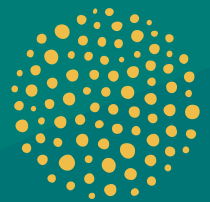


National Optional Standards of Accreditation

for Children's Advocacy Centers

2023 EDITION



**National
Children's
Alliance®**

*The Force Behind
Children's Advocacy Centers*

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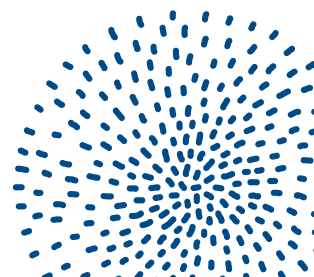
Introduction

This manual outlines the three new optional standards for both new and existing Children's Advocacy Centers (CACs) seeking National Children's Alliance (NCA) accreditation or reaccreditation in one or more of these optional standards. It provides the foundation for understanding how the Standards for Accredited Members support NCA's mission and ensures the integrity of the CAC model of response to reports of abuse. This manual also enables users to conduct an analysis of accreditation readiness for the three new optional standards and stimulates strategic program planning aimed at delivering comprehensive, evidence-based services.

NCA sets minimum standards that inform and strengthen professional practice and are consistent and updated with the state of the field. These three new optional standards were developed with consideration of the vast diversity of communities in which CACs operate. As a national organization, NCA recognizes and values the variety of ways in which the standards are implemented based on a particular locale's unique needs and resources. By virtue of the multidisciplinary, interagency nature of CAC work, NCA also recognizes that CACs will not likely meet all the required criteria perfectly and consistently over time. Factors such as longevity of the center, community resources and funding, geography, demographics, and size and location of a center's facility, all affect a CAC's ability to meet the required standards and its method

of implementation. However, the beauty of the CAC model is its ability to deliver high quality services to children and families in creatively adapted and operationalized ways. While NCA accredits CACs based on the minimum standards it has established, centers are encouraged to continuously aspire to exceed these standards however possible. This manual, therefore, also serves as a tool for dynamic and creative evidence-based program development.

Each of NCA's three additional optional standards are addressed individually in this manual, and includes a stated rationale, as well as a statement of intent for all specific criteria that must be met. This manual also contains examples of implementation that are reflective of the diversity of CACs. The examples provided are neither the ideal nor the only options for implementation. They simply represent a range of methods that are currently in use, some of which are quite basic and others that are more elaborate. The examples are intended to stimulate team discussion and help you to determine the best ways for your CAC to meet and/or strengthen particular program components. In addition, this manual contains numerous resources from NCA and the Regional Children's Advocacy Centers (RCACs) that you and your teams are encouraged to utilize as you further develop your programs and services. CACs are also encouraged to utilize their state chapters for additional technical assistance.



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Commercial Sexual Exploitation of Children

The CAC identifies, screens, and provides services to children and youth who are at risk of, or have experienced the Commercial Sexual Exploitation of Children (CSEC).

For the purpose of NCA's National Standards for Accreditation for Children's Advocacy Centers, CSEC is defined using the OJJDP definition below. Please note that no monetary transaction needs to occur for children/youth to be eligible for services under this Standard or this Standard to apply to services rendered.



11. Commercial Sexual Exploitation of Children (CSEC)

OJJDP Office Of Juvenile Justice And Delinquency Prevention - CSEC Definition

Commercial Sexual Exploitation of Children (CSEC) refers to a range of crimes and activities (solicited, patronized or advertised) involving the sexual abuse or exploitation of a child for the benefit of any person or in exchange for anything of value (including monetary and non-monetary benefits) given or received by any person. Examples of crimes and acts that constitute CSEC:

- child sex trafficking (CST)/the prostitution of children;
- child sex tourism involving commercial sexual activity;
- commercial production and/or distribution of child sexual abuse materials (formerly called child pornography);
- online transmission of live video of a child engaged in sexual activity in exchange for anything of value; Child sexual abuse enticement (coercion, grooming)

CSEC also includes situations where a child, whether or not at the direction of any other person, engages in sexual activity in exchange for anything of value, which includes non-monetary things such as food, shelter, drugs, or protection from any person.

Depending on the specific circumstances, CSEC may also occur in the context of internet-based marriage brokering, early marriage, and

children performing in sexual venues.

Rationale

With growing awareness and understanding of the complex problem of CSEC, CACs and their MDT law enforcement and child- and youth-serving partners have been expanding their capacity to identify and respond to the needs of children and youth who may be at risk, or being recruited and exploited, including necessary protections and referrals to specialized services. To do so requires the development and implementation of relevant training, policies, and protocols that guide coordinated interdisciplinary screening, investigations and service delivery.

