Enhancing Follow-up Care of Sexually Assaulted Children: Outcomes of a Forensic Nurse Care Coordination QI Initiative

Mary Smith, MSN, RN, CPEN, SANE-A, SANE-P, AFN-C[1], Sandra P. Spencer, MD[1,2], and Antonia Chiesa, MD[3,4]

Background: Nurse care coordination for children and adolescents experiencing acute sexual assault is rarely done but could yield positive outcomes. Demonstrating the value of forensic nurse care coordination (RNCC) is challenging: No benchmarks or metrics existed to measure the impact of RNCC on patient care or outcomes. Hours could be tracked, contact attempts could be tallied, but evaluating the value and outcomes of a forensic RNCC was lacking.

Methods: Using quality improvement (QI) methodology, we identified measures to quantify the impact of care coordination by a forensic nurse for pediatric and adolescent patients who had experienced acute sexual assault. Measures included attending follow-up clinic, obtaining follow-up labs at 6 weeks and 3 months post-assault, and patient concordance with an established clinical care follow-up pathway. We implemented the forensic RNCC between October 2022 and June 2023, with pre- and post-QI intervention chart review to establish baseline and post-QI outcome measures.

Results: The forensic RNCC role was successfully implemented. All measures demonstrated improvement from pre- to post-intervention. Clinic follow-up increased from 70% to 98% of patients. Patients obtaining screening labs 6 weeks post-assault increased from 53% pre-intervention to 92% post-intervention. The pathway recommends patients obtain labs 3 months post-assault as well, and we saw an increase from 67% to 89% of the post-intervention group obtaining labs at 3 months. Overall concordance to the system's evidence-based clinical care pathway increased from 45% to 83% of the post-intervention group.

Conclusions: This QI initiative achieved measurable improvement in patient care and outcomes by leveraging the expertise of a forensic RNCC.

KEY WORDS:

Acute sexual assault; adolescent; care coordination; care coordinator; care pathway; case management; case manager; evidence-based; follow-up; lab; pediatric; protocol; quality improvement

Author Affiliations: [1]Children's Hospital of Colorado, [2]University of Colorado, [3]University of Colorado School of Medicine, and [4]Kempe Center for the Prevention and Treatment of Child Abuse and Neglect.

The authors declare no conflict of interest.

Correspondence: Mary Smith, MSN, RN, CPEN, SANE-A, SANE-P, AFN-C, Children's Hospital of Colorado, Box 138, 13123 E. 16th Ave., Aurora, CO 80045. E-mail: Mary.Smith@ChildrensColorado.org. Mary Smith (ORCID: 0000-0002-6203-317X)

The Child Protection Team (CPT), a hospital-based medical group specializing in the diagnosis and treatment of child abuse, identified opportunities to improve care delivery, consistent with established care guidelines, to enhance patient care. Specifically, patients reporting acute sexual assault were not obtaining labs for early detection of sexually transmitted infections as recommended by the Centers for Disease Control and Prevention (CDC, 2024), nor completing follow-up clinic visits with the child protection and infectious disease teams, as recommended by the hospital's clinical care pathway. Acute sexual assault is defined in our institution as any unwanted sexual act perpetrated by force or threat, or by a person in a position

of trust, that has occurred within 72 hours for developmentally prepubescent patients and 120 hours for developmentally pubertal patients. The CPT identified a solution and brought a forensic registered nurse care coordinator (RNCC) onto their team to provide care coordination.

Background

Patient care coordination is not a new concept, though it has gained traction over the past decade. The Agency for Healthcare Research and Quality (AHRQ) recognizes the benefit of care coordination and recommends its inclusion in primary care settings to "achieve safer and more effective care" (AHRQ, 2019). The Colorado Health Institute (2020) identified care coordination as one strategy to deliver efficient, safe, high-quality health care. Both agencies identify that care coordination can help patients and their families navigate disjointed care plans and daunting processes. AHRQ, the Colorado Health Institute, as well as the Centers for Medicare & Medicaid Services (CMS, 2023) published broad recommendations for primary care coordination. AHRQ (2019) recommends care coordination include facilitating creation and communication of an adequate care plan, incorporating patient needs to promote both patient autonomy and healthcare beneficence, and incorporating access to community resources.

