

# **Best Practice Standards for Medical Providers**

## **Colorado Child Abuse Response and Evaluation Network**

### **Best Practice Standards for Medical Providers**

#### **INTRODUCTION**

##### **DIRECT PATIENT CARE**

The primary mission of the CARE Network is to provide every child easy access to quality and compassionate medical care to ensure health and safety through proper diagnosis and treatment. This is typically performed as a scheduled visit to a designated provider at a child advocacy center or clinic in the child's community. Some designated providers are available to respond to emergency departments or hospitals when medically necessary or provide expert consultation/review of medical records if direct care of the child is not possible.

##### **COMMITMENT TO QUALITY**

The CARE Network is committed to ensuring that all children have access to quality medical examinations by offering numerous training opportunities for designated providers, other medical providers, and non-medical professionals involved in the assessment and care of maltreated children. All designated providers maintain ongoing education & peer review/mentorship requirements, as designated providers must be able to recognize, respond, refer, report, and reduce the incidence of child maltreatment in Colorado.

##### **TRAINING**

- New provider training is an annual, two-day conference that teaches medical providers how to diagnose and treat child physical and sexual abuse and neglect.
- Training is designed to keep active designated providers up-to-date on new and advanced topics.
- Our mentorship program pairs new providers with child abuse experts from the Resource Center, facilitating easy access to expert consultation.
- Regular case review sessions encourage continuous improvement and fidelity to the program's standard of care.

##### **COLLABORATION**

Designated providers understand that their work does not end when a patient walks out of the clinic. The care of maltreated children requires close collaboration with other agencies and institutions responsible for the health and safety of children. This involves producing a meaningful report, communicating with multi-disciplinary team members, and testifying in court when necessary.

- The Colorado Department of Health and Environment administers the funding for the CARE Network program.
- The Resource Center informs the program's development, programming, and education.
- Designated providers are physicians, physician assistants, nurse practitioners and nurses that have successfully completed special training and have made a commitment to providing quality evaluations to maltreated children in their communities. Providers encompass a wide range of experience: urban to rural, small private practice to large children's hospitals. Each plays a valuable role in ensuring that Colorado's children have access to the best possible care.
- Child abuse experts from the Resource Center provide all of our training and serve as mentors to new designated providers. They also provide consultation services to the child welfare agencies and handle the most serious cases of child maltreatment.

## **SERVICE OUTLINE**

Exams are provided by a designated provider (physician, nurse practitioner, physician assistant or nurse) who has met criteria for the CARE Network.

Referrals are received from a county child welfare agency, law enforcement agency, other health provider, public health agency or child advocacy center due to concerns for child maltreatment.

Medical providers shall evaluate children referred without regard to race, color, religion, national origin, or payment source and render the same quality of services to these recipients as would be rendered to private individuals.

Services may be provided in a number of different settings (outpatient child maltreatment evaluation clinics, child advocacy centers, medical provider offices).

Medical providers will need to maintain independent malpractice insurance.

The Resource Center will require name and contact information for supervising physicians or nurses who are designated providers. These physicians, while they do not have to be Network designated providers (this is encouraged), will remain responsible for supervision of the nurse's work.

A Consent Form shall verify legal guardian consent for the CARE Network evaluation. When referred by county child welfare agency, the child welfare caseworker's name and agency information will be included.

Medical providers shall review family and social history and document pertinent medical history, developmental and behavioral history, and information related to suspected maltreatment, including information provided by the county child welfare agency.

Medical providers shall perform a complete physical examination and provide documentation of apparent injuries or visible medical conditions indicative of abuse or neglect. Documentation should be provided in written form and should be illustrated by use of body diagrams and/or digital photographic injuries (strongly encouraged to have these for illustration in legal proceedings, continuous quality improvement and consultation as needed).

Medical providers are expected to perform medical evaluations, authorize the performance of diagnostic testing and develop treatment recommendations in accordance with recommended best practices on the medical evaluation of child maltreatment, such as from the American Academy of Pediatrics. Providers are encouraged to reference the resources cited at the CARE Network website.

It is the provider's responsibility to ensure proper billing documentation.

Medical providers shall participate in a case conference when appropriate, that includes an interdisciplinary team of health care professionals and community agency representatives for the purposes of coordinating care when there is suspected maltreatment.