Essential Component A

CAC/MDT members must participate in a combined total of 15 hours of CSEC training inclusive of the following and as appropriate to their roles:

- Introduction to CSEC (types and dynamics of exploitation and trafficking, role of MDT partners, federal and state laws)
- CAC role in CSEC investigation and intervention
- Interviewing CSEC/CST victims
- Addressing the unique needs of CSEC victims (victim-centered, trauma-informed response)
- Trends and innovative programs

STATEMENT OF INTENT

Training, knowledge and skill-building are core to the expansion of CAC capacity to meet the needs of potential CSEC victims who are often an invisible and underserved population. The CAC, therefore, needs to assume responsibility for making specialized training available to, and ensuring participation of, all MDT members, including additional members serving CSEC children and youth.

PRACTICAL APPROACHES TO MEET THIS STANDARD:

1. All CAC/MDT members providing services to CAC clients must demonstrate a minimum of 15 hours of CSEC training as appropriate to their roles, by relevant documentation of attendance and completion. Such trainings may include
 - Statewide, regional, or national child abuse conferences with CSEC focus
 - Credible provider of online CSEC training
 - Online trainings available on NCA Engage

Essential Component B:

The following CSEC services are provided at the CAC, or in collaboration and coordination with other community resources. CSEC service provision requirements must include at a minimum:

- Victim outreach and identification
- Screening and risk factor identification
- Service planning and delivery
 - ◆ Case management/case coordination
 - ◆ Risk assessment and safety planning
 - ◆ Victim advocacy
 - ◆ Mental health services
 - ◆ Medical services

- ◆ Interpersonal support
- ◆ Forensic interviews – advanced training in conducting a CSEC forensic interview required
 - Timing and protocols for this type of forensic interview may differ from other CAC cases

STATEMENT OF INTENT

To ensure that a CAC/MDT has the capacity to address the needs of possible CSEC victims, a comprehensive array of skills, services and interventions are required. This includes screening for, and identification of, those at risk of exploitation, how and when to conduct forensic interviews and CSEC-specific investigations, additional MDT partners to engage, unique and/or additional services needed and how they should be coordinated.

PRACTICAL APPROACHES TO MEETING THE STANDARD:

1. The CAC convenes the MDT and invites additional agencies and providers uniquely serving CSEC clients. All participants discuss and collaboratively develop policies and protocols relative to the expanded MDT, investigation and service delivery practices, the role of the CAC and ongoing methods for coordination and collaboration. The CAC can develop and ensure agreement among the participants via a detailed MOU specific to CSEC cases or create an addendum to the MDT's existing MOU. Once policies and practices are agreed upon, they would then be codified in written protocols.

Essential Component C

CAC/MDT written protocols and guidelines include service provision for CSEC victims throughout the life of a case, and delineate confidentiality and information sharing.

STATEMENT OF INTENT

These protocols include the MDT's agreed-

upon philosophy, values, and approach to CSEC cases (e.g., victim-centered, trauma-informed, arrest/no arrest, recovery vs. rescue, etc.). Said protocols are to include any additional MDT members and relevant service providers and how the CAC/MDT response is similar and distinct from other CAC cases, including, but not limited to: the role of the CAC in CSEC cases, a description of additional agency partners and their roles, and whether services are provided at the CAC and/or in coordination with other MDT partners uniquely serving this population. The protocol should also outline how information is shared and confidentiality respected, how the MDT coordinates with and makes referrals to CSEC-serving agencies, and how children, youth and families access needed services, regardless of cost or ability to pay.

PRACTICAL APPROACHES TO MEETING THE STANDARD:

1. The CAC's protocol defines the mission, goals, and expectations of the MDT process and delineates cross-disciplinary training requirements, roles of each agency/discipline relative to CSEC cases including, but not limited to: intake, investigations, forensic interview guidelines, service planning, case coordination, medical, mental health and victim advocacy services and referrals, information sharing and confidentiality, case review process, follow-up, case tracking, and methods for client and team feedback and quality improvement. The protocol is reviewed and revised by the MDT and CAC staff and approved by agency leadership every three years at a minimum.
2. In addition to a more detailed protocol that guides all aspects of investigations and interventions after a CSEC case is referred to the CAC, the CAC's formal interagency agreement is collaboratively amended. The agreement needs to delineate the importance of interagency information sharing that benefits the child and youth clients and their families in accordance with, and understanding of, legal, ethical, and professional requirements to do so. MDT partner agencies review, discuss, and revise proposed language for said agreement to ensure compliance by all partners. Sample language is as follows:
3. Agencies/organizations participating in the CAC will immediately share and receive pertinent case information in accordance with relevant state laws. Every effort will be made to gain informed consent from the legal guardian of child clients to enable the MDT to respond to the immediate and ongoing needs of the child and family. Said consent will be limited to a prescribed and agreed upon period of time.
4. Once the content of the interagency agreement and protocols is determined and agreed upon, all aspects of them are fully explained to each family, including identified children or youth, so that they understand the importance and benefits of information sharing for the child, youth, and family and so that team members can make informed decisions. Said release describes MDT investigation and interventions, confidentiality requirements, limits to information sharing, and case review practices, and indicates a prescribed and agreed upon period of time.
5. The interagency agreement outlines the importance of information sharing among the MDT members at all points during the case. The related protocol delineates the roles of CAC and/or MDT personnel and clearly explains the importance of information sharing for the child, family, and team members. It states how information is shared, the limitations prescribed by law, and the need for consent to share legally protected information for a prescribed period of time.