Despite all the endorsements for primary care coordination, these recommendations are difficult to apply directly to specialty clinics such as the CPT. When specialty care is involved, CMS and AHRQ offer little guidance or specific recommendations. However, AHRQ notes that outreach to the patients' primary care and adjacent specialist providers can help with transitions and communicate a proactive care plan (AHRQ, 2019). Care coordination can promote adequate follow-up care and ongoing awareness of patients' needs beyond the specialist's purview. What is not outlined is how these care coordination tasks are done and measured.

Professionals including nurses and social workers have clearly defined scopes of practice based on education, licensure, state, and national practice acts. Care coordination and case management are defined differently depending on the healthcare system they practice in and the tasks assigned by the organization. Currently, to the best of our knowledge, care coordination certification or licensure is nonexistent at the national level, statewide, or within any hospital system. Therefore, a nurse filling a care coordinator role has clearly defined nursing tasks but not necessarily clearly defined care coordination tasks.

CMS (2023) provides billing codes for care coordination; however, these are based on time spent with the patient and patient diagnosis rather than on coordination tasks completed. There are National Provider Identifiers (NPIs) for RNCCs (NPI Dashboard, 2024); however, this taxonomy does not yet define the tasks expected to be completed by nurses filling a care coordination role. Wong et al. (2024) identified five tasks commonly completed by care coordinators. These include assessment and mitigation of risks, services provided in a primary care setting, support of emotional and psychological needs, education and health promotion, and assistance with financial barriers to care.

The most compelling evidence of positive impact on patient outcomes by care coordination is found in a comprehensive 2019 systematic review by Conway et al. (2019); the review revealed increased quality of life based on patient ratings and increased patient survival when a care coordinator was involved.

While Conway et al. (2019) illustrate the benefits of care coordination, their review did not measure how tasks performed by care coordinators affected patient outcomes. Evaluating the effectiveness of the interventions can be more complicated than simply examining the interventions themselves. Wong et al. (2024) found that pediatric cancer survivors transitioning to adult care had improved outcomes with care coordination as part of a multidisciplinary care team. Most studies have been limited to adult, primary care populations and do not speak to the vulnerable pediatric population seen by the CPT. Unfortunately, there is a dearth of data on the impact of care coordination on post-sexual assault care for children and adolescents.

Rationale

Although no studies demonstrate the effects of care coordination on the pediatric population who have been victims of assault, abuse, and neglect, it is likely that care coordination would have a positive effect on these patients. Because coordination with outside agencies and community providers proved inconsistent, the CPT believed patients and their caregivers would be better served by a dedicated forensic RNCC who would also participate in their outpatient clinic. The CPT director and nursing leadership identified a pediatric forensic nurse to join the team. The RNCC had 3 years of practice as a forensic nurse caring for both adult and pediatric patient populations, was SANE-A certified, and was in the process of obtaining a master's of science in nursing with a focus on forensic nursing. Appropriate healthcare utilization and clinical care pathway adherence were identified as measures that could be directly affected by the actions of a forensic RNCC. These measures would quantify the forensic RNCC's impact on biopsychosocial health outcomes for this patient population.

SMART Goal

To demonstrate the value of integrating a forensic RNCC, we sought to primarily increase patient adherence to the existing evidence-based clinical pathway for care of patients who have experienced acute sexual assault to 90% within 10 months. We measured adherence by the following four data points: attended CPT clinic, obtained 6-week follow-up

labs, obtained 3-month follow-up labs, and globally all interventions were concordant with the clinical pathway.

Methods

The Six Sigma process known as DMAIC (define, measure, analyze, improve, and control) guided the team in this quality improvement (QI) project (Monday, 2022). The Standards for Quality Improvement Reporting Excellence framework (Ogrinc et al., 2016) was used to guide the organization and presentation of this article.

Setting

The study institution is a private, nonprofit pediatric healthcare network and includes the only dedicated pediatric Level 1 trauma center in our seven-state Rocky Mountain region. The CPT consists of six physicians, one nurse practitioner, one social worker, one administrative professional without medical training, and the appointed forensic RNCC. The team serves patients of the hospital and consults with community providers when there is concern for abuse, neglect, and sexual assault of children and adolescents. This institution defines a pediatric patient as any person until their 22nd birthday.

Project Team

The QI team consisted of the CPT medical director and the forensic RNCC, with the support of hospital ambulatory nursing leadership. The forensic RNCC participated in QI certification program while initiating this QI project, applying knowledge gained in real time.

