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) ■■, ■■-■■.

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KEY WORDS

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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 neglect (CAN) has been prioritized by national children's organizations, including the American Academy of Pediatrics, 2018. The specialized expertise of medical providers working in CAN was validated when child abuse pediatrics (CAP) became a board-certified medical subspecialty in 2009 (American Board of Pediatrics, n.d.) with Accreditation Council for Graduate Medical Education (ACGME) Fellowship status. At this time, there is a shortage of CAP and CAN-trained clinicians across the country, with many CAP clinician and leadership positions unfilled.

At the time of writing, there were 20 posted positions for board-certified child abuse pediatricians on the Helfer Society Employment page (Ray E. Helfer Society, n.d.). In 2016, there were 13 Level 3 fellows who became board eligible, representing a deficit of at least seven positions. Although specific numbers are unavailable, there are likely numerous positions nationwide that are not posted on the Helfer Society

employment page. Of the current 328 board-certified child abuse pediatricians, 68 (representing 21%) are over the age of 61 years (American Board of Pediatrics, 2017). There is concern that CAP fellowship programs may not be graduating sufficient numbers of child abuse pediatricians necessary to fill either existing CAP positions (Panks, Moffatt, & Narayan, 2017) or the increasing number of CAP positions that will be vacated by senior child abuse pediatricians retiring. National efforts are already in progress to increase the recruitment of physicians to CAP fellowships (Narayan, Leventhal, Makaroff, Herman, & Moffatt, personal communication, April 2017). Physicians practicing in the CAP field who are not board certified provide important contributions, but staffing shortages remain. Additional strategies are needed to address the immediate workforce needs while these recruitment efforts are under way.

Pediatric nurse practitioners (PNPs) may help address the CAN clinician shortage. PNPs are already providing "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). PNPs have already begun establishing their role in the diagnosis and treatment of maltreated children, with most practicing in child advocacy centers (Hornor & Herendeen, 2014). Child advocacy centers are free-standing, multidisciplinary facilities to which children are referred for assessments for possible sexual abuse, physical abuse, or neglect. (National Children's Alliance, 2017).

Currently, PNPs are primarily involved in the outpatient evaluation of child maltreatment; however, there are no aspects of PNP licensing that would restrict PNPs to the outpatient setting. Nurse practitioners (NPs) are already well established in general inpatient medical and surgical services (Rejtar, Ranstrom, & Allcox, 2017). However, there is a paucity of data on the integration of the NP into medical child abuse teams serving various settings. Effective training of PNPs in the inpatient and outpatient care of child abuse and neglect can help child abuse pediatricians meet clinical demands during workforce shortages. Using the outcomes logic model as an evaluative framework, we present a successful process for integrating a PNP into an established child abuse team.

METHODS

The outcomes logic model is a practical method for systematically collecting data for community-based programs (Medeiros et al., 2005). Logic models provide the synthesis of a program, explaining how interventions can be successful. We used The University of Wisconsin-Extension outcomes logic model (University of Wisconsin-Extension, n.d.). The outcomes logic model is presented as a conceptual framework with the following steps: clarifying background; describing the intervention; and identifying inputs, outputs, and outcomes.

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BACKGROUND

Before hiring a PNP, our child abuse team consisted of two child abuse pediatricians, totaling 1.5 full-time equivalents (FTEs), and 1.0 FTE social worker. Responsibilities included outpatient and inpatient evaluations and being on call every other week. On-call responsibilities included 24 hours/day, 7 days/week phone consultation, immediate availability for emergencies, routine inpatient consultations within 24 hours, and urgent outpatient referrals. Child abuse pediatricians were also responsible for training of residents, students, nurses, and social workers.

Compared with peer programs (Children's Hospital Association, 2012), our child abuse team was understaffed by 1 to 2 FTEs for the number of inpatients and outpatients referred. Understaffing resulted in lengthy wait times (> 3 weeks) for appointments, delayed distribution of medical evaluation reports to referring agencies (up to 3-4 weeks after evaluation), limited follow-up for inpatient CAN consultations, and inconsistent rounding on inpatients. Given the high degree of responsibility with a demanding schedule, the child abuse pediatricians were at high risk for burnout and adverse wellness outcomes.

Child abuse teams at similar regional institutions have taken up to 3 years to recruit child abuse pediatricians to their programs, with some positions still unfilled to date (Narayan, 2011). There were additionally budgetary limitations in our CAN program regarding the hiring of a third child abuse pediatrician. The CAN team institution has a long history of using advanced practice providers to include PNPs, family NPs, NPs, physicians, and midwives as members of medical, surgical, and critical care teams

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