Essential Component D

All MDT members, including appropriate CAC

staff, are routinely involved in investigations and/or MDT interventions, as defined by the needs of CSEC cases. These MDT members include those outlined in the Multidisciplinary Team Standard and additional partners based on community resources and relevant CSEC services.

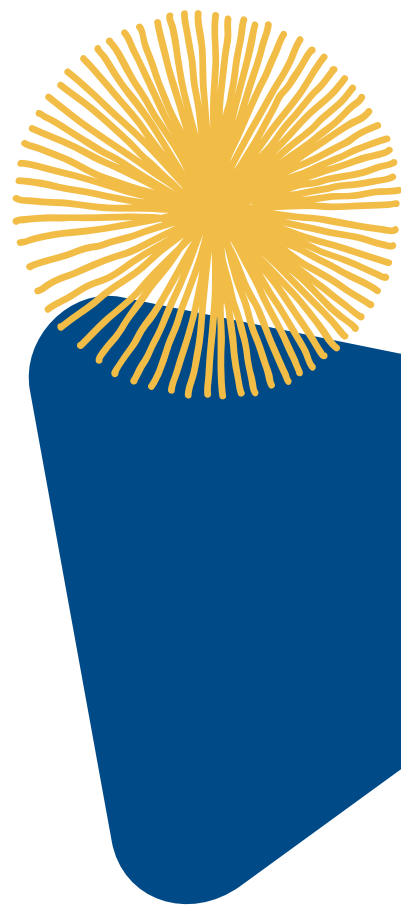
Additional partners may include, but are not limited to domestic violence agencies, rape crisis agencies, local agencies serving minority racial and ethnic communities, LGBTQ+ service agencies, federal partners, survivors, juvenile probation, shelter agencies, legal advocacy, congregate care, missing and runaway youth providers and mentors.

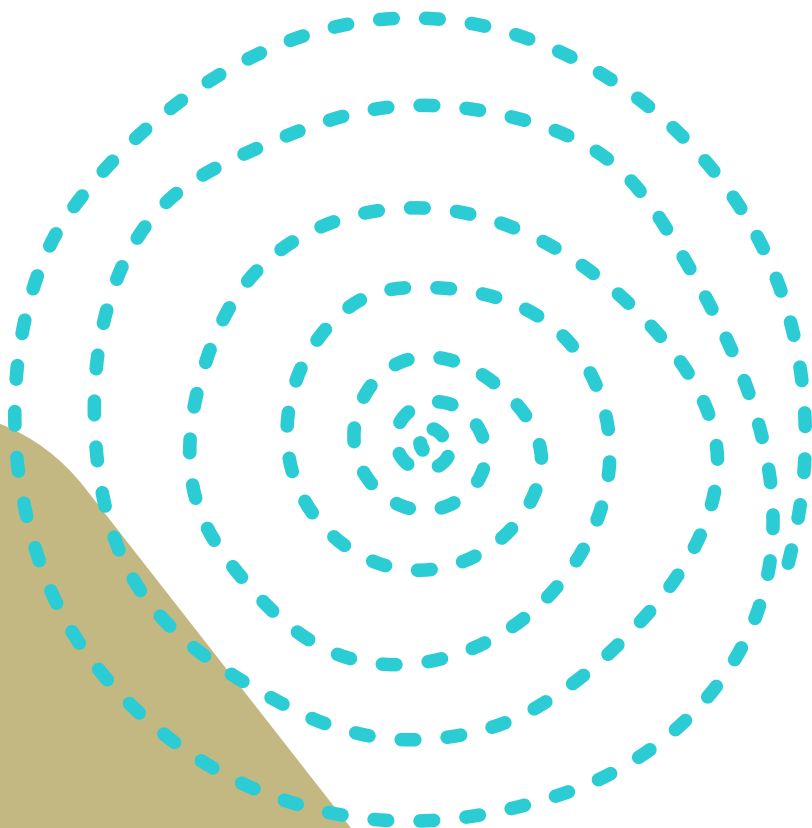
STATEMENT OF INTENT:

CAC/MDT interventions assure that the unique needs of children, youth and families in CSEC cases are assessed and addressed. As with other CAC cases, MDT involvement begins at the time of initial reports and continues through all stages of investigations and interventions. Coordination and collaboration among MDT members in CSEC cases typically require additional agency partners, disciplines and community organizations, all of whom are integral to informed and effective decision-making regarding investigations and service delivery.

PRACTICAL APPROACHES TO MEETING THE STANDARD:

1. The CAC routinely has all relevant MDT members involved in the forensic interview process and case review or CSEC cases. The CAC protocol should clearly delineate all MDT participants and their scope of expertise for CSEC case review meetings, such as those outlined above.





Standard 12

Child Abuse Prevention

The CAC provides evidence-supported child abuse prevention education, training, and community awareness.



