Guiding Principles for Creating a Solo CAP Practice

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A note from the author

Solo child abuse pediatricians (Solo CAPs) face unique challenges, including limited resources, high workloads, and professional isolation. This handbook is based on my personal experience. It offers practical strategies and tools to address some of the challenges of creating a solo practice.

This handbook contains information about:

What Is Solo CAP Practice?

In an era marked by dynamic shifts in medical practice, solo practicing child abuse pediatricians (Solo CAPs) have emerged as pivotal figures in this evolving landscape. Presently, the demand for CAPs far surpasses the availability of new practitioners in the United States, leading some professionals to operate independently or in small groups due to limited resources.

Background of Solo CAPs

In September 2022, the Ray E. Helfer Society (the primary sub-specialty society for physicians devoted to the problem of maltreated children) established the Solo CAP Special Interest Group (SIG) to address these issues on a national scale. This special interest group serves to support the challenges of Helfer members who operate as Solo CAPs. The SIG is co-chaired by Dr. Dana Kaplan and Dr. Kerri Weeks, both Solo CAPs, and welcomes all members of the Helfer Society who define themselves as Solo CAPs.

Broader Definition of a Solo CAP

As the national leaders in the Solo CAP domain, the Helfer Solo CAP SIG reached a consensus on the broader criteria for what defines a Solo CAP: < 2.0 FTE of a Board Eligible/Board Certified CAP with or without other dedicated non-Board Eligible/Board Certified provider support.

This is the definition currently adopted by NYS CHAMP.

Where Will You See Patients?

Will you be hospital based?

- Where will you work?
    - Outpatient hospital-based clinic?
    - Inpatient/ED
- What will you cover?
    - All forms of maltreatment?
    - Medical child abuse?
    - Inpatient/ED assessments?
    - Will you do chart reviews?
- Leverage the use of remote tools such as photography and remote access to your EMR.
- Consider a fully remote practice for inpatient/ED assessments.

Will you be working at a CAC?

- What are the CAC needs?
- Will you see cases other than sexual abuse?
- Will you be a member of the MDT?
    - What does that entail?
- Will patients physically come to you?
    - Have a transportation strategy
- Consider a hybrid practice – some patients will be seen in person; some will be remote.
- Consider how to provide wrap around care at multiple locations and possibly across multiple geographic areas.

Introducing Yourself and the Role of a CAP

- Meet the people you will be working with: other staff, social workers, CPS, police, lawyers
- Provide education about child abuse pediatricians
    - Who we are and what we do.
    - How to best utilize us.
    - Sometimes you may need to explain we are not CPS.
- Did the institution previously have a CAP?
    - If are you taking over for someone
        - What are the expectations?
        - Will you be altering these expectations?
    - If you are the first CAP
        - Consider the sub-culture at the institution
        - Identify potential allies.
- Remember - change takes time.
- Continue to provide education as policies and guidelines develop.

What Policies and Guidelines Will You Be Working Under?

Hospital policies

- Ensure there is a hospital policy consistent with local social services/public health law on mandatory reporting and all that goes along with that.
- Ensure there is an updated contract/MOU with your CAC/offsite partners.
- Even if there is an MOA, for extra protection, there may still be additional documents prior to the exchange of information.
- Know the experts at your institution that may be called upon (e.g., radiology).
- Partner with the legal team to understand:
    - The policy on HIPAA info exchange with CPS and the police department
    - The release of medical records
    - Parent visitation when in custody of CPS
    - The process for subpoenas
    - Whether there is a hospital assigned counsel for court
    - When prepping for court, who can you speak to and when

Clinical Guidelines

- What clinical guidelines exist at the institution?
- What guidelines need to be created?
- What needs to be updated to reflect the standard of care and your resources?
    - Example: Can you collect a Forensic Evidence Kit (FEK) in the middle of the night when working solo?
        - What other supports/resources are available that you can engage to help with this?
            - Emergency Department, SANE, SAFE, etc.
- Is this an academic institution with medical students, residents and/or fellows?
    - What would you need to accommodate these additional learners?

