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Frequently Asked Questions

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DATA ENTRY FAQ

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Inclusion/Exclusion Criteria:

Q.1. What are the inclusion criteria for CAPNET?

A.1. A child must meet all of the following criteria to be included in CAPNET

Age < 10 years age at start of encounter

Clinical evaluation performed by CAPNET team medical provider during the enrollment period due to *recent concerns for suspected physical abuse.*

Clinical Evaluation

Q.2. What is defined as a clinical evaluation?

A.2. A clinical evaluation is defined to have occurred when

- A child is physically seen by a medical provider somewhere within the CAPNET team healthcare system(s); and
- A CAPNET team medical provider documents medical recommendations or assessment related to recent concerns for physical abuse in the medical record.

Q.3. What is NOT a clinical evaluation for suspected child physical abuse?

A.3. Shared exclusion criteria include

- *Protocol review* of all cases of a particular category (eg, all photodocumented injuries, all EHR screening triggers, all social work consults) in which there is no CAPNET team recommendation or documentation in the medical record; or
- *Outside consults* in which CAPNET team involvement in occurs outside of a "primary" health care system (eg, a burn unit in a general hospital that consults the CAPNET team for suspected inflicted burns who relies on a separate EMR); or
- *Welfare check, wellness, or custody* cases in which children present with concerns for physical abuse in which all the following elements are true
    - non-medical referral source, and
    - no witnessed or disclosed recent injury event (<1 month), and
    - no injury or symptoms of injury present at time of evaluation.

Recent Abuse

Q.4. How should we determine whether the abuse concern is recent?

A.4. The concern for abuse *from a medical perspective* should be less than 1 month old.

- A CAPNET medical provider is consulted because patient admitted with pneumonia is found to have healing rib fractures that may be 6 weeks old. Evaluation performed due to *recent medical concern* raised for abuse. **Include** in CAPNET.
- A CAPNET medical provider conducts a medical record review and gives a second opinion about etiology of bruises that were identified and evaluated by another provider 3 months prior. In this case, the *medical concern for abuse is not recent*. **Do not include** in CAPNET.
- A CAPNET medical provider is consulted for a generally well child due to parental concerns for physical abuse reported to CPS. There is no specific report of a known injury event. In this case, the *non-medical concern for abuse lacks a known event and child without current symptoms of injury.* **Do not include** in CAPNET.

Q.5. How broadly should we define "Suspected physical abuse"?
A.5. Indicated by CAPNET medical provider directing or interpreting an evaluation for physical abuse.

- A CAPNET medical provider is seeing an infant with suspected ingestion and recommends a skeletal survey. Include in CAPNET.
- A CAPNET provider is seeing a 7-year-old with a recent disclosure of sexual abuse. The child has bruising of the inner thigh that is attributed to sexual assault. This is not evaluated as a distinct concern for physical abuse. Do not include in CAPNET.
- A CAPNET medical provider is consulted due to parental concerns for physical abuse reported to CPS. The child has disclosed spanking and other forms of corporal punishment last weekend. This is a non-medical concern for physical abuse with a disclosure of recent possible injury event. Include in CAPNET.

Q.6. Does being a "sibling at risk" or "contact child" qualify for CAPNET
A.6. Yes. If you are seeing kids <10yo as contacts of a child who does not qualify for CAPNET—perhaps they are siblings of a 14 yo with physical abuse, or siblings of an infant who was found deceased in the home—those siblings are CAPNET eligible with "reason for presentation" captured as "exposure to family violence".

Deleting a Case that was Erroneously Entered

Q.7. I entered a case and then realized the child did NOT meet CAPNET inclusion criteria. What do I do?
A.7. If you erroneously entered a case and need the record to be deleted, please email the CAPNET DCC (capnetdcc@chop.edu).