12. Child Abuse Prevention

Rationale:

CACs/MDTs are the essential and proven approach for coordinating the investigation of child abuse reports and collaborating to optimize the safety, well-being, healing and pursuits of accountability and justice for children and families. In performing its key functions, CACs/MDTs strive to prevent the recurrence of abuse and victimization for the children and families they serve. In addition to these efforts, CACs/MDTs often expand their commitment to prevention by including compatible primary prevention initiatives, for their respective communities. All child abuse prevention efforts in which the CAC is engaged should be based on principles that are research-supported.

Essential Component A

The CAC must conduct an assessment of current prevention activities/programs in the community to avoid duplication, ensure coordination, and demonstrate how its efforts fit into the larger array of prevention education, training and services. This assessment must be repeated prior to the launch of any new prevention initiatives.

STATEMENT OF INTENT

There may be more than one provider of child abuse community awareness, and prevention education and training in any local community. The numbers of individuals who need and would benefit from prevention education, training and related services may exceed the capacity of any one agency. Community assessments need to focus on the relevance and accessibility of prevention education and other initiatives to diverse populations in the community. These community assessments should also be informed by the community

assessment CACs are required to conduct in accordance with the Diversity, Equity and Access Standard. The results of this community assessment will help prevent unnecessary duplication and ensure coordination and accessibility of existing and planned prevention programs. MDT partners, in collaboration with others in the community with prevention expertise, should identify prevention initiatives for which there is available evidence of effectiveness and that are consistent with the CAC's child- and family-centered, trauma-informed, culturally relevant approach.

PRACTICAL APPROACHES TO MEETING THE STANDARD:

1. CACs identify community organizations that provide prevention education and other relevant activities through outreach and networking with others including, but not limited to, the following types of organizations:
 - primary prevention programs
 - rape crisis centers (required to provide prevention education)
 - intervention services for children who have been abused
 - parent-focused early intervention and prevention programs
 - legal advocacy and other direct services for sexual assault and domestic violence survivors
 - law enforcement
 - child protective services

Collaboration with of key agencies and professionals with prevention expertise helps CACs assess both strengths and gaps in the provision of prevention education and other initiatives.

2. CACs participate in, or help to organize, a child abuse prevention coalition within their community to assess existing prevention activities and identify potential duplication and/or gaps in service provision. This coalition can then collaboratively discuss the feasibility and priorities for filling identified gaps and how that would get accomplished among all participating agencies.

Essential Component B

School-based child abuse prevention education is conducted by the CAC and/or in collaboration with community partners. Prevention education program requirements for school aged children must include the following research-supported features:

- Multi-session
- Multi-modal:
 - ◆ Various training modalities
 - ◆ Role play/practice
- Developmentally appropriate
- Culturally relevant and responsive
- Parent involvement component
- Peer victimization (youth sexual behaviors) component
- Policy and train-for-the-trainers on managing disclosures that may result during the delivery of prevention education.

STATEMENT OF INTENT:

Over the past two decades, there has been a growing amount of research regarding the effectiveness of school-based prevention programs. While curricula may differ in content, number of hours, and other factors, there is a constellation of features necessary for such programs to be deemed evidence-

supported and effective. If the CAC seeks to engage its staff and/or MDT members in providing prevention education independently and/or in collaboration with other relevant community organizations and individuals, it must integrate components delineated above that are deemed to have evidence of effectiveness.

PRACTICAL APPROACHES TO MEETING THE STANDARD:

1. CACs can identify staff and/or MDT members to partner with public and/or private schools within their community and conduct prevention education. The CAC can provide such education on its own and/or through collaboration with community partners. The prevention education must include the requirements outlined above.

Essential Component C

CAC must provide or help coordinate prevention education training for CAC staff and MDT members.

STATEMENT OF INTENT:

Whether a CAC chooses to lead or be a partner in the development and implementation of prevention initiatives in its community, all staff should have requisite prevention training in addition to that associated with their specific responsibilities for investigations and service delivery. Likewise, these training opportunities should be made available to MDT members. Ensuring that MDT is knowledgeable in child abuse prevention can both expand the CAC's capacity to provide education and awareness in the community and improve service delivery to children and families. The delivery of said training can be accomplished in a manner that is consistent and/or in collaboration with existing prevention initiatives, specialists and resources in their community.

PRACTICAL APPROACHES TO MEETING THE STANDARD:

1. CACs may provide child abuse prevention trainings for CAC staff, MDT and community members several times throughout the year to ensure access given varied schedules.
2. CACs may provide prevention training for CAC staff and MDT members as one of their regularly scheduled training opportunities, either live or virtually.
3. CACs may facilitate CAC staff and MDT members' participation in prevention training and other initiatives conducted by others in the community.
4. CACs may create a webinar on child abuse prevention, on its own or in collaboration with community specialists, to be viewed as part of the CAC onboarding process for staff and MDT members.

