Midwest Regional Medical Academy

Midwest Regional CHILDREN'S ADVOCACY CENTER

PROTOCOL, TRAINING, AND TECHNOLOGY GUIDELINES FOR THE MEDICAL STANDARD - 2017

Overall Goals for Medical Protocol:

1. Identify clear guidelines on the types of medical services provided by your CAC and the accessibility of your medical staff for such services
2. A process should be put in place to test for STIs and pregnancy when indicated
3. Establish clear protocols for which cases of abuse need immediate medical evaluations and where that evaluation will occur
4. Address forensic evidence collection and chain of custody
5. An exam for suspected sexual abuse should be a health-related visit and not just for evidence collection
6. Addressing the child's additional health issues should become the norm and not the exception
7. Recognize situations that might benefit from a follow-up examinatn and establish a process for what that evaluation will consist of
8. All medical protocol needs to follow the medical standard minimums

Training Guidelines for Medical Providers:

1. According to the NCA Medical Standard for Accreditation: *Medical evaluations should be conducted by healthcare providers with specific training in child sexual abuse and that meets one of the following training standards:*
    a. Child Abuse Pediatrics Sub-board eligibility or certification **or**
    b. Physicians without such eligibility or certification, Advanced Practice Nurses, and Physician Assistants that have a minimum of 16 hours of formal didactic training in the medical evaluation of child sexual abuse **or**
    c. SANE (Sexual Assault Nurse Examiners) without advanced practitioner training must have a minimum of 40 hours of coursework specific to the medical evaluation of child sexual abuse, followed by a competency-based clinical preceptorship. This means a preceptorship with an experienced provider in a clinical setting where the SANE can demonstrate competency in performing exams.

2. Didactic training for CAC medical providers must cover examination positions (supine, lateral, knee chest, etc), examination techniques (gathering of forensic evidence, samples for STI testing, labial traction, use of cotton swab with pubertal females to demonstrate edges of hymen, foley catheter, etc), and the review of multiple examples of:
    a. anatomical variants
    b. acquired or developmental conditions that mimic abuse
    c. accidental trauma and sexual abuse trauma
    d. STIs, including information on each STI and on forensic evidence

3. In addition to didactic curriculum, medical training should include an observational clinical component to teach exam techniques and history taking

4. Providers should be familiar with the article: Adams JA, Kellogg ND, Farst KJ, Harper NS, Palusci VJ, Frasier LD, Levitt, CJ, Shapiro RA, Moles RL, Starling SP, *Updated Guidelines for the Medical Assessment and Care of Children Who May Have Been Sexually Abused*, Journal of Pediatric and Adolescent Gynecology (2015) and continue to stay abreast of current research and best practices in the field.

5. According to the NCA Medical Standard for Acreditation, medical professionals providing services to CAC clients must demonstrate continuing education in the field of child abuse consisting of a minimum of 8 hours every 2 years of CEU/CME credits effective 2017.
    a. The CAC should have included in their policies and procedures how continuous quality improvement activities (CQI) are documented.
    b. In the event of a practice audit, a log of CQI activities provides tangible evidence that a provider participates in quality improvement practices such as expert review.

Best Practices:

1. Examiners who have performed less than 100 exams **and/or** have less than 1 year of experience should have 100% of their cases reviewed by an advanced medical consultant. This includes all photodocumentation and case notes. *(See continuous quality improvement below for a definition of advanced medical consultant)*
    a. Supervision can decrease when providers demonstrate competence with recognizing the variations in normal exams. Supervision should continue for exams that are unclear or possibly abnormal.
    b. For clinicians who cannot treatment plans such as prescribing medications within their scope of practice, a medical director in their community who is comfortable supporting the work they do should be identified and a MOU is recommended.

2. Medical providers should regularly review cases with an expert. A provider should be able to estimate the percentage of the exams they have diagnosed as "abnormal" or “diagnostic of abuse”.
    a. **IMPORTANT:** Nationally, less than 5% of non-acute exams are abnormal. If the center’s number is above 10%, the provider might be over-calling non-specific findings, which could mislead an investigation. If a center performs primarily acute assault exams, the number of abnormal exams may be in the 15-20% range, but anything more would indicate the need for better peer review, supervision, or additional education. If CAC Directors find that their center’s positive numbers are higher than expected, they can contact the Midwest Regional CAC for advice about how to obtain quality improvement and expert review services for their medical providers (www.mrcac.org).