Clinical Guidelines for Clinical Teams

- Ensure there are clear and current guidelines regarding:
    - Triage, including referrals to the Emergency Department
    - Photography
    - Communication with MDT

- Establish a protocol with the lab regarding obtaining samples
    - Partner with the lab to ensure specimens are treated as forensic
    - Consider creating an order set with details about specimen collection/laboratory requirements
    - If patients are going to the lab, is it close to your clinic to ensure the patient gets there?
    - If the samples will be transported? What courier service will you use and at what cost?
    - Have a chain of custody for all off-site labs
- Chain of custody for photos
    - Have a protocol for all photos/colposcopies
    - See the patient, upload the photos/colposcopy to an encrypted/HIPAA secure folder
    - Organize by year, month to make it easily accessible. This way the chain of custody is always the same
- Chain of custody for remote consults
    - Create a PowerPoint for each case with collateral information and images as well as the communicated assessment
    - Store in a secure, HIPAA-compliant encrypted folder
- Testifying in Court
    - How often is the expectation?
    - Is there a remote option for family courts?
    - How is reimbursement structured? Does the fee go directly to you, the CAC, the department, the hospital?

Who Will Be Assisting You?

- Who will be on your medical team?
    - MA, RN, DNP, PA, other?
- Emphasize that there should always be at least 2 members of the medical team present for all outpatient examinations.
- There should be at least one MA who is trained in labial traction to assist with sexual abuse exams.
- Training a Non-Board Eligible/ Board Certified Provider
    - Start with sexual abuse (SA). The process for development of a SA evaluation is more straight forward than physical abuse.
    - Training an MA in labial traction to assist with sexual abuse exams.
    - Start with direct supervision and progress to indirect supervision

        - Record all colposcopy exam and review notes
        - Learners cannot fill other needs such as being a chaperone or filling in for a staff member. They do not know the routine the same way a dedicated and trained team member does.
- Find a scheduler, a point person that will work with you in scheduling patients. This should be done in partnership to prevent triage mishaps.

Time Management

- Set Limits
    - Create boundaries from the start. This is a marathon, not a sprint. Make decisions with sustainability in mind; make sure to care for yourself.
    - Work/life balance and availability – what is realistic? One or 2 providers cannot cover 24/7. This is not a sustainable practice.
- Manage Availability
    - Consider a separate work phone.
        - Keeps information separate from personal information
        - Can be turned off when on PTO
    - Utilize “do not disturb” (DND) during your off hours so you are not tempted to pick up and help.
    - Arrange that phone messages and EMR be checked on a routine basis. These should not be used for stat consults.
        - If it is available, use an EMR in-basket when on PTO.
- Utilize a scheduler at a CAC or Outpatient Clinic
    - All patients should be triaged by the medical director.
    - Scheduling and confirmation should be done by support staff, i.e., an MA. These tasks are too much to try to do alone.
- Streamline the approach for referrals from an MDT and hospital personnel. For example:
    - They should provide the name and DOB as well as any photos prior to discussing the case.
    - They should email relevant information prior to the outpatient appointment
- Coverage for PTO
    - If institution does not pay for coverage, then there is no coverage.
    - You still need to take PTO.

Setting Up Your Physical Space

- **Outpatient office space considerations**
    - How often will you have access to the physical space?
    - Are you utilizing a pre-existing space or creating a new space?
    - How many rooms?
    - Ensure separate areas for the exam and admin work. If necessary, the spaces can be separated by a sheet.
    - Provide comfort by providing windows with appropriate privacy and ventilation.
    - Create an inclusive, culturally sensitive and patient-centered atmosphere.
    - Practice trauma informed care, including decorating with calming colors. Do not have typical pediatrics characters on the wall, such as animals. These may be triggering if child was abused and taken to a zoo.
    - Ensure adequate security presence
        - Consider a closed-circuit TV for teaching/safety.
        - Have a safety/exit plan.

- **Is the space to be used for sexual abuse evaluations and/or physical abuse evaluations?**
    - For sexual abuse, consider the need for medications, labs, and forensic evidence kits:
        - Will there be a medical dispenser?
        - Can you use services of another facility?
        - Do you need courier services to a lab?
    - For physical abuse: consider the proximity to radiology
        - There needs to be a process to ensure initial and follow-up skeletal surveys can be performed quickly (ex. triage to emergency department).