Essential Component D

The CAC must provide Mandated Reporter training directly or in partnership with other community agencies, that includes, but is not limited to, the following components:

- Recognizing signs of child sexual abuse and other forms of child maltreatment
- Identifying grooming behaviors
- Responding to disclosures of abuse
- Reporting suspected child abuse
- Understanding the CAC/MDT response

STATEMENT OF INTENT:

All 50 states, D.C. and U.S. territories have laws that require reporting of suspected abuse and neglect, most of which outline the professionals mandated to do so. As research indicates, the primary reasons individuals, mandated or otherwise, do not report abuse is that they are unsure of the signs, how and to whom to report abuse, and what happens after a

report is made. Effective mandatory reporter training can ensure that individuals are aware of the legal mandate to report and are well equipped to appropriately respond when cases of suspected abuse arise. Given the expertise and responsibilities that CACs/MDTs have relative to reporting abuse and neglect and participating in investigations, case planning and service delivery, prevention initiatives in their communities must ensure a focus on raising awareness of child maltreatment and the legal mandates for reporting suspicions of abuse and neglect. CACs should create and foster partnerships with others providing said training in their communities and collaboratively determine how best to coordinate and conduct such trainings to be most effective and efficient.

PRACTICAL APPROACHES TO MEETING THE STANDARD:

1. CACs determine what, if any, prevention resources currently exist in their community that deliver Mandated Reporter training and collaboratively discuss how best to partner in such efforts.
2. CACs identify staff and MDT members that can participate in a train-the-trainer provided by community prevention specialists to build internal capacity for delivering Mandated Reporter training to others on staff, their MDT and community members.
3. CACs develop a training webinar on their own, or in collaboration with, prevention specialists to facilitate access and use for purposes of onboarding new staff and MDT members. This recorded training can be a resource for others in the community as well.
4. CACs may take advantage of trainings offered by national organizations that provide child abuse prevention training.

Standard 13

Physical Abuse

Specialized care, evaluation and treatment services are available to all clients in cases of alleged physical abuse, and are coordinated as part of the multidisciplinary team response.

13. Physical Abuse



13. Physical Abuse

Rationale

All children who are suspected victims of child physical abuse are entitled to medical evaluations by qualified health care professionals with specialized training and expertise. This evaluation serves to document any injuries, determine the cause of the injuries, and develop a diagnostic and treatment plan for the child. The complexities inherent in this process require that a trained, skilled medical professional conduct said evaluations to determine the safety of a child, ongoing risk and needed treatment and care.

Some children will need to be seen on an emergency basis by professionals qualified to intervene with serious medical diagnoses (e.g., head injury, fractures, and burns). Most of these children will not be initially seen and evaluated at a CAC, but may have follow-up provided by CAC staff and MDT members. However, children with minor injuries (e.g., bruises) may present to a CAC for investigation, evaluation and intervention. Specially trained medical providers need to determine and guide an appropriate course of action, including relevant medical facility referrals. In addition, a CAC needs access to a facility and child abuse expert with laboratory and radiologic services and a mechanism for sharing medical information with MDT members.

There are some distinct dynamics in physical abuse cases that are different from those in cases of child sexual abuse. An accurate and complete medical history is essential in making medical diagnoses and determining appropriate treatment of child physical abuse. Since many of the victims of child physical abuse are very young, the history that is taken from their caregivers is crucial in order to determine the cause of their injuries. In some cases, the perpetrator of the

injury to the child is unknown and could be the caregiver who accompanies the child to give the history. The risk of danger to other clients from the presence of caregivers who have caused physical injury to their children is likewise, quite different from sexual abuse cases. The medical evaluation and treatment of physical abuse require the participation of caregivers, potentially including those who may have harmed their children. For purposes of Standards compliance, CAC policies and procedures need to specifically address any unique safety concerns, keeping in mind the complex nature of these cases (e.g., prohibition of offenders and/or separation between children and alleged abusers at the CAC, exclusion of alleged abusers from receiving CAC services, etc.)

Essential Component A

Medical examinations and documentation are conducted by healthcare providers with specialized child physical abuse training that meets at least ONE of the following training standards:

- **Pediatricians with Child Abuse Pediatrics (CAP) subspecialty board certification or eligibility**
- **Physicians without CAP board certification or eligibility, but who have advanced training in the field of CAP, who have practiced in the field for a minimum of 5 years and/or at least 50% of their cases are child physical abuse cases.**
- **NOTE: This can be demonstrated through an affidavit and/or case data information.**
- **Physicians without CAP board certification or eligibility (excluding those above with advanced training and expertise),**

Advanced Practice Nurses, and Physician Assistants, all of whom are required to collaborate with a Child Abuse Pediatrician or someone acting as a CAP.

- Forensic Nurses without advanced practitioner training should have a minimum of 40 hours of training specific to the medical evaluation of child physical abuse and must work in conjunction with an advanced medical team that includes an advanced practitioner.