Continuous Quality Improvement (CQI):

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1. According to the NCA Medical Standard for Accreditation the following providers qualify as an *"Advanced Medical Consultant"* able to provide expert case review.
    a. **Child Abuse Pediatrician** (preferred)
        i. Review with a Child Abuse Pediatrician could occur via direct linkage agreement with specific provider or through myCasereview (http://www.mrcac.org/medical-academy/mycasereview/) hosted by the Midwest Regional CAC, or other identified State-based medical expert review systems that have access to an "advanced medical consultant" **or**
    b. **Physician or Advanced Practice Nurse** with the following qualifications:
        i. Has met the minimum training outlined for a CAC provider (see above)
        ii. Has performed at least 100 child sexual abuse examinations
        iii. Current in CQI requirements (continuing education and participation in expert review on their own cases)

2. **All** examiners should have abnormal exams reviewed by an expert in the field. **Beginning in 2017**, the NCA Medical Standard for Accreditation states that "*all medical professionals providing services to CAC clients must demonstrate, at a minimum, that 50% of all findings deemed abnormal or "diagnostic" of trauma from sexual abuse have undergone expert review by an advanced medical consultant*".
    a. Advanced Medical Consultants as defined above should also have abnormal exams reviewd by another expert.
    b. An "abnormal" exam is one that has acute or healed physical findings in the ano-genital area felt to indicate that abuse/assault has occurred. Laboratory testing for STI's or pregnancy and DNA evidence collection are NOT included in the definition of an abnormal exam.

3. Expert review of examination findings is a de-identified continuous quality improvement (CQI) activity and is NOT a consultation/second opinion.
    a. The CAC should have included in their policies and procedures how the continuous quality improvement activity of expert review is documented.
    b. The CAC should track if an exam is felt to be abnormal either through a patient log kept in a secured location or through the MDT case review process. The number of abnormal exams and percent of exams reviewed by an expert provider should be available if requested for site review purposes/practice audits.
    c. The medical provider or organization who provides the expert review should maintain a de-identified log noting how many times they have provided examination review for a specific provider. Notation of whether consensus was reached is also recommended.
    d. A MOU between the CAC/medical provider and the person serving as the expert reviewer outlining the roles and responsibilities should be considered to delineate roles and expectations.

Medical Exam Photodocumentation Equipment:

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The following are equipment suggestions for photodocumentation of medical exams. All exams must be photodocumented, preferably in a digital format. Equipment costs will vary. Equipment needs in general should include: a colposcope or digital camera or digital videocamera that can provide at least 10X magnification is necessary. CACs may want to contact their IT professional/department (if applicable) for additional suggestions appropriate to their respective center.

More specific suggestions:

1. Genital photos
    a. Colposcope with mounted DSLR camera or video camera **OR**
    b. Camera specs: 35 mm DLSR camera with 15+ megapixel resolution, 50 or 60 mm prime lens with macro capability (minimum focusing distance < 12 cm, capable of "1:1" photography), Ring flash OR LED ring light **OR**
    c. Digital video camera system and tripod with focusing rails
2. Body photography (can be the same as the camera above but nice to have a separate one.)
    a. 35 mm DSLR camers with 15MP+ resolution
    b. 50 or 60 mm prime lens with macro capability
    c. Ring flash
    d. Battery grip with portrait shutter button. (Not essential but nice feature)
3. Misc photographic supplies
    a. ABFO #2 (American Board of Forensic Odontology Standard # 2 -- standard ruler for body photography)
    b. Extra batteries and battery chargers
    c. Memory cards (minimum 4 GB) for each camera plus a spare
    d. Data transfer cables and HDMI cables for the camera
4. External monitor (Nice but nonessential)
    a. HDMI capable computer monitor
    b. Mount that allows the monitor to be in portrait configuration. (Some monitors come with this)
    c. Micro HDMI to HDMI converter
    d. 10-15 ft HDMI cable
5. Exam furniture
    a. Backless rolling stool for the examiner
    b. Exam table with lithotomy stirrups