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CAPNET – A Child Abuse Pediatrics Research Network

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Frequently Asked Questions

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DATA ENTRY FAQ

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Updated 11/06/2021

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.*

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.

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.

Static Demographics

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

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.

CAPNET Dates

Q.1. What is the date of encounter/admission?

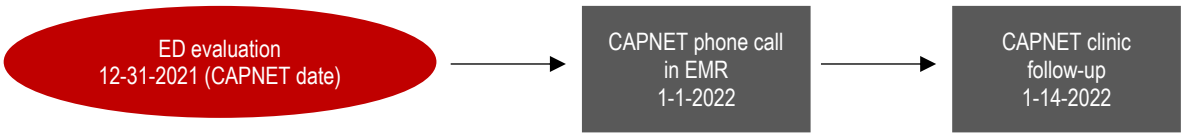
A.1. This date should reflect the date that the child came to medical attention for suspected child physical abuse. Because this data point is used to calculate hospital LOS, there are cases that can cause confusion. Date of hospital admission will supersede almost every other potential date except in one important context (bullet point 3). In the diagrams, the RED FORM represents the date of encounter/admission for CAPNET

Hospital admission after ED evaluation and before CAP inpatient consultation should be documented as the DATE OF ADMISSION (even if CAP conversation with ED is one day prior to admission and CAP consult is the day after admission).

Hospital admission to outside hospital with outpatient follow-up at CAPNET center within 1 month should be documented as the DATE OF ADMISSION to the outside hospital, even if the CAP was unaware of the case until the clinic follow up (because CAP evaluation is based on events leading to that hospitalization).

Hospital admission for a **COMPLETELY NON-ABUSE REASON** (the 24-week premature infant is the classic example) is the exception to the rule. If you have a patient admitted at DOL 0 and the CAP consult for a broken rib is at DOL 60, document the date of consultation at DOL 60 and not the date of admission.

ED encounter with discharge home after a CAP evaluation documented in the medical record (by phone or in person) should be the DATE OF ENCOUNTER even if the child is seen for follow-up in the CAP outpatient clinic.



CAP outpatient clinic is the DATE OF ENCOUNTER when there is no preceding (or immediately following) admission. This includes cases originating from outside settings (clinics, CPS, schools, etc) where there is no documented CAP evaluation.

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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 morning, 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. I just realized that I didn't enter a case for a month that has already closed. What should I do?
A.4. 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 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 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. A patient was referred for a CAP evaluation of a sentinel injury by a local urgent care. What is the source of referral?
A.2. 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 for evaluation without contacting the CAP team, and the CAP team was contacted by the ED, choose "Emergency Department."
- If an independent urgent care reached out directly 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.

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 recognized 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. 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. What am I supposed to say?
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 JJS as an adolescent and was on probation for 5 years as a teenager. Is this a prior law enforcement history?
A.9. Yes, this would be counted as prior law enforcement 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 father of my patient apparently uses cannabis regularly, but doesn't seem to be impaired by this. Is this "Problem substance use"?
A.10 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

Reason for Presentation

Q. 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

Q. 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

Q. 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

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?"?
Q. 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.

Presenting Symptoms

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

Physical Abuse Examination Findings

Cutaneous

Q. Should I document birth marks, dermal melanosis and other non-traumatic findings under cutaneous findings.
A. No.

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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 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

Fractures on Abdominal CT

Q. 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. 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."

Outcomes

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

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 their ages. 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.