Static Demographics

Race & Ethnicity

Q.1. Patient race/ethnicity wasn't recorded in the medical record. Should I select race/ethnicity based on my observations of the patient?
A.1. No. Select "unknown" for race/ethnicity in this case. Only the documented self-reported race/ethnicity should be used.

Q.2. Patient race/ethnicity was updated in the hospital record after CAPNET episode. Should I update the CAPNET record?
A.2. If race/ethnicity is updated after initial entry but prior to final upload to the DCC, include most recent data available. There is no reason to update any data after final upload to the DCC.

Q.3. Patient race/ethnicity was unknown in the first CAPNET episode, but updated (or changed) during a second CAPNET episode. Should it be updated?
A.3. Yes, please update race/ethnicity at each CAPNET episode.

CAPNET Episodes

Definitions

Q.1. What is a "CAPNET episode"?

A.1. A CAPNET episode is the period inclusive of all signs, symptoms, and medical encounters associated with the specific injury or illness for which the CAP consultation was initiated. For most CAPNET cases, a CAPNET episode is inclusive of

- All time (minutes, hours, or days) during which there are symptoms attributable to the injury,
- The initial telephone consultation, clinic visit, or hospitalization,
- All time through follow-up medical testing (FUSS, OI testing, hematological evaluation), and
- The initial period of active consultation with child protective services and law enforcement.

Q.2. What is not included in a "CAPNET episode"?

A.2. A CAPNET episode does not include time dedicated to child welfare, investigative, or legal decision-making without active CAPNET provider medical decision-making OR new concerns for separate abuse episodes in the same patient

- CAPNET provider is asked to review a medical report authored by a CAP hired by the defense, which includes a report of new laboratory testing ordered by a provider several months after the original CAPNET episode. These studies are not part of the initial CAPNET episode and are not included in CAPNET as they have occurred outside of the initial period of consultation with CPS and LE.
- A CAPNET provider is asked to consult on a child hospitalized with suspected abusive head trauma. This child was previously entered in CAPNET for isolated bruising. This is a new injury and was not present in the initial CAPNET episode. This case is a new CAPNET episode under the same record id.
- A CAPNET provider consults on a child hospitalized with new subdural bleeding after AHT 6 weeks ago. Neurosurgery and neuroradiology are concerned that this reflects a second AHT event. The CAPNET provider reconsults and enters a medical note recommending repeat SS and ophtho exam. The CAPNET provider ultimately determines that this is most likely innocent/asymptomatic rebleeding into healing SDH. This is a new consult for a new concern and is not included in the original CAPNET episode. Enter this case as a new CAPNET episode under the same record id
- A CAPNET provider is asked to consult on a child hospitalized with new subdural bleeding attributed by neurosurgery and neuroradiology to innocent/asymptomatic rebleeding after AHT 6 weeks ago. The CAPNET provider is recontacted by neurosurgery "as a courtesy." The CAPNET team enters a brief note in the medical record describing current placement and safety plan. There is no new concern for abuse, this is not part of the initial CAPNET episode.

Dates

* Please note that the below guidance applies to cases from January 1, 2022 on. If you have a question about dates for a case from 2021, please contact your nodal administrator.

Q.1. I was called from the emergency department about a child with concern for abuse. I provided additional recommendations and wrote a brief note. I then saw the child in clinic 1 week later. Which date should I enter as date of first consultation, the date I was called from the ED or the date I saw the child in clinic?
A.1. Date contacted by the emergency department. First consult occurs when CAP first documents recommendations for evaluation or management of suspected child abuse.

Q.3. A child was referred to our clinic for an outpatient evaluation by child protective services (CPS). I spoke to the CPS worker on the phone to schedule the appointment. Two weeks later I evaluated the child in clinic. Which date should I enter as the date of first consultation?
A. 1. Include the date you evaluated the child in the clinic. First consult occurs when CAP first documents recommendations for evaluation or management of suspected child abuse. Just scheduling an appointment does not count as documenting recommendations for evaluation or management of suspected abuse.

