit for integration of the NP into the child abuse team.
- Internship
- On site training

Lets do this!!

- Integrate the nurse practitioner into the child abuse team

Questions?

Additional Resources

- Herold and Narayan et al, Integration of the Nurse Practitioner into your Child Abuse Team. J Pediatr Health Care. (2018) 32, 313-318.
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- American Board of Pediatrics, Child Abuse Entrustable Professional Activities
  - https://www.abp.org/subspecialty-epas#Child%20Abuse