Define the Problem

The population studied for this QI project were patients under 22 years of age evaluated for acute sexual assault by a member of the CPT, the sexual assault nurse examiner (SANE) team, or an emergency room physician coupled with a phone consultation with CPT or SANE within this healthcare system. This population accounts for about 10% of all patients who have contact with CPT. These patients should be treated using an existing evidence-based clinical care pathway (Clinical Improvement Team, 2024) that is available throughout the hospital system. The pathway provides guidance to clinicians for care of patients presenting for acute sexual assault in the emergency room and includes lab studies, medications, and post-assault care recommendations as per the CDC guidelines.

The CDC's (2024) testing recommendations included Nucleic Acid Amplification Test (NAAT) testing at sites of penetration for *Chlamydia trachomatis* and *Neisseria gonorrhoeae*; urine NAAT testing for *Trichomonas vaginalis* for patients with female genitalia; and serology testing for HIV, hepatitis B, and syphilis to be completed in the emergency department (ED). The pathway also includes pregnancy testing if indicated. If testing is negative and prophylactic medications are indicated and administered in the ED, then follow-up serologic testing at 6 weeks post-assault consists of syphilis, HIV, and hepatitis B. Serologic testing at 3 months post-assault consists of syphilis, HIV, and hepatitis C. In all cases, the provider ordering the tests is responsible for following up with patients and caregivers for all positive lab results, including sexually transmitted infections as per hospital policy.

The CDC guidelines for prophylactic treatment are dependent on the pubertal stage of the patient. Pubertal patients should be offered Ceftriaxone, Doxycycline, and Metronidazole or Tinidazole for biologically female patients (CDC, 2021b). The hospital pathway also includes offering emergency contraception when indicated. Prepubertal patients should be offered sexually transmitted infection (STI) treatment based on symptomatic presentation or if initial testing and confirmatory testing is positive (CDC, 2021a). Based on risk stratification, HIV PEP (post-exposure prophylaxis) should be offered to prepubertal and pubertal patients. For patients seen for acute sexual assault, the forensic RNCC completes a comprehensive chart review and ensures follow-up is initiated.

Clinic follow-up with CPT is concordant with CDC guidelines, particularly if the patient of any pubertal stage initiates HIV PEP (CDC, 2021b). In this hospital system, a multidisciplinary visit includes the forensic RNCC, CPT provider, an infectious disease provider, and a behavioral health specialist. This clinic visit may include education and offering completion of recommendations if declined in the ED, such as labs if not completed in the ED based on patient history and risk factors; STI prophylaxis if not completed in the ED based on patient history and risk factors; and follow-up labs at 6 weeks, 3 months, and sometimes 6 months after assault based on patient history and risk factors.

The defined problems for this QI intervention project were as follows:

- suboptimal rates of patient follow-up to clinic as recommended,
- suboptimal rates of patients obtaining follow-up lab tests as recommended, and
- patient care was often discordant to the existing evidence-based clinical care pathway established within this hospital system

To determine where care coordination could improve care, current communication methods and workflows were studied. E-mail, electronic health records (EHRs), and messaging within the EHR system were used for communication among the team. The CPT provider or SANE who provided phone consultation or direct care to the patient supplied a summary via e-mailed shift reports. An abbreviated history of the assault, patient medical history, course of care in the ED, and care recommendations were usually included. The

administrative professional would use the shift report to guide scheduling of follow-up appointments. Patients were added to user-managed lists in the EHR based on the history of the event. Lists can be manually created based on user preference or as part of automated processes within the EHR.

Current practices regarding the cadence of clinic visits and providing follow-up care were also analyzed. Prior to this QI project, CPT clinic visits included follow-up labs being ordered by either the CPT or infectious disease providers. No consistent process existed for this; thus, no consistent follow-up for positive results existed. Also, there was not a reminder process built into the system to communicate to patients and their caregivers when they needed to return for 6-week and 3-month follow-up labs.

Measures and Data Analysis

To provide baseline measures, a comprehensive chart review of all patients seen for acute sexual assault in the hospital system from January 2022 through October 2022 was completed. This pre-intervention group consisted of 47 distinct patients. Data were collected on 11 unique metrics obtained through the EHR (e.g., medications administered, follow-up clinic visits, subsequent emergency department visit). These metrics were chosen based on an existing evidence-based clinical care pathway used throughout the hospital system (Clinical Improvement Team, 2024). Measures were grouped based on which healthcare team member could most significantly affect the completion of the measure based on phase of care (refer to Table 1 for the outcomes targeted in this QI project with the forensic RNCC role).