All required exam documentation will be sent to the CARE Network for reimbursement and QI purposes.

Contents of exam reports:

1. Summary of the relevant aspects of the medical history.
2. The result of any information with the child, whose age and developmental level will allow.
3. The results of a thorough physical examination, including photodocumentation.
4. Any significant exam findings, their interpretation and whether they represent abuse/neglect.
5. Any concerning or unusual information or statements made by the family or child.
6. A determination as to whether the conditions or injuries that are present could have:
  - a. Resulted from the causes reported by the caregiver
  - b. Resulted of other medical or accidental conditions
  - c. Resulted from abuse
7. Behavioral health screening
8. Other relevant recommendations based on psychosocial or medical information. (Example, need for developmental therapies, immunizations, family community resources)

## **EVIDENCE-BASED GUIDELINE RESOURCES**

### **MANDATED REPORTER TRAINING**

CO DHS weblink

<https://www.coloradocwts.com/mandated-reporter-training>

### **SEXUAL ABUSE**

Kellogg N. The Evaluation of Sexual Abuse in Children. American Academy of Pediatrics. 2005;116(2):506-512.

Adams J, Kellogg N, Farst K, et al. Updated Guidelines for the Medical Assessment and Care of Children Who May Have Been Sexually Abused. Journal of Pediatric and Adolescent Gynecology. 2016;29(2):81-87.

Sexual Assault and Abuse and STDs – CDC 2015 STD Treatment Guidelines:

<https://www.cdc.gov/std/tg2015/default.htm>

### **PHYSICAL ABUSE**

Christian CW. The Evaluation of Suspected Child Physical Abuse. Pediatrics. 2015;135(5).

### **ADDITIONAL RESOURCES**

<https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/resilience/Pages/Child-Abuse-and-Neglect.aspx>

<https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Pages/Child-Abuse-Prevention.aspx>

<https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/resilience/Pages/Sexual-Abuse.aspx>

## **ABUSIVE HEAD TRAUMA**

Narang SK, Fingarson A, Lukefahr J, COUNCIL ON CHILD ABUSE AND NEGLECT. Abusive Head Trauma in Infants and Children. Pediatrics Mar 2020. e20200203; DOI: 10.1542/peds.2020-0203  
<https://pediatrics.aappublications.org/content/early/2020/03/19/peds.2020-0203>

### **COMMON PRESENTATIONS FOR ASSESSMENT** (not an exhaustive list)

#### **PHYSICAL ABUSE**

1. Determining the plausibility of the parent's or caretaker's explanation for any injury (e.g. bruise, wound).
2. Interpreting whether bruises or marks are the result of normal childhood activities. Certain locations of bruises raise concern for abuse/neglect in young children: bruises on vulnerable areas of the body such as on the head, torso, genitalia, and buttocks.
3. Understanding whether significant bruising (such as multiple or extensive bruises) are a result of normal play, a medical condition, or abuse/neglect.
4. Interpreting fractures and whether they are the result of abuse and/or neglect, normal childhood activities, or a medical condition.
5. Evaluating head injuries. Any concerns for a head injury in an infant or young child should be evaluated by a medical provider. This includes allegations that a child was shaken, hit, or fell and sustained head trauma. Head trauma evaluations can include children who are alleged to be victims of shaken baby syndrome (which may also be referred to as abusive head trauma, non-accidental trauma, and other terms).
6. Understanding if a burn is a result of abuse, neglect/lack of supervision, or accidental means.
7. Evaluating statements made to parents, teachers, or other individuals that may represent physical abuse.
8. Assessing children when physical abuse was witnessed.

#### **NEGLECT**

1. Evaluating and interpreting developmental delays in a child.
2. Evaluating and interpreting delays in a child's growth (e.g. failure to thrive).
3. Evaluating allegations of Munchausen by Proxy (this may also be referred to as Pediatric Condition Falsification and Medical Child Abuse).
4. Assisting with the interpretation of behavioral concerns and recommending appropriate referrals.
5. Evaluating untreated or inadequately treated medical conditions which have had a negative impact on the child's overall health or physical development.
6. Assessing children when an investigation of the home environment reveals a lack of basic necessities to ensure a safe and healthy environment for the child.