Q.2. How do I calculate the ICU length of stay?
A.2. Please count the number of midnights spent in the ICU. If a child is admitted to the PICU at 11pm, and transferred to the general inpatient unit at 6am the next day, the ICU LOS is 1.

Q.3. What do I do for the discharge date if I need to finalize a record, but the patient is still admitted?
A.3. If child is not yet discharged at 42 days after admission date, enter -9996.

Q.4. A patient was discharged from inpatient status to rehab status but is still in my hospital. Is data of discharge the inpatient or rehab discharge?
A.4. Inpatient discharge date.

Q.5. I just realized that I didn't enter a case for a month that has already closed. Help!
A.5. Before beginning this entry, please email your nodal administrator for guidance.

CAPNET Providers

Q.1. If two CAPNET providers were involved in care during a CAPNET episode, which one should be entered?
A.1. Please choose the provider who was most involved. This might be the provider most likely to be called to testify in court if needed. For example, if provider A entered a phone consult on 12/31/2021, but provider B documented a full CAP clinic visit with physical exam and FUSS on 1/14/2021, it would likely be provider B who should be selected.

Q.2. We have a new CAPNET provider who isn't on the provider list. Who should I choose?
A.2. Congratulations on the new hire! Please reach out to the CAPNET DCC (capnetdcc@chop.edu) so that we can have the new provider added to CAPNET and to provide training.

Episode Demographics

Q.1. I am seeing the sibling of a child entered in CAPNET for an episode of suspected physical abuse last year. Should they be marked as a contact of a child previously entered?
A.1. No. Within CAPNET, contact groups are defined by episode and not over time (as these can change). If your team entered this child as a sibling at risk in the prior episode, this will be a new episode under the same CAPNET id. If you did not previously see this child, create a new CAPNET id not linked to the previously entered sibling.

Q.2. A child was placed in foster care due to the injury for which he is currently being seen (e.g., the injury didn't occur in foster care). Should I use the zip code in the medical record, which is probably the foster home, or should I search for the prior zip code?
A.2. Although not ideal, please use the zip code in the medical record to assure consistency in this data. Investigators using data for children in foster care at the time of abuse will need to understand limits of geographic information.

Q.3. The insurance type listed is Office of Crime Victims. How should I code this?
A.3. If there is another payer listed that would cover other types of encounters (e.g. private insurance or Medicaid) please choose that payer. If another payer is not listed, select "Other" and free text response. If this becomes a common finding, we may make adjustments.

Source of Referral

Q.1. A patient was referred for a CAP evaluation of a sentinel injury by a local urgent care. What is the source of referral?
A.1. This depends somewhat on local context.

- If the urgent care is simply an extension of your ED, please choose "Emergency Department."
- If an independent urgent care referred the child to the ED without contacting the CAP team, and you were contacted by the ED, choose "Emergency Department."
- If an independent urgent care reached out to the CAP team and the child was seen in your outpatient clinic, choose "Other" and report as "Urgent Care Clinic" in the free text box.
- If an independent urgent care contacted the CAP team but referred the child to the ED, which then contacted the CAP provider as well, both options ("Other" and "Emergency Department") should be selected.

Q.2. I was consulted by and evaluated a child in our hospital's observation unit. What should I select as source of referral and initial setting of consult?

A.2. In general, patients admitted to observation units should be coded the same as those admitted to the inpatient unit but there may be some differences based on site specific definitions and uses of observation units.

- Observations units or short stay units are commonly used for patients that present to an emergency department and require a significant period of treatment in order to make a decision concerning admission or discharge.
- Observation units may be used for cases in which a patient is not ready for discharge from the emergency department but is expected to be ready for discharge in less than 24 hours to 48 hours.
- At CHOP, the Observation Unit or Emergency Department Extended Care Unit (EDECU) should be coded the same as an inpatient unit.
- At CHP, the ED Observation Unit is classified as inpatient.
- At PCH, the RTU is classified as inpatient.
- If you, have specific questions about an observation unit at your center, please contact your nodal administrator.