When all 11 aspects of patient care were indicated and completed, this care was considered concordant with the clinical care pathway. When care was not indicated and therefore not completed, care was considered concordant with clinical care pathway. When the chart was missing documentation that care was not indicated and care was not completed, care was considered discordant with the clinical care pathway.

Quality Improvement (QI) Process

The QI intervention process consisted of five tactical interventions by the forensic RNCC. The first intervention was to include the forensically trained RNCC in shift report e-mails. This allowed for easy access to review the patient charts to identify care gaps, deviations from established care pathway, and documented recommendations. This information was then used to communicate follow-up recommendations clearly with the patient, CPT, hospital, and community providers.

The second intervention was to utilize "Care Teams," an electronic health record (EHR) feature. The forensic RNCC was assigned to the care team of all patients seen for acute sexual assault that were known to CPT. This provided teams throughout the hospital system a direct CPT contact to help coordinate care. This reduced duplication of services and promoted patients obtaining follow-up lab work in coordination with other healthcare visits.

To address missed lab and follow-up appointments, the forensic RNCC utilized EHR patient lists to track upcoming and missed appointments throughout the hospital system as the third intervention. An EHR reminder alert also notified the forensic RNCC when patients had labs or follow-up appointments due, allowing for notification of patients and their caregivers using secure digital communication, or by telephone when labs or follow-up were due, thereby encouraging patients and their caregivers to obtain labs during other upcoming encounters.

Fourth, to address overall care concordance, the QI team collaborated with the clinical effectiveness team to create evidence-based standing order protocols for nurse-entered lab orders. All results were automatically sent to the forensic RNCC for review, who would coordinate treatment with a CPT provider or the patient's primary care provider, based on patient and caregiver preference.

Finally, the forensic RNCC engaged with patients and their caregivers at the start of the clinic visit, explaining the clinic visit steps and interdisciplinary team roles. Patients and their caregivers were reassured that a retelling of their traumatic experience would not be necessary to provide medical, social, and mental health support, and they were guided through digital chart access to streamline future communication and follow-up. The forensic RNCC updated the medical record, including primary care provider and pharmacy preferences. This made prescribing and coordinating future care easier and was used to address overall care concordance.

Based on interventions and subsequent chart review, inconsistencies in ED discharge instructions were quickly identified. This was a blind spot not previously identified as a contributor to gaps in care. Specifically, follow-up recommendations as outlined by the clinical care pathway were not clear and consistent. After templated discharge instructions were edited for accuracy, messaging to patients and their caregivers from their first sexual assault-related medical encounter became consistent with the care pathway. These included new follow-up instructions and were available to all providers across the institution.

The interventions were implemented from October 2022 through June 2023. A second chart review was conducted in July 2023 using the same template as the pre-intervention review. Standard statistics were applied to compare the pre- and post-intervention groups.

Control and Sustainability

The QI initiative outcomes have been sustained as interventions have become normalized within the day-to-day health system process.

Ethical Considerations

This QI initiative did not meet criteria for human subjects' research because the team applied what was known (i.e., care

TABLE 1. Patient Outcomes Targeted by the Forensic RNCC Role

Targeted Measures Impacted by RNCC	Baseline	Improved
Attended CPT clinic	70%	98%
Attended infectious disease clinic	79%	98%
Obtained 6-week follow-up labs	53%	92%
Obtained 3-month follow-up labs	67%	89%
Cares were concordant with clinical care pathway	45%	83%

coordination improves patient outcomes) to an established clinical team; therefore, institutional review board approval was not required. The Organizational Research Risk and Quality Improvement Review Panel concurred.

Results

As demonstrated in Table 1, results surpassed the goal of 90% concordance in two measures and were progressing toward the goal in the other two measures. Clinic follow-up was completed by 70% of the pre-intervention group. This measure saw near-complete concordance after adding the forensically trained RNCC, with 98% of patients attending clinic in the post-intervention group. Patients who obtained screening labs 6 weeks post-assault accounted for 53% of the preintervention group. Ninety-two percent of patients in the post-intervention group obtained labs 6 weeks post-assault. The clinical care pathway recommends patients obtain labs 3 months post-assault as well, and 67% of the pre-intervention group did so. After adding care coordination to the team, 89% of patients obtained these labs, narrowly missing the target of 90%. Just 45% of pre-intervention patients received care concordant to the clinical care pathway. This increased to 83% of the postintervention group.

By employing a forensically trained nurse, the team saw additional improvements, such as increased trauma screening, that they did not anticipate at the onset of this project.