STATEMENT OF INTENT

A medical **examination** of a potentially abused child involves the physical examination and the written and photographic documentation of any injuries present. No assessment is made of the cause of the injuries during the examination. In contrast, a medical assessment (see Essential Component B) takes into account both the history provided and the physical exam documentation to inform an opinion regarding the likelihood of child physical abuse.

Child abuse physicians, general physicians, advanced practice nurses, physician assistants and SANEs without advanced practice training may all engage in medical examinations and documentation of child physical abuse at a CAC. Some evaluations of children will be provided by medical professionals at medical clinics and hospitals that may or may not be associated with the CAC. In such cases, the CAC should forge an affiliation and develop a linkage agreement with the facility that delineates the coordination and collaboration necessary to optimize evaluations, investigations and service delivery..

PRACTICAL APPROACHES TO MEET THIS STANDARD:

1. CAC hires, contracts and/or has a signed linkage agreement with a physician with Child Abuse Pediatrics board certification/eligibility.
2. CAC hires, contracts and/or has a signed linkage agreement with a physician acting

as a CAP who has practiced in the field for 5 years and/or at least 50% of their cases are child abuse cases.

3. CAC hires, contracts and/or has a signed linkage agreement with a non-specialized physician, advanced practice nurse or physician assistant. These providers must have a connection to a Child Abuse Pediatrician or someone acting as a CAP
4. CAC hires, contracts and/or has a signed linkage agreement with a forensic nurse with a minimum of 40 hours of coursework specific to the medical evaluation of child physical abuse who also works in conjunction with an advanced medical team that includes a qualified advanced practitioner. This nurse can provide a medical exam and documentation but will not be able to provide the medical assessment as outlined below.

Essential Component B

Medical **assessments** are conducted by healthcare providers with specific child physical abuse training meeting at least ONE of the following qualifications:

- Pediatricians with Child Abuse Pediatrics board certification or eligibility
- Physicians without Child Abuse Pediatrics board certification or eligibility, but who have advanced training in the field of CAP, who have practiced in the field for 5 years and/or at least 50% of their cases are child physical abuse cases
- Physicians without Child Abuse Pediatrics board certification or eligibility (excluding those above with advanced training and expertise), Advanced Practice Nurses, and Physician Assistants must have a connection to a Child Abuse Pediatrician or a medical professional, acting as a CAP.

STATEMENT OF INTENT

A medical **assessment** takes into account both the history taken and the physical examination findings, and draws on provider experience and training to offer a medical opinion as to the cause of a child's physical injuries. There are differences in foundational training for medical providers in pediatric assessment. Due to said differences, only child abuse physicians, general physicians, advanced practice nurses, and physician assistants may provide assessments regarding the diagnosis of child physical abuse. Forensic nurses without advanced practitioner training can examine and document a child's physical injury(ies) as noted in Component A, but cannot provide an assessment of abuse.

CONTINUOUS QUALITY IMPROVEMENT (CQI)

The medical provider must be familiar and up to date with published research studies on findings in abused and non-abused children and current medical guidelines and recommendations from national professional organizations such as the American Academy of Pediatrics. Accuracy in interpretation of examination findings is vitally important to the child, family, and the MDT as a whole. The medical provider must provide documentation of participation in CQI activities, including continuing education and expert review of findings with an advanced medical consultant relative to child physical abuse.

PRACTICAL APPROACHES TO MEET THIS STANDARD:

1. CAC hires, contracts and/or has a signed linkage agreement with a Child Abuse Pediatrician, physician acting as a CAP (see Component A), Advanced Practice Nurse, or Physician Assistant, all of whom may provide an assessment of child physical abuse in a case.
2. The CAC contracts with a forensic nurse, who is not eligible to provide an assessment of child physical abuse in a particular case, but can document the

history and physical examination and collaborate with an advanced practice provider in formulating a diagnosis. In this circumstance, the CAC contracts with local or national experts to provide their forensic nurses with access to them for purposes of assessment and case review.

Essential Component C

Medical professionals providing services to CAC clients must demonstrate continuing education in the field of child physical abuse consisting of a minimum of 8 contact hours every 2 years.

STATEMENT OF INTENT

The accuracy and integrity of forensic medical evaluation findings is critically important in all child abuse cases. Research indicates that ongoing medical education in child physical abuse is key to diagnostic accuracy and reliability. Medical providers are expected to remain current by participating in continuing medical education specific to child physical abuse.

PRACTICAL APPROACHES TO MEET THIS STANDARD:

1. All CAC medical providers are expected to attend and participate in Continuing Medical Education in the field of child physical abuse and neglect which may include:
 - Online medical training approved for Continuing Education Credits
 - Local, statewide, or national conferences approved for Continuing Education Credits
 - Medical provider serves as an instructor for an educational lecture/course approved for Continuing Education Credits

2. CAC providers participate in a child abuse listserv such as:

- AAP Council on Child Abuse and Neglect
- SIGCA (special interest group for child abuse)
- Helfer society

Essential Component D

Medical professionals providing physical abuse evaluations for CAC clients must demonstrate participation in peer review of physical abuse exam findings. These medical professionals must demonstrate participation in an expert peer review process a minimum of 6 times per year.