#### **SEXUAL ABUSE**

1. Evaluating concerns for sexual abuse which includes fondling, penetration, and exposure to sexualized materials (e.g. pornography).
2. Evaluating trauma or bleeding in the genital or rectal area.
3. Diagnosing and interpreting sexually transmitted diseases in prepubertal and post-pubertal children.
4. Assisting with evaluation of children who have sexualized behaviors including those who put foreign objects in the vagina, urethra, or rectal cavity.
5. Interpreting statements made by children to a caregiver, teacher, or other individual regarding possible sexual abuse.
6. Evaluating for pregnancy.

## **CARE NETWORK MEDICAL STANDARDS**

Designated providers may be asked to provide medical-forensic evaluations and/or case reviews of many different types of cases. Training is designed to provide essential skills to equip medical providers to evaluate the majority of cases of alleged child maltreatment. However, training cannot reasonably prepare providers to evaluate highly complex cases, which require input from a Board Certified Child Abuse Pediatrician. These standards of care clarify the types of cases for which training provides appropriate preparation to medical providers.

<b>Provider Type</b>	<b>Level 1 Conditions</b>	<b>Level 2 Conditions -- <i>These types of cases require an in-person evaluation or complete case review by a Board Certified Child Abuse Pediatrician, and/or direct mentoring by a CARE Network Resource Center</i></b>
<b>Physician</b>	<u>Physical Abuse/Neglect</u> <ul style="list-style-type: none"> <li>• Bruising</li> <li>• Single fractures</li> <li>• Minor burns (not requiring admission to the hospital)</li> <li>• Medical/physical/supervisional neglect</li> <li>• Child abuse in the medical setting</li> </ul> <u>Sexual Abuse</u> <ul style="list-style-type: none"> <li>• Non-acute sexual abuse of a child</li> <li>• Acute sexual abuse of a child</li> </ul>	<u>Physical Abuse/Neglect</u> <ul style="list-style-type: none"> <li>• Child death</li> <li>• Intensive Care Unit level hospitalization</li> <li>• Burns requiring hospitalization</li> <li>• Multiple fractures</li> <li>• Intracranial hemorrhage</li> <li>• Intra-abdominal trauma</li> </ul> <u>Sexual Abuse</u> <ul style="list-style-type: none"> <li>• Sexually transmitted infections in children who were previously not consensually sexually active</li> <li>• Positive findings of penetrative trauma on genital exam</li> </ul>
<b>Advance practice provider – Nurse Practitioner Physician Assistant</b>	<u>Physical Abuse/Neglect</u> <ul style="list-style-type: none"> <li>• Bruising</li> <li>• Single fractures</li> <li>• Minor burns (not requiring admission to the hospital)</li> <li>• Medical/physical/supervisional neglect</li> <li>• Child abuse in the medical setting</li> </ul> <u>Sexual Abuse</u> <ul style="list-style-type: none"> <li>• Non-acute sexual abuse of a child</li> <li>• Acute sexual abuse of a child</li> </ul>	<u>Physical Abuse/Neglect</u> <ul style="list-style-type: none"> <li>• Child death</li> <li>• Children requiring hospitalization due to the injuries</li> <li>• Burns requiring hospitalization</li> <li>• Multiple fractures</li> <li>• Intracranial hemorrhage</li> <li>• Intra-abdominal trauma</li> </ul> <u>Sexual Abuse</u> <ul style="list-style-type: none"> <li>• Sexually transmitted infections in children who were previously not consensually sexually active</li> <li>• Positive findings of penetrative trauma on genital exam</li> </ul>
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\* “Direct mentoring” is used to describe the process of a CARE Network Resource Center reviewing the entirety of the case, including the documentation of the CARE Network Provider, and then directly discussing the case with CARE Network Designated Provider by verbal, written, or electronic communication.

**MEDICAL PROTOCOL FOR RESPONDING TO SEXUAL ABUSE**

All children who are suspected victims of child sexual abuse should be offered a timely medical evaluation by a provider skilled in performing such evaluations. The primary purpose of the medical evaluation is to identify, document, diagnose, prevent, and treat medical conditions and/or trauma (resulting from abuse and unrelated to abuse), as well as to assess issues related to patient safety and wellbeing. An additional purpose of the medical evaluation is to determine the appropriateness of trace evidence collection and, if indicated, to ensure that biologic trace materials are properly collected and preserved.