Discussion

To our knowledge, this is the first study introducing forensic RNCC in a pediatric specialty care environment and measuring its impact. Here, we demonstrated improved care of pediatric patients reporting sexual assault by providing forensic RNCC. The processes implemented by a forensic RNCC proved to positively impact post-sexual assault patient outcomes by enabling the hospital system to deliver care concordant with their own recommendations.

Interpretation

Our team theorizes that the greatest contributing factor to increased follow-up lab concordance is the initiation of care

coordination at the time of the hospital visit (e.g., forensic RNCC role assignment to patient's care team in the EHR). The forensic RNCC is now automatically alerted in real time when a patient interacts with the hospital system for future encounters. This provides an opportunity to coordinate follow-up lab tests with other clinic visits, ED visits, or hospital admissions as applicable. The forensic RNCC can contact patients and their caregivers to coordinate lab testing and assess other barriers to care like transportation and care for other children, which are addressed by appropriate teams before the appointment day. Performing and responding to this type of comprehensive needs assessment is widely recognized as a cornerstone of delivering trauma-informed care (Trauma-Informed Care Implementation Resource Center, 2018). While the team did not measure patient compliance with HIV PEP protocol, this will be explored by the team moving forward. Improved patient clinic attendance is likely influenced by a chart review completed by the forensic RNCC rather than the nonclinical administrator. When the forensic RNCC performs chart review, they are able to interpret lab results, check medications administered, identify gaps in care, and can succinctly communicate services recommended at clinic visits to the nonclinical administrator.

During clinic visits, the forensic RNCC builds rapport with patients and caregivers, becoming a trusted part of the healthcare visit, who establishes and documents preferred methods of communication, like confidential phone numbers, and helps patients and caregivers gain digital chart access. This likely contributes to ease of communicating follow-up lab reminders as they became due.

Creating the EHR order set contributes to the value-based healthcare model by ensuring the correct orders are placed. Providers anecdotally report increased confidence in the order process with the standing order protocol. As part of the standing order set, lab results are routed to the forensic RNCC, who can relay these results to patients and their caregivers. If treatment is recommended, this can be coordinated with either the patients' primary care provider or CPT provider per patient and their caregiver's preference. This outreach provides another opportunity for the forensic RNCC to assess other patients' needs and coordinate care as indicated.

As a forensic nurse, the RNCC is qualified to complete additional tasks, including providing education regarding the legal processes, victim advocates, and resources for victims' compensation, as well as screening for environmental safety and social determinants of health. The CPT also implemented a confidential, evidence-based, validated tool known as the Care Process Model (Intermountain Healthcare, 2020) for screening trauma symptoms and administered by the forensically trained RNCC, who is able to provide support services based on results of both safety and screening for trauma.

Furthermore, all other care teams in the hospital system can easily identify the forensic RNCC as someone with an

established relationship with patients and caregivers once the nurse self-assigns to the patients' care team. Other care teams gain direct contact with CPT to field questions about patient history and related care needs without requiring the patient or caregiver to retell the traumatic event. Finally, an unanticipated result is that the forensic RNCC now participates in complex discharge care conferences and follow-up telehealth appointments for the purpose of providing psychosocial context for the child, caregivers, and the concerns for abuse and/or neglect. This promotes a system-wide trauma-informed response to the patient and caregivers.

While our study demonstrated a positive change for 48 patients per our post-QI period chart review, we have cared for an additional 62 patients reporting sexual assault since June 2023 that likely have benefited from the implementation of the forensic RNCC role (we speculate this based on our ongoing and normalized care coordination).

Within this hospital system, concordance to this clinical care pathway was not measured prior to this QI project. Now that it has been measured, it can be compared to concordance of other care teams that rely on clinical care pathways, both with and without nurse care coordinators. Globally, further research would help illuminate the impact that care coordination delivered by a forensically trained nurse in the trauma clinic space can have on patient outcomes. This may be useful in developing similar programs that operate on a value-based healthcare model.

Limitations

Several limitations of this project exist, including patients were limited to those patients manually assigned to the appropriate patient list. There may be patients seen and treated for sexual assault but not placed onto the list. Chart review was completed by a single team member, so data errors may not have been mitigated by independent double check. Some providers may have discussed pathway interventions with patients yet neglected to document either the conversation or the outcome, such as patient refusal to submit to testing. In these instances, patient care was tallied as discordant yet may have been concordant.

Implications for Clinical Forensic Nursing Practice

This QI study has practical implications for forensic nurses who might be expanding into the outpatient care delivery sphere or into care coordination roles. By coordinating the interdisciplinary care of patients who are victims of violence, forensic nurses treat the whole patient—not the event. By administering and acting upon safety and trauma screening, the forensic nurse delivers holistic nursing care that extends beyond the exam room.

While there is a clearly defined, evidence-based clinical care pathway for treating patients reporting acute sexual assault, there are no equivalent clinical care pathways for the remaining CPT patient population. Due to the success of the standing order set for follow-up labs, the forensically trained RNCC and the CPT have established a standing order protocol for follow-up skeletal survey, an imaging series utilized to assess for child physical abuse. The effect of this standing order has not yet been measured. Expanding the role of the forensically trained RNCC to all populations cared for by CPT should be analyzed for efficacy.

Conclusion

Enhancing care delivery through the integration of a forensic RNCC holds promise in improving outcomes for pediatric patients experiencing acute sexual assault. By aligning with established guidelines and leveraging QI methodologies, we achieved measurable improvements in patient care and outcomes. The forensic RNCC is essential to the CPT to promote holistic, trauma-informed, evidence-based care and care coordination.

References

Agency for Healthcare Research and Quality. (2019). *Care coordination.* https://www.ahrq.gov/ncepcr/care/coordination.html

Centers for Disease Control and Prevention. (2021a). *Sexual assault or abuse of children.* http://www.cdc.gov/std/treatment-guidelines/sexual-assault-children.htm

Centers for Disease Control and Prevention. (2021b). *Sexual assault and abuse and STIs—Adolescents and adults.* https://www.cdc.gov/std/treatment-guidelines/sexual-assault-adults.htm

Centers for Disease Control and Prevention. (2024). *Screening recommendations and considerations referenced in treatment guidelines and original sources.* https://www.cdc.gov/std/treatment-guidelines/screening-recommendations.htm

Centers for Medicare & Medicaid Services. (2023). *Care coordination.* https://www.cms.gov/priorities/innovation/key-concepts/care-coordination

Clinical Improvement Team. (2024). *Blood or bodily fluid exposure in the community (non-occupational).* https://www.childrenscolorado.org/globalassets/healthcare-professionals/clinical-pathways/blood-or-bodily-fluid-exposure-in-the-community-non-occupational_external.pdf

Colorado Health Institute. (2020). *Coordinating to somewhere.* https://www.coloradohealthinstitute.org/blog/coordinating-somewhere

Conway, A., O'Donnell, C., & Yates, P. (2019). The effectiveness of the nurse care coordinator role on patient-reported and health service outcomes: A systematic review. *Evaluation & the Health Professions, 42*(3), 263–296. 10.1177/0163278717734610

Intermountain Healthcare. (2020). Diagnosis and management of traumatic stress in pediatric patients. https://intermountainhealthcare.org/ckr-ext/Dcmnt?ncid=529796906

International Association of Forensic Nurses. (2022). *Become a forensic nurse.* https://www.forensicnurses.org/page/BecomeFN/

Lukersmith, S. (2017). *A taxonomy of case management: Development, dissemination and impact.* https://ses.library.usyd.edu.au/bitstream/2123/17000/1/Lukersmith%20PhD%20thesis_11_7_2017.pdf

Monday, L. M. (2022). Define, measure, analyze, improve, control (DMAIC) methodology as a roadmap in quality improvement. *Global Journal on Quality and Safety in Healthcare*, *5*(2), 44. 10.36401/JQSH-22-X2

NPI Dashboard. (2024). *Taxonomy code 163WC0400X: Registered nurse (case management)*. https://www.npidashboard.com/taxonomy/163WC0400X

Ogrinc, G., Davies, L., Goodman, D., Batalden, P. B., Davidoff, F., & Stevens, D. (2016). *SQUIRE 2.0 (Standards for Quality Improvement Reporting Excellence): Revised publication guidelines from a detailed consensus process.* https://www.squire-statement.org/

Trauma-Informed Care Implementation Resource Center. (2018). Trauma-Informed Care Implementation Resource Center. http://www.traumainformedcare.chcs.org/what-is-trauma-informed-care

Wong, C. L., Chan, C. W. H., Zhang, M., Cheung, Y. T., Chow, K. M., Li, C. K., Li, W. H. C., Brauer, E., & Chen, Y. (2024). Care coordination models for transition and long-term follow-up among childhood cancer survivors: A scoping review. *BMJ Open*, *14*(8), e087343. 10.1136/bmjopen-2024-087343