Q.3. I am in clinic seeing the sibling of a child that our team was consulted on in the PICU. What should I select as source of referral? What if the ED consulted me on the child?
A.3. If you are seeing this child as a sibling or contact at risk, the referral source is THE SAME as the index child. "If sibling evaluation, please select source of consult for index child." In addition to data entry awareness, this is important to recognize in any analysis of this field.

Medical and Social History

Q.1. How hard should I dig through the record to obtain a complete PMH for CAPNET?

A.1. Known Past Medical History reflects what is known by the CAP during this episode of care.

- In general, the PMH captured in CAPNET should be reflected in CAP medical notes around this episode of care.
    - PMH should not reflect a secondary chart review by a data abstracter delving deep into the medical history of a nine-year-old child.
    - If there is a quick phone consult on an isolated skull fracture and later chart abstraction for CAPNET reveals a special health care need or history of prematurity, this is not part of the CAPNET data,
    - If the medical history of a child in foster care is unknown by the end of the CAPNET episode, the CAPNET medical history is unknown.

Q2. Is asthma considered a special health care need? What about speech delay?

A.2. Special health care needs reflect conditions that currently affect daily life.

- Based on federal definitions, this can include anything requiring medications, technologies, therapies or medical visits above what is typically required by another child of a similar age. If a child with asthma is requiring daily medications and more medical care, this is a SHCN. If the speech delay is requiring therapies above and beyond the usual care, this is a SHCN
- Branching questions will clarify whether this qualifies as a more complex chronic condition, so don't overthink this question.

Q.3. My patient has a history of subconjunctival hemorrhages, clavicle fractures, and skull fracture from birth. Or clearly iatrogenic injuries. I know they weren't abuse. Do you really want me to record those?

A.3. If these are documented in the CAP note or captured in CAP decision-making, they should be included. If you want to clarify, please leave non-identifying free text note at the end of the survey.

- Think of it this way—if we only record histories of subconjunctival hemorrhage when we think it's a prior case of abuse, and not when we know that there was a reason for it…our data will suggest that we basically always find abuse based on this history rather than reflecting careful decision making.

Q.4. My patient has a diagnosed seizure disorder. Should I check "Seizures or seizure-like activity" under "Signs of possible prior TBI" even though there is a medical diagnosis and not from trauma?

A.4. See Q.4 above. Yes, please include these.

- We recognize that there may be some discretion is what the CAP records related to these categories, but are trying to capture what the CAP is consider in their decision-making. So if it is in the CAP note, it is in the CAP brain.

Q.5. What if there were concerns for neglect documented in the medical record that the CAP records, but it isn't know whether these were specifically reported to CPS?
A.5. A history of neglect does not require documentation of CPS involvement. There should documented concern for nutritional, supervisional or other type of neglect.

Q.6. The child has a documented failure to thrive (FTT) which was attributed to a medical etiology. Should I indicate that there is a history of neglect?
A.6. No. "Failure to thrive / nutritional" neglect should be selected only IF the child has a history of FTT that is attributed to a nutritional neglect.

Q.7. It was just a phone consult! I don't know any social history! Now what?
A.7. Unknown/Not assessed for all categories is fine. It means the CAP didn't use it in their decisions.

Q.8. My patient lives in two different households and also goes to daycare eight hours a day. Who am I supposed to choose as the "primary caregiver"?
A.8. Primary caregiver is defined as the person(s) with the greatest responsibility for daily care and rearing of the child, regardless of whether the suspected abuse occurred in a different setting (daycare, babysitter).

- This is typically the parent, but may be another kin.
- This may include multiple different caregivers. We are trying to capture the "swimming pool" of social risk in which a child swims, not the risk factor of any individual caregiver.
- If the child has been brought to care by someone not involved in daily care (CPS, emergency foster family), it is possible that this information will be unknown/not assessed.