An expert peer review consultant is defined as:

- Physician with Child Abuse Pediatrics Sub-board eligibility or certification
- Physicians without board certification or eligibility in Child Abuse Pediatrics, but who have advanced training in the field of CAP, who have practiced in the field for a minimum of 5 years and/or are engaged in a practice in which at least 50% of their cases include child physical abuse.

STATEMENT OF INTENT

The accuracy and integrity of forensic medical evaluation findings are critically important in all child physical abuse cases. Because both false positive and false negative diagnoses can have deleterious effects on a child and family, it is essential that medical findings be periodically peer/expert reviewed for accuracy and reliability. This requirement must be included in the CAC protocols and all medical providers must be able to provide documentation of their participation in peer/expert review sessions.

PRACTICAL APPROACHES TO MEET THIS STANDARD:

1. The CAC can assist in addressing this requirement by funding and promoting:
 - expert review through a linkage agreement with an advanced medical consultant
 - use of computer-based expert review platforms
2. In addition, the CAC and medical provider(s) collaboratively establish a method to track de-identified case information as part of this CQI process.

Essential Component E

Physical abuse evaluations are available to CAC clients onsite and/or through an agreed upon referral process that is formally outlined in protocol and a formal or informal linkage agreement .

STATEMENT OF INTENT

The CAC is best positioned to ensure access to specific designated facilities for child physical abuse evaluations for all children, including: a comprehensive head-to-toe physical, inspection of all cutaneous surfaces and a neurologic status check with appropriate referrals, as deemed appropriate. Some CACs have a qualified medical provider on-site while, in other communities, the child is referred to a medical clinic or emergency department for this service. Any location where evaluations of child physical abuse are conducted must have access to radiology (bone x-rays and CT/ MRI) and laboratory services to adequately evaluate the child.

The CAC must have policies and protocols in place outlining and facilitating the linkage with, and referrals to, a facility with a qualified medical provider and other required health care services. Screening criteria should be developed to determine which children can

be evaluated at the CAC and which need to be referred and/or transferred to a medical facility best qualified to conduct specialized examinations and assessments.

PRACTICAL APPROACHES TO MEET THIS STANDARD:

1. Medical examinations and assessments are conducted on-site at the CAC by a Board-certified child abuse pediatrician or another qualified medical professional, with the ability to readily obtain necessary ancillary services such as radiology and laboratory.
2. Medical examinations and assessments are conducted at the local medical clinic/hospital by a qualified medical professional with onsite ancillary services.
3. Medical examination and documentation are conducted at CAC by a forensic nurse who then collaborates with a qualified medical professional by the CAC's linkage agreement to provide an assessment of abuse or neglect.

Essential Component F

CAC/MDT written protocols and guidelines include access to appropriate physical abuse medical evaluation and treatment for all CAC clients. CACs must have the ability to access and provide medical evaluations for children who present at the CAC with suspected minor physical abuse and the ability to refer to a more experienced medical provider for more serious cases.

STATEMENT OF INTENT

Children with suspected physical abuse may be seen both in CACs and other medical facilities. Policies should be in place that guide whether children can and should be evaluated at the CAC and which should be referred or transferred to another facility (see Component E). The cost of a physical abuse medical evaluation may be covered in part by public

funds in some communities; however, in most settings, individuals who can pay or are insured may pay for the examinations. Regardless of the source of funding, the client's ability to pay should never be a factor in determining who is offered and able to access a medical evaluation.

PRACTICAL APPROACHES TO MEET THIS STANDARD:

1. The CAC's policies and protocol clearly outline the importance of access to physical abuse examinations and assessments that are available to clients regardless of their ability to pay. The CAC collaborates with relevant MDT partners and others to develop payment options, including but not limited to the following:
 - A. CAC obtains unrestricted grant funds to cover the cost of medical evaluations
 - B. Medical evaluations are reimbursed by funds from local MDT partner agency(ies) or state agency (e.g., law enforcement, child protection, or prosecutor's office)
 - C. CAC submits medical costs to client's insurance for reimbursement
 - D. Hospital/clinic billing departments bill by utilizing patient insurance information. If a client is underinsured, the hospital may assist the client in applying for state insurance or other available funds.

Essential Component G

CAC/MDT written protocols and guidelines include the circumstances under which a medical evaluation for child physical abuse is recommended. The medical evaluation needs to be completed by an appropriately trained medical provider.

STATEMENT OF INTENT

The circumstances under which a medical evaluation for child physical abuse can be provided at a CAC must be defined and agreed upon by a medical provider that meets the professional requirements outlined in Essential Component A. The severity of injuries to children is variable. Seriously ill children with such diagnoses as head injury, fractures, and burns will need to be seen on an emergency basis by professionals and in a facility designated to evaluate serious injury. However, children with minor injuries (e.g., bruises) may have an evaluation conducted at CACs with appropriate on-site facilities. Written policies and procedures regarding the screening of all potentially physically abused children guide determination of the appropriate medical facility. The CAC must have access to a facility able to provide laboratory and radiologic services. In addition, there needs to be a mechanism for the sharing of relevant information with the MDT.