A medically based screening process can guide health providers and community partners in determining whether a child requires an immediate medical examination by an emergency health provider, mental health provider, or social worker. A child who does not require emergency services will be more effectively served by being offered a medical evaluation by a CARE Network provider during regular clinic hours.

**WHEN A CHILD HAS DISCLOSED ABUSE:**

Victims of child sexual abuse present for medical care in many different ways. Some children will tell someone they trust about the abuse. A child does not have to repeat the disclosure to a medical provider to be offered appropriate medical care. A provider must remember that children frequently do not disclose all aspects of the abuse immediately. Some children do not disclose sexual abuse but other credible evidence is obtained or found, such as a witness disclosure or photographs of abuse are found. Providers should use the best and most complete information available in determining the need for emergency medical services.

**TRIAGE:**

While most child victims of sexual abuse/assault do not require emergency medical evaluations, reasons for emergency medical examinations include, but are not limited to:

1. The alleged assault may have resulted in the transfer of trace biological material and occurred within the previous 2 days for prepubertal children and 5 days for pubertal children with a history of penile/vaginal intercourse.

Indications that trace evidence collection may provide forensically valuable information include:

- Debris or body fluid is visible on child's body or clothing, -or-
- The contact included possible body fluid (semen, blood, saliva) or debris transfer,
  - This includes (but is not limited to) a perpetrator licking, biting, or using genitals to touch a child anywhere on their body.
  - Remember that a child may not disclose or have knowledge of all details of an abusive act; therefore, do not use an assumption of "no ejaculation" or "no penetration" as a reason to defer trace evidence collection.

When determining how long after an alleged abusive act trace evidence should be collected, use your local MDT agreed upon interval, which may range from 1-7 days, depending on the age of the child and the nature of contact.

- After 24 hours, the likelihood of obtaining trace evidence from a young child's body is low.
- It is well established that trace evidence collection from anywhere on or in a child is never indicated past 7 days.
- Clothing and bedding from a scene may yield positive results even years after the crime has occurred. Encourage law enforcement investigators to collect evidence from the scene or clothing as soon as possible.

2. The alleged assault may have placed the child at risk for pregnancy and occurred in the previous 5 days.
  - Pregnancy prophylaxis is available and should be offered to females who meet the following criteria:
    - History of menarche or has a Sexual Maturity rating (breast or pubic hair) of 3 or greater
    - Suspected penile-vaginal contact, with or without a history of penetration, condom use, or ejaculation
    - Contact occurred in the previous 5 days
3. The child complains of pain in the genital or anal area -- Current anogenital pain or bleeding may represent a traumatic injury from sexual abuse/assault or other medical condition which requires emergency medical intervention. A history of distant anogenital pain or bleeding, now resolved, typically does not require emergency medical care; but that historical information should be communicated to the medical provider responsible for the scheduled comprehensive medical evaluation.
4. There is evidence or complaint of anogenital bleeding or injury.

Reasons for emergency mental health or social interventions include, but are not limited to:

1. Intervention is needed emergently to assure the safety of the child.
2. The child is experiencing significant behavioral or emotional problems that could make the child a danger to themselves or others.



**MEDICAL HISTORY:**

Child history	Teen history
Interview parent/guardian alone	Interview patient alone
Interview child alone	Discuss confidentiality
Use open-ended questions	High risk behaviors
Identify patient's "body part" language	

**HISTORY FOR ALL SEXUAL ABUSE PATIENTS:**

Type of question	Details				
What?	Date, time, location, use of threats, force, restraint Memory loss, loss of consciousness, drugs, alcohol Contact — oral, vaginal, rectal, ejaculation, condom use Bleeding, pain, any other trauma After the event: bathed, changed clothing, ate, mouthwash, barrier contraceptive device				
Who?	Perpetrator identification, age relationship Current location				
When?	Beginning, last contact, last possible contact				
Where?	Location of any injury What has been done for this episode?				
Review of Systems/Symptoms	<table border="0"> <tr> <td>Genital complaints</td> <td> <ul style="list-style-type: none"> <li>• Vaginal irritation, bleeding, discharge</li> <li>• Dysuria, urinary frequency, enuresis</li> <li>• Rectal pain, bleeding</li> </ul> </td> </tr> <tr> <td>Behavioral problems</td> <td> <ul style="list-style-type: none"> <li>• Recent “acting out”, hyperactivity, withdrawn</li> <li>• Sexually explicit behavior inappropriate for age</li> <li>• Nightmares or recent change in sleeping habits</li> </ul> </td> </tr> </table>	Genital complaints	<ul style="list-style-type: none"> <li>• Vaginal irritation, bleeding, discharge</li> <li>• Dysuria, urinary frequency, enuresis</li> <li>• Rectal pain, bleeding</li> </ul>	Behavioral problems	<ul style="list-style-type: none"> <li>• Recent “acting out”, hyperactivity, withdrawn</li> <li>• Sexually explicit behavior inappropriate for age</li> <li>• Nightmares or recent change in sleeping habits</li> </ul>
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	relationships with during the past 96 hours. Immunization <ul style="list-style-type: none"> <li>• Hepatitis B</li> </ul>
Social History	Family history of sexual abuse Exposure to explicit material Prior reports to police or social services History of violence in home Need for community resources

**SEXUAL ABUSE EXAM:**

*General Physical Exam*

Complete physical exam including inspection of all body parts and thorough skin exam  
Oral exam with attention to lips, tongue, buccal mucosa, frenula, palate, and teeth  
Complete genital and anal examination

*Forensic Evidence Collection if indicated – by state or county approved kit, per instructions on kit and include clothing*

*Photographs*

Patient identification label  
Date of birth, medical record number  
Photograph each injury separately  
Start with a photograph of the region and then do a close-up  
Photograph against a neutral background (the wall is the best place)  
Do not use a flash, use AUTO FOCUS.  
Use MACRO mode (press flower button on back of camera to focus on close objects)  
Set zoom to widest angle setting; move camera closer to the patient for close-up photographs  
Always use the ruler in the close-up shot of the injury  
Always use ruler with color guide (in cart) to show size, detail of injury

**TREATMENT -- designed to help medical providers identify, screen, and treat children at-risk of transmission of infectious agents from blood or bodily fluid from sexual exposures.**

*Sexually transmitted disease testing and post-exposure prophylaxis*

*High risk features:*

- Intoxicated, or altered patients
- Type of sexual contact
- Mucosal surface(s) involved
- Pubertal status
- Vaccination status for hepatitis B
- Assailant risk factors --
  - Is the assailant known to be infected with HIV, hepatitis B, or hepatitis C?
  - Does the assailant agree to be tested for HIV, hepatitis B, or hepatitis C?
- Any injuries that could increase the risk exposure

For a complete guideline, see:

Children’s Hospital Clinical Care Pathway -- COMMUNITY (NON-OCCUPATIONAL) BLOOD OR BODILY FLUID EXPOSURE

## **MEDICAL PROTOCOL FOR RESPONDING TO PHYSICAL ABUSE AND NEGLECT**

### **TRIAGE**

If a situation that medical professionals would consider a true emergency is reported to the child welfare hotline, the response needs to be an immediate referral to medical care. Or, if you are a child welfare professional and you encounter a situation or emergency of one of these types while working with a family on an assessment or case, you need to contact medical professionals immediately for consultation and refer the family immediately to medical care:

- any infant or child old for whom there is a history or suspicion of being shaken, of blunt impact, or of other inflicted head trauma;
- any infant with bruises (anywhere, but especially head, face, neck, or abdomen), fractures, or burns;
- any child with suspected, inflicted, or suspicious trauma to the abdomen;
- any child with genital burns, stocking or glove distribution of burns, branding, or extensive burns/

### **MEDICAL HISTORY**

History is extremely important here; *every* medical diagnosis starts with history. The different types of history taken by providers are standard of care, and they are all important in confirming or ruling out a child abuse diagnosis. The medical diagnosis of physical abuse is based on the presence of a discrepant history; that is, the history offered by the caregiver is not consistent with the clinical findings. The discrepancy may exist because the history is absent, partial, changing over time, or simply illogical or improbable. A neglect history requires weighing the needs of the child versus ability of caregivers to meet the child’s need.

### **HISTORY FOR ALL PHYSICAL ABUSE AND NEGLECT PATIENTS:**

Type of question	Details
What?	What is the developmental age of the child? Does child have underlying medical conditions? What are child’s basic health and wellbeing needs? What events preceded the injury? What is the severity of the injury? What is the apparent age of the injury? Is the injury unexplained by history? Is there an absent, changing, or evolving history?
Who?	Who is primary caretaker of child? Who else helps take care of child? Who was with child at the time of injury? Does caregiver have unrealistic expectations for child?

	<p>Does caregiver have prior history of abuse of caregiver as child?</p> <p>What was the caretaker’s response to the injury?</p> <p>What is the affect of the caregiver?</p> <p>If the child is verbal, what does he or she say happened?</p> <p>Are there any adult or child witnesses?</p>				
When?	<p>Is there a delay in seeking medical care?</p> <p>When did the child last feed and behave normally?</p> <p>Is there a recent crisis or stress in child’s environment?</p> <p>Is there chronic social or physical isolation of child or family?</p> <p>Is there a triggering event causing loss of control in caregiver (the 3 Ts: tears, toileting, tantrums/temperament)?</p> <p>Is there a pattern of increasing severity or escalation of events over time?</p>				
Where?	<p>What is the location of the injury?</p> <p>What has been done for this episode?</p> <p>What does scene or home environment look like?</p>				
12 suspicious stories for physical abuse – These are unusual histories that should make professionals pause and consider the accuracy of what is provided. They rarely explain serious bodily injury or death in a child.	<p>Child fell from low height.</p> <p>Child fell onto furniture, floor, object.</p> <p>Child was unexpectedly found dead.</p> <p>Child choked and was shaken to dislodge object.</p> <p>Child turned blue and was shaken to revive.</p> <p>Child experienced sudden seizure activity or stopped breathing.</p> <p>Resuscitation efforts caused injuries.</p> <p>Traumatic event occurred a day or more prior.</p> <p>Someone tripped or slipped while carrying the child.</p> <p>Child was left alone for short time.</p> <p>Child fell down stairs.</p> <p>Sibling did it.</p>				
Review of Systems/Symptoms	<table> <tr> <td>General complaints</td> <td> <ul style="list-style-type: none"> <li>• Weight</li> <li>• Appetite</li> <li>• Sleep regulation</li> <li>• Energy level</li> </ul> </td> </tr> <tr> <td>Behavioral problems</td> <td> <ul style="list-style-type: none"> <li>• Peer interactions</li> <li>• School performance and attendance</li> <li>• Mood</li> <li>• Recent “acting out”, hyperactivity, withdrawn</li> </ul> </td> </tr> </table>	General complaints	<ul style="list-style-type: none"> <li>• Weight</li> <li>• Appetite</li> <li>• Sleep regulation</li> <li>• Energy level</li> </ul>	Behavioral problems	<ul style="list-style-type: none"> <li>• Peer interactions</li> <li>• School performance and attendance</li> <li>• Mood</li> <li>• Recent “acting out”, hyperactivity, withdrawn</li> </ul>
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Past Medical History	<p>Birth history</p> <ul style="list-style-type: none"> <li>Problems during mother's pregnancy</li> <li>Prematurity</li> </ul> <p>Other history</p> <ul style="list-style-type: none"> <li>Chronic conditions</li> <li>Medications</li> <li>Access to care</li> </ul> <p>Immunization</p> <ul style="list-style-type: none"> <li>Up to date?</li> </ul>
Social History	<p>Who lives in the home?          What is family employment and financial status?          Is there domestic violence or substance abuse in the home?          Prior family history of physical or sexual abuse?          Any prior involvement with social services or law enforcement?          What are the family support?          What are the family strengths?</p>

**PHYSICAL EXAM:**

*General Physical Exam*

Complete physical exam including inspection of all body parts and thorough skin, oral and ear exam  
 Complete genital and anal examination

*Forensic Evidence Collection if indicated – by state or county approved kit, per instructions on kit and include clothing*

*Photographs*

Patient identification label  
 Date of birth, medical record number  
 Photograph each injury separately  
 Start with a photograph of the region and then do a close-up  
 Photograph against a neutral background (the wall is the best place)  
 Do not use a flash, use AUTO FOCUS.  
 Use MACRO mode (press flower button on back of camera to focus on close objects)  
 Set zoom to widest angle setting; move camera closer to the patient for close-up photographs  
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**TREATMENT -- designed to help medical providers identify, screen, and treat children at-risk of physical abuse and neglect.**

For a complete guideline, see: Physical Abuse Screening and Treatment Guideline