Q.9. Mother says that she had trouble with juvenile justice system as an adolescent and was on probation for 5 years as a teenager. Is this a prior criminal history?
A.9. Yes, this would be counted as prior criminal history. Any prior history of arrest, incarceration, and probation regardless of specific offense or age of caregiver (juvenile or adult) at time of event should be included.

Q.10. The mother of my patient has a "Protection from Abuse" order against the baby's father (or a comparable CIVIL court order). Is that considered a criminal history?
A.10. A protection from abuse (PFA) issued as part of a civil (not criminal) court proceeding does not signify a criminal history. Protection from abuse orders may not apply to all states, but, in general, civil court decisions should not be classified as a criminal history. Statutes regarding their issuance may vary across states. Data enterers should be familiar with the relevant statutes for their sites.

Q.11. The father of my patient apparently uses cannabis regularly, but doesn't seem to be impaired by this. Is this "Problem substance use"?
A.11. Problem substance use is increasingly in the eye of the beholder, particularly given variability in state law related to cannabis. As a rule of thumb, if substance use is legal, under

medical supervision, and/or does not interfere with parenting or day-to-day activities, this would not be coded as “problem substance use.”

Physical Abuse Presentation

General Considerations

A common source of confusion are the differences between REASON FOR PRESENTATION, PRESENTING SYMPTOM, and INJURY PROMPTING EVALUATION. We acknowledge that these can be difficult to tease apart even in real time, and more in retrospect. As much as possible, please consider the following:

- **Reason for presentation:** It might help to think of the second cell in this question first—what is the chief complaint? Not breathing, known injury, seizing? After you have answered this, you can think about what history was provided with this chief complaint.
- **Presenting symptoms:** Think of this as what might be on a nursing triage form.
- **Injury prompting CAP evaluation:** This is probably what the ED told you when they paged.

Reason for Presentation (accidental trauma, inflicted/abusive trauma, no trauma history)

Q1. A child presented for another reason (e.g. a behavioral health evaluation) and was found to have injuries (e.g. bruising). The family was asked about the injuries and then provided a history of accidental trauma but this was not part of the initial presentation. How should the question "Did the child present with a history of trauma?" be answered.

A. Select "No history of trauma." The question is asking about the reason child was initially brought for care. There will be an option later to indicate that a history of trauma was provided later.

Changing History

Q2. After discharge from the hospital, the parent told the police a different history then he/she told in the hospital. Should this be counted as a changing history?

A. This should be categorized as a changing history if it occurred within the initial management period. The 'initial management period' includes the time of the initial CAP involvement including communications with CPS and law enforcement. It may extend beyond the period of the initial hospitalization to include multi-disciplinary team meetings or other communications but does not include subsequent periods such as a later criminal trial. It is generally less than one month

Self-inflicted Trauma

Q3. A child presented with a reported history of head banging and scalp swelling. How should the history of trauma be categorized?

A. Indicate that the child presented with a history of accidental trauma. Self-inflicted trauma should be categorized as accidental.

Implausible Accidental Trauma History

Q4. A child presented with a history of a very short fall and multiple severe injuries. The reported history does not at all explain the injuries and this case is being diagnosed as abuse.

How should I answer the following question "Did the child present with a history of trauma?"?
A. Select "Yes- - History of Accidental trauma" if the child presents with a history of accidental trauma even if that history is not plausible explanation for the injuries.

Inferred Trauma History

Q5. A parent reports leaving a child on a bed when they went to the bathroom, hearing a thump, followed by a child crying, and then finding the child on the floor. They did not actually witness the fall. Is this considered an accidental trauma?
A. Yes. A history that provides you with sufficient detail (specific time, place, context), even if not directly witnessed, should generally be considered a history of accidental trauma. A parallel rule should be applied to inflicted trauma histories (parent reports hearing other parent slam door, yell "I'm going to whoop you", hears whipping followed by crying, and finds child sobbing with belt marks across back). These examples should be distinguished, however, from the **hypothesized trauma history (below).**

Hypothesized Trauma History

Q6. A caregiver reports no trauma history, but on discovery of a femur fracture wonders if maybe the dog sat on child. They caregivers did not actually witness the dog sitting on the child or offer any specific knowledge of this event, just hypothesize that it might have happened and that the dog is like the scary dog in Harry Potter. Is this considered an accidental trauma?
A. No. This is conjecture which has no specific information or context and should not be offered as a trauma history. A parallel rule can be applied to inflicted trauma histories (parent reports that a child has bruising and suspects that the parent may be hitting the child). There is insufficient knowledge of events to justify including this as a true trauma history.

Alleged Perpetrators—Parents, Paramours, and Others

Q7. Is a step-parent a "Paramour" or "Parent" or "Other"? What about an adoptive parent?
A. <u>This was identified as an area of confusion in CAPNET in late 2021</u>. The following definition of a paramour was added "A paramour includes a boyfriend, girlfriend, or other unmarried partner of a parent." Biological parents should be coded as "Parent".

- Step or Adoptive parents should be coded as "Other" with Step or Adoptive parent written in the "other" text field.
- Unrelated, legally undetermined significant others (boyfriends/girlfriends) as "Paramour".

Changing Perpetrators

Q7. A child presented with a femur fracture after mother witnessed biological father grabbing his leg and twisting with force. Subsequently, the father reported that this had actually been done by mom's boyfriend. Who should I list as perpetrator?
A. In general, we recommend recording the first history provided, as subsequent histories are less likely to appear in the medical record reliably. There is the option of noting this as a

"change in the history" and submitting information about the changing perpetrator. If you have two parents accusing each other at presentation, we recommend selecting multiple perpetrators and then including free text information.

Presenting Symptoms

Q.1 The child presented with seizure activity but parents also report episodes of limpness and fussiness two days prior. Should the fussiness and limpness be included in the symptoms that the child presented with?

A.1 Yes, please include all reported presenting symptoms for that illness/injury episode and not just symptoms occurring on the day of presentation.

Q.2. A child is referred to the CAP clinic with bruising that has resolved by the time of the appointment 1 week later. Are the reported bruises a presenting symptom, a physical finding, both, or neither?

A.2. This is complicated.

- If the prior bruising is seen in the context of a medical involvement with CAPNET documentation (eg phone consultation)
  - It is an exam finding (and may be a presenting symptom and a reason for evaluation)
- If the prior bruising is seen in a medical evaluation without CAPNET documentation (eg, the ED evaluated but didn't call your team)
  - It is an exam finding (and may be a presenting symptom and a reason for evaluation)
  - If it is described by an ED, but you don't have access to this report, you must base the decision on your confidence in the report of the medical evaluation
- If the prior bruising is seen only outside of a medical evaluation (eg, CPS or parent photos)
  - bruising is a presenting symptom (but not an exam finding)
  - bruising may also be the reason for evaluation

Q.3. The child presents in cardiac arrest. Do I indicate that the child is limp, unresponsive?

A. 3. Yes. Think about what would happen if an investigator wants to find all children presenting with change in mental status. We would want these children included.

Physical Abuse Examination Findings

Q.1. Should I document birth marks, dermal melanosis and other non-traumatic findings under cutaneous findings?

A.1. Typically no—this field is intended for injuries. If non-injury cutaneous findings were critical to the child abuse evaluation (eg, child was referred for bruising but lesions were determined to be congenital dermal melanosis), these should be described on the Diagnoses page under "**Did the child have a finding that was mistaken for a traumatic injury by a medical provider?**"

Q.2. A child is referred to the CAP clinic with bruising that has resolved by the time of the appointment 1 week later. Are the reported bruises a presenting symptom, a physical finding, both, or neither?

A.2. This is complicated.

- If the prior bruising is seen in the context of a medical involvement with CAPNET documentation (eg phone consultation)
    - It is an exam finding (and may be a presenting symptom and a reason for evaluation)
- If the prior bruising is seen in a medical evaluation without CAPNET documentation (eg, the ED evaluated but didn't call your team)
    - It is an exam finding (and may be a presenting symptom and a reason for evaluation)
    - If it is described by an ED, but you don't have access to this report, you must base the decision on your confidence in the report of the medical evaluation
- If the prior bruising is seen only outside of a medical evaluation (eg, CPS or parent photos)
    - bruising is a presenting symptom (but not an exam finding)
    - bruising may also be the reason for evaluation

Q.3. A child presents to an outside hospital with a GCS of 14. She deteriorates in transport and must be intubated in flight. GCS in our ED is 3T. Which GCS should I document?

A.3. Document the first reliably recorded GCS. Please also document the deterioration in the free text box.

Q.3. A child is being evaluated for bruising. On the face, technically, there are three individual bruises, but they all could be related to a single slap. On the arm, there are three oval bruises consistent with a single grab. Does this child have 2 bruises or 6 bruises?

A.3. Bruises that are likely related to a single action (a slap or a grab) are best described as a single bruise. In some cases, the reported number of bruises will be imprecise because bruising may overlap, because multiple areas of bruising may or may not be counted as a single patterned bruise, or because CAPs may not have examined the child in person.

Laboratory Tests

Missing Results

Q. A CBC was ordered but the platelets clumped and couldn't be counted. What should I put for the platelet value?

A. If a test was ordered but could not be completed you can put "-9999" for the result.

Spurious Results

Q. A lab test result was unexpectedly very abnormal, and we suspected a lab error. We immediately repeated the test and received a normal result. Should we report the first result?

A. No, do not enter values that are spurious or due to lab values.

Laboratory Tests Not Ordered by CAP

Q. The emergency department ordered abdominal bone health lab tests that I didn't ask for and didn't want. Should I enter the results?

A. Yes, we are capturing the results of all laboratory testing and imaging even if not ordered specifically by the CAP.

Laboratory Tests Obtained after Initial Visit

Q. Additional laboratory tests including testing for factor levels were sent when a patient follow-up in outpatient clinic a few weeks after an inpatient hospitalization for injuries that were evaluate for abuse. Should those values be included in CAPNET?

A. Yes, these laboratory results should be included. The first result obtained during a CAPNET episode should be included. A CAPNET episode is the period inclusive of all signs, symptoms, and medical encounters associated with the specific injury or illness for which the CAP consultation was initiated. The initial hospitalization, all follow-up medical testing (including FUSS, OI testing, or other imaging or radiology) and the initial period of active consultation with child protective services and law enforcement.

Radiologic Testing

Q.1. The initial skeletal survey reveals a possible fracture. Focused imaging at that time is performed to clarify this finding. Should I categorize this finding (fracture, no fracture, possible fracture) based only on the initial skeletal survey, or should it reflect the totality of the imaging triggered by the initial skeletal survey?

A.3. If additional imaging is triggered **specifically to clarify inconclusive findings**, the interpretation of the skeletal survey can reflect your best understanding of the study findings. This is only for additional plain films taken almost concurrent with the original skeletal survey. It should not include different imaging modalities or radiographs obtained days later.

Q.2. The skeletal survey identified numerous rib fractures. The abdominal CT also demonstrates the rib fractures but no other abdominal injuries. Should I indicate that the abdominal CT shows injuries.

A.2. No. The intent of this question is to determine the value of abdominal imaging in **identifying new injuries.** If the abdominal imaging is just confirming previously identified fractures, select: "No abdominal injuries."

Q.3. The head CT identified soft tissue swelling that was not identified on exam. There are no intracranial injuries. Do I indicate that the head CT identifies new injuries?

A. No. Do not include scalp swelling identified on neuroimaging as a new finding.

Outcomes

Expected Medical Outcomes

Q. A 3-month-old presents with seizures and respiratory failure. MRI shows SDH and regions of cytotoxic edema. After 3 days in the PICU and 3 days on the floor, she is discharged home on full oral feeds and Keppra. She looks fantastic at 2-week follow-up. I'm not sure how to code her "expected medical outcome".

A. This is the ***expected*** outcome. You might expect a 3-month-old with diffuse cytotoxic edema to have long-term disability even if well-appearing in the short-term. We may see some disagreement in this field, and will monitor this.

Initial CPS & Legal Outcomes

Q. The child was discharged home with parents but a few days later was moved to kinship care. Should kinship placement be included under outcomes even though it occurred after discharge?

A. Yes, outcomes occurring in the initial management period should be included. The initial management period includes the time of the initial CAP involvement including communications with CPS and law enforcement. It may extend beyond the period of the initial hospitalization to include multi-disciplinary team meetings or other communications but does not include subsequent periods such as a later criminal trial. It is generally less than one month

Level of Concern

Q.1. I am seeing a child who was violently shaken (captured on video) but has no identifiable injury after full evaluation. Is this a 1 or a 7? What if there isn't a video, but a bystander report that you can't verify? What if the alleged perpetrator continues to deny this report?

A.1. These are difficult and we may identify legitimate differences in opinion. The level of certainty scale does allow for consideration of "any action that results in a physical impairment of the child or creates risk of physical impairment." The video case, therefore, could be reasonably rated a "7". The bystander case, however, may introduce bias in terms of who a provider chooses to believe or not. This field will be monitored for variability.

Q.2. I am seeing a child who reports corporal punishment by his parent, but has no physical findings on exam. How should I rate this case?

A.2. These are difficult and we will identify legitimate differences in opinion. The level of certainty scale does allow for consideration of physical abuse even if there is not an injury present at the time you are evaluating the child. Please make your best assessment of your level of certainty for physical abuse based on the information available. In cases with a clear and detailed disclosure of physical abuse by the child, you may have a high-level of concern. In cases with vague disclosures or in which another caregiver reports the child made a disclosure but the child has not disclosed to medical, CPS, or law enforcement, you may have more uncertainty.

Contacts

Q.1. I am seeing the sibling of a child entered in CAPNET for an episode of suspected physical abuse last year. Should they be marked as a contact of a child previously entered?
A.1. No. Within CAPNET, contact groups are defined by episode and not over time (as these can change). If your team entered this child as a sib-at risk in the prior episode, this will be a new episode under the same CAPNET id. If you did not previously see this child, create a new CAPNET id not linked to the previously entered sibling.

Q.2. What if I know that a contact is under age 10 but don't know the exact age?
A.2. If a contact is under 10 years old but the exact age in years is not known, enter -9997 for age.

Q.3. I know that there are 2 contacts, but I don't know if they are under age 10. What should I do?
A.3. Please described this in the "Complex Contacts Situation" free text box.

Q.4. This child has two households and 1 daycare setting. We recommended that all children be seen, but only have accurate information for one set of household contacts. How do we enter this?
A.4. Enter information available, including children seen in your center. For other household settings, please use "Complex Contacts Situation" free text box to describe the children in other settings and whether you made recommendations related to evaluation.

Q.5. I am in clinic seeing the sibling of a child that our team was consulted on in the PICU. What should I select as source of referral? What if the ED consulted me on the child?
A.5. If you are seeing this child as a sibling or contact at risk, the referral source is THE SAME as the index child. "If sibling evaluation, please select source of consult for index child." In addition to data entry awareness, this is important to recognize in any analysis of this field.