PRACTICAL APPROACHES TO MEET THIS STANDARD:

1. CAC protocol outlines the criteria for determining where medical evaluations can be conducted, relevant referral mechanisms, and that reflects legal and ethical standards of practice and confidentiality requirements.
2. CAC has a linkage agreement, included in the overall CAC protocols/guidelines, and/or a memorandum of understanding with a qualified medical provider/hospital that outlines the criteria for medical evaluation referrals, the information sharing process with relevant medical colleagues and the MDT, and . This agreement or MOU is included in the general CAC protocols/guidelines.
3. All approaches are reflective of legal and ethical standards of practice and confidentiality requirements.

Essential Component H

Documentation of medical findings is maintained by written record and photo-documentation. Medical record storage must be HIPAA-compliant, secure, sufficiently backed up, and accessible to authorized personnel in accordance with all applicable federal and state laws.

STATEMENT OF INTENT

The medical history and physical examination findings must be carefully, thoroughly, and legibly documented in the medical record and the privacy of said records upheld in accordance with federal privacy rules and any other relevant statutes. The medical record should include a statement as to the significance of the findings and treatment plan. Photographic documentation allows for review for CQI and for obtaining medical consultation or a second opinion. Medical records should be maintained in compliance with federal rules governing protection of patient privacy. However, they may be made available to other medical providers for the purpose of needed treatment of the patient and to those agencies mandated to respond to reports of suspected child physical abuse. Even in situations where the medical record can legally be provided without separate written consent or court order, a log of disclosures should be maintained with the medical record in accordance with federal privacy rules.

Diagnostic-quality photographic documentation of the injuries should be obtained in all cases of suspected physical abuse using still and/or video documentation. If photo documentation equipment is not available, CPS/LE should be contacted to photo document injuries. Photographic documentation allows for review for CQI and for obtaining consultation or second opinion. CACs should have policies in place for storage and release of examination images that protect the sensitive nature of the material. Images should not be stored on desktop or laptop computers or retained on camera memory sticks.

PRACTICAL APPROACHES TO MEET THIS STANDARD:

1. CAC medical providers with the delineated qualifications collect photographic documentation of injuries in all cases of suspected physical abuse using any of the following:
 - Digital still or video camera
 - Hospital medical record-based photo program (such as Haiku)
 - Investigator-provided images

If photo documentation equipment is not available, CPS/LE should be contacted to photo document injuries. CACs should have policies in place for storage and release of examination images that protect the sensitive nature of the material. Images should not be stored on desktop or laptop computers or retained on camera memory sticks.
2. The CAC has established capacity for secure storage for photographic images in the following ways, listed in order of that which is considered optimal:
 - Within an electronic medical record (EMR)
 - Secure server managed by IT professionals
 - Photo management system outside of EMR, designed for medical use
 - External hard drive, secured and periodically backed up
 - CD or DVD, one per patient encounter, secured

Essential Component I

MDT members and CAC staff are trained regarding the purpose and nature of the child physical abuse evaluation. Designated MDT members and/or CAC staff educate clients and/or caregivers regarding the physical abuse medical evaluation.

STATEMENT OF INTENT

The medical evaluation is an important part of any child abuse investigation. MDT partners and CAC staff should have the necessary training to explain the nature and purpose of a medical evaluation, and to respond to common questions, concerns, and misconceptions.

PRACTICAL APPROACHES TO MEET THIS STANDARD:

1. Medical providers assume responsibility for directly educating clients and/or caregivers and MDT partners regarding the purpose and nature of a medical evaluation.
2. Medical providers conduct in-service trainings for MDT members and CAC staff on the purpose and nature of a medical evaluation to assist them in educating clients and/or caregivers.
3. CAC designates one or more members of the MDT or staff to educate clients and/or caregivers on the purpose and nature of a medical evaluation.

Essential Component J

Findings of medical evaluations are shared with the MDT in a routine, timely and meaningful manner.

STATEMENT OF INTENT

The legal duty to report findings of suspected child abuse to appropriate authorities is an exception outlined by the HIPAA privacy requirements, allowing for ongoing relevant communications among the members of the MDT. Because the medical evaluation is an important part of the response to suspected child physical abuse, findings of the medical evaluation should be shared with, and explained to, members of the MDT in a routine and timely manner to facilitate discussion of concerns and ensure that informed case decisions can be made and coordinated promptly for purposes of safety, treatment and other services.

PRACTICAL APPROACHES TO MEET THIS STANDARD:

1. The CAC collaboratively develops and implements an agreed-upon formal protocol for MDT members with investigative responsibilities and other service providers to receive verbal and written findings of the medical evaluation within a timely manner. Said protocol also outlines a process for MDT members to convene and engage in formal and informal case discussions regarding the findings of a physical abuse evaluation and next steps in investigations and service delivery to appropriately identified caregivers.