- **Equipment**
    - Necessary basic equipment:
        - A sink in the room
        - A table that moves up and down and has stirrups
        - Equipment drawers and cabinets that can be locked
        - Computer with printer
        - Share drive that is encrypted and HIPAA secure
        - EMR

- Essential medical equipment for sexual abuse exams
    - Video colposcope
    - Blue maxx (forensic light source) if seeing acute cases
    - Pregnancy tests (POC)
    - Lab equipment to take blood and urine samples
- Additional equipment for physical abuse exams
    - An EMR with a companion app for photos
    - A good quality photo/video recorder
        - For more complex injuries
        - As a backup if the colposcope is not working
    - Measuring tool
    - Gloves that are not blue in color as this can cause shadow effect to give the appearance of bruising
- Medications
    - Can you keep them there?
    - Or will patients be triaged to the ED?
- Supplies. These should be stocked and maintained by the MA
    - Lubricant
    - Speculums
    - Gowns
    - Gloves
    - Swabs
    - Chucks
    - Foley
- Distraction toys/objects for comfort during the examination
    - What is the policy?
    - Would they be obtained by donations?
    - Can the children keep them?

Other Practice Issues

- **Testimony in Court**
    - Who will accept subpoenas?
        - Will it go through your legal team first?
        - What is your institution's practice?
        - Is there one?

- Does your hospital assign you counsel?
    - There are benefits of having an advocate (e.g., they protect your time).
- Who will testify?
    - If you are training someone, discuss this upfront.
- Consider co-signing all notes so that you can testify even if you did not physically see the patient. This allows time for training and observing court proceedings.

- **Who Will Do Your Peer or Case Reviews?**
    - CHAMP
    - Your internal team (if there are others)
    - A colleague who is a CAP
    - Solo CAP SIG
    - The myCasereview system sponsored by the Midwest Regional CAC
    - State-based review systems that have access to advanced medical consultants
        - Consider asking for time/funding to participate

- **Billing**
    - Remote consultation should be reimbursed
    - CAC visits – reimbursement through the Office of Victim Services
    - Are you reimbursed for physical abuse cases?
    - Do not double dip
        - If it is a patient you have seen, you provide the wrap around care.
    - Decide billing on workflow
        - If you saw the patient in the hospital and there is a re-eval (e.g., FUSS) and you see the patient at a hospital clinic, it is billed through insurance.
        - If the patient is seen at a CAC, then do not bill separately.
        - If the patient is seen inpatient/ED and follows up at CAC, do not bill twice. You should not bill for inpatient consultation and only seek reimbursement through OVS, or vice versa.

Sample Budget

Expenses Personnel	Current Year/anticipated
Physician salary plus fringes (per FTE)	
NP salary plus fringes	
Staff salary plus fringes	
Contracted/temporary support	
On-call stipends or coverage fees	
Expenses Education	
Conference fees/Travel	
MOC/ CME/ related (ABP)/Dues (Helfer)	
Other education (wellness lunches for staff)	
Books	
Other expenses	
Overhead, rent, service charges for equipment, new equipment (colposcop) for start-ups	
Clinical expenses if not covered	
Children's toys, decorations	
Revenue	
Clinical encounter charges	
Donations/foundation funds	
Contracts with counties	
Grant contracts	

Compensation

- **We Are Needed for Verification**
  - NCA states that a medical partner is needed for CAC verification
    https://www.nationalchildrensalliance.org/wp-content/uploads/2021/10/2023-RedBook-v5B-t-Final-Web.pdf
  - ACS states that child abuse pediatricians are needed for Level I or II pediatric trauma center verification.
    https://www.facs.org/quality-programs/trauma/quality/verification-review-and-consultation-program/

- **We Should Be Compensated Appropriately**
    - Supervisor/leadership needs to understand we are not an RVU based model.
    - Metrics should be based on achievements other than patient volume.
    - We are a resource not a money maker — hospitals might consider our work "mission based" or a "cost center."